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OREGON'S GUIDELINES FOR PHYSICIAN-ASSISTED SUICIDE: A LEGAL AND ETHICAL ANALYSIS

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*Oregon's Death With Dignity Act was first passed by a ballot initiative in 1994, but implementation was delayed by numerous judicial challenges. In November of 1997, following the United States Supreme Court decisions in *Vacco v. Quill* and *Washington v. Glucksberg* which left the states' power to regulate physician-assisted suicide undisturbed, the Oregon voters upheld their law. Oregon remains the only state in the nation to authorize physician-assisted suicide. The Task Force to Improve the Care of Terminally-Ill Oregonians published a Guidebook for healthcare providers on the Oregon Act, and the New England Journal of Medicine recently issued a special report on the first year's experience under the Act. This paper analyzes the legal context of the Oregon Death With Dignity Act, discusses the efficacy of the tenets in the Guidebook, and explores ethical issues underlying the guidelines, particularly those pertaining to the meaning of a patient's request for assisted suicide and processes supporting informed consent.*

INTRODUCTION

The United States Supreme Court has left the states' power to regulate physician-assisted suicide undisturbed in two cases involving

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state statutes that prohibited the practice.¹ In June 1997, the Court issued decisions in cases arising from the Courts of Appeal for the Second and Ninth Circuits, with the Justices ruling unanimously to uphold the constitutionality of state statutes from New York and Washington that banned physician-assisted suicide.² While the Court refused to proclaim a fundamental right to die in the form of a constitutional guarantee of physician-assisted suicide, it also reserved significant latitude for the states to experiment in the area.³ Such is the

¹ *Vacco v. Quill*, 521 U.S. 793 (1997); *Washington v. Glucksberg*, 521 U.S. 702 (1997). See also Christine Neylon O'Brien & Gerald A. Madek, *Physician-Assisted Suicide: New Protocol for a Rightful Death*, 77 NEB. L. REV. 229-80 (1998) (discussing the two decisions in more detail); Martha Minow, *Which Question? Which Lie? Reflections on the Physician-Assisted Suicide Cases*, 1997 SUP. CT. REV. 1 (1997); James L. Underwood, *The Supreme Court's Assisted Suicide Opinions in International Perspective: Avoiding a Bureaucracy of Death*, 73 N. D. L. REV. 641 (1997); Katherine C. Glynn, Note, *Turning to State Legislatures to Legalize Physician-Assisted Suicide for Seriously Ill, Non-Terminal Patients after Vacco v. Quill and Washington v. Glucksberg*, 6 J.L. & POLY 329 (1997); Richard H. Fallon, Jr., *The Supreme Court 1996 Term, Foreword: Implementing the Constitution*, 111 HARV. L. REV. 51, 137-41 (1997) (discussing constitutional fidelity and the judicial role in the right to die cases); *The Supreme Court 1996 Term, Leading Cases*, 111 HARV. L. REV. 237-48 (1997) (discussing due process and equal protection clauses in physician-assisted suicide cases).

² See Janny Scott, "Court, 9-0 Upholds State Laws Prohibiting Assisted Suicide, An Issue That Won't Die, Court's Ruling on Doctor-Assisted Suicide Leaves Some Basic Questions Unresolved," N. Y. Times, June 27, 1997, at A1.

³ See *Washington v. Glucksberg*, 521 U.S. at 736. The jurisprudence of the right to privacy and personal autonomy provides the historical background for a discussion of the right to die. See generally Louis D. Brandeis & Samuel I. Warren, M.D., *The Right to Privacy*, 4 HARV. L. REV. 193 (1890). The first major right-to-die case was *In re Quinlan*, 355 A.2d 647, 70 N.J. 10 (1976) cert. denied sub nom. *Garger v. New Jersey*, 429 U.S. 922 (1976), in which the Supreme Court of New Jersey held that the decision to terminate life support of a noncognitive, vegetative patient flowed from the patient's right of privacy, and after proper medical, ethical, and legal consultation, the guardian, physician and hospital were permitted to withdraw the life sustaining apparatus to allow death by natural forces without civil or criminal liability for their action. 355 A. 2d 671-72. The United States Supreme Court granted *certiorari* in a similar case, *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1989). The Court in *Cruzan* considered the question whether a patient in a persistent vegetative state had a "right under the United States Constitution which would require the hospital to withdraw life-sustaining treatment from her." *Id.* at 269. The right to refuse treatment in cases subsequent to *Quinlan* has been grounded upon the right to informed consent and/or a constitutional privacy right. *Id.* at 271, citing LAWRENCE TRIBE, *AMERICAN CONSTITUTIONAL LAW* 1365 (2d ed. 1988); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 37-38 (1977). The constitutionality of the State of Missouri's requirement that evidence of an incompetent's wishes as to the withdrawal of life-sustaining treatment be proven by clear and convincing evidence depended upon the state's interests which the Court characterized as the "choice between life and death ... a deeply personal decision of obvious and overwhelming finality." *Cruzan*, 497 U.S. at 281. The Due Process Clause protects the interest in life as well as the interest of the individual in refusing life-

natural province of the legislature,⁴ and in this instance, the states must fashion the procedure and determine what safeguards are necessary.

If the voters of a state support a right to assisted suicide, and a bill is enacted, then opponents of the assisted suicide measure may at best resort to repeal efforts or judicial challenges. Oregon alone has endured this complete scenario.⁵ As the first state with a statute to legalize physician-assisted suicide, Oregon has blazed a trail for the nation, and fought a fight that may more fully filter down to other states in the years to come.⁶ Meanwhile, the Oregon statute and its implementation provide a focus and a testing ground for the debate on physician-assisted suicide, with Oregon setting a standard for future legislative efforts, and providing a real point of comparison for proposed model acts.⁷ The Oregon Death With Dignity Act, for all its six pages of

sustaining medical treatment, and in light of the substantial interests at stake, the heightened standard of proof reflects the importance of the matter. *Id.* at 281-84.

⁴ See *Glucksberg*, 521 U.S. 735 (Rehnquist, C.J.); *id.* at 792 (Souter, J., concurring); *id.* at 704 (O'Connor, J., concurring).

⁵ See Sheryl Gay Stolberg, "Guide Covers Territory Suicide Law Does Not Explore," N.Y. Times, April 21, 1998, at F4. Other states have sought to enact bills that regulate and authorize physician-assisted suicide, but at the present time, Oregon is the only state with a statute facilitating physician-assisted suicide. See O'Brien & Madek, *supra* note 1, at 272-73. Opponents of the Oregon law speculate that Oregon residents may have "a greater moral deficit than the other states," noting that the state has one of the lowest churchgoing populations, and one of the highest divorce rates in the nation. See Charles Ornstein, "Oregon and Michigan a study in contrasts on assisted suicide," Dallas Morning News, March 30, 1998, at 1A, quoting from Dr. N. Gregory Hamilton, a Portland psychiatrist and president of Physicians for Compassionate Care, a group of 1,000 doctors who oppose the law. Supporters of the Oregon law see the Oregon population as open to new concepts, and as having a "strong libertarian undercurrent" citing examples of Oregon's other prescient actions. For example, Oregon was the first state to adopt a recycling law and bottle bill more than twenty years ago and Oregon is the only state that maintains open public access along its entire Pacific coastline. *Id.* A group in Michigan was recently reported to have garnered enough support to place the issue of assisted suicide on the ballot there. See Michael J. Sniffen, "Reno Refuses to Allow U.S. Drug Agents to Thwart Oregon's Assisted-Suicide Law," Buffalo News, June 6, 1998, at 4A.

⁶ See "Assisted Suicide, at State Discretion," N.Y. TIMES, June 8, 1998, at A20 (noting that nation is grappling with "individual's right to control how life ends" and in light of national poll showing 68% supporting physician-assisted suicide, more states are likely to follow Oregon's lead). A more recent poll by an independent national opinion survey firm showed that "an overwhelming majority [69%] of Americans support physician-assisted suicide for the terminally ill and [72%] oppose legislation before Congress that would prohibit doctors from prescribing lethal doses to patients who want to hasten death." See *Assisted suicide backed in poll*, BOSTON GLOBE, July 30, 1998, at A9.

⁷ See Charles H. Baron et al., *Statute: A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 HARV. J. ON LEGIS. 1 (1996); see generally, Charles H. Baron, *Pleading for Physician-Assisted Suicide in the Courts*, 19 W. NEW ENG. L. REV. 371-73 (1997) (comparing legislative to judicial law-making, noting strengths and

simplicity, leaves a broad wake.⁸ This article analyzes the Oregon Death With Dignity Act and the Task Force's Guidelines for their ethical content, as well as for their legal context.

The Oregon voters upheld the Oregon Death With Dignity Act in November, 1997, and fifteen hastened deaths have since been reported there.⁹ After three years of work, the Task Force to Improve the Care of Terminally Ill Oregonians has published a Guidebook for health care providers on the Oregon Act.¹⁰ The Oregon Guidelines illustrate the complexity of the issues surrounding physician-assisted suicide. Even deciding upon the term "physician-assisted suicide" for use in the Guidebook evoked some conflict among proponents of the "hastened death" camp.¹¹ The Guidebook contains no recipes for suicide drinks nor does it advocate the practice of assisted suicide.¹² And yet it does

weaknesses of each, and necessity of resorting to the courts where state legislatures "ignore the plight of patients who suffer").*Id.* at 403.

⁸ See generally Stolberg, *supra* note 5; THE OREGON DEATH WITH DIGNITY ACT, OR. REV. STAT. sec. 7800-897 (1995); O'Brien & Madek, *supra* note 1, at 265-72 & nn. 232-95 and accompanying text (discussing Oregon law and judicial challenges).

⁹ See Sam Howe Verhovek, "Oregon Reporting 15 Deaths in Year Under Suicide Law," N. Y. Times, Feb. 18, 1999, at A1; Arthur E. Chin, et al., *Special Report, Legalized Physician-Assisted Suicide in Oregon- The First Year's Experience*, 340 NEW ENG. J. MED. 577-83 (1999) (detailing the parameters of study of physician-assisted suicide in Oregon for period January 1, 1998 through December 31, 1998 and concluding that decision to request and use prescription of lethal medication appears to be associated with concern about loss of autonomy or control of bodily functions, rather than fear of severe pain or financial consequences); Stolberg, *supra* note 5 (reporting first death); Neal A. Lewis, "Reno Lifts Barrier to Oregon's Law on Aided Suicide," N.Y. Times, June 6, 1998, at A1 (reporting three deaths pursuant to Oregon law); William McCall, "8 in Oregon use state's law to aid death," Boston Globe, August 19, 1998, at A3 (reporting eight deaths from lethal drugs prescribed under Oregon law with patient's average age of 71); see also Jane Meredith Adams, "Ethics, Assisted suicide gains in propriety, Oregon vote confirms years of steadily growing public support," Boston Globe, Nov. 9, 1997, Focus, at D3.

