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**PHYSICIAN-ASSISTED SUICIDE:  
CURRENT LEGAL DEVELOPMENTS**  
*1996 Warren M. Anderson Legislative Breakfast Series*

**JUNE 4, 1996**



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CURRENT LEGAL DEVELOPMENTS**

*A monograph of the presentation delivered at the 1996  
Warren M. Anderson Legislative Breakfast Series*

**JUNE 4, 1996**

**Associate Dean and Professor Dale Moore  
Albany Law School**

**The Garden Room  
Empire State Plaza  
Albany, N.Y.**

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**Warren M. Anderson is a distinguished alumnus of Albany Law School, and an active member of the Government Law Center Advisory Committee. Having served in the New York State Senate for thirty-five years, he is perhaps best known for his leadership during his tenure as President Pro Tem and Majority Leader from 1973 to 1988.**

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## PHYSICIAN-ASSISTED SUICIDE: CURRENT LEGAL DEVELOPMENTS

Presentation by --  
Associate Dean and Professor Dale Moore \*

In your folder there is a brief outline of my remarks along with a bibliography on the topic of "physician-assisted" suicide. The bibliography is limited in the sense that a huge amount has been written on this topic, particularly in the last few years, but the sources that I've cited are some of the more important and prominent ones. The report issued by the New York State Task Force on Life and the Law, which is listed in the bibliography, is the product of thorough research and provides a comprehensive set of citations on this topic. The Ninth Circuit opinion, *Compassion in Dying v. State of Washington*, also contains a very complete list of citations.

I'll start with a definition of the practice with which the term "physician-assisted suicide" has come to be associated: a physician's providing medication or other interventions -- but usually medication -- to a patient, with the understanding that the patient intends to use that medication to end his or her own life. Medications such as barbiturates are examples of the sort that might be used. With that in mind, let me go on to talk about the history of this practice, the legislation and litigation that have developed surrounding it, and then examine some of the potential future developments in the area.

First, the history: how did this come to be such a high-profile issue? Physician-assisted suicide received significant public attention in 1988, when the Journal of the American Medical Association published (anonymously) a very brief essay, written by a resident physician. During a night on call, this physician administered a dose of morphine to a relatively young woman who was dying of ovarian cancer. The essay, "It's Over, Debbie," described his brief encounter with the patient, her somewhat enigmatic statement that led him to believe she was ready to end her life, and his administering 20 milligrams of morphine to her.

A couple of points should be emphasized about this case. The dosage of morphine was on the high side but still could have been enough simply to supply pain relief for some patients. In addition, the resident apparently did not really know the patient -- he had had a very short relationship with her. Moreover, this incident occurred in the middle of the night, when fewer caregivers are available and when things might look bleaker to a patient in her circumstances. But if this resident really did administer the morphine with the intent to cause the patient's death, then he was engaging in the practice of "euthanasia," as that term has come to be used today, rather than physician-assisted suicide.

That's because most people talking about physician-assisted suicide intend to refer

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to situations in which the patient is the one who takes the actual final step of administering the drug. The principal question in the "It's Over, Debbie" case, however, dealt not with the label to be given to the physician's conduct but rather with "voluntariness" -- that is, whether a lethal dose of medication was really what the patient wanted. The publication of this essay sparked a great deal of discussion and debate. Ultimately, as has been the case in many of the discussions about Dr. Kevorkian, procedural criticisms concerning the resident's conduct came to dominate the discussion. It seemed that less attention was devoted to the purely substantive issue of the scope of a patient's right to physician assistance with suicide.

Shortly afterward, in 1990, Dr. Kevorkian began his novel work--or at least began to make it public. Since 1990 he has admitted helping almost 30 people die. You probably know that he has been acquitted by four juries thus far, and there simply must be a reason why these juries are acquitting him. Certainly he's been much criticized by the medical community and others on procedural grounds, including the following: his medical specialty is pathology, and generally pathologists seldom deal directly with living patients; he has no underlying relationship with his "patients" at all, they are people who seek him out solely for the purpose of obtaining assistance with suicide; his evaluation of their mental capacity seems open to question, at least in some of the cases; it's not clear whether some of his patients have relinquished hope without knowing all of the possible alternatives that might be available to relieve their suffering without causing death; and finally that the deaths he offers aren't very dignified, occurring as they have in the back of a van, perhaps without the attendance of loved ones. Moreover, some of his other fairly unconventional beliefs have, I think, led some people to wonder whether he's just a crackpot.

