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A Graceful Exit: Redefining Terminal to Expand the Availability of Physician-Facilitated Suicide

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ABSTRACT

For almost ten years, Oregon stood alone as the state that permits terminally ill persons to choose the time and manner of their deaths. Finally, in 2009, Oregon received company when the state of Washington's physician facilitated suicide statute officially went into effect in March of that year. Supporters of the statutes hailed the enactments as a victory for persons seeking to die with dignity. Persons from groups like Compassion & Choices vowed to seek similar legislation in the remaining states. Representatives from the Washington State Medical Association, hospice groups and hospitals argued that the mandates of the statutes place physicians in an unnatural position. In particular, the Medical Association's spokesman stated that physicians take an oath to save lives, not to end them. The number of persons in the country who support physician-facilitated suicide has continued to grow. At the end of 2009, the Montana Supreme Court indicated that physician-facilitated suicide is not against the state's public policy. In this article, instead of joining the debate about the legalization of physician assisted suicide, I analyzed the law in Oregon and Washington. That analysis shows that the legislatures in those states attempted to regulate the process in order to protect the interests of terminally ill patients and physicians.

The statutory mandates are a step in the right direction, but there is still work that needs to be done. The statutes should be amended to close certain loop holes and to ensure that the physician-facilitated suicide option is available to all of the patients who need it. Persons suffering from physical conditions that will lead to death within six months should not be the only persons permitted to exit gracefully. As long as the safeguards included in the statutes are followed, there is no good reason to prohibit persons suffering from irreversible and incurable physical diseases that lead to death from being classified as terminal. In addition, persons diagnosed with irreversible and incurable brain disorders, like severe dementia or Alzheimer's disease should be able to avail themselves of the rights provided by the physician-facilitated suicide statutes. Alzheimer's patients suffer a slow, painful death. They revert to childhood and forget everyone around them. The mental death they suffer is similar to the physical death experienced by terminally physically ill patients. During the early stages of the disease, most Alzheimer sufferers are still competent enough to request physician-facilitated suicide. Therefore, the statutes should be amended or interpreted to give them that option.

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“Life is pleasant. Death is peaceful. It’s the transition that’s troublesome.”¹

INTRODUCTION

My English is good; my Spanish is okay; and my French is nonexistent. I was panicking. I was in a foreign country and I could not speak the language. My hike through the woods had turned into a disaster after some unknown critter bit me. I went to the Swiss doctor prepared to use sign language to get her to understand that I needed to know that it was not a tick bite. The doctor smiled and said hello. Thankfully, she spoke English. After she examined the bite, she assured me that it was just an ordinary insect bite. While she wrote out a prescription for antibacterial crème, she asked me the reason for my stay in Switzerland. I told her about my research on physician-assisted suicide. In response, she told me that she had written a prescription for lethal medicine earlier that week, so a man could end his life. The doctor’s eyes became misty as she described the eighty-two year old man who had suffered from terminal stomach cancer. Since her only involvement was writing the prescription, the doctor stated that she did not feel like she had assisted in the suicide. She viewed herself as more of a facilitator. I agreed with her assessment. Thus, in this article, I will not use the term physician-assisted suicide or physician-aided death. Instead, I will refer to the process as physician-facilitated suicide.

While conducting research for this article, I came across a quote from an unknown source that states, “Pain is inevitable; suffering is optional.”² With the advances in medical technology and the creation of new drugs, health care providers have taken great steps to ensure that patients can manage their pain effectively. Thus, the average person does not have to suffer the pain

¹ Isaac Asimov

² Source unknown

brought on my injury, disease, and/or age. Nonetheless, for many patients, there comes a time when pain wins, and the suffering becomes inevitable. For those patients, the only alternative may be the ingestion of enough medication to permanently end the pain. The fact that most suicide attempts are unsuccessful³ indicates that people need help determining the correct dosage of medicine to consume in order to commit suicide. It is logical for that assistance to come from physicians.

After Carnegie-Mellon computer science Professor Randy Pausch was diagnosed with terminal pancreatic cancer, he gave an inspirational last lecture to his class. Prior to his death, Professor Pausch wrote a book based on his lecture.⁴ The book serves as a legacy for his wife and three small children. Professor Pausch tolerated the pain, so he could spend his last days with his family. Thousands of terminally ill patients do not want to emulate Professor Pausch. Those persons search for a way out of an existence filled with constant pain and no hope. One way for these persons to make a graceful exit is physician-facilitated suicide. Currently, the option of utilizing physician-facilitated suicide is only available in three states---Montana, Oregon, and Washington. Even in those states, some patients are denied the opportunity to exit gracefully. I begin with a brief description of two such patients.

Mary and Anna

Mary celebrated her 40th birthday by hand gliding off a cliff. A few months later, doctors diagnosed Mary with stomach cancer. Mary's cancer was deadly, but slow acting. It was like a hurricane that hits land and stays over a small area for hours. The damage is overwhelming, but not quick. The doctors treated Mary's cancer with chemotherapy, radiation and surgery, but, the cancer continued to ravage her body. Finally, Mary refused any further treatment and went home. Doctors told Mary that she had about a year to live. Mary was given comfort care, but she was never comfortable. She was in constant pain. The pain medication dulled the pain, but

³ Andrew J. McClurg, *The Public Health Case For the Safe Storage of Firearms: Adolescent Suicides Add One More "Smoking Gun"*, 51 HASTING L.J. 953, 963-964 (July 2000).

⁴ Randy Pausch & Jeffery Zaslow, *THE LAST LECTURE*, (New York: Hyperion, 2008).

never totally eliminated it. Mary signed a do not resuscitate (DNR) form, but her heart refused to stop beating. During the progression of the disease, Mary's pain intensified. Mary slowly lost her sense of humor and her voice. She possessed the physical capacity to speak, but the pain made it too hard for her to form a thought and to articulate it. After about seven months, Mary's body finally gave out, and she was pronounced dead.

Anna was married to Steve, the love of her life, for almost forty-seven years until he died. About five years after Steve's death, doctors diagnosed Anna with Alzheimer's disease. After Anna's children could no longer care for her, they placed her in a long-term care facility. Anna had good days when her memory was clear. On those days, she engaged in pleasant conversations. On her bad days, Anna screamed and cried for no apparent reason. Anna got thinner and became terrified of everything and everybody. Eventually, Anna's bad days outnumbered her good days. The facility personnel restrained Anna when she started spitting, scratching and fighting the members of the staff. The disease stole Anna's memories and her personality. It robbed Anna's children, Alice and Clinton, of their mother. They watched in horror as Anna died in stages. Anna remained in that condition for almost twenty years before her body finally died. By that time, Anna's children had already gone through all the stages of grief.⁵

Doctors provided Mary and Anna with the best available medical care. Yet, they still suffered horribly. Under the current legal regime, neither Mary nor Anna would be entitled to the option of physician-facilitated suicide. Only three states permit physicians to provide the knowledge and or means by which a patient can commit suicide.⁶ Two of those states, Oregon

⁵ The common stages of grief are denial, anger, bargaining, depression and acceptance. Andrew J. McClurg, *Dead Sorrow: A Story About Loss And A New Theory of Wrongful Death Damages*, 85 B.U.L. REV. 1, 15 (Feb. 2005).

⁶ Those states are Montana, Oregon and Washington.

and Washington, authorize physician-facilitated suicide by statute.⁷ The statutory provisions of both states are similar. Although Mary suffered from an incurable, irreversible physical condition, she would not be eligible to take advantage of the statutory provisions of either Oregon or Washington because she was not technically terminally ill. Mary did not qualify for the “terminally ill” status because doctors predicted that she had more than six months to live. Anna would not have been a candidate for physician-facilitated suicide because she was physically healthy. It was her mind that slowly died. In a state that permits physician-facilitated suicide, should these women be given the opportunity to take advantage of that option? Is it ethical to refuse these women the chance to make a graceful exit?

Exiting Gracefully

In the United States, the law recognizes that a person has the right to refuse medical treatment.⁸ That right exists even if the refusal of medical treatment will lead to death.⁹ Recently, the mother of one of my friends needed emergency surgery to remove her stomach after a ruptured tumor caused severe internal bleeding. The eighty-one year old woman calmly told her doctors that she was going to leave the world with all of her body parts intact. Consequently, the doctors made her comfortable until she drew her last breath. At the patient’s request the doctors watched passively as she died. My friend felt a sense of peace as she watched her mother die on her own terms. Prior to her passing, my friend’s mother suffered tremendously. At times, she complained of being tired of suffering. However, the only option available to her doctors was to increase her pain medication. If her doctors took a more active

⁷ Those statutes will be discussed in Part I.