¹⁰ See Stolberg, *supra* note 5; see also TASK FORCE TO IMPROVE THE CARE OF TERMINALLY-ILL OREGONIANS, THE OREGON DEATH WITH DIGNITY ACT, A GUIDEBOOK FOR HEALTH CARE PROVIDERS (1998) [hereinafter GUIDEBOOK]. The Guidebook is analyzed in Part II of this paper. The Oregon Task Force was comprised of over two dozen members including lawyers, health care professionals, clergy and ethicists. *Id.* This composition was similar to the New York State Task Force on Life and the Law which published its findings and recommendations in WHEN DEATH IS SOUGHT, ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT (1994 & Supp. 1997).

¹¹ See Stolberg, *supra* note 5. In fact, numerous proponents of physician-assisted suicide prefer the word death to suicide because of the pejorative use of the term suicide. See Tom L. Beauchamp, *The Justification of Physician-Assisted Deaths*, 29 INDIANA L. REV. 1173, 1200 (1996); Sylvia A. Law, *Physician-Assisted Death: An Essay on Constitutional Rights and Remedies*, 55 MD. L. REV. 292,306 n.60 (1996); Timothy E. Quill, *Physician-Assisted Death: Progress or Peril?*, 24 SUICIDE AND LIFE THREATENING BEH. 315 (1994).

¹² See Stolberg, *supra* note 5; GUIDEBOOK, *supra* note 10, at 3-4, 34.

provide tips for increasing the effectiveness and palatability of a lethal cocktail, including recommending a preliminary or test dose for tolerance prior to the planned final exit.¹³ Physicians are not required to participate in assisted suicide, nor should they initiate the discussion of it, according to the Oregon Guidebook.¹⁴ Nonetheless, the individual health care provider who does not wish to discuss or assist a patient must furnish an alternative provider who will meet the patient's needs.¹⁵ The Guidebook encourages family involvement in decisionmaking on this important issue, and advocates full information and planning for complications.¹⁶ The need to comply with the Oregon Act and its safeguards requires that reports be compiled.¹⁷ Even malpractice insurance coverage for health care providers who participate in physician-assisted suicide is discussed in the Guidebook.¹⁸ The sticking point on traditional malpractice insurance is that it usually does not cover intentional acts, and thus the commission of assisted suicide must be specifically addressed in order to ensure that participants are protected from claims relating to their assistance with the lawful act.¹⁹ In order to more fully understand the legal context of state regulation of the right to die, and thus the backdrop for the Oregon Death With Dignity Act and its implementation, recent judicial review of state legislation is analyzed next.

I. THE UNITED STATES SUPREME COURT STRUGGLES WITH RIGHTFUL DEATH²⁰

There is no explicit right to die embodied in the United States Constitution. The Supreme Court proclaimed no fundamental right or liberty interest in physician-assisted suicide based upon the Fourteenth Amendment Due Process Clause.²¹ Thus, the standard of review for the

¹³ See Stolberg, *supra* note 5; GUIDEBOOK, *supra* note 10, at 34-35.

¹⁴ See GUIDEBOOK, *supra* note 10, at 5, 7.

¹⁵ *Id.* at 7.

¹⁶ *Id.* at 17, 38.

¹⁷ See Stolberg, *supra* note 5; GUIDEBOOK, *supra* note 10, at 40, 43-45; Chin, *supra* note 9 (reporting on the first year's experience with the Oregon Act).

¹⁸ See GUIDEBOOK, *supra* note 10, at 46.

¹⁹ See *id.* Nurses are particularly concerned about their role in assisting patients under the Oregon law and an administrator at the Oregon Nurses Association finds the 91 page guidebook "little help for nurses." See Timothy Egan, "No One Rushing in Oregon To Use a New Suicide Law," N.Y. Times, March 15, 1998, at Sec. 1, 18.

²⁰ The authors coined the term "rightful death" to reflect an individual's right to control the timing and manner of his or her imminent death. See O'Brien & Madek, *supra* note 1, at 245, & n.87.

²¹ See *Washington v. Glucksberg*, 521 U.S. at 723. See also Minow, *supra* note 1, at 1, 3 & n.10 (1997) (discussing that Justices frame the question differently in their various concurring opinions in *Glucksberg* and *Quill*).

Washington statute was simply that the ban on assisted suicide be rationally related to a legitimate state interest, a standard that the Court found was readily met by the Washington statute.²² While the Court declined to overturn either state statute based upon the facial attack presented, there was a door left open for a more particularized challenge.²³ The framing of the question as whether the Washington statute was facially valid or invalid "as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors" resulted in a rote response by the Court.²⁴ There is no fundamental right to assisted suicide expressed in the United States Constitution or in prior case law, nor is there a right to suicide itself for that matter.²⁵ However, the case of a competent person who is suffering from pain that is not capable of alleviation under existing law and medical procedure would present a different question. Based upon the particular facts of such a case, the Justices may be forced to answer a different question, and may prove willing to answer the question in a way that will permit active assistance with suicide.²⁶

In *Vacco v. Quill*, the challenge to New York's prohibition on assisted-suicide pertained to the Fourteenth Amendment's Equal Protection Clause, and there, once again, the United States Supreme Court found no substantive rights inherent in the Constitutional provision.²⁷ The classification of persons under the New York State statute in question distinguished those in the final stages of illness who were on life-support from others similarly situated in terms of illness, but who were not sustained by life-support.²⁸ Those patients not attached to life-support were restricted from hastening their deaths by active means such as injection of a lethal dose of prescribed drugs. The

²² The State's interests included preventing suicide, protecting depressed or mentally ill persons or those suffering from untreated pain, protecting the integrity and ethics of the medical profession, protecting vulnerable groups from abuse, neglect and mistakes, and preventing the slippery slope to euthanasia. *Id.* at 728-732. The Washington ban reasonably addressed these issues in the Court's view. *Id.* at 734.

²³ See *Glucksberg*, 521 U.S. at 735 n. 24; *Supreme Court Foreword*, *supra* note 1, at 138. Even opponents of physician-assisted suicide note the existence of particularly troubling cases, e.g., where a dying person is experiencing unavoidable pain. See Yale Kamisar, *Pope & John Lecture on Professionalism, Physician-Assisted Suicide: The Problems Presented by the Compelling, Heartwrenching Case*, 88 J. CRIM. L. & CRIMINOLOGY 1121, 1122 (1998).

²⁴ See *Glucksberg*, 521 U.S. at 735; Harvard, *Leading Cases*, *supra* note 1, at 244-45; Minow, *supra* note 1, 3-11.

²⁵ See *Glucksberg*, 521 U.S. at 713.

²⁶ See *Leading Cases*, *supra* note 1, at 245-46 (noting four of the concurrences "explicitly expressed concern" about such cases and others alluded to the problem).

²⁷ *Vacco v. Quill*, 521 U.S. 793, 799 (1997).

²⁸ *Id.* at 799.

Court of Appeals for the Second Circuit ruled that the distinction between those persons on life-support who would be able to lawfully discontinue the artificial life-support and hasten their deaths, and those other persons who were restricted by the statute from hastening their deaths by more active means was not rationally related to a legitimate state interest.²⁹ The United States Supreme Court overruled the Second Circuit, in part because the distinction between active and passive deeds has long been recognized in the medical and legal fields.³⁰ In addition, the statutory classification involved was not suspect, and thus the States' burden was not that difficult to meet.³¹

Consequently, both the Washington and New York statutes survived the challenges of their opponents at the highest level of judicial review, and the outcomes and rationale of the Court left the field free for other state legislation.³² As will be discussed in the next section, the Oregon bill provides a different type of law on assisted suicide than those considered by the Supreme Court in *Vacco* and *Glucksberg*, because the Oregon statute authorizes and regulates the practice, and yet the Oregon Act has also survived numerous challenges.

The United States Supreme Court, in its own inimitable fashion, has relegated the responsibility for the specifics of regulation on this important topic to the states and they will proceed to deal with the thorny legal, procedural, and ethical concerns engendered by any resulting legislation.³³ For example, shortly after the Court's ruling in *Vacco* and *Glucksberg*, the Florida Supreme Court upheld that state's prohibition on assisted suicide, finding no federal or state constitutional violations were present.³⁴ As in *Vacco*, the distinction between the passive act of refusing medical intervention, which is generally the right of a patient, and the patient's request for active assistance in terminating life, provided the State of Florida with a convincing justification for its statute's differential treatment of the two situations.³⁵ The judicial scrutiny is not strict, and the state's interests in preserving life,

²⁹ See *Quill v. Vacco*, 80 F.3d 716, 731 (2d Cir. 1996), *rev'd*, 521 U.S. 793 (1997).

³⁰ See *Vacco*, 521 U.S. at 800 & n.6 (discussing active-passive distinction).

³¹ See *id.* at 800 (noting that laws not involving suspect classifications are entitled to a "strong presumption of validity"), citing *Heller v. Doe*, 509 U.S. 312, 319 (1993).

³² See, e.g., *Glucksberg*, 521 U.S. at 704 (O'Connor, J., concurring) (describing States as appropriate laboratory for crafting procedures to safeguard liberty interests).

³³ The Court apparently did not see itself as the appropriate body to declare a right to assisted suicide. See *Washington v. Glucksberg*, 521 U.S. at 735 (1997).

³⁴ See *Krischer v. McIver*, 697 So.2d 97 (Fla. 1997). The patient was competent and terminally ill with AIDS. *Id.* at 99. The Florida court analyzed the statute for potential violations of the state's constitutional right of privacy, and for the statute's consonance with the United States Constitution's Fourteenth Amendment Equal Protection Clause. *Krischer*, 697 So.2d at 104.

³⁵ *Id.* at 102.

preventing suicide, and "maintaining the integrity of the medical profession" were compelling enough to permit the infringement of the right of privacy.³⁶

The United States Supreme Court's formulation of the interests at stake in the two right to die cases has left the American people with a dilemma. We are faced with gaps in the availability and quality of medical care, and financial concerns will ultimately impact upon personal choices as well as upon institutional processes for the distribution of services at the end of life. Who will have access to just what they need when they need it? And when will the "bureaucracy of death" as one scholar has termed the safeguards surrounding assisted suicide, result in loss of control and less privacy for the individual?³⁷ The State of Oregon is presently the proving ground for implementation of physician-assisted suicide.