But, as I said, he's been acquitted by four different juries. In his own defense in these cases he's described his intention as an intention to end suffering. The unfortunate consequences of his actions taken to end suffering are that the patients have died, but his primary intention, as he characterizes it, is to end their suffering. The juries must be believing him.

After Dr. Kevorkian started to publicize his work, he received a great deal of attention in the press. Much public discussion took place and, as I noted earlier, much of the criticism was on procedural grounds. Then, in March of 1991, Dr. Timothy Quill published his remarkable essay in the *New England Journal of Medicine*. It's cited in your bibliography. If you are at all interested in pursuing this topic, I strongly recommend that you read this extraordinary essay. It is a fascinating and very moving story. The story is about a patient to whom Dr. Quill referred to as Diane, a woman in her forties who had been diagnosed as suffering from acute leukemia. After learning her diagnosis and her treatment options, Diane decided to reject chemotherapy and any other aggressive treatment. Dr. Quill described his discussions with Diane about treatment and other matters. Ultimately she came to the view that she wanted to have control over her own dying process. She sought Dr. Quill's help.

Although the essay is not very long, it gives some detail about the procedural care

with which Dr. Quill approached this case. Diane was evaluated by a psychologist whom she had seen in earlier years. She was fully aware of her options, including the availability of hospice care. She was not depressed, and she used her remaining time to be with family and other loved ones. Dr. Quill did provide her with a prescription for barbiturates, knowing that she might use them at some point to control the timing of her own death. Apparently she felt very strongly that she did not wish to spend her remaining time in a clouded, drugged state, being so sedated by narcotics and other medications that she would lose control. Eventually she apparently did take the barbiturates, all alone. She asked her husband and her son to leave her because she didn't want them to be implicated in any way in her death. Dr. Quill signed her death certificate stating as her cause of death "acute leukemia." He did this, knowing that most likely she had taken the barbiturates, because he did not wish to trigger an investigation into her death.

Dr. Quill then published his essay in the New England Journal of Medicine, identifying the patient only as "Diane." Initially, some people thought that this was not a real case but rather a hypothetical or composite account that Dr. Quill had written to provoke debate about the topic. I agree that Dr. Quill wanted to provoke debate, but it was soon revealed that the account was by no means hypothetical. An anonymous phone call either to Monroe County's police or to its medical examiner led to the discovery of Diane's body in the Monroe Community College nursing lab, where it was scheduled to be used as a cadaver for instructing student nurses. An autopsy revealed that Diane had indeed died of an overdose of barbiturates. At that point the district attorney initiated a grand jury proceeding. Dr. Quill testified before the grand jury, without immunity. He was not indicted.

Dr. Quill also underwent scrutiny by the Board for Professional Medical Conduct (BPMC), the state agency charged with the responsibility for investigating complaints against physicians and for recommending the appropriate penalties (if any), such as loss of licensure, to which they should be subjected. The BPMC concluded that under these circumstances Dr. Quill had not violated the ethical and legal standards to which physicians are held.

Dr. Quill took a terrific risk in publicly "confessing" to his conduct. My own view is that he acted very courageously. No matter our individual views concerning physician-assisted suicide, we all owe Dr. Quill our gratitude. Because his procedures in this case were above reproach, he has forced us to confront directly the substantive issue: that is, should a patient ever be able to obtain a physician's assistance with suicide? Dr. Quill took away the possibility of our avoiding this issue by focusing on procedural matters. He took all of the cautionary steps that could have been taken: making sure that Diane was fully informed of all alternatives, making sure that she was evaluated by a mental health professional to be certain that her judgment was not impaired by depression, being certain that she was not ambivalent by having numerous discussions with her over time. In all respects his behavior was so different from that of Dr. Kevorkian that it became essential for us to take him seriously.

And, in fact, shortly after Dr. Quill underwent the grand jury's and the BPMC's

scrutiny, the New York State Task Force on Life and the Law took up the issue of physician-assisted suicide. The Task Force's report, "When Death is Sought," is quite thorough, well researched and well written. The report's conclusion is that there should be no change in the law, in other words that physician-assisted suicide should not be expressly "decriminalized." Whether one agrees or disagrees with that conclusion, the report is certainly worth reading and is in some respects quite persuasive.