⁸ *Cruzan v. Dir., Mo. Dept. of Health*, 497 U.S. 261 (1990).

⁹ Elizabeth Helene Adamson, *The Right to Refuse Life Sustaining Medical Treatment and the Noncompetent Nonterminally Ill Patient: An Analysis of Abridgment and Anarchy*, 17 *Pepperdine L. Rev.* 461, 466 (Jan. 1990).

role in my friend's mother's death, they might have been prosecuted for murder because euthanasia is not legal in any jurisdictions in the United States.

Physician-facilitated suicide occurs when a licensed physician supplies lethal medication to a patient, so the patient can use the medication to end his or her life.¹⁰ Dr. Jack Kevorkian was a primary figure in the aid-in-dying movement. According to Dr. Kevorkian, dying and suffering patients deserved the right to die with dignity. In order to achieve that goal, Kevorkian advocated that physicians be allowed to actively assist patients who wanted help to die.¹¹ Even legislators in the jurisdictions that have legalized physician-facilitated suicide have refused to go as far as Kevorkian recommended.¹² Currently, in Oregon and Washington, physicians can provide the means for the patients to end their lives, but cannot administer the lethal medication.¹³

The purpose of this article is not to debate whether or not physician-facilitated suicide should be legal. My objective is to focus on how the states that have legalized the practice can ensure that it is properly regulated and available to those persons who want it.¹⁴ The article is divided into three parts. In Part I, I describe the applicable laws in Washington, Oregon, and Montana. In Part II, I examine the manner in which the Oregon and Washington statutes address some of the main concerns raised by opponents of physician-facilitated suicide. I also note some of the concerns that the statutes do not address. In the final part, I explore ways in which the application of the statutes may be expanded to make physician-facilitated suicide available to

¹⁰ Kathy L. Cerminara & Alina Perez, *Therapeutic Death: A Look At Oregon's Law*, 6 PSYCHOL. PUB. PO'LY & L., 503, 506 (June 2000).

¹¹ Cyril H. Wecht, *The Right to Die and Physician-Assisted Suicide: Medical, Legal and Ethical Aspects (Part II)*, 17 MED. & L. 581, 589-591 (1998).

¹² Cynid Bollman, *A Dignified Death? Don't Forget About the Physically Disabled and Those Not Terminally Ill: An Analysis of Physician-Assisted Suicide Laws*, 34 S. ILL. U. L. J. 395, 395 (Winter 2010).

¹³ Glen R. McMurtry, *An Unconstitutional Death: The Oregon Death With Dignity Act's Prohibition Against Self-Administered Lethal Injection*, 32 U. Dayton L. rev. 441, 443-444 (Spring 2007).

¹⁴ This article is a part of a bigger writing project that I will work on as a visiting researcher at the Brocher Foundation in Geneva, Switzerland.

people like Mary and Anna, so they can exit gracefully. I make two primary recommendations. After receiving the lethal medication from their physicians, in some cases, patients should be able to request help to take the medication from non-medical personnel, including friends and family.¹⁵ Moreover, legislatures and courts should recognize that the traditional definition of “terminal” is not adequate to meet the needs of all persons desiring to exit gracefully.

I. Legalizing the Use of Physician-Facilitated Suicide

The law recognizes that people have the right to refuse medical treatment.¹⁶ Since a majority of states no longer criminalize suicide, people in most states have the right to take their own lives.¹⁷ However, the right to physician-facilitated suicide is not a fundamental right.¹⁸ Therefore, states have the authority to make the procedure illegal.¹⁹ The legislators in the majority of states have either enacted legislation making physician-assisted suicide illegal or have not addressed the issue.²⁰ Three states have made it possible for suffering people to receive aid to die.²¹ In this section, I will provide an overview of the law in those states. Then, in the next section, I will analyze the statutory provisions of the Oregon and Washington physician-facilitated suicide statutes.

A. Through Judicial Interpretation

¹⁵ This practice is permissible in Switzerland because the person assisting does not have to be a physician. Thus, most of the facilitated suicides are performed by volunteers working for non-governmental organizations. Rohith Srinivas, *Exploring the Potential for American Death Tourism*, 13 MICH. ST. U.J. MED. & L. 91, 106 (Winter 2000).

¹⁶ *In re Quinlan*, 355 A.2d 647 (N.J. 1976); Elizabeth Helene Adamson, *The Right to Refuse Life Sustaining Medical Treatment and the Noncompetent Nonterminally Ill Patient: An Analysis of Abridgement and Anarchy*, 17 PEPPERDINE L. REV. 461, 467-472 (Jan. 1990).

¹⁷ Rebecca C. Morgan, Thomas C. Marks, Jr. & Barbara Harty-Golder, *The Issue of Personal Choice: The Competent Incurable Patient and the Right to Commit Suicide?*, 57 MO. L. REV. 1, 10-11 (Winter 1992).

¹⁸ *Washington v. Glucksberg*, 521 U.S. 702 (1997) (holding that the right to receive help to commit suicide is not a fundamental liberty interest that is protected by the federal due process clause.); The right to refuse medical treatment does not lead to the right to assisted suicide. Thus, a state can make the assisted suicide illegal without violating the Equal Protection Clause. *Vacco v. Quill*, 521 U.S. 793 (1997).

¹⁹ *Krischer v. McIver, M.D., et al.*, 697 So. 2d 97 (Fla. 1997).

²⁰ See e.g., Alaska Stat. 11.41.120(a)(2) (“A person commits the crime of manslaughter if the person intentionally aids another person to commit suicide.”) cited in *Sampson v. State*, 31 P.3d 88 (Alaska 2001).

²¹ Shelly A. Cassity, *To Die or Not to Die: The History and Future of Assisted Suicide Laws in the U.S.*, 2009 Utah L. Rev. 515, 522 (2009).

Most courts have deferred to the legislatures to resolve disputes involving physician-facilitated suicide. Nonetheless, if no dispositive statute exists, courts evaluate the legal issues surrounding physician-facilitated suicide on a case by case basis. For instance, in *Baxter v. State*, the Montana Supreme Court ruled that physician-assisted suicide²² is not against the public policy of the state. Therefore, the Court concluded that doctors who lend aid to terminally ill patients should not be treated like criminals.²³ Retired truck driver Robert Baxter suffered from lymphocytic leukemia. Even though doctors treated Baxter with multiple rounds of chemotherapy, they did not expect him to survive the cancer.²⁴ The combination of the cancer and chemotherapy caused Baxter to experience several debilitating symptoms and to endure constant pain. Since doctors informed Baxter that his condition would get progressively worse, he sought help from his physician to end his life. Specifically, Baxter wanted his doctor to give him a lethal dose of prescription medication that he could take when he was ready to die.²⁵

At the time, Montana prosecutors applied the state's homicide statutes to doctors who assisted in suicide. Consequently, Baxter filed a lawsuit claiming that the application of the homicide statutes to cases involving physician-assisted suicide was unconstitutional. Four physicians and a nonprofit organization called Compassion & Choices joined Baxter in the suit.²⁶ The District Court ruled in Baxter's favor. The Court reasoned that the privacy and dignity clauses of the Montana Constitution gave a person the right to die with dignity. Part of that right was the right to receive help from a physician.²⁷ To protect the patients' right to physician-

²² In this section, I am using the term physician-assisted suicide to remain consistent with the language used by the court.

²³ *Baxter v. State*, 224 P.3d 1211 (Montana 2009).

²⁴ *Id.* at 1214.

²⁵ *Id.*

²⁶ *Id.*

²⁷ *Id.*

assisted suicide, the Court ordered the State to refrain from prosecuting doctors who helped terminally ill patients to die with dignity.²⁸

The State appealed the case to the Montana Supreme Court (Supreme Court). The Supreme Court decided that it was not necessary to address the constitutional issue. In order to resolve the case, the Supreme Court had to decide whether it was against public policy to permit physicians who assisted in suicides to use the consent defense to avoid prosecution for homicide. The Supreme Court held that physician-assisted suicide was not contrary to the public policy of the state because it did not violate any state laws.²⁹ Moreover, the Supreme Court relied upon common law and statutory provisions to justify its decision. First, the Court determine that physician-assisted suicide did not fall into the common law's "against public policy exception to the consent defense" because it did not constitute "violent, peace breaching conduct" that endangered the lives of others.³⁰

Second, the Supreme Court opined that the actions of a physician who helped a person commit suicide did not violate the state's homicide statute. Under the statute, in order to be guilty of homicide, a person had to "purposely or knowingly" cause another person's death. The physician's role was limited to providing the terminally ill patient with the means to end his or her life. Hence, since the physician did not force the patient to take the medication, the person's death was not a direct result of the physician's actions. In Montana, it is not a crime to commit suicide. Therefore, by providing the lethal medication, the physician was not aiding in the commission of a crime.³¹

²⁸ *Baxter*, 224 P.3d at 1214.