II. THE TASK FORCE GUIDEBOOK FOR HEALTH CARE PROVIDERS

When the State of Oregon passed its Death With Dignity Act, known as Measure 16 in 1994, it became the first state where physician-assisted suicide could be lawfully performed.³⁸ Despite its primacy on the topic, Oregon has not yet had much real experience with assisted suicide.³⁹ Opponents of the Oregon assisted suicide bill have prevented its implementation until November 1997.⁴⁰

³⁶ *Id.* at 102-03. See also Baron, *Pleading for Physician-Assisted Suicide in the Courts*, *supra* note 7, at 400-02 for an excellent discussion of the trial court's decision in *McIver*.

³⁷ See Underwood, *supra* note 1, at 681-84 (criticizing elaborate safeguards as impeding exercise of right to control the choices at end of life and concluding that such procedures result in less individual autonomy and dignity). Professor Scott FitzGibbon argues that legalized assisted suicide does not enhance freedom or promote utility. See Scott FitzGibbon, *The Failure of the Freedom-Based and Utilitarian Arguments for Assisted Suicide*, 42 AM. J. JURIS. 211,12 (1997).

³⁸ See OR. REV. STAT. secs. 7.800-897(1995); *Lee v. Oregon*, 891 F. Supp. 1429, 1431 (D. Or. 1995) (finding Constitutional violation in Oregon Act), *vacated and remanded*, 107 F.3d 1382 (9th Cir. 1997), *cert. denied*, 66 U.S.L.W. 3282 (U.S. Oct. 14, 1997).

³⁹ See generally Verhovek, *supra* note 39 (noting recent report on use of Oregon law); Chin, *supra* note 39 (outlining report of first year); Stolberg, *supra* note 5 (discussing first reported death under the Oregon law was disclosed on March 25, 1998 by the advocacy group, Compassion in Dying).

⁴⁰ See Stolberg, *supra* note 5; Lewis, *supra* note 8 (describing political battle over Oregon law's execution wherein the U.S. Attorney General overruled the federal Drug Enforcement Agency chief who had issued a policy statement in November 1997 that would have imposed severe sanctions on physicians who prescribed lethal doses of medicine in accordance with the Oregon law); Robert L. Jackson & Kim Murphy, "Nation, Reno ruling boosts Ore. law," *Boston Globe*, June 6, 1998, at A3 (describing Attorney General Janet Reno's ruling that federal drug agents may not interfere with the drug prescriptions written by physicians under the Oregon Death With Dignity Act). A recent

When the Oregon Death With Dignity Act finally cleared the hurdles of law and public opinion, the state was faced with making the Act work, while remembering that a substantial number of Oregon residents were uncomfortable with this law. To this end, the Oregon Health Sciences University Center for Ethics in Health Care convened the *Task Force to Improve the Care of Terminally-Ill Oregonians*. The very name of this Task Force suggests clearly that its mission was not to address narrowly the issues raised by the Death With Dignity Act. Rather, the Task Force looked at the larger context of care for the terminally ill, viewing the request by a "competent, terminally-ill adult" patient for "a physician's prescription for drugs to end life" as only one of many significant issues needing discussion.⁴¹ The resultant Guidelines are meant to "promote excellent care of the dying and to address the ethical and clinical issues posed by enactment" of the Act. To this end, the Guidebook focuses heavily on what each involved health care professional should do to comply with the Act and it includes Guidelines for each chapter.⁴² However, within this discussion, the request for physician-assisted suicide is clearly just one element of care of the dying. In fact, the Guidebook devotes much attention to other important aspects of such care, including open communication, universal access to hospice care/comfort care and respect for different views of suffering, and of death. In effect, the Guidebook makes clear that a request for physician-assisted suicide is not a necessary component of "excellent care," but simply one available option.

The first specific issue addressed by the Guidebook is the importance of open communication. Under the Act, a patient should initiate the request for life-ending medication to be self-administered. This request must be made twice orally and once in writing. The first oral request must precede the doctor's prescription by 15 days, while the second oral request must come at least 15 days after the first. The written request must be submitted 48 hours before the prescription is written. Upon a patient's first oral request, the physician, according to the guidelines, must assume responsibility for ascertaining the meaning behind the patient's request. What this signifies is that, while the Task Force explicitly and repeatedly protects a doctor's right to refuse to participate in an assisted suicide, the Guidebook in Chapter 13 just as

report indicates that further efforts to clarify and reform the use of controlled substances for pain control as distinguished from assisted-suicide are underway at the federal level. See Ralph Miech, "A new law to help the dying," *Boston Globe*, Aug. 25, 1998, at A15 (predicting Congress's consideration of proposed Lethal Drug Abuse Prevention Act in fall session, a bill seeking to codify that such drugs for pain control are legitimate, even if they hasten death, as long as the purpose is not to cause death). *Id.*

⁴¹ See, GUIDEBOOK, *supra* note 10, at 3.

⁴² *Id.*

specifically mandates that the doctor must undertake a thorough and psychologically sophisticated discussion of a patient's request, whether or not the doctor intends to participate in the assisted suicide. Thus, if a terminally-ill patient requests a life-ending prescription, a doctor must try to determine if the patient is motivated by the fear of pain which can be dealt with in an alternate way, or, is the patient motivated by a realistic or unrealistic fear of becoming a burden to relatives. The chapter Guidelines emphasize that the doctor should make a special effort to determine if financial motives are behind the patient's request.⁴³ The doctor's role here is to help the patient see his or her motives more clearly, rather than responding immediately with an answer.

On the other hand, the doctors must, at this point, also examine their own feelings about providing a lethal prescription, making every effort to explore as fully as possible their own motivations.⁴⁴ This examination should include consideration of their own financial stake in the patient's decision. In fact, the Guidelines suggest that doctors should be willing to discuss with patient and family the issue of their financial interest if this question arises.⁴⁵

While physicians cannot ethically refuse to discuss a request for assisted suicide openly with the patient, the Act makes clear that doctors should not initiate such a discussion. Any request for assisted suicide should be initiated by the patient, to preclude the possibility of undue influence. By suggesting that physicians should not decide whether or not to participate without some rigorous self-examination, the Guidelines mandate open-mindedness and respect for divergent viewpoints. The bottom line, however, is concern for the patient's welfare. The Guidelines insist that doctors must make clear that the patient will not be abandoned, or symptoms left untreated during the dying process, regardless of the doctor's personal beliefs.⁴⁶

While this may seem like a commonsense Guideline, in reality many patients and doctors may find it a difficult one with which to comply. The relationship described here, which resembles in many respects a therapeutic relationship, is not one for which all doctors and patients are prepared. Many patients may not have an emotional style which allows them to confront such issues with a relative stranger, or at all. Many doctors see themselves as providing discrete medical services

⁴³ *Id.* at 42 (directing health care providers to "fully explore" any evidence of personal financial factors and those of any others who may "be perceived to have a direct or indirect financial interest").

⁴⁴ *Id.* at 5-6 (directing the physician to "act in ways that are consistent with his/her personal beliefs, while respecting the beliefs of the patient").

⁴⁵ See *supra* note 43 and accompanying text.

⁴⁶ *Id.* at 7, 15.

rather than therapeutic discussions. In fact, either or both parties may find themselves unwilling or unable to rise to the challenge of mature, sophisticated exploration of motivation. While the intensity of the death experience may make some patients more open, it is highly unlikely to have this effect on every patient. Since these are voluntary Guidelines, there is no specific penalty for doctors who cannot offer their patients this kind of intimate discussion. Nevertheless, the Guidelines are spelling out here an ethical responsibility which seems to expand a doctor's traditional role in care of the dying. To the extent that this Guideline raises the awareness of doctors about the importance of open communication, it may add to the impact of the Act on the overall quality of care for terminally-ill patients.

Chapter Three of the Guidebook examines extensively how to proceed if this initial open discussion leads to a doctor's decision not to participate in an assisted suicide. Every doctor, health care worker, institution and health care system is clearly entitled, under the Act, to the right of "conscientious practice."⁴⁷ The thrust of this right, as defined by the Task Force, reflects again an emphasis on respect for divergent viewpoints. Thus, health care workers have an absolute right to take only those professional actions which are the result "of respecting one's own moral beliefs while at the same time respecting the moral beliefs of others."⁴⁸ What this means in practice is that if a doctor or hospice nurse must, for reasons of conscience, refuse to assist in a suicide, they must also arrange for a transfer of care to a doctor who can meet the patient's stated needs for care, rather than leaving the patient with the choice of being abandoned or abandoning the request for a lethal prescription.⁴⁹ If doctors cannot, in conscience, arrange for transfer to another doctor, they cannot hinder such a transfer when it is facilitated by others. In addition, the Guidelines emphasize a doctor's ethical responsibility to continue to care for these patients while a transfer to another doctor is being arranged.

In this context, the Task Force suggests that institutions and health care systems who cannot, in conscience, participate in assisted suicide should make this known to both patients and employees at the initial point of contact. Institutions should work out in advance a policy for resolving conflicts which arise when health care workers cannot in conscience comply with a patient's request. Health care systems which opt not to participate in assisted suicide, as did the Veterans Adminis-

⁴⁷ *Id.* at 7 (distinguishing this from the concept of "conscientious objection" in which people are not obligated to perform acts that violate their consciences).

⁴⁸ *Id.* at 7-8.

⁴⁹ *Id.*

tration Medical Centers,⁵⁰ must arrange for a patient who requests assistance with an in-patient suicide, to be transferred to another health care system. However, such a health care system cannot censure a doctor who complies with a patient's request for a lethal prescription outside of the context of their institutions. Further, the discussion of "conscientious practice" emphasizes that a request for assisted suicide should be a clear sign that the patient's care needs are unmet and that some of these needs can be satisfied immediately by the attending doctor, even if that doctor is not ultimately willing to participate in ending life.⁵¹

Again here, the emphasis is on "total care" and planning for different moral positions. While the rights of health care workers and health care systems are clearly protected, their ethical responsibility not to abandon patients but rather to meet as many of patients' needs as can be conscientiously met is emphasized repeatedly. The approach here suggests that there are few situations where the needs of both parties in a conflict involving conscientious practice cannot be met, provided the caregiver maintains open communication and has done some advance planning to handle the conflict.