It's important to keep in mind throughout all this discussion that we know that many other physicians have helped their patients to die. We don't know how often this occurs because the behavior is generally secretive, with both physicians and families exposing themselves to some risks by their conduct. Dr. Quill forced us to look at it openly.

In November 1994 the citizens of Oregon enacted by referendum the Death with Dignity Act. That statute allows competent, terminally ill adults to receive physician assistance with suicide without criminal or other penalties for the physician or any other health-care provider involved in the case. Quite a few procedural protections are built into the Oregon statute. The patient must be at least 18 years old and must be terminally ill, which is defined as having a prognosis of death within six months. The patient must voluntarily make an oral request to a physician. That request triggers a 15-day waiting period during which the attending physician evaluates the patient's diagnosis, prognosis, and decisionmaking capacity. The physician is obligated to inform the patient fully about all other options, in line with the view that physician-assisted suicide should be a last-resort, not a first-resort, alternative. The attending physician also must consult another physician, who then engages in an evaluation of the same diagnostic, prognostic, and decisional-capacity criteria. The two physicians must concur that the patient meets all eligibility criteria (age, terminal illness, etc.). After these two evaluations, and after the expiration of the 15-day waiting period, the patient must sign a written request that is witnessed by two other people. Finally, the patient must make a second oral request for physician assistance with suicide.

Throughout this process, at different times, the attending physician is required to advise the patient that the request may be withdrawn at any time. Of course, this entire scheme contemplates the patient's ultimately administering the medication him- or herself in any event. No sooner than 15 days after the first oral request and 48 hours after the written request may the patient receive a prescription for medication to end his or her own life. So that's the mechanism that's been created in Oregon.

Shortly after the Death with Dignity Act was enacted, efforts were undertaken to prevent it from going into effect. A lawsuit filed in a federal district court resulted in a declaration by the judge that the Act is unconstitutional and therefore may not become effective. So at this point, matters are suspended in Oregon pending appeal of this decision. I think, however, that in light of another court's decision, which I'll discuss in a few minutes, that the judge's decision about the Oregon Act is likely to be reversed on appeal.

Aside from the Dr. Kevorkian litigation, almost all of which has occurred in Michigan's criminal courts, there have been two very recent decisions by federal courts of

appeal on the issue of physician-assisted suicide. The United States Court of Appeals for the Ninth Circuit, which covers California and other states on the west coast, as well as the United States Court of Appeal for the Second Circuit, which covers New York, have issued very significant decisions in this area.

The decision in the first of these cases was made public on March 6, 1996, in *Compassion in Dying v. State of Washington*. The opinion is quite long but it is well worth reading, and essential for someone who is pursuing further research into this topic. The lawsuit was initiated by an organization called Compassion in Dying, which provides assistance of various kinds to the terminally ill. Other plaintiffs were physicians who wished to provide assistance to their patients but feared the the criminal penalties that might follow. Several terminally ill individuals were plaintiffs as well. They were seeking a declaration by the judge that the Washington statute that criminalizes the behavior of those who assist another with suicide violated their federal constitutional rights.

Initially, a federal district court judge declared the Washington statute unconstitutional. The State of Washington appealed, and a three-judge panel of the ninth circuit appellate court reversed the district judge's decision, saying that the statute is indeed constitutional. The plaintiffs sought what is referred to as a "rehearing *en banc*"; their request was granted and the case was "reheard" by an 11-judge panel of the ninth circuit.

The ninth circuit is very large, having 23 full-time judges, and so generally an *en banc* rehearing involves a group larger than three but smaller than the total number of judges. The 11 judges who reheard this case reached a conclusion different from that of the original three-judge panel. They decided, in fact, to affirm the original district court decision, saying: "We hold that insofar as the Washington statute prohibits physicians from prescribing life-ending medication to terminally ill, competent adults who wish to hasten their own deaths, it violates the Due Process Clause of the 14th Amendment." The court dealt with only one small piece of the Washington statute, the verb "aids." The Washington statute says that someone who "aids" another person to commit suicide is guilty of a crime. It also says that someone who "causes" another person to commit suicide is guilty of a crime. The court saw no constitutional problem with the legislative conclusion that "causing" another person to commit suicide is criminal. But the case of a physician who "aids" another person to commit suicide is quite different.