²⁹ *Id.*

³⁰ *Baxter*, 224 P3d at 1216.

³¹ *Id.* at 1217.

Lastly, the Supreme Court stated that physician-assisted suicide did not violate the provisions of the Terminally Ill Act.³² That Act gave doctors who complied with patients' requests to withhold or withdraw life-sustaining treatment immunity from criminal and civil liability. By immunizing the physicians' conduct in those types of cases, the legislators indicated that it is in the public's interest to permit patients to refuse medical treatment even if that refusal will result in death. Furthermore, nothing in the Act indicates that physicians cannot go a step further and provide patients with the means to end their lives.³³ A physician who withdraws medical care is directly involved in the death of the patient. To the contrary, a physician who supplies the patient with the means to end his or her life is only indirectly involved in the patient's death. As result, the Court concluded that if direct physician assistance is not against public policy neither is indirect physician assistance.³⁴

The legislature's intent in enacting the Terminally Ill Act was to ensure that a terminally ill patient was given the opportunity to choose the time and manner of his or her death. Permitting physician assisted suicide will help to carry out that intent. Thus, the Court held that it was not against public policy for a physician who assisted in a suicide to use consent as a defense to a homicide charge.³⁵ As a consequence of the *Baxter* decision, terminally ill patients in Montana may receive assistance to die from willing physicians. However, nothing in the decision prevents the legislature from banning the practice in the state. Consequently, Montana residents are forced to live with uncertainty when it comes to the availability of physician-facilitated suicide. Persons living in states that statutorily permit the practice are in a better position to exit gracefully.

³² *Id.*

³³ *Baxter*, 224 P.3d at 1218.

³⁴ *Id.*

³⁵ *Id.* at 1219.

B. Through Legislative Action

In late 1997, Oregon was the first state to make physician-facilitated suicide legal by statute.³⁶ The Oregon Death With Dignity Act (DWDA) permits terminally ill persons to obtain prescription medication from their doctors in order to end their lives. Washington enacted its own DWDA in the fall of 2008.³⁷ The provisions of the statutes are similar. In both states, the law permits a *capable terminally ill adult*³⁸ resident to request a prescription for lethal medication from a physician.³⁹ After acquiring the medication, the person can ingest it if and when he or she so desires. The statutes focus upon the person's capacity to request the medication and the person's adherence to the procedures necessary to request the medicine.

Necessary Characteristics of the Patient

Eligibility to take advantage of the availability of physician-facilitated suicide depends on the patient meeting certain specified criteria. The right to utilize physician-facilitated suicide is limited to residents of the states. In order to be considered a resident, the patient must show a connection to the state. The acceptable forms of proof of residency include the following: (1) a state driver's license; (2) a state voter's registration card; (3) ownership or rental of real estate in the state; or (4) a recent state income tax return.⁴⁰ A crucial requirement of the statutes is that the patient seeking the lethal medication be terminally ill. A terminally ill person is defined as a person who has been diagnosed with a disease that is incurable and irreversible.⁴¹ To be labeled as terminally ill, doctors must expect the person to die within six months of the diagnosis.⁴²

³⁶ Katherine A. Chamberlain, *Looking For A "Good Death": The Elderly Terminally Ill's Right to Die By Physician-Assisted Suicide*, 17 Elder L.J. 61, 85 (2009).

³⁷ Kathryn L. Tucker, *The Campaign to Deny Terminally Ill Patients Information and Choices at the End of Life*, 30 J. LEGAL MED. 495, 502 (Oct.-Dec., 2009).

³⁸ O.R.S.127.800 § 101(1) (West 2010); R.C.W. § 70.245.010(1) (West. 2010)

³⁹ O.R.S.127.825 § 2.01 (West 2010); R.C.W. § 70.245.020 (West 2010).

⁴⁰ O.R.S.127.860 § 3.10 (West 2010); R.C.W. § 70.245.130 (West 2010).

⁴¹ O.R.S.127.825 § 1.01(12) (West 2010); R.C.W. § 70.245.010(13) (West 2010).

⁴² *Id.*

In order to be considered capable under the statutes, the patient must be able to make and communicate health care decisions to the appropriate medical personnel.⁴³ Prior to requesting the medication, the patient does not have to undergo counseling. However, a patient who is deemed to be suffering from a psychiatric or psychological disorder or depression causing impaired judgment must go through counseling to be considered competent to receive the lethal medication.⁴⁴ The requirement of mental competency does not apply to the revocation of the request to receive the lethal medication.⁴⁵ As a result, a mentally incompetent patient has the right to change his or her mind and withdraw his or her request for the medication.

After the patient meets the initial statutory capacity mandates, the patient's decision to request the lethal medication must be informed,⁴⁶ and the request must be executed in conformance with the statutory requirements. The patient cannot make an informed decision unless the physician makes sure that the patient understands the following: the medical diagnosis and prognosis; the potential risks and the probable results of taking the medication⁴⁷ and the other available options including comfort care, hospice care and pain control.⁴⁸ This informed consent is similar to the consent a patient has to give before a physician can perform a medical

⁴³ O.R.S.127.800 § 101(3) (West 2010)(“‘Capable’ means that in the opinion of a court or in the opinion of the patient’s attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient’s manner of communicating if those persons are available.”); The Washington statute uses the term ‘competent’ instead of ‘capable’. R.C.W. § 70.245.010(3) (West. 2010). (“‘Competent’ means that, in the opinion of a court or in the opinion of the patient’s attending physician or consulting physician, psychiatrist, or psychologist, a patient has the ability to make and communicate an informed decision to health care providers, including communication through persons familiar with the patient’s manner of communicating if those persons are available.”).

⁴⁴ O.R.S.127.825 § 3.03(West 2010); R.C.W. § 70.245.060 (West 2010).

⁴⁵ O.R.S.127.825 § 3.07(West 2010); R.C.W. § 70.245.100 (West 2010).

⁴⁶ O.R.S.127.830 § 3.04 (West 2010); R.C.W. § 70.245.070 (West 2010).

⁴⁷ Some patients have survived after taking the lethal drugs for days or months. Other patients have regurgitated the medication.

⁴⁸ O.R.S.127.825 § 1.01(7)(a)-(e)(West 2010); R.C.W. § 70.245.010(7)(a)-(e) (West 2010).

procedure on the patient.⁴⁹ The purpose is to ensure that the patient has all of the relevant facts before making the decision to request the lethal medication.⁵⁰

The Mandated Procedures

Patients deemed eligible to make the request must follow the procedure set forth in the statutes. Traditionally, when the law sets forth requirements for a person to make a life-changing decision, the execution process is rigid. For instance, a person making a will must have it signed, witnessed and/or acknowledged.⁵¹ The Oregon and Washington statutes require the patient seeking life-ending medication to follow a set procedure. In fact the mandated process is similar to the will execution process. The patient must sign and date the written request for the medication. In the patient's presence, at least two persons must attest that "to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request."⁵² The law restricts the pool of persons who can serve as witnesses to protect the interests of the patient. Thus, one of the witnesses must be disinterested.⁵³ Further, the doctor caring for the patient is not permitted to act as a witness to the request.⁵⁴ Nevertheless, when the patient is a resident of a long-term care facility, one of the witnesses must be a person designated

⁴⁹ Jennifer Y. Seo, *Raising the Standard of Abortion Informed Consent: Lessons to Be Learned From the Ethical and Legal Requirements for Consent to Medical Experimentation*, 21 Colum. J. Gender & L. 357, 357 (2011) (stating "all states required informed consent before medical procedures either by statute or case law").

⁵⁰ Nadia N. Sawicki, *The Abortion Informed Consent Debate: More Light, Less Heat*, 21 Cornell J.L. & Pub. Pol'y, 13, 13 (Fall 2011).

⁵¹ Joseph Karl Grant, *Shattering and Moving Beyond the Gutenberg Paradigm: The Dawn of the Electronic Will*, 42 U. MICH. J.L. REFORM 105, 118 (Fall 2008).

⁵² O.R.S.127.810 § 2.02(1) (West 2010); R.C.W. § 70.245.030(1) (West 2010).

⁵³ In order to be considered disinterested, the person must not be: "(a) A relative of the patient by blood, marriage or adoption; (b) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or (c) An owner, operator or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident." O.R.S.127.810 § 2.02(2)(a)-(c) (West 2010); R.C.W. § 70.245.030(2)(a)-(c) (West 2010).