When a patient initiates a request for a lethal prescription, the doctor must not only undertake open discussion of the reasons behind the request but must, under the Act, make certain that the patient is able to make an informed decision about the request. To fulfill this obligation, the doctor must provide the patient with detailed information about his/her medical diagnosis, prognosis, potential risks of taking the medication, the probable result of taking the medication and feasible alternatives to assisted suicide. Under the Act, terminally ill residents of Oregon have the alternative options of hospice, comfort care, palliative care, pain management, refusal of treatment, and request for a prescription to end life. To fully meet this obligation, doctors must educate themselves about the range of services involved in these options. Patients should be informed that hospice, comfort care and palliative care all involve treatments whose goal is comfort and dignity rather than cure. Patients must be told that hospice programs seek neither to prolong life nor to hasten death, but rather to manage pain. In addition, patients, especially those who can't self-administer life-ending medication, should be informed, if they request such medication, that they can instead request termination of forced feeding and hydration.

⁵⁰ *Id.* at 91 (stating Veterans Affairs policy prohibiting the practice of dispensing lethal doses of medication to veterans at VA hospitals).

⁵¹ *Id.* at 7.

As part of the process of insuring informed consent, attending physicians must make clear that patients have the right to rescind any request for a lethal prescription at any time, through the fifteen-day waiting period and the actual issuance of the prescription. Obviously, the patient may also change his/her mind about using the prescription at any time. Again, the doctor must make certain the patient is aware of this right of rescission. In fact, the doctor should remind the patient of this right at every point in the process leading to a prescription for life-ending medication.⁵² If patients continue to insist on assisted suicide after they have been fully informed, doctors must then ascertain that the decision is truly voluntary on the patient's part, not the product of undue influence by others. When the attending physicians are satisfied as to the patient's volition, they should inform the patient that he/she can enter a hospice program for the fifteen-day waiting period after the initial request.

Since hospice teams generally coordinate all services available to terminally-ill patients, one of the central recommendations of the Guidelines is that the state of Oregon make certain that hospice care is available to all terminally-ill Oregonians, even those who are uninsured. The Task Force recommends that insurance plans be encouraged to find ways to cover hospice care, and "supports universal access to hospice and comfort care."⁵³ If patients do not or cannot elect hospice care, the Guidelines suggest that doctors have an ethical obligation to make certain that patients get the necessary comfort care anyway. This emphasis on hospice care flows naturally from the central premise of the Guidelines, that the important issue for doctors is upgrading the total quality of care for the terminally ill, not simply dealing with requests for assisted suicide. Significantly, the Guidelines stress the importance of comfort care irrespective of the decision to request assisted suicide. The suggestion here is clear: assisted suicide may be a rare request, while comfort care should be the norm for all terminally-ill patients.

The section of the Guidelines which deals with patient rights and responsibilities emphasizes that a patient has the essential right to be the primary decision-maker about health-care. Further, the patient has the right to receive enough information about his or her options to make an informed decision.⁵⁴ In addition to re-emphasizing the doctor's obligation to fully inform a patient, the Guidelines recommend that

⁵² *Id.* at 22 (directing physicians to remind patients that it is possible to have a change of mind at any time during the process).

⁵³ *Id.* at 11.

⁵⁴ *Id.* at 15 (discussing in Chapter 5, patients' rights and responsibilities including the right to have questions answered honestly).

health care systems provide the necessary social and counseling services to allow patients to process this information effectively within a context which respects their personal values. Again, the Guidelines make clear that patients always have the right to privacy and confidentiality regarding treatment decisions. On the other hand, doctors have a competing responsibility to communicate to other caregivers the information necessary for these caregivers to perform their duties effectively within the context of their own moral code. In other words, the doctor should prevent a situation where another health care worker unknowingly and unwillingly participates in or interrupts an assisted suicide. This presents a conflict for the doctor which must be resolved, under the Act, in favor of patient privacy. However, the Guidelines suggest that a patient has a concomitant responsibility to consider the rights of these health care workers to "conscientious practice."⁵⁵

The Oregon Death With Dignity Act adds to these general patient rights the right to know as soon as an attending physician diagnoses that one has a life-threatening illness which will probably result in death within six months. This information is essential for the patient to "make personal plans, seek hospice benefits, or request a prescription for a lethal dose of medication."⁵⁶ In addition, patients have the right, under the Act, to know if their doctor and/or health care system will participate in physician assisted suicide, as well as whether their insurance will cover the associated costs. As mentioned above, patients also have the right to change physicians and to obtain assistance in finding another physician.⁵⁷ Clearly, the thread which runs through these rights and responsibilities is the one we have seen in previous portions of the Guidelines—the importance of full and open discussion of the patient's situation and the importance of respecting both the patient's values and the values of health care providers. This section emphasizes most strongly, however, the patient's right to be the principal decision-maker. Indeed, this is the right which drives the rationale for allowing physician-assisted suicide.

While the Death With Dignity Act focuses almost exclusively on the patient and the attending physician, the Guidelines give more attention than does the Act itself to the role of the family in the decision for assisted suicide. The Act itself mentions only that the doctor should encourage the patient to inform family members of a decision to request lethal medication, that a family member can be one of the witnesses to the written request for a lethal prescription and that, like the doctors, family members are immune from prosecution relative to the suicide if

⁵⁵ *Id.*; see *supra* note 47 and accompanying text.

⁵⁶ *Id.* at 15.

⁵⁷ *Id.* at 15-16 (stating that this request must not be hindered).

the provisions of the Act have been followed. However, the Act also makes clear that the patient may refuse to notify family of a suicide decision.⁵⁸ If the patient does refuse such notification, the doctor cannot then refuse to consider the patient's request.

The Guidebook in Chapter 6 spells out in some detail the reasons why the doctor should attempt to involve personal others in a discussion of assisted suicide. The Task Force suggests that family members can be useful in helping the patient to make a decision about end-of-life options, as well as in offering emotional support if assisted suicide is requested. If family are involved in the decision, the doctor can inform them fully about what to expect and how to act during and after the suicide in order to facilitate completion of necessary paperwork without involving the State Medical Examiner. In addition, the family themselves, will probably suffer less from the patient's death if they are involved in and knowledgeable about the patient's decision-making.⁵⁹ Again here, the Guidelines emphasize the patient's right to decide whether or not to involve family and the doctor's obligation to provide more than medical support. Doctors here are seen as ethically responsible for encouraging patients to see the advantages of involving family in decisions about suicide. In a sense, this emphasis on doctor responsibility casts some doubt on the patient's self-sufficiency in decision-making. Perhaps these Guidelines are suggesting that terminal illness renders most normally competent decision-makers so emotionally confused as to need more than the usual support in decision-making.

After discussing the communication which should take place prior to assisted suicide, the Guidelines turn to a discussion of the role of the attending physician in the actual death experience of a terminally-ill patient. Here the Guidelines re-emphasize the need for defining care of the terminally ill in terms of comfort care rather than in terms of frantic, costly and futile attempts to prolong life. Once a patient requests assisted suicide, the Guidelines spell out the doctor's obligations in executing this request.

First, the doctor must determine a patient's eligibility for assisted suicide under the Act. An eligible patient will be an Oregon resident over the age of 18 who has a terminal illness and less than six months to live. In addition, such a patient must be capable of making his/her own health care decisions and must make the request voluntarily. Under the Act, the doctor must determine these conditions to be present

⁵⁸ *Id.* at 17 (noting that the Act "focuses almost exclusively on the patient and the physician").

⁵⁹ *Id.* at 17-18 (citing studies about the effect of a suicide on family members).

before proceeding further to implement a request for assisted suicide.⁶⁰ Once a patient is determined to qualify for such a request, the attending physician must enlist the services of a qualified second physician, who must confirm the patient's diagnosis, the patient's capacity to make a decision about suicide, and the voluntary nature of this decision. The Guidebook in Chapter 7 suggests that this consulting physician be brought in from outside of the attending physician's practice community to avoid any possible conflict of interest. The consulting physician must base this second opinion on a review of the medical record, an interview with the patient and an examination of the patient.⁶¹

In discussing the doctor's responsibility to determine that a patient is competent to make a suicide decision, the Oregon Act requires that the attending physician rule out the presence of a mental condition which would impair the patient's ability to make this decision. Since attending physicians are often incapable of accurately diagnosing mental health problems, the Guidelines suggest that a clinical psychologist or a psychiatrist be brought in to make this determination.⁶² If the attending physician has not procured such a mental health consultant, the Guidelines suggest that the consulting physician should do so.⁶³

These mental health consultants are engaged by the attending physician specifically to determine the patient's competency to make a decision to "hasten death by self-administering a lethal medication."⁶⁴ Clearly, however, mental health workers have the same right as other health care professionals to conscientious practice. In fact, the Guidelines suggest that mental health workers must reveal strong bias for or against assisted suicide before accepting an invitation to consult. The Guidelines further suggest that a mental health worker who is opposed to physician-assisted suicide should refuse to perform such a consult. In fact, the Task Force reports that only 36% of Oregon psychologists are willing to perform such competency evaluations.

The psychologists' reluctance may be due to the fact that there are, at the moment, no firm guidelines for determining competency. Thus, even mental health professionals with the suggested background in psychodiagnostics and medico-legal matters face an ambiguous task. While determining competency is never a certain science, such a determination is even more difficult in the case of a terminally-ill patient who requests assisted suicide. For one thing, time and financial

⁶⁰ *Id.* at 22 (discussing the three-part process of screening).

⁶¹ *Id.* (noting that this may require more than one meeting).

⁶² *Id.* (citing studies indicating PCPs have "difficulty identifying significant depression and other mental health conditions").

⁶³ *Id.*

⁶⁴ *Id.* at 30.

constraints usually limit the mental health consultant to one meeting with a patient. Few consultants feel comfortable determining competency on the basis of such short acquaintance.⁶⁵ In addition, the circumstances of terminal illness make a determination of competency more difficult. Classic symptoms of depression such as weight loss can very often be attributable to a patient's physical disease. Likewise, depression, when present, may not be a sign of mental illness which impairs competency, but may instead be a realistic response to terminal illness. Delirium, often present in heavily medicated patients in the last weeks of life, clearly affects competency. But, delirium comes and goes and the Act does not specify whether the patient must be consistently competent during the whole of the fifteen-day waiting period.⁶⁶

What often happens, according to the Task Force's research, is that a mental health consultant can treat a depressed patient and that "[t]reatment of psychiatric disorders in those who attempt suicide is very effective in abolishing suicidal ideation."⁶⁷ The Guidelines suggest the desirability of such a result. In fact, the possibility of treating depression and thus removing the desire for suicide is one of the main reasons why the Task Force recommends routine employment of mental health consultants when fulfilling the conditions of the Oregon Death With Dignity Act. If, however, a mental health consultant determines a patient to be competent, but recommends treatments and the patient refuses such treatment, the doctor must provide the requested prescription for life-ending medication, in spite of the psychologist's treatment recommendation. On the other hand, once a mental health consultant is employed, a doctor may not write such a prescription unless the mental health consultant can comfortably certify competency.⁶⁸

This suggestion by the Task Force that doctors obtain a mental health consult before complying with a request for life-ending medication seems a suggestion which will dramatically reduce the number of actual physician-assisted suicides. If mental health professionals follow the Guidelines in evaluating patients, it seems likely that, given the lack of consensus on requirements for competency, many patients will be found not competent to make the decision for suicide. An additional number of patients will probably change their mind about ending their lives when provided with palliative psychiatric care. In fact, the Task Force appears to hope for this result based on an assumption that most

⁶⁵ *Id.* (noting a survey of all Oregon psychiatrists showed a split in support of the ethical permissibility of physician-assisted suicide).