The ninth circuit made clear that the State of Washington is entitled to regulate the process by which physicians assist their patients with suicide. It is not, however, entitled to prohibit that behavior entirely. The court declined to find a violation of the federal Constitution's Equal Protection clause, but the language of the opinion strongly suggests that the court could have been persuaded that such a violation also existed. Officially, however, the decision was based on the Due Process Clause. Here's another sentence in which the court summarized its conclusion: "We hold that a liberty interest exists in the choice of how and when one dies, and that the provision of the Washington statute banning assisted suicide, as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors, violates the Due Process

Clause."

This talk of a "liberty interest" is derived from language in the United States Supreme Court's decision in the case of Nancy Cruzan. In that case, which was decided in 1990, the Supreme Court identified a constitutional liberty interest as the source of the right of competent adults to decline medical treatment. The ninth circuit further developed this concept of a liberty interest in the choice of how and when one dies, ultimately finding, as noted, that the Washington statute banning assisted suicide in some cases would have to yield to this individual liberty interest. The ninth circuit's opinion is rich in its discussion of history and precedent.

Subsequent to the 11-judge panel decision, an attempt was made to obtain another rehearing, this time including all 23 of the ninth circuit's judges. That request was denied. Last Wednesday, Justice O'Connor of the United States Supreme Court issued an order staying the effectiveness of the ninth circuit ruling pending the completion of a petition for certiorari by the State of Washington.

The case that was decided in the second circuit is called *Quill v. Vacco*. It was decided about a month after *Compassion in Dying*, in early April of this year. The second circuit relied on a very different rationale in coming to its conclusion that the New York statutory ban on physician-assisted suicide is also unconstitutional. The second circuit found a violation of the federal Equal Protection clause. The court said that to the extent that the New York statutes at issue prohibit a physician from prescribing medications to be self-administered by a mentally competent, terminally ill person in the final stages of his terminal illness, they are not rationally related to any legitimate state interest.

The second circuit focused on exactly the same population of patients as the ninth circuit: competent, terminally ill adults who will self-administer medication prescribed by a physician. The second circuit also leaves open the opportunity for New York to regulate this practice. Moreover, the second circuit's decision would not affect cases such as the prosecution of George Delury, about which many of you have probably read. He was the man who assisted his wife, who suffered from multiple sclerosis, to commit suicide last summer. The circumstances of this event seemed rather dubious in light of the details he recorded in a diary, describing among other things his frustration with her illness and the burdens she presented for him.

On April 17, 1996, about two weeks after its initial decision, the second circuit stayed the effectiveness of its ruling to allow the State of New York to file a petition for certiorari with the United States Supreme Court. That petition was filed in mid-May, and we don't know whether the Supreme Court will grant it.

What are the potential future developments in this area? Since both courts left open the possibility of regulation, I think it's appropriate to consider the forms of regulation that might be desirable as well as the sources from which they might come. One source certainly might be professional ethical standards that physicians themselves would develop and enforce in their private organizations. Physicians have developed such standards and guidelines in many areas of practice (e.g., the appropriateness of cardiac surgery or

chemotherapy; the diagnostic procedures that should be undertaken in light of particular symptoms, etc.). Indeed, physicians have already demonstrated their interest in contributing in this manner -- an article I've cited, written by Quill, Cassel, and Meier, is one example.

Even if private regulation takes place, however, it's doubtful that legislatures and the public will consider it sufficient. Even institutional standards probably will not be enough. I suspect that we will be seeing numerous proposals for the legislative regulation of physician-assisted suicide, and that the debate will be robust.

Legislatures will be forced to deal with this issue no matter what the Supreme Court does. Certainly, if the Supreme Court denies New York's and Washington's petitions for certiorari, then the appellate decisions stand. But even if the Supreme Court hears the cases and concludes that the criminal statutes are not unconstitutional, this issue has been with us for too long simply to be dropped without further consideration. After all, juries have amply demonstrated their intolerance for prosecution of criminal charges in these cases.