⁵⁴ O.R.S.127.810 § 2.02(3) (West 2010); R.C.W. § 70.245.030(3) (West 2010).

by the facility.⁵⁵ After the request is made, another physician must examine the patient's medical records to confirm the diagnosis.⁵⁶

Oregon and Washington have attempted to regulate the use of physician-facilitated suicide in a manner that protects the rights of patients and the interests of physicians. Patients are given the opportunity to choose to exit gracefully. The statutory requirements are in place to ensure that the patients are voluntarily making the choice to obtain the lethal medication. In addition, the patient can change his or her mind at any time. The rights of the patient are further protected by the existence of a waiting period⁵⁷ and reporting requirements.⁵⁸ The statutes protect physicians from civil and criminal liability.⁵⁹ By enacting the statutes, the legislatures attempted to address several key concerns raised by the opponents of legalized physician-facilitated suicide.

II. Regulating the Use of Physician-facilitated Suicide

A. Answered Questions

Persons who think that physician-facilitated suicide should not be legal have expressed concerns about the safety of specific segments of the population. In particular, they are afraid that patients who are part of vulnerable populations will be disadvantaged by the existence of legal physician-facilitated suicide.⁶⁰ This fear stems from the philosophy put forth by some advocates of eugenics, a movement devoted to improving the human species by controlling

⁵⁵ O.R.S.127.810 § 2.02(4) (West 2010); R.C.W. § 70.245.030(4) (West 2010).

⁵⁶ O.R.S.127.820 § 3.02 (West 2010); R.C.W. § 70.245.050 (West 2010).

⁵⁷ O.R.S.127.850 § 3.08 (West 2010); R.C.W. § 70.245.110 (West 2010).

⁵⁸ O.R.S.127.865 § 3.11(West 2010); R.C.W. § 70.245.150 (West 2010).

⁵⁹ O.R.S.127.885 § 4.01 (West 2010); R.C.W. § 70.245.190 (West 2010).

⁶⁰ M. Cathleen Kaveny, *Managed Care, Assisted Suicide, and Vulnerable Populations*, 73 NOTRE DAME L. REV. 1275, 1304-1307 (May-July, 1998).

heredity.⁶¹ In addition, opponents of physician-facilitated suicide are worried about physicians who may have a Kevorkian complex that lead them to think that all of their terminally ill patients are better off committing suicide. Based upon their biases and prejudices, physicians may decide that some lives are more worthy or better lived than others. That concern leads opponents to fear that, instead of being considered a last resort option, doctors may see physician-facilitated suicide as the first treatment option for some terminally ill patients.

The Elderly and Disabled

Persons opposing the legalization of physician-facilitated suicide have argued that, in order to reduce end-of-life costs, doctors may pressure the elderly and the disabled to request the lethal medication.⁶² Opponents have also raised the fear that the elderly and the disabled will be targeted as candidates for physician-facilitated suicide. They contend that doctors may aggressively encourage terminally ill elderly or disabled patients to consider physician-facilitated suicide. Given the lack of quality of life, some doctors may assume that those patients would want to request the lethal medicine. In his book, *Forced Exit: Euthanasia, Assisted Suicide and the New Duty to Die*⁶³ bioethicist Wesley J. Smith contends that the elderly and the disabled are often made to feel like they have a duty to die so they will not be a burden on society and their families.⁶⁴ In order to protect persons in those populations, the statutes explicitly state that a patient's eligibility for physician-facilitated suicide cannot be based exclusively on his or her age or disability.⁶⁵ According to the statutes, those characteristics alone should not result in the

⁶¹ Shoshana K. Kehoe, *Giving the Disabled and Terminally Ill a Voice: Mandating Mediation For All Physician-Assisted Suicide, Withdrawal of Life Support, or Life-Sustaining Treatment Requests*, 20 HAMLINE J. PUB. L. & POL'Y 373, 378 (Spring 1999).

⁶² Anthony J. Dangelantonio, *Physician-Assisted Suicide: The Legal and Practical Contours*, 4 RISK: ISSUES HEALTH & SAFETY 55, 60-61 (Winter 1993).

⁶³ Wesley J. Smith, *Forced Exit: Euthanasia, Assisted Suicide and the New Duty to Die* (New York: Encounter Books, 2003).

⁶⁴ *Id.*

⁶⁵ O.R.S.127.805 § 2.01(2) (West 2010); R.C.W. § 70.245.020(2) (West 2010).

presumption that the patient would want physician aid in dying. This clarification and other safeguards in the statute reduce the chance that elderly and disabled patients will be sacrificed to save medical costs. It is unclear if the language in this statute is sufficient to address the concerns put forth by opponents of physician-facilitated suicide. In order for the statutory preclusion to mean any thing, doctors must be better educated about the needs of elderly and disabled patients and must be taught that those lives have value.

Suicidal Persons

Some persons feel that citizens might perceive legalized physician-facilitated suicide as the state giving its stamp of approval to suicide. They opine that, once the stigma is removed from suicide, the practice might become wide-spread.⁶⁶ They are afraid that the availability of physician-facilitated suicide may encourage terminally ill persons who are depressed to request the lethal medication instead of “fighting” the disease.⁶⁷ This is a legitimate concern because the statutes do not require all patients to undergo counseling before they choose physician-assisted suicide. The fear is that terminally ill persons who are clinically depressed or mentally ill may seek the lethal medication.⁶⁸ Currently, the law takes steps to prevent suicidal persons from taking their own lives. For instance, prisoners are placed on “suicide watch” if the guards think that they are a danger to themselves.⁶⁹ Ironically, prison guards take steps to prevent death row inmates from committing suicide.⁷⁰ Authorities may also place persons who are suspected of

⁶⁶ Laura Trenaman-Molin, *Physician-Assisted Suicide: Should Texas Be Different*, 33 Hous. L. Rev. 1475, 1488-1489 (1997)

⁶⁷ Eric Chevlen, *The Limits of Prognostication*, 35 DUQ. L. REV. 337, 346-349 (Fall, 1996).

⁶⁸ James Bopp, Jr. & Richard E. Coleson, *The Constitutional Case Against Permitting Physician-Assisted Suicide For Competent Adults With “Terminal Conditions”*, 11 ISSUES L. & MED. 239, 243 (Winter 1993)

⁶⁹ *Nelson v. State*, 916 A.2d 74, 84 (Conn. App. 2007).

⁷⁰ Christopher J. Skinner, *Retaining the Cultural Meaning of Capital Punishment By Prohibiting Volunteerism On Death Row and the Implications of Its Continued Practice*, 39 LINCOLN L. REV. 55, 71-72 (2011-2012).

being a danger to themselves and/or others on a seventy-two hour hold at a psychiatric facility.⁷¹ Any person diagnosed with a terminal illness is likely to be depressed. That depression may lead the person to become suicidal.⁷²

Members of the public are uncomfortable with the possibility of the state helping a suicidal person to commit suicide. It is too much like “suicide by cop” where a person pulls a loaded gun in order to get a police officer to kill him or her.⁷³ Some persons even believe that it is unethical for the state to execute death row inmates who ask to die.⁷⁴ The Oregon and Washington statutes address this issue in several ways. If a health care professional thinks that the person is suffering from a mental illness or depression that impairs his or her judgment, the statutes require the physician to refer the person to counseling before providing the lethal medication. In addition, the person is permitted to rescind the request for the medication at any time. The statutes also mandate a waiting period between the request for the medication and the writing of the prescription. That waiting period allows the physician to make sure that the patient is capable of making an informed decision about committing suicide. Depression and/or mental illness should not prevent a patient from choosing physician-facilitated suicide. However, to protect persons who are clinically depressed or mentally ill, the statutes should require the court to appoint a guardian to assist them in making the decision to request the lethal medication.

Weeding Out Poor Patients and Patients of Color

⁷¹ Lynne N. Henderson, “We’re Only Trying to Help”: *The Burden and Standard of Proof in Short-Term Civil Commitment*, 31 STAN. L. REV. 425, 430-431 (Feb. 1979).

⁷² James Bopp, Jr. & Richard E. Coleson, *Three Strikes: Is An Assisted Suicide Out?*, 15 ISSUES L. & MED. 3, 20 (Summer 1999).

⁷³ Rahi Azizi, *When Individuals Seek Death at the Hands of the Police: The Legal and Policy Implications of Suicide by Cop and Why Police Officers Should Use Nonlethal Force in Dealing With Suicidal Suspects*, 41 GOLDEN GATE U.L. REV. 183, 187-188 (Winter 2011).