⁶⁶ *Id.*

⁶⁷ *Id.* at 31.

⁶⁸ *Id.* at 30.

people, if given the appropriate mental health support will not choose death, even when they are terminally ill. Since the Guidelines seem to put so much burden on the attending physician to provide therapeutic support that they may not be trained to provide, the inclusion of a mental health professional does seem critical to executing the mandate of the Oregon Death With Dignity Act.

If, after the medical and mental health consultants provide the necessary corroboration and the patient has been fully informed, the patient indicates a continued desire for help in committing suicide, the attending physician must take responsibility for facilitating the final act. This facilitation goes beyond writing the necessary prescription for lethal medication. A doctor should also arrange for procurement of the prescription, preferably by obtaining and delivering it personally, and then informing the patient, family members, and other involved health care workers about what to expect once the medication is taken. The doctor is also responsible for providing anti-emetics and analgesics to increase the patient's comfort once the lethal prescription is taken, and being available at the time of the suicide to contact the funeral home and sign the death certificate. The Guidelines suggest further that the attending physician complete a POLST Form (Physician's Orders for Life-Sustaining Treatment), which includes the patient's wishes about resuscitation and other medical interventions should EMTs later have to be involved because the patient experiences medical complications or has a change of opinion. Ethically, the doctor has an additional obligation to console the family after the death.⁶⁹

One of the most important responsibilities which the attending physician incurs under the Death With Dignity Act is the responsibility to carefully document compliance with each of the Act's mandates. Thus, the doctor must document and date all conversations undertaken to make certain that the patient can give "informed consent." In addition, doctors must note the dates, times, and circumstances of the patient's two oral requests, as well as making sure the written request uses the correct form and is properly witnessed. All required consults must be carefully documented. The doctor must also take responsibility for filling out the necessary paperwork required by the state of Oregon, to prove compliance with the Act. This paperwork is important since the Act mandates the Oregon Health Division to collect data on use of the Act and enforcement of its provisions.⁷⁰ Doctors need to make certain that patients know this information will be shared with the Health Division and that confidentiality cannot be assured in this

⁶⁹ *Id.* at 25 (noting "physician continues to have responsibility, as with other patient deaths, for supporting loved ones in their bereavement").

⁷⁰ *Id.* at 43 (discussing in Chapter 14 of the GUIDEBOOK, reporting requirements).

context. The Health Division, however, must keep the information submitted confidential. The Death With Dignity Act does not specify any legal penalties for a physician or other health care worker who fails to comply with the documentation requirements of the Act. If such failure comes to light, however, the health care worker can be reported to the appropriate licensing board.

The Guidelines also point out that the attending physician may possibly incur some conflicts and legal liability during this process. As mentioned above, if the patient requests privacy, this supersedes the doctor's obligation to inform a pharmacist or other health care workers about the patient's decision.⁷¹ Here, the doctor might knowingly be forced to put these other health professionals in the position of partaking in an act they cannot condone morally. Again, if a physician decides to procure the medicine from the pharmacist personally, the physician incurs the legal liability "for the preservation and timely delivery of the medication."⁷² If doctors are present at an assisted suicide of a patient who cannot self-administer the medication without help, these professionals encounter a legally ambiguous situation. The Act clearly prohibits ending a patient's life "by lethal injection, mercy killing or euthanasia," but does not provide guidance on the degree of assistance a doctor may provide to enable the patient to self-administer the drug. The Guidelines suggest that the healthcare worker make certain that "the patient remains in control of the decision, timing and every aspect of the action."⁷³

The doctor who is present when a patient takes a lethal medication also takes on the responsibility of providing life-saving measures if the patient then has a change of mind. The Act makes clear that the patient can rescind the decision at any point, even after ingestion of medication. If the patient does so, the attending physician then has the responsibility to decide what constitutes appropriate action. The doctor's ability to act is made more difficult if the patient's wish to rescind is communicated by the family. The Act makes clear that only the patient can rescind the decision. Here, the doctor is faced with the difficult task of determining the patient's true wishes and acting accordingly.⁷⁴ The Guidelines suggest that the attending physician can be best protected in this scenario by having the patient complete an advance written directive before the medication is taken. In such a directive, the patient can appoint a health care representative autho-

⁷¹ *Id.* at 23 (discussing physicians' responsibility to other health care providers).

⁷² *Id.* at 24 (noting also the physicians' commensurate increased liability).

⁷³ *Id.* at 28.

⁷⁴ *Id.* (stating that "life-saving interventions should be based on professional judgment").

alized to make decisions for him or her as well as specifying directly what lifesaving measures should be employed in what circumstances.⁷⁵

The Guidebook also suggests several ways in which an attending physician can minimize his/her liability when participating in an assisted suicide. In Chapter 15, the Task Force suggests the physician should make certain that "patients receive appropriate care, that only qualified patients are given a prescription for medication to end life, and that only the limited assistance authorized by the Act is given."⁷⁶ The physician should also be careful to verify and document the patient's qualifications, mental capacity, volition, informed decision, and compliance with the procedure for oral and written request. In fact, the Guidelines suggest that the physician will be best protected by having a witness in the room during sessions when the patient is given the detailed explanation necessary for an informed decision and at the time of the oral requests, even though the Act does not require such witnesses. The presence of these witnesses should be noted in the record. Doctors should also document all conversations with family about the patient's decision. In addition to following the requirements of the Oregon Death With Dignity Act scrupulously, the attending physician would be wise to resolve any situation where there is doubt about the patient's qualification or volition by declining to prescribe life-ending medication. In all cases, consulting available legal experts and checking with malpractice insurers about coverage of possible claims resulting from participation in assisted suicide are prudent protective actions.⁷⁷

All in all, the Guidelines place great responsibility on an attending physician whose patient decides to request assisted suicide. Not only must this physician assume responsibility for informing the patient and arranging the logistics of the act, but this physician must also be responsible for follow-up after the patient's death. In truth, while the Act focuses mainly on the need for a physician to respect a terminally-ill patient's right to choose death, the Guidelines focus heavily on the physician's responsibility to deal with the patient's emotional and physical well-being during this period, as well as on the well-being of the patient's family and other health-care workers. While this is a humane ideal, one wonders whether real-life physicians can, or will devote so much time to an individual patient. It seems like such a role

⁷⁵ *Id.* at 49 (finding that there are added complexities when a family member rather than the patient communicates the recission).

⁷⁶ *Id.* at 46. See generally M. Cathleen Kaveny, *Propter Honoris Respectum: Managed Care, Assisted Suicide, and Vulnerable Populations*, 73 NOTRE DAME L. REV. 1275, 1277 n.5 (1998) (discussing Oregon's GUIDEBOOK as problematic in that physicians may follow or ignore its guidelines).

⁷⁷ See GUIDEBOOK, *supra* note 10, at 46 (discussing goal of minimizing liability).

requires a Marcus Welby rather than a graduate of today's medical schools who compete for jobs in high tech medical environments.

At this point, the Guidelines turn to a consideration of the role of other health-care providers, including nurses, pharmacists, and EMTs in an assisted suicide. In general, nurses, social workers, and counselors who are involved with the patient and family are often the first ones a patient approaches about a request for assisted suicide. Thus, these workers should inform themselves fully of the provisions of the Oregon Death With Dignity Act. At the outset, they should provide the same kind of open discussion of the decision as is required of doctors. Again, they too should consider ahead of time, their own values regarding participation in an assisted suicide. If they are unable to provide the necessary discussion and support for a patient, these healthcare workers, like unwilling attending physicians, must make sure the patient receives this support from someone else. In this situation, most health care workers should simply refer the issue to the attending physician who must ultimately be consulted anyway. If these health care workers are present at the actual suicide, they face the same problems as doctors in determining how much assistance to provide in self-administration of drugs as well as in deciding about life-preserving interventions.⁷⁸

Pharmacists, too, have a right to refuse to participate in assisted suicides if this practice is against their personal moral codes. As with other health-care workers, pharmacists who cannot, in conscience, assist in a suicide should attempt to refer the patient to a pharmacist willing to fill a life-ending prescription. If the pharmacist cannot, in conscience, make such a referral either, the pharmacist should refer the patient back to the attending physician.⁷⁹ Any pharmacist who fills a lethal prescription has an obligation to consult with the prescribing physician about the patient's total pharmacological history and the implications of this history for the current prescription. In addition, the pharmacist should provide medication counseling, in a private setting, for the patient or family member who picks up the prescription, assuming the family member involved knows the purpose of the medication. Such counseling may be provided by telephone to patients who are bedridden. If a patient refuses such counseling, or if the pharmacist knows the attending physician is providing the needed medication counseling, the pharmacist may forego this requirement. However, the pharmacist should document carefully any medication

⁷⁸ *Id.* at 27-28 (finding a lack of clarity in the Act with respect to health care providers other than physicians).

⁷⁹ *Id.* at 35 (noting Act does not require anyone to participate in physician-assisted suicide).

counseling provided in conjunction with the Oregon Death With Dignity Act, as well as filling out the requisite forms when a lethal prescription is dispensed.⁸⁰

The Task Force's discussion of possible life-ending prescriptions continues the emphasis on total patient care, even in the context of an assisted suicide, suggesting combinations of drugs which will minimize negative reactions, providing information about how to make extremely bitter barbiturates more palatable and suggesting information that patients and family must be given, including the amount of time it may take for the patient to die, which can be up to 24 hours in the worst case scenario.⁸¹

When considering the role of emergency medical personnel in assisted suicide, the salient point is that these personnel are called upon when things have not gone as planned. If the patient changes his or her mind after ingesting the medication, or if family members panic because of patient reactions to the drug, or if death takes too long to occur, EMT's are often brought in by a 9-1-1 call. The Act is not specific about what an EMT can do in such a situation, particularly if a technician, in an emergency situation, cannot in conscience refrain from attempting to save the terminally-ill person's life.⁸² The Guidelines suggest that doctors make provision for advance written directives from the patient together with the Oregon Division of Health's POLST form⁸³ to be physically available at the scene of an assisted suicide. This will give the emergency personnel a written record of a patient's prior wishes, as documented by the attending physician.

In addition, the Act encourages emergency departments to develop guidelines for making treatment decisions for terminally-ill patients who have self-administered a lethal drug. These guidelines should address circumstances under which a patient who has self-administered a lethal drug in connection with the Death With Dignity Act will be allowed to die without intervention, documentation which will be required to honor a patient's previously-stated wishes, procedures for administering comfort care to such patients, and procedures for honoring conscientious practice by emergency staff who cannot, in conscience, participate in assisted suicide.⁸⁴ Of all the health-care workers involved in an assisted suicide, EMT's are probably given the

⁸⁰ *Id.* at 36 (additionally, pharmacists are required to initiate counseling about medication).

⁸¹ *Id.* at 33-35 (discussing various reasons for drug reactions and slower-than-expected deaths).

⁸² *Id.* at 38 (suggesting that emergency personnel develop protocols for handling such calls).

⁸³ *Id.* Appendix C, at 71-72.

⁸⁴ *Id.* at 38-39.

least guidance by the Death With Dignity Act. Thus, there is a need for these professionals to agree on common guidelines for use in 9-1-1 calls involving an assisted suicide.

All healthcare providers, including physicians, nurses, physician's assistants, social workers, and pharmacists, share responsibility under the Act for enforcement of its provisions. The Guidebook in Chapter 12 emphasizes that any health care provider who knows that another provider is not complying with the Act must report that provider to the appropriate licensing board and to whatever other agencies—hospital, insurance carrier, physician's group—are involved. So, if a nurse witnesses a doctor giving a lethal prescription to a clearly incompetent patient, she/he must report the doctor's behavior to the appropriate agencies. If the nurse fails to do so, she/he becomes subject to disciplinary action. If a health care professional is not sure about the legality of another professional's actions, he/she should consult the appropriate licensing board. This is the only enforcement policy contained in the Guidelines.⁸⁵ Dependent as this policy is on individual judgment, its efficacy is unclear. Since competency, for example, is difficult for even mental health professionals to determine, many health care providers will probably not feel comfortable making judgments about the actions of other professionals. Again, the wide differences of opinion on the appropriateness of assisted suicide and the subjective nature of many of the judgments which must be made, complicate the question of trusting one professional to report another professional. In reality, anything but extremely egregious malpractice will probably go unreported in most cases.

In summary, it is clear that the Task Force wrote these Guidelines for implementing the Death With Dignity Act in full awareness of the division of public opinion and the wide range of professional values within the State of Oregon. The central thrust of the Guidelines is respect for the right of both patient and doctor to follow their individual consciences. A second key element of the Guidelines is the emphasis on the use of comfort care and hospice services to make the death experience as bearable and dignified as possible. In fact, there is incredible effort made to accord the terminally-ill patient respect, options, and autonomy. Again, there are so many safeguards built into the process delineated in the Guidelines to specifically protect these patient rights, that any patient who elects assisted suicide in this context will most probably be very sure of what he or she is doing. The process is designed to suggest alternatives and provide constant checks on the patient's true condition and true desires. All but the most

⁸⁵ *Id.* at 40 (adding that failure "to report a fellow licensee may result in disciplinary action against the professional who knew of the illegal conduct").

determined patients are likely to be dissuaded from assisted suicide in the course of fulfilling the requirements of the Act. In fact, the dominant impression one receives as one reads these Guidelines is that suicide will not really be necessary in most cases. Rather, many patients will probably discover that attentive listening and counseling along with improved comfort care makes it feasible to wait for death to come on its own. At bottom, however, in spite of offering many inducements to live, a patient's right to choose suicide, once fully informed, is rigorously protected.

One of the most striking features of the Guidelines is the stress from the tremendous responsibility an attending physician takes on when a patient requests assistance with suicide. The reality is that this responsibility requires a doctor to be not only careful about complying with the requirements of the Act but also self-protective if the physician is to avoid possible liability. It is unclear whether most physicians will have the resources to provide the extensive therapeutic involvement with patients recommended by the Guidelines. What is clear is that any physician who makes a conscientious effort to fulfill the obligations set forth by the Task Force will most probably benefit from greatly improved communication skills and increased self-knowledge. Most probably, however, a significant number of doctors will decide not to become involved in a process which involves so much time and risk. While the Act suggests that a physician should decline to participate in assisted suicide only for reasons of conscience, the reality may be that many physicians decline for more self-interested reasons.

In this context, the most significant deterrent to a physician's participation in assisted suicide might be the increased risk of liability in a wrongful death suit. In fact, the Guidelines in question might very well create a climate within which a physician's risk of being found negligent in a civil suit for wrongful death would hinge on the care with which the physician adhered to the Task Force's Guidelines. More specifically, in a case where close relatives do not support a terminally ill patient's decision for assisted suicide, these relatives might very well bring a civil action for wrongful death against the assisting physician. In such a suit, the Guidelines would most likely play a very important part.

Thus, in spite of the voluntary nature of the Guidelines, their very existence could give a plaintiff's attorney the opportunity to enter the issue of the Guidelines, or pertinent parts of them, into the record during cross-examination of the physician-defendant. Here, this attorney could ask the physician if he/she was familiar with the Guidelines. If the physician answered that he/she knew of the existence of the voluntary Task Force Guidelines but had not read them, a jury might reasonably conclude that the physician had been negligent.

Again, if the physician admitted having read the Guidelines but not following them, this too could be construed as grounds for a finding of negligence. In either case, these voluntary Guidelines might reasonably be seen as the logical standard against which to measure level of care. Given this reality, the prudent Oregon physician should become thoroughly conversant with the provisions of these Guidelines and adhere to them scrupulously when granting a patient's request for assisted suicide. Physicians who do not wish to incur this level of commitment would do well to avoid completely any involvement in assisted suicide.

Perhaps the most important discussion about the Task Force's Guidelines for implementing the Death With Dignity Act is the discussion about the ethical implications of this Act.

III. ETHICAL ANALYSIS OF OREGON'S GUIDELINES FOR HEALTH CARE PROVIDERS

A. Task Force Responds to the Oregon Death With Dignity Act

It is critical at the outset to understand the role of the Task Force in establishing Guidelines to the Oregon Death With Dignity Act. Its expressed purpose was "...to promote excellent care of the dying and to address the ethical and clinical issues posed by enactment of the Death With Dignity Act."⁸⁶ In fact, the Task Force's intent was to maintain a neutral position on physician-assisted suicide.⁸⁷ Representatives of the Task Force included physicians, a psychiatrist, a hospice worker, a lawyer, a Roman Catholic priest, and others representing the Oregon consortium of health care professional organizations.

Their mission was difficult. End-of-life care issues are almost insurmountably diverse and complex. Values and bioethical considerations on euthanasia ethics⁸⁸ had to be confronted within the context of

⁸⁶ *Id.* at 3. Members of the Task Force intended representatives from the State of Oregon's health care professional organizations, state agencies involved with health care and health care systems in the Portland, Oregon area. *Id.*

⁸⁷ *Id.*

⁸⁸ See C. Everett Koop, M.D., KOOP, THE MEMOIRS OF AMERICA'S FAMILY DOCTOR 293 (1991) (stating, "I believe "euthanasia" lies outside the commonly held life-centered values of the West and cannot be allowed without incurring great social and personal tragedy."), and see generally Yale Kamisar, *Physician-Assisted Suicide: The Problems Presented by the Compelling, Heartwrenching Case*, 88 J. CRIM. L. & CRIMINOLOGY 1121 (1998). Professor Kamisar states that the question "What would you want done to you if you were in this person's shoes?" is the wrong question to ask regarding a patient experiencing unmitigated pain, rather we should ask "Should we enact a law allowing PAS under certain circumstances?" Professor Kamisar considers a "middle ground" on PAS that includes "guidelines ..so detailed ..that compliance with them virtually guaranteed immunity from prosecution. Then a significant number of physicians

physician-assisted suicide and Oregon's Death With Dignity Act. There now appear to be two layers of public debate at the state level: first, should the state legalize a physician's right to prescribe a lethal drug intended to end the life of a competent, terminally-ill adult? Second, if so, to what extent should that right be regulated? Since the Oregon voters decided in November 1997 to reaffirm their law on physician-assisted suicide, the Task Force's mission was to address the process of developing professional standards to protect vulnerable, terminally-ill patients while respecting their values and privacy concerns.⁸⁹

B. Ethical and philosophical considerations of the Oregon Guidelines for Health Care Providers

The ethical landscape in the physician-assisted suicide debate profiles a vast array of moral agents on the end-of-life care team. Added to the obvious group of physicians, family and loved ones, nurses, hospital and hospice administrators, pharmacists, psychologists, psychiatrists, and the clergy, are the ethical theorists who provide principles that are applicable to euthanasia issues. This is significant to the legal community because legal analysis on physician-assisted suicide is often based on moral and ethical arguments.⁹⁰ The authors of the Guidelines were sensitive to the ethical development of physician-assisted suicide and acknowledge its importance in the Guidebook. There it states:

probably would practice PAS/euthanasia in the open-fully and freely consulting colleagues and other professionals and perhaps even ethics committees." He then concludes by stating a rejection of a "middle ground" since this would "convey the message that the practice was now considered ethical." It appears that Professor Kamisar's utilitarian calculus precludes a justification of the Oregon's Guidelines for Health Care Providers since it may encourage the open practice of PAS with the perception that it is ethical. See generally, John Deigh, *Physician-Assisted Suicide and Voluntary Euthanasia: Some Relevant Differences*, 88 J. CRIM. L. & CRIMINOLOGY 1155 (1998).

⁸⁹ See GUIDEBOOK *supra* note 10, at 3, and see generally Scott FitzGibbon, *The Failure of The Freedom-Based and Utilitarian Arguments for Assisted Suicide*, 42 AM. J. JURIS. 211 (1997) Professor FitzGibbon queries, "Would freedom be enhanced by the practice of physician assistance in suicide or by legal doctrines permitting it?" His thesis is that PAS violates a person's freedom because it ends further activities and projects and violates commitments the patient may have made. Professor FitzGibbon would possibly find the Oregon Guidelines a transgression of a patient's values and privacy concerns since they violate his conception of free choice.