⁷⁴ Kristen M. Dama, *Redefining A Final Act: The Fourteenth Amendment and States’ Obligation to Prevent Death Row Inmates From Volunteering to Be Put to Death*, 9 U. PA. J. CONT. L. 1083 (April 2007).

The existence of inequalities in health care has been a concern in the United States for decades.⁷⁵ Consequently, it is not surprising that some people are concerned that poor people and people of color may be disadvantaged by the existence of physician-facilitated suicide. Instead of investing resources to treat certain patients, physicians may decide that it is more cost effective to just write a prescription. Terminally ill low-income patients and patients of color often do not receive the same level of treatment as their counterparts.⁷⁶ When New York explored the possibility of legalizing physician-facilitated suicide, this was a major concern of the members of the task force. To illustrate, the New York State Task Force on Life and the Law stated in its 1994 report on physician assisted suicide and euthanasia:

The risk of harm is greatest for the many individuals in our society whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized social group. The risks of legalizing assisted suicide and euthanasia for these individuals, in a health care system and society that cannot effectively protect against the impact of inadequate resources and ingrained social disadvantages would be extraordinary.

The members of the Task Force reasoned that, if the law could not protect socially and economically disadvantaged persons from being given inadequate medical treatment, it could not protect them from abuses that might occur if physician-facilitated suicide was legalized. That concern has been proven to be unfounded.⁷⁷ The typical patient requesting physician facilitated suicide in both states has the following profile: He is white; he is over the age of 52; he has some form of cancer; he is married; he is college educated; he has private health insurance; he is primarily concerned about the loss of autonomy; he is enrolled in hospice care and he died at

⁷⁵ Erika Blacksher, *Health Reform and Health Equity: Sharing Responsibility For Health in the United States*, 39 HOFSTRA L. REV. 41, 42-43 (Fall 2011).

⁷⁶ Paul S. .Kawai, *Should the Right to Die Be Protected? Physician Assisted Suicide and Its Potential Effect on Hawaii*, 19 U. HAW. L. REV. 783, 797-798 (Fall 1997).

⁷⁷ Christin A. Batt, *The Pain Relief Promotion Act of 1999 and Physician-Assisted Suicide: A Call For Congressional Self-Restraint*, 38 SAN DIEGO L. REV. 297, 305 (Winter 2001).

home.⁷⁸ Given the demographics of the persons requesting the lethal medication, it appears that the existence of physician-facilitated suicide has not unduly burdened poor people and people of color. Nonetheless, it should be noted that the populations of Oregon and Washington are predominately white. Thus, the demographics of the patients requesting the medication may be different if physician-facilitated suicide was available in a diverse state like California or Texas. On the other hand, members of those populations may have a greater need for physician-assisted suicide. Studies have shown that low-income people and people of color often receive inadequate pain treatment.⁷⁹ Therefore, when they are diagnosed with terminal illnesses, members of those populations frequently are forced to tolerate significant pain. The availability of physician-facilitated suicide may offer them a way out of their horrible circumstances. However, low-income persons will probably not be able to afford to take advantage of physician-facilitated suicide because the lethal medication is expensive and is usually not paid for by insurance.

Over Eager Physicians

According to stories on the Internet and in the news, people living in the Netherlands carry “do not euthanize” cards.⁸⁰ Recently, the media reported that clinics in the Netherlands are offering mobile services for persons who want to die at home.⁸¹ Euthanasia and physician-facilitated suicide are legal and actively used in the Netherlands.⁸² Opponents of physician-facilitated suicide some times unfairly link the two practices. Thus, those persons are afraid that, if they suddenly become ill, doctors will consider facilitated suicide as just another treatment

⁷⁸ Peg Sandeen, Oregon Death With Dignity 2011 Report, www.deathwithdignity.org (posted March 7, 2012).

⁷⁹ Yoel Goldfeder, *Assisted Suicide and the Illusory Poverty Component*, 5 GEO. J. ON FIGHTING POVERTY 335, 336 (Summer, 1998).

⁸⁰ Martin Beckford, *Fearful elderly people carry ‘anti-euthanasia cards’*, www.telegraph.co.uk (posted April 21, 2011).

⁸¹ Ben Brumfield, *Dutch euthanasia clinics offers mobile services*, www.cnn.com (posted March 8, 2012).

⁸² Kurt Darr, *Physician-Assisted Suicide: Legal and Ethical Considerations*, 40 J. HEALTH 29, 51-52 (Winter 2007).

protocol. They maintain that, to save costs, physicians may encourage patients to request the lethal medication as soon as they are diagnosed with a terminal illness. Given the staggering costs of end-of-life care, this may be a valid concern.⁸³ People making this argument may feed into the distrust that some people have of doctors. For example, some people refuse to carry organ donor cards because they are afraid that doctors will be more concerned about harvesting their organs than treating them.⁸⁴ In order to avoid that possibility, the statutes have safeguards to ensure that patients are protected from over eager physicians. For instance, the patient must give written informed consent. The written request form must be witnessed by independent parties. In addition, the patient cannot request the medication without being examined by at least two physicians—the doctor who diagnoses the illness and the doctor who confirms it. Since the patient must take the medication without assistance, the physician’s role in the process is limited. Thus, the physician does not have the option of euthanizing the terminally ill patient.

The Floodgates

According to some people, the availability of physician-facilitated suicide may open the floodgates for people to start committing suicide. Those people raise the specter of a “Jim Jones” kind of mass suicide movement.⁸⁵ They are afraid that, instead of taking advantage of comfort care or hospice care, terminally ill patients will choose to take the lethal medication. The fear is that some patients who have the possibility of going into remission may miss that chance because they select physician-facilitated suicide too early in the process. The statutory reporting requirements will help to safeguard against this happening. Both statutes require

⁸³ Greer Donley & Marion Danis, *Making the Case For Talking to Patients About the Costs of End-of-Life Care*, 39 J.L. MED. & ETHICS 183, 184-185 (Summer, 2011).

⁸⁴ Jay A. Friedman, *Taking the Camel By the Nose: The Anencephalic As a Source For Pediatric Organ Transplants*, 90 COLUM. L. REV. 917, 963 (May 1990).

⁸⁵ Jim Persels, *Forcing the Issue of Physician-Assisted Suicide Impact of the Kevorkian Case On the Euthanasia Debate*, 14 J. LEGAL MED. 93, 119-120 (March 1993).

annual reporting of patients requesting the lethal medication. Thus, the appropriate state agency will be able to monitor the trend of patients taking the medicine.

The reports indicate that Oregon and Washington are a long way from wide-spread physician-facilitated suicide.⁸⁶ For instance, in Oregon, the annual reports show that between 1998 and 2010 only 525 patients requested the medicine.⁸⁷ Every patient requesting the lethal medicine did not take it. To illustrate, in Washington, in 2010, of the 87 persons who requested the medicine only 51 died after ingesting the medication.⁸⁸ This data shows that some terminally ill persons requested the medication not because they wanted to commit suicide, but because they were comforted by having the ability to do so if their suffering became unbearable. As a part of the legalization and regulation of physician-facilitated suicide, legislatures in Oregon and Washington tried to alleviate some of the most commonly raised concerns. However, the legislatures need to amend the statutes to deal with other potential problems.

B. Unresolved Issues

Death Tourism

A number of newspaper articles and a few documentaries have focused upon international “death tourism” International death tourism occurs when United States citizens go to places like Switzerland⁸⁹ and the Netherlands to receive lethal medication to commit suicide.⁹⁰ Given the ease in which persons can travel from state to state, domestic death tourism may become a problem. The legislatures have not taken steps to discourage “domestic death

⁸⁶ The 2011 Oregon Death With Dignity Report indicates that in the 14 year history of implementation physicians have written 935 prescriptions and 596 people have ingested the medication.

⁸⁷ Peg Sandeen, Oregon Death With Dignity 2010 Report, www.deathwithdignity.org (posted January 25, 2011).

⁸⁸ Peg Sandeen, Washington Death With Dignity Report 2010, www.deathwithdignity.org (posted March 10, 2011).

⁸⁹ In Switzerland, only one organization, Dignitas, facilitates the death of non-Swiss residents. Alexandra R. Safyan, *A Call For International Regulation of the Thriving “Industry” of Death Tourism*, 33 LOY. L.A. INT’L. & COMP. L. REV. 287, 311 (Winter 2011).

⁹⁰ Diana Hassel, *Sex and Death: Lawrence’s Liberty and Physician-Assisted Suicide*, 9 U. PA. J. CONST. L. 1003, 1024-1025 (April, 2007).

tourism”.⁹¹ “Domestic death tourism” happens when patients from other states go to Oregon or Washington to obtain the right to physician-facilitated suicide.⁹² The residency requirements of both statutes are inadequate to discourage terminally ill persons from travelling to those states to obtain the lethal medication.