⁹⁰ For the first time in American judicial history, six moral philosophers, Ronald Dworkin, Thomas Nagel, Robert Nozick, John Rawls, Thomas Scanlon and Judith Jarvis Thomson, filed an *amicus curiae* brief in the State of Washington v. Glucksberg physician-assisted suicide case.

....[w]e present ethical and practical guidelines to enhance compassionate care whether or not a physician or health care system is willing to participate in providing a lethal prescription as set forth in the Act... Each chapter begins with a philosophical section follow by guidelines and references.⁹¹

The following discussion analyzes Guideline No. 2. *The Meaning Behind a Patient's Request*, and its related comments on the ethical and philosophical underpinnings. It was selected from the other Guidelines as the patient's understanding of his/her meaning in requesting physician-assisted suicide goes to the very essence of moral and ethical values.

C. Guideline No. 2. - *The Meaning Behind a Patient's Request*

Guideline No. 2 establishes procedures to assist the attending and consulting physician in a discussion of a patient's request for a lethal prescription.⁹² The Guidelines address the complex issue of the patient and attending physician's *motivation* once the patient begins a discussion of physician-assisted suicide. Various theories of jurisprudence develop frameworks of analysis to determine intent, negligence, vicarious liability and constructive intent that, in some fashion, relate to the issue of *motivation* and the state of mind of the actor. It seems appropriate that the Task Force should have addressed this issue at the beginning of its report.

(i) *Rawlsian analysis of Guideline No. 2*: In our pluralistic democracy of choice and self-determination a prominent legal and political theory is based on government neutrality.⁹³ Professor John Rawls's book published in 1971, *A Theory of Justice*,⁹⁴ explains what he calls a *Second Principle of Justice*, that is especially relevant to this theory. The principle states:

⁹¹ See GUIDEBOOK *supra* note 10, at 2, see Yale Kamisar, *The Future of Physician-Assisted Suicide*, TRIAL, July 1998 at 48. Professor Kamisar stated that "PAS opponents would fight hard to include a "family approval" provision in any legislation regulating assisted suicide (and) would also want mandatory waiting periods, specific information and procedures to ensure that the decision to choose PAS is "truly informed," and all sorts of notification requirements and bans on the use of public facilities, public employees and public funds." Note that the Oregon Death With Dignity Guidelines discussed in this paper make reference to the "truly informed" mandate seen by Professor Kamisar as an opponent's requisite condition to regulating the right to PAS.

⁹² See GUIDEBOOK *supra* note 10, at 5.

⁹³ See generally John P. Safranek & Stephen J. Safranek, *Assisted Suicide: The State versus the People*, 2 SEATTLE U.L. REV. 261, 262-63 (1997).

⁹⁴ See JOHN RAWLS, *A THEORY OF JUSTICE* (1971).

Social...inequalities are to be arranged so that they are both (a) to the greatest benefit to the least advantaged, and (b) attached to offices and positions open to all under conditions of fair equality of opportunity.⁹⁵

Rawls refers to this as the *Difference Principle*. The power of the "least advantaged" in society is to be equated to those with greater wealth, income, and authority. Within this Rawlsian theory, the discussion between the "least advantaged" competent adult terminally ill patient and the attending physician is to be taken very seriously.

According to the Guideline 2.1,⁹⁶ the attending physician is to explore the *meaning* behind the question, regardless of his/her personal views or willingness to participate in the suicide.⁹⁷ This Guideline is consistent with Rawls's *Difference Principle*. Irrespective of the patient's wealth, power, income, and authority, a pain-filled terminally ill person is among the "least advantaged" in society. Rawls posits that social justice requires a change in the basic structure regarding the distribution of what he calls *primary goods*. Rawls does not limit primary goods to economic well-being but rather defines them as "...things that every rational man is presumed to want. These goods normally have a use whatever a person's rational plan of life."⁹⁸ Guideline 2 follows Rawls's respect for "a person's rational plan of life," that within the context of a terminally ill patient's rationale, may be to end his/her life. The "rational plan" of the patient must be well explored by the attending physician who may or may not be willing to participate in physician-assisted suicide.

Assume the hypothetical case where a patient feels his/her terminal illness during the next six months will drain the inheritance of his/her adult married children in need of the money. The patient feels he/she has been a responsible parent, and at an elderly age, no longer sees any reason to go on living. If this conversation is developed by the patient and attending physician, perhaps the family may wish to speak openly with the parent/patient to explain their thoughts on this matter.

This presupposes the attending physician is willing to take the time to show an interest in this dialogue. Is this asking too much from the "fee-for-services" physician? Is the HMO cost-conscious delivery health care system willing to allow its physicians to engage in this time-consuming counseling? Are our best medical schools and their professors willing to develop courses in "the meaning behind" a patient's request for physician-assisted suicide? That depends on how we view health care services. Guideline 2 does not ask the nurse, social worker,

⁹⁵ *Id.* at 302.

⁹⁶ See GUIDEBOOK *supra* note 10, at 5.

⁹⁷ *Id.*

⁹⁸ See RAWLS, *supra* note 94, at 62.

or clergy to respond, but rather the attending physician. A suggested revision would require other health care providers to engage in this discussion, and perhaps then report to the attending physician.

Note the number of questions to be asked under the Guidelines to "explore the meaning" behind the request of the rational, competent patient. Consider the following hypothetical conversation:

Patient: Doctor, I have thought carefully about this and want you to give me a pill to end my life.

Physician: As an Oregon licensed physician, I want to be in compliance with our health care Guidelines. May I ask you a few questions?

Patient: Why? I'm an adult, it's my choice, and I've made up my mind.

Physician: I have to be sure your decision is informed. Only by appreciating the available options for end-of-life care will your choice be rational.

Patient: I'm very weak and in pain, so be brief.

Physician: OK.

Then the physician has to go over a series of questions as stated in Guideline 2.1.⁹⁹ For example, is the patient's decision based on: loss of control, abandonment, financial hardship, burden to others, or personal or moral beliefs? In addition, Guideline 2.2 requires a discussion about what constitutes acceptable suffering in the patient's view. And when this dialogue is concluded, the Guidelines suggest the attending physician reflect on his/her own motivation.

Guideline 2 surely is a clear ethical implementation of Rawls's *Difference Principle* for the "least advantaged." It assures the "primary good" of a rational plan for life (or ending life) is taken seriously. We suspect it also creates a burden on the attending physician and the health care system that should be further discussed by the Task Force or an other appropriate group.

(ii) *Natural Law and Professor Finnis and a Kantian analysis of Guideline No. 2:* Professors Caryn L. Beck-Dudley and Edward J. Conry in their article *Legal Reasoning and Practical Reasonableness*¹⁰⁰ give an extensive review of natural law in the United States. They note:

By the eighteenth century under the influence of the Enlightenment, the notion of higher law became more secular and rational; still loaded with moral imperatives, it found its way into enlarging American constitutional law, first in the form of the Declaration of Independence and later in the Constitution.¹⁰¹

⁹⁹ See GUIDEBOOK *supra* note 10, at 5.

¹⁰⁰ See generally Caryn L. Beck-Dudley & Edward J. Conry, *Legal Reasoning and Practical Reasonableness*, 33 AM. BUS. L. J., 91 n.1 (1995).

¹⁰¹ *Id.*, citing KERMIT L. HALL, *THE MAGIC MIRROR: THE LAW IN AMERICA* 14-15 (1989).

Its history started with the Greek philosophers.¹⁰² Hobbes, Locke, Rousseau and Kant all made references to natural law as promulgations of the natural order. Immanuel Kant stated:

...he who contemplates suicide should ask himself whether his action can be consistent with the idea of humanity as an end in itself. If, in order to escape from burdensome circumstances, he destroys himself, he uses a person merely as a means to maintain a tolerable condition up to the end of life. Man, however, is not a thing, and thus not something to be used merely as means, he must always be regarded in all his actions as an end in himself. Therefore, I cannot dispose of man in my own person so as to mutilate, corrupt or kill him.¹⁰³

This application of Kant's 'categorical imperative' would clearly show his opposition to physician-assisted suicide. However, Guideline 2 treats the patient with great dignity and as an end in him/herself, and is ethically consistent with Kant's imperative. The two foremost proponents of Natural Law theory are Professor John Finnis of Oxford University and the doctrines of the Catholic Church, the latter to be discussed in the following section of this paper.

John Finnis's book, *Natural Law and Natural Rights* is the classic contemporary work on natural law theory. In this book he explains the basic forms of human flourishing and basic requirements of practical reasonableness, both of which are relevant to Guideline 2 concerning the meaning behind the patient's request for physician-assisted suicide.¹⁰⁴

Finnis follows an Aristotelian premise of the good life.¹⁰⁵ He starts with the question "What ...are the basic forms of good for us? ...A just basic value, corresponding to the drive for self-preservation, is the value of life. ...life here includes bodily health, and freedom from the pain that betokens organic malfunctioning or injury." His sixth basic freedom is *Practical Reasonableness*. He defines this as "...the basic good of being able to bring one's own intelligence to bear effectively. ...on

¹⁰² See generally ROSCOE POUND, *LAW AND MORALS* 4 (1924) (...all discussions of the relation of...jurisprudence to ethics goes back to the Greek thinkers).

¹⁰³ See IMMANUEL KANT, *FOUNDATIONS OF THE METAPHYSICS OF MORALS* 47 (Lewis White Beck trans., Library of Liberal Arts 1959), and see IMMANUEL KANT, *CRITIQUE OF PRACTICAL REASON*, ed. Cassirer 5:35. Kant states his categorical imperative as the "fundamental law of pure practical reason" as "So act that the maxim of your will could always hold at the same time as the principle of a universal legislation."

¹⁰⁴ See JOHN FINNIS, *NATURAL LAW AND NATURAL RIGHTS* 23 (1980).

¹⁰⁵ See ARISTOTLE, *RHETORIC AND POETICS*, Book 1, ch. 6, at 27 (1981). The Franklin Library ("We may define a good thing as that which ought to be chosen for its own sake...")

the problems of choosing one's actions and life style and shaping one's own character." ¹⁰⁶

Finnis's principles of Natural Law provide strong ethical support for the Guidelines philosophy of "learning the meaning behind the patient's questions on physician-assisted suicide." Finnis's definition of *life* includes *freedom from pain*. Guideline 2.2 asks the attending physician to "...seek to understand what constitutes unacceptable suffering in the patient's view." It is implied the attending physician will consider and treat the patient's subjective state with the best available palliative care.