Nothing in the statutes requires the patients to take the medication in the state. Thus, they will be able to return to their own states and consume the medicine. Opponents of physician-facilitated suicide are concerned that this may make it difficult for the state agencies to monitor the use and abuse of the medication. The physician is not required to be in attendance when the medicine is taken and the annual reports show that a significant percentage of the cases involved patients taking the lethal medication without the presence of physicians. Unlike in the Netherlands, nothing in the Oregon and Washington statutes mandates that the physician has a long-standing relationship with the patient prior to writing the prescription for the legal medication. In order to resolve this issue, the legislatures should strengthen the residency requirements. For example, the person could be required to stay in the state for a certain number of days before having the right to obtain the documents that make him or her a resident of the state for purposes of requesting the lethal medication. This is the procedure in place for obtaining benefits states reserve for their citizens like marriage licenses, in state tuition and welfare benefits. By limiting the potential patients eligible to obtain the medication to the true residents of the states, the legislatures may be better able to protect the patients from abuse. Currently, the statutes do not have mechanisms in place for persons to report and investigate abuses.

⁹¹ Nicholas P. Terry, *Under-Regulated Health Care Phenomena in a Flat World: Medical Tourism and Outsourcing*, 29 W. NEW ENG. L. REV. 421, 433 (2007).

⁹² Brian H. Bix, *Physician-Assisted Suicide and Federalism*, 17 NOTRE DAME J. L. ETHICS & PUB. POL’Y 53, 60 (2003).

Unused Medication

According to some opponents of physician-facilitated suicide, a practice that is just as dangerous as domestic “death tourism” may be the distribution of the medication outside of the state. For instance, there is nothing to prevent persons from giving or selling unused medication to other persons. Moreover, a depressed family member may use the medication to commit suicide. The Washington statute requires that the unused medication be discarded in a lawful manner.⁹³ Nevertheless, there is no mechanism in place to monitor what happens to the medication after it is dispensed. The 2010 Washington Report indicated that there was only evidence that fifty-one people ingested the medication.⁹⁴ Further, the 2011 Oregon Death With Dignity Act Report states that 114 patients received prescriptions for legal medication, but only 71 persons died from ingesting the medication. Hence, the medication obtained by the remaining people was either unaccounted for or unused. As the number of patients requesting physician-facilitated suicide increases, this may become a major problem. Currently, teenagers are routinely raiding their parents’ medical cabinets looking for a quick high. A dangerous new activity is the “pharm party” where teenagers and young adults toss different pills into a bowl and pass it around, so they can take a random selection of pills to get high.⁹⁵ If some of the unused lethal medication ended up in one of those bowls, it would be a major tragedy.

A possible resolution to this problem is to assign a social worker to the person electing physician-facilitated suicide. That person could be responsible for following up to determine if and when the persons ingested the lethal medication. If the medication is not ingested within a reasonable period of time, the patient would be required to return the medication to a central

⁹³ RWCA 70.245.140 (West 2010).

⁹⁴ Washington State Department of Health, 2010 Death With Dignity Report (released March 4, 2010).

⁹⁵ Monica Kim Sham, *Down On the Pharm: The Juvenile Prescription Drug Abuse Epidemic and the Necessity of Holding Parents Criminally Liable For Making Drugs Accessible in Their Homes*, 27 J. Contemp. Health L. & Pol’y 426, 436-437 (Spring 2011).

location, so it can be destroyed. Another option is to track the lethal medication through a prescription drug monitoring program (PDMP).⁹⁶ Currently, thirty-seven states have agencies set up to monitor the distribution of prescription drugs.⁹⁷ Oregon recently created a PDMP. Washington does not have such a program, but one can be easily established. The lethal medication can be labeled and given a tracking number. The patient's estate could face a penalty if the unused medication is not returned to the state agency for disposal. Since the physicians writing the prescription has to be residents of the states, the number could be assigned at the time the prescription is written. The legislatures could also mandate prescription drug "take back" programs similar to the programs that permit persons to turn in guns.⁹⁸

Doctor Shopping

The statutes contain no clear definition of "competency". That determination is made by treating physicians. Thus, opponents of physician-facilitated suicide are afraid that some patients and/or their family members may engage in doctor shopping, so that the patient can be declared competent to request the lethal medication. After a medical professional determines that a patient is incapable of requesting the lethal medication that should be the end of the story. Nevertheless, the patient and/or the patient's family members can keep having the patient tested until a physician concludes that the person is competent.⁹⁹ A prime example of doctor shopping is the situation involving Oregon resident Kate Cheney. Kate, an 85-year-old woman who lived with her daughter, Erika, and Erika's husband, suffered from terminal stomach cancer. Kate told

⁹⁶ According to the National Alliance for Model State Drug Laws (NAMSDL), a PDMP is a statewide electronic database which collects designated data on substances dispensed in the state. www.namsdl.org (last visited March 8, 2012).

⁹⁷ Alliance of States With Prescription Monitoring Programs at www.pmpalliance.org (last visited March 8, 2012); See also Amy L. Caldwell, *In the War on Prescription Drug Abuse, E-Pharmacies Are Making Doctor Shopping Irrelevant*, 7 Hous. J. Health L. & Pol'y 85, 91-94 (Fall 2006) (discussing different types of state PDMPs).

⁹⁸ Oregon is attempting to establish such a program. *Melanie Leitman, Water Rx The Problem of Pharmaceuticals in Our Nation's Waters*, 29 U.C.L.A. J. Envtl. L. & Pol'y 395, 423-424 (2011).

⁹⁹ According to the official Oregon reports, at least five of the fifteen deaths in the first year of the law's operations were of people who had first been turned down by at least one doctor.

Erika, that she was considering physician-facilitated suicide. Thus, Erika accompanied Kate to Kate's treating physician. After Kate informed that physician of her wish, he referred her to a psychiatrist, so she could be evaluated. After that examination, the psychiatrist declared Kate ineligible for physician-facilitated suicide because she was cognitively impaired. The psychiatrist was concerned because Kate could not remember recent events and people. He also thought that Kate's family was pressuring her to request the medication.¹⁰⁰

The psychiatrist's opinion angered Erika, so a representative from Kate's HMO recommended that Kate seek a second opinion from an outside consultant. As a result, Erika took Kate to a psychologist who said that she was competent. The psychologist declared Kate to be capable of requesting the medication even though he noted that Kate was having short-term memory problems and was being pressured by Erika to request the medication. After the opinion by the second psychologist, Kate received the lethal medication. Then, Erika sent Kate to a nursing home for a week. During her stay at the nursing home, Kate repeatedly begged Erika to let her return home. Finally, Erika relented and took Kate back to her house. After Kate left the nursing home and returned to Erika's house, she took the lethal medication and died.¹⁰¹ This story was reported in the Oregon print and television news. It is unclear how many of the facts are true. Nonetheless, the story indicates that the statutes do not provide enough protections for the terminally ill patient.

In order to resolve issues like the ones raised by Kate's story, the statutes should appoint an independent board to evaluate the competency of a patient requesting the medication if the opinions of two or more doctors evaluating the person's competency are in conflict. That board

¹⁰⁰ Herbert Hendlin & Kathleen Foley, *Physician-Assisted Suicide in Oregon: A Medical Perspective*, 24 Issues L. & Med. 121, 131-132 (Fall 2008).

¹⁰¹ Herbert Hendlin & Kathleen Foley, *Physician-Assisted Suicide in Oregon: A Medical Perspective*, 106 Mich. L. Rev. 1613, 1624-1625 (June 2008).

should also be responsible for investigating abuse complaints. In order to be competent to request the medication, every patient requesting the medication should be required to undergo counseling with an appropriate medical professional. Once the professional declares the person to be capable of requesting the lethal medication, the person would be eligible to get the medication. However, if the professional concludes that the person is suffering from clinical depression or another condition that impacts the person's mental capacity, the person would not be approved to receive the medication unless the psychological condition is resolved.

The current system in place fails to serve the needs of two categories of patients. Some patients, like Mary, who suffer from diseases that destroy the physical body are not considered terminal because their doctors predict that they will survive longer than six months. In those cases, the doctors use their medical judgments to conclude that the patients will die at some specified time in the future. A patient in that class has a predicted expiration date, but that date is too far in the future for the patient to be labeled as terminal. Another group of patients like Anna suffer from progressive, irreversible brain disorders that gradually destroy their memories, and their abilities to learn, reason, and make decisions. Those patients can physically survive their conditions for an indeterminate period of time. Therefore, for purposes of requesting physician-facilitated suicide, those patients are not recognized as being terminal. The law needs to be expanded to serve the needs of patients in both of those groups.

III. Expanding the Availability of Physician-Facilitated Suicide

Some statutory changes should be made to increase the number of patients who are eligible to obtain assistance to commit suicide. The primary goals cited for legalizing physician-facilitated suicide include the following: permitting terminally ill patients to die before they lose autonomy; easing the pain and suffering of terminally ill patients; and reducing the costs of end-

of-life care. Expanding the availability of physician-facilitated suicide is consistent with those objectives.

A. Planning for Terminal

Under the current statutes, the terminally ill patient must take the lethal medication without assistance. Once the physician writes the prescription his or her role in the process ends. In order to avoid abuse, doctors should not be allowed to help their patients take the lethal medication. Permitting that would be too much like legalizing active euthanasia.¹⁰² Nonetheless, there should be a procedure which allows the patient to request assistance from a friend or family member. Some patients have progressive diseases that may prevent them from being able to take the medication. For instance, persons with Amyotrophic Lateral Sclerosis (ALS) may only be able to take the medication in the early stages of the disease. Those patients may feel pressure to request and take the lethal medication before they are really ready. They may be afraid if they wait too long, they will not be able to take the medication without assistance.¹⁰³ This is a valid concern because the Oregon statute prohibits lethal injection, so people who are unable to swallow may not be able to take the lethal medication.¹⁰⁴ If the proper safeguards are put in place, those patients should be able to receive physical assistance to take the medication. In some cases, this may entail the medication being administered through a feeding tube. This is consistent with the way that disabled persons have been treated in other areas of the law. For instance, physically incapacitated persons can receive assistance to sign

¹⁰² Active euthanasia occurs when doctors take some deliberate steps to put their patients to death. Thane Josef Messinger, *A Gentle and Easy Death: From Ancient Greece to Beyond Cruzan Toward A Reasoned Legal Response to the Societal Dilemma of Euthanasia*, 71 Den. U.L. Rev. 175, 180 (1993).

¹⁰³ Raphael Cohen-Almagor, *Euthanasia and Physician-Assisted Suicide in the Democratic World: A Legal Overview*, 16 N.Y. Int'l L. Rev. 1, 33 (Winter 2003).

¹⁰⁴ David L. Sloss, *The Right to Choose How to Die: A Constitutional Analysis of State Laws Prohibiting Physician-Assisted Suicide*, 48 Stan. L. Rev. 937, 971 (April 1996).

their wills.¹⁰⁵ One option is for the statutes to be amended to permit the patient to include a clause in the written request form indicating his or her desire to receive assistance when taking the medication.¹⁰⁶

Under the statutes, the person is not permitted to request the lethal medication until he or she has been diagnosed with a terminal illness. There should be a system in place for a person to have the option to request physician-facilitated suicide before he or she becomes terminally ill. For example, a provision for physician-facilitated suicide could be added to a living will or a health care directive.¹⁰⁷ At that time, the person is thinking clearer so the competency issue would be better addressed. Medication and pain may cloud the person's judgment after the doctor starts treating the disease. Also, the request for the lethal medication will probably be more voluntary prior to the terminal diagnosis. After the person is diagnosed with a terminal disease he or she may be motivated by fear or guilt to request the medicine. Those emotions may come from not wanting to be a burden on family members.¹⁰⁸ Even if the person requests the medication in advance he or she can either rescind the request after he or she becomes terminal or not take the medicine.

B. Getting to Terminal

My biggest concern is the fact that the opportunity to seek aid in dying is not available to more patients, including patients in situations similar to Mary and Anna. The statutes define terminal illness as: "an incurable and irreversible disease that has been medically confirmed and

¹⁰⁵ Restatement (Third) of Property: Wills and Other Donative Transfers §3.1, cmt. J (1999).

¹⁰⁶ See attached sample form.

¹⁰⁷ There are three main types of advance directives. In instructional directives like living wills, the person states the level of medical treatment he or she wants to receive in the event he or she becomes incompetent or terminal. In proxy directives like durable health care power of attorneys, the person appoints a third party to make health care decision in the event the person is not able to do so. In hybrid directives, the person both appoints a third party to make medical decisions and indicates his or her treatment preferences. Dukeminier, Sitkoff, & Lindgren, WILLS, TRUST, AND ESTATES 457 (New York: Aspen Publishers, 2009).

¹⁰⁸ Paul S. Kawai, *Should the Right to Die Be Protected? Physician Assisted Suicide and Its Potential Effect on Hawaii*, 19 U. Haw. L. Rev. 783, 797-798 (Fall 1997).

will, within reasonable medical judgment, produce death within 6 months.” I recommend removing the durational requirement and broadly interpreting the meaning of terminal.

Physical Conditions

A person suffering from a disease that cannot be cured or adequately treated and that a doctor reasonably expects to result in death within a specified period of time should be considered terminal. If the condition is incurable and irreversible, why should the person have to die in 6 months? Even some doctors disagree with limiting physician-facilitated suicide to persons who are predicted to die within six months.¹⁰⁹ The longer the person is expected to suffer, the more desperately that person needs the option of getting the lethal medicine. It does not seem fair that Mary who was predicted to die in eight months would have to suffer for two months before she was eligible to request the medicine. Once a doctors diagnoses a person with an incurable disease that is expected to result in death that should be sufficient to trigger the application of the physician-facilitated suicide statute. If not, the patient may take steps to hurry the progression of the disease, so they can get to the six month mark with the minimum amount of suffering. For example, the person may refuse treatment or not take the prescribed medication. Mary was forced to suffer because her cancer was not aggressive enough. However, she still had to live with the physical pain caused by the disease and the treatment and the emotional pain resulting from knowing that her body was being attacked by a disease that would kill her. The legislatures should remove the six-month requirement and give a person who has been diagnosed with an incurable and irreversible disease the opportunity to request the lethal medication.

¹⁰⁹ See F.G. Miller, T.E. Quill, H. Brody, J. C. Fletcher, L.O. Gostin, and D.E. Meier, “Requesting Physician-Assisted Death”, *New England Journal of Medicine*, no. 331 1994, pp. 119-123.

If the six-month requirement is removed, persons may be worried that patients with chronic illnesses or disabled persons may be considered terminal. Members of the public will probably be uncomfortable with a system that permits those persons to request the lethal medication. I am not advocating that the legislatures remove the terminal requirement. Thus, the availability of physician-facilitated suicide would still be limited to persons suffering from medical conditions that doctors reasonably expect to result in death in a certain time period—that time period may be shorter or longer than six months. Another option available to the legislatures is to adopt the definition of terminal illness included in the Uniform Rights of the Terminally Ill Act (URTIA). Under the terms of that statute, a terminal condition is one that is incurable and irreversible. The condition must be one that a doctor predicts will result in death within a “relatively short time” unless the patient receives life-sustaining treatment.¹¹⁰ The drafters intentionally used the phrase “relatively short time” instead of requiring death to occur within a certain time period. By using that broad phrase, the drafters hoped to give physicians the flexibility to evaluate patients on a case-by-case basis.¹¹¹ Several states have adopted versions of the URTIA.¹¹²

A final possibility is for terminal to be triggered by the stages of the disease. Most diseases have several stages.¹¹³ Once the patient is in the end stage of the disease, he or she should be classified as terminal. Some conditions like end stage renal failure are terminal, but doctors cannot predict exactly when the patient will die. Patients with that condition can live and suffer for years. The focus should be on the progression of the disease and not on the amount of time that the person is predicted to live. For instance, a person diagnosed with stage two breast

¹¹⁰ Unif. Rights of Terminally Ill 1989 §1 (9); Marguerite Ann Chapman, *The Uniform Rights of the Terminally Ill Act: Too Little, Too Late?*, 42 Ark. L. Rev. 319, 350 (1989).

¹¹¹ Unif. Rights of Terminally Ill comment (2001).

¹¹² See e.g. A.C.A. § 20-17-201; M.C.A. § 50-9-102; N.R.S. § 449.590.

¹¹³ Hunter J. Shkolnik, *Overcoming Defenses and Developing Winning Themes in the Failure to Diagnose Case*, Winter 2005 ATLA-CLE 487 (Jan. 2005)(describing the stages of cancer).

cancer may progress to stage four faster than someone diagnosed with stage three. If the person is in the final stage of the disease, the next stage is death. Thus, that person should be considered to be terminal for purposes of requesting the lethal medication.