This, however, assumes the attending physician is either acquainted with the latest pain management or a consulting physician is a specialist in this area, and immediately available to see the patient. Neither assumption is probable in many health care facilities. However, one can see Finnis's ethical principles of Natural Law being followed in the Guidelines as the attending physician carefully probes the reasons behind the patient's request.

(iii) *Natural Law, the Catholic Church and Guideline No. 2.*: Since the Catholic Church has been one of the most outspoken institutions against physician-assisted suicide, its position should be examined relative to the Guidelines, and in particular Guideline No. 2 on the Meaning Behind a Patient's Request.¹⁰⁷ One of the many *amicus* briefs filed in *Washington v. Glucksberg*¹⁰⁸ was submitted by the Catholic Health Association of the United States.¹⁰⁹ The brief immediately commented on "...the distinction between declining medical treatment and administering a lethal agent with the intentional purpose of causing death."¹¹⁰ This distinction appears to be critical to the Catholic

¹⁰⁶ See FINNIS *supra* note 104, at 101 (discussing practical reasonableness). The author states: "Many moral questions can only be answered correctly by 'someone who is wise, and who considers them searchingly.' Therefore, natural law theory must account for this variability in human skill." *Id.*

¹⁰⁷ It may be of interest to note that the only clergyperson on the Task Force was Rev. Norbert Novak, O.S.B. who authored Guideline No. 5, *Patient's Rights and Responsibilities*. The Guidelines are based on *informed consent*. In Appendix H of the Guidelines, Disclaimers, Fr. Novak states, "As a Roman Catholic who is both an ordained priest and an ethicist, I am in full accord with ...the long-standing moral tradition of the Catholic Church...stating that in no way will we offer, facilitate, encourage, participate in, support or provide any act that leads to anyone to participate in assisted suicide or euthanasia."

¹⁰⁸ There were 61 *amicus* briefs filed for the case *Washington v. Glucksberg*. These briefs are available in LEXIS, Gen Fed Library, Briefs File.

¹⁰⁹ Brief for the Catholic Health Association of the United States, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 95-1858, No. 96-110).

¹¹⁰ *Id.*

perspective in its moral teaching on physician-assisted suicide.¹¹¹ In the *Catechism of the Catholic Church* its provision on *Euthanasia* states:

Discontinuing medical procedures that are burdensome, dangerous, extraordinary or disproportionate to the expected outcome can be legitimate, it is the refusal of "overzealous" treatment. Here one does not will to cause death; one's ability to impede it is merely accepted...[and] the use of painkillers to alleviate the sufferings of the dying, even at the risk of shortening their days, can be morally in conformity with human dignity if death is not willed as either an end or a means, but only foreseen and tolerated as inevitable.¹¹²

Exploring the *meaning* behind the patient's request per Guideline 2 includes a discussion of the consequence of refusing medical treatment in the face of death. Should this include, at least for the Catholic patient, an explanation of this position? Should the attending physician reasonably be expected to engage in this dialogue?

Assume a hypothetical case where a terminally ill patient requests physician-assisted suicide. It would appear the intent of Guideline 2 is for the attending physician to help the patient make an informed decision regarding do-not-resuscitate (DNR) orders and palliative care. The Guideline is clear that a "range of available options for end-of-life care" is essential for the patient to make the appropriate choice. A state with a physician-assisted suicide statute having guidelines similar to the Oregon law would assure that the patient understands the

¹¹¹ See generally POPE JOHN PAUL II, VERITAS SPLENDOR 106, (St. Paul Books and Media 1993). Pope John Paul states, "Euthanasia must be distinguished from the decision to forego so-called "aggressive medical treatment"...medical procedures which no longer correspond to the real situation of the patient, either because they are now disproportionate to any expected results or because they impose an excessive burden on the patient and his family. In such situations when death is clearly imminent and inevitable, one can in conscience refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person is not interrupted....To forego extraordinary or disproportionate means is not the equivalent of suicide or euthanasia; it rather expresses acceptance of the human condition in the face of death." *Id.* See generally Cristina H. Traina, *Religious Perspectives on Assisted Suicide*, 88 J. CRIM. L. & CRIMINOLOGY 1147 (1998) (noting that "Roman Catholicism and Eastern Orthodoxy oppose PAS/ euthanasia, for strenuous efforts to hasten death or to prolong life interfere with God's plan for the soul. Many approve passive euthanasia, ceasing all but palliative treatment for a dying patient." Professor Traina explores the feminist contributions to the PAS debate that reexamines cultural assumptions. Among them are those formulated by Professor Cathleen Kaveny who stated "[r]ights language creates and legitimates social practices" that are "hardly neutral," and philosopher Susan Sherwin's research that indicates doctors do not treat female patients with the same care and respect as male patients. Professor Trainer asks will women patients be granted the same "rights of the dying to palliative care that would reduce their desire for euthanasia?"

¹¹² See UNITED STATES CATHOLIC CONFERENCE, INC., CATECHISM OF THE CATHOLIC CHURCH, 608, no. 2278 & 2279 (Image/Doubleday 1994).

distinction between passive euthanasia and the intentional act that causes death in order to alleviate suffering.¹¹³ The United States Supreme Court in *Vacco v. Quill*¹¹⁴ recognized the distinction between withdrawing life-sustaining treatment and physician-assisted suicide as "endorsed in the medical profession and in our legal tradition." Guideline 2 would, in effect, assure all patients understand this distinction in making an "informed consent." Although a physician-assisted suicide statute clearly violates Catholic medical ethics, Guideline 2 (and others) will assure a patient's understanding of euthanasia consistent with its teaching.

Although this section only reviewed Guideline 2, it would appear from a number of different ethical perspectives that the Task Force accomplished its declared intent to promote "excellent care of the dying" and to provide "ethical and practical guidelines" within the physician-assisted suicide statute. Under Oregon law, a terminally-ill patient's end-of-life options will be fully explored to assure genuine "informed consent." Irrespective of a patient's values, philosophy and belief system, one could hardly ask for anything more within this ethos.

CONCLUSION

The discussion surrounding physician-assisted suicide continues to evolve set against the legal and moral backdrop of our society. The right to die is not fundamental nor is it universal. It is as controversial as the right of reproductive choice. Perhaps this is so because physician-assisted suicide raises similar issues about whether human beings should have so much personal control over life and death. The United States Supreme Court reserved for the states the power to enact legislation in this complex area of assisted suicide, in much the same way the states have legislated reproductive rights. As long as the state statute withstands constitutional challenge, a state may provide its citizens with the right to terminate life.

The State of Oregon has vested in competent adult, terminally-ill individuals the right to control their final stages of life, and other states may legislate similar last rights. In its published Guidebook, the

¹¹³ See generally Matthew P. Previn, *Assisted Suicide and Religion: Conflicting Conceptions of the Sanctity of Human Life*, 84 GEO. L. J. 589, 616 (1996) (stating "[t]he government ought to permit individuals to decide, on the basis of their own religious views, whether they believe that physician-assisted suicide denigrates the sanctity of life"); Yale Kamisar, "Opposition to assisted suicide involves more than morality," *Detroit News*, Oct. 15, 1998, at A12 (stating that religious leaders' opposition to Oregon's law is not enough to defeat such proposals); George Bullard, "Minister outlines argument favoring assisted suicide," *Detroit News*, Oct. 10, 1998, at C3 (noting Christian Clerics' opposition to new proposal in Michigan).

¹¹⁴ 521 U.S. 793 (1997).

Oregon Task Force to Improve the Care of Terminally Ill Oregonians showed concern for broader issues than access to physician-assisted suicide. The improvement of overall quality of care, especially in the areas of communication, pain management, and treatment for the depression or other psychiatric ailments that often accompany terminal illness, are specifically targeted by the Oregon Task Force. Its Guidelines are thoughtful, and address the underlying meaning of a patient's request for assisted suicide. Where the decision to actively end one's life persists despite the alleviation of other preventable problems experienced by the terminally-ill adult, Oregon provides a process that protects the patient's choice, as well as the health care provider who assists the patient. Whether Oregon will provide the origin of a physician-assisted suicide model that will spread to other states remains to be seen.

How well the Oregon model will work in the managed health care environment of the next millennium is an economic as well as a legal or ethical question. The specter of rationed health care is now a reality, and it may undermine even the most thoughtfully planned assisted-suicide law. In the meantime, the fact that Oregon is the only state with a statute authorizing a procedure for physician-assisted suicide presents its own problems. For if the Oregon process is an answer for Oregon's residents, what about the citizens of the other states who are similarly situated? The battles over abortion rights instruct that state by state skirmishes provide a prolonged pathway to rights that are delineated in different ways in different states. The right to control death, perhaps the right to define life and death, hang in the balance. Just as the beginning of life has been redefined by law, the end of life is subject to short-circuiting with legal processes that prioritize concepts of individual rights, or institutional and economic concerns. The spiritual meaning of death may be overlooked in this context.

An additional concern is that a more active physician-assisted suicide or euthanasia may follow from the initial model of physician's prescriptions for assisted suicide in Oregon. Dr. Kevorkian's murder machines may seem extreme examples, but the line once again may soon be crossed where patients are so debilitated that they require active assistance to carry out their choice.¹¹⁵ As columnist Ellen Goodman notes concerning the debacle of assisted suicide as murder in the United States, Holland does not draw the line between active and

¹¹⁵ See generally Tatsha Robertson, "Kevorkian conviction alters scene little for right-to-die movement," *Boston Sunday Globe*, March 28, 1999, at A3 (discussing Dr. Jack Kevorkian's development and use of suicide machine).

passive assisted suicide.¹¹⁶ Rather, the Dutch have a "very careful set of guidelines for terminally ill and suffering patients."¹¹⁷ "What if we had guidelines instead of hard lines?," she concludes.¹¹⁸

If Congress ultimately enacts a bill such as the proposed Lethal Drug Abuse Prevention Act,¹¹⁹ the federal law may preempt, or at a minimum, impinge upon a state scheme that regulates physician-assisted suicide. A fresh contest of Oregon's Death With Dignity Act, and implicitly, state rights in this area, may then present itself to the United States Supreme Court.

¹¹⁶ See Ellen Goodman, "The shades of gray that surround Dr. K," Boston Sunday Globe, March 28, 1999, at D7.

¹¹⁷ See *id.*

¹¹⁸ *Id.*

¹¹⁹ See *supra* note 40 discussing bill.