Brain Disorders

Presently, in order to be a candidate for physician-facilitated suicide, the person must be diagnosed with a condition that results in physical death. Thus, persons like Anna are not permitted to seek assistance to exit gracefully. In order to remedy this, the legislature should remove the death requirement from the definition of terminal or redefine death to include non-physical death. The changes would apply to persons suffering from dementia and other progressive, irreversible brain disorders. Dementia is a gradual and progressive loss of memory, thinking and reasoning skills. One example of dementia that could be classified as a terminal mental condition is Alzheimer's disease.¹¹⁴

A person who is suffering from an incurable and irreversible mental disease that significantly impairs his or her quality of life should be considered to be suffering from a terminal condition. Thus, the person should be given the option of selecting physician-facilitated suicide. The person can achieve that goal by making physician-facilitated suicide a part of planning for incapacity. To that end, the person should be able to include their preferences in a living will or another type of advanced directive. The person should also be able to choose physician-facilitated suicide in the earlier stages of his or her disorder.

In the alternative, the courts should broadly interpret the word death to include mental death as well as physical death. The definition of death is still evolving because of advances in medical technology. Thus, the law has recognized different definitions of death. Historically,

¹¹⁴ Bruce Jennings, *Freedom Fading: On Dementia, Best Interests, and Public Safety*, 35 Ga. L. Rev. 593, 595 (Winter 2001).

death was defined as the cessation of a person's heart and lung functions. A person was declared dead when the heart stopped beating.¹¹⁵ However, medical advances made it possible for a person to breathe artificially and for the heart to beat indefinitely. This became a problem when the person was an organ donor. In order to keep the organs viable, the patient was kept on a ventilator. As a result, the person was breathing and had a heart beat. Thus, under the legal definition of death, the person was still alive. Doctors were reluctant to harvest organs from a live person.¹¹⁶ In response, Dr. Henry Beecher and a group of other physicians formed an Ad Hoc Committee at the Harvard Medical School to consider expanding the definition of death. The Committee issued a Report advocating for the recognition of whole brain death.¹¹⁷ Kansas became the first state to recognize brain death by statute.¹¹⁸

In 1980, the President's Commission for the Study of Ethical Problems in Medicine proposed a model statute to expand the definition of death. The result of that proposal was the Uniform Determination of Death Act (UDDA). The Act states "An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions (heart death) or (2) irreversible cessation of all functions of the entire brain, including the brain stem (whole brain death), is dead."¹¹⁹ Some persons contend that the law should recognize higher brain death. Persons supporting that theory of death argue that the irreversible loss of higher brain functions, including personality, memory, and consciousness, is technically death.¹²⁰

¹¹⁵ R. Alta Charo, *Biological Determinism in Legal Decision Making: The Parent Trap*, 3 Tex. J. Women & L. 265, 273 (Spring, 1994).

¹¹⁶ Kirsten Rabe Smolensky, *Defining Life From the Perspective of Death: An Introduction to the Forced Symmetry Approach*, 2006 U. Chi. Legal F. 41, 45-47 (2006).

¹¹⁷ Tom Stacy, *Death, Privacy and the Free Exercise of Religion*, 77 Cornell L. Rev. 490, 518-519 (March, 1992).

¹¹⁸ Samantha Weyrauch, *Acceptance of Whole-Brain Death Criteria For Determination of Death: A Comparative Analysis of the United States and Japan*, 17 U.C.L.A. Pac. Basin L.J. 91, 102-103 (Summer, 1999).

¹¹⁹ Unif. Determination of Death Act §1.

¹²⁰ T.A. Tucker Ronzetti, *Constituting Family and Death Through the Struggle With State Power: Cruzan v. Director, Missouri Department of Health*, 46 U. Miami L. Rev. 149, 201 (1991).

The brain dies in stages, so the option of terminal mental disorders should not be removed from the table.¹²¹ Life is not just breathing; it is living. Once a brain disorder causes a person's quality of life to be totally depleted, that person should have the option of being declared mentally terminal. The purpose of the physician-facilitated suicide statute is to permit a person to die with dignity. Persons suffering from incurable and irreversible brain disorders may experience even more indignities than persons suffering from terminal physical conditions. If Anna had been given the option in the earlier stage of her disease to select physician-facilitated suicide, she might have requested the lethal medication. In order to prevent abuse, persons suffering from brain disorders should have to preselect physician-facilitated suicide prior to their diagnosis. Even after the diagnosis, if the doctor indicates that the person is still capable of making an informed decision, he or she should be able to follow the procedure to request the lethal medication.

CONCLUSION

For almost ten years, Oregon stood alone as the state that permits terminally ill persons to choose the time and manner of their deaths. Finally, in 2009, Oregon received company when the state of Washington's physician assisted suicide statute officially went into effect in March of that year. Supporters of the statutes hailed the enactments as a victory for persons seeking to die with dignity. Persons from groups like Compassion & Choices vowed to seek similar legislation in the remaining states.¹²² Representatives from the Washington State Medical Association, hospice groups and hospitals argued that the mandates of the statutes place physicians in an

¹²¹ Kathleen L. Paliokas, *Anencephalic Newborns As Organ Donors: An Assessment of "Death" and Legislative Policy*, 31 Wm. & Mary L. Rev. 197, 202-203 (Fall 1989).

¹²² www.compassionandchoices.org (last visited March 8, 2012).

unnatural position.¹²³ In particular, the Medical Association's spokesman stated that physicians take an oath to save lives, not to end them.¹²⁴ The number of persons in the country who support physician-facilitated suicide has continued to grow.¹²⁵ At the end of 2009, the Montana Supreme Court indicated that physician-facilitated suicide is not against the state's public policy. In this article, instead of joining the debate about the legalization of physician-facilitated suicide, I analyzed the law in Oregon and Washington. That analysis shows that the legislatures in those states attempted to regulate the process in order to protect the interests of terminally ill patients and physicians.

The statutory mandates are a step in the right direction, but there is still work that needs to be done. The statutes should be amended to close certain loop holes and to ensure that the option of physician-facilitated suicide is available to all of the patients who need it. Persons suffering from physical conditions that will lead to death in six months should not be the only persons permitted to exit gracefully. As long as the safeguards in the statutes are followed, there is no good reason to prohibit persons suffering from irreversible and incurable physical diseases that lead to death from being classified as terminal. In addition, persons diagnosed with irreversible and incurable brain disorders, like severe dementia or Alzheimer's disease should be able to avail themselves of the rights provided by the physician-facilitated suicide statutes. Alzheimer's patients suffer a slow, painful death. They revert to childhood and forget everyone around them. The mental death they suffer is similar to the physical death experienced by terminally physically ill patients. During the early stages of the disease, most persons are still

¹²³ *As I-1000 Signatures are counted, WSMA Opposition to Physician-Assisted Suicide Reiterated*, www.wsma.org (posted July 2, 2008).

¹²⁴ *Id.* The AMA also takes this position. Leslie L. Mangini, *To Help or Not to Help: Assisted Suicide and its Moral, Ethical, and Legal Ramifications*, 18 Seton Hall Legis. J. 728, 754 (1994).

¹²⁵ *Large Majorities Support Doctor Assisted Suicide for Terminally Ill Patients in Great Pain*, www.harrisinteractive.com (posted January 25, 2011) (results from the BBC World News America/Harris Poll of 2340 adults surveyed online).

competent enough to request physician-facilitated suicide. Therefore, the statutes should be amended or interpreted to give them that option. The Oregon and Washington statutes should be amended to give patients like Mary and Anna the chance to exit this life gracefully.

REQUEST FOR MEDICATION
TO END MY LIFE IN A HUMANE
AND DIGNIFIED MANNER

I, _____, am an adult of sound mind.

I am suffering from _____, which my attending physician has determined is a terminal disease and which has been medically confirmed by a consulting physician.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care and pain control.

I request that my attending physician prescribe medication that will end my life in a human and dignified manner.

In the event that I am unable to take the medication without assistance, I appoint _____ as the person I would like to assist me.

INITIAL ONE:

_____ I have informed my family of my decision and taken their opinions into consideration.

_____ I have decided not to inform my family of my decision.

_____ I have no family to inform of my decision.

I understand that I have the right to rescind this request at any time.

I understand the full import of this request and I expect to die when I take the medication to be prescribed. I further understand that although most deaths occur within three hours, my death may take longer and my physician has counseled me about this possibility.

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

Signed:_____

Dated:_____

DECLARATION OF WITNESSES

We declare that the person signing this request:

- (a) Is personally known to us or has provided proof of identity;
- (b) Signed this request in our presence;
- (c) Appears to be of sound mind and not under duress, fraud or undue influence;
- (d) Is not a patient for whom either or us is attending physician.

_____Witness1/Date

_____Witness 2/Date