So what form might the legislation take? Let's start with the assumption that we are talking about decriminalization of a willing physician's supplying of assistance to a patient. In other words, we're not talking about giving people a right to demand that a physician assist them in this manner. Rather, this would be right to receive the assistance of a willing physician. I don't think anyone is ready to talk about forcing physicians to participate in this process.

One issue is patient eligibility. Who will have access to physician-assisted suicide? A number of eligibility criteria should be considered. One is age. Is this an "adults-only" phenomenon? What about children who are suffering greatly during a terminal illness?

What about health status? Should there be a requirement of "terminal illness" as exists in the Oregon statute? Or should a larger group of people be entitled to physician assistance with suicide. For example, what about someone with an incurable condition that is not presently terminal but causes great suffering (e.g., multiple sclerosis, amyotrophic lateral sclerosis [Lou Gehrig's disease])?

One proposal, which is also cited in the bibliography and is published in the Harvard Journal on Legislation, would allow patient eligibility to encompass those who have incurable, not presently terminal conditions that are causing great suffering. Interestingly enough, a survey of physicians in the State of Washington, which inquired about requests for assisted suicide and euthanasia, revealed that quite a few came from people with very serious, debilitating neurological conditions that would not have been terminal within six months. This suggests that a serious issue of expanded eligibility needs to be explored.

Are we talking also about only those people who can self-administer the needed medication or would we include those who would need medication administered for them? Some people are too frail physically, for example, to administer medication to themselves. Certainly, the easiest case is the one on which the two appellate courts focused -- the competent, terminally ill adult who can self-administer the medication, who takes the final act him- or herself. But it's not clear to me why a physically frail or physically incapacitated

person who is competent and terminally ill should be denied the assistance of a physician under these circumstances.

What about physician eligibility? Should eligibility be limited to physicians who have a Doctor Quill-Diane type of relationship with their patients? Certainly that relationship would seem to be the ideal. It was a very supportive and strong relationship in which Doctor Quill knew the patient very well and could be very confident, I think, in his conclusions about her reasoning process, her judgment, and her lack of depression. But theirs is not the "norm" of physician-patient relationships. Others, I think, must also be eligible to provide assistance as well. That leads me to the question whether assistance with suicide should be a specialty or a subspecialty in medicine. The idea sounds somewhat unappealing, I think, especially since Dr. Kevorkian has proposed something of the sort. The fact is, however, that this is not a topic that people are taught in medical school. Medical students don't learn, as part of their education how to help people commit suicide. In fact, in a survey of Michigan physicians, some expressed great uncertainty about what medications or dosages to prescribe.

Certainly, the procedures and formalities associated with this practice would be very important as well. One procedural aspect should be the means of determination of patient eligibility. Who makes the determination? How many opinions do you need to have, for example, about the diagnosis, the prognosis, and the patient's decisional capacity?

The northern territory of Australia, which has recently enacted physician assisted suicide legislation, would require a psychiatrist or other mental health professional to evaluate the patient. Requiring that kind of evaluation would certainly impede access for some people. Moreover, primary care physicians are very capable of assessing whether a patient has decisional capacity. In any event, however, any legislation must address the issue of determining eligibility.

What would happen if a consultant disagrees with a primary physician's conclusion? Will we have forum shopping? Legislators should at least consider whether means can be created to discourage forum shopping or pro forma determinations by consultants in these cases.

Other aspects of patient eligibility are very important. Certainly that the patient must be fully informed of all the alternatives, as was the case with Doctor Quill's patient, and the request must be truly voluntary. The patient must be told that a change of mind is permitted. It should go without saying that coercion will not be tolerated.

There's something of an interesting flip side to this -- is it incumbent on a physician to inform a person who is terminally ill that he or she has the right to request physician assistance with suicide? Should patients' bills of rights address this issue explicitly? These are posted in health-care facilities, and they advise patients of their right to refuse treatment. If they have the right to request assistance with suicide, perhaps they should be told. It's somewhat unpleasant to contemplate including such information in a sign that's posted in hospitals, but the question should be raised and decided.

How many requests would be required? Must they be in writing? May they be oral?

How long a waiting period should there be between requests? I think all of these kinds of things are intended to ensure that the patient's request is an enduring one, something that the patient has carefully considered. This decision should not be the product of whimsy or ambivalence. So, most of the proposals that I've seen created waiting periods, called for more than one request, and have generally tried to be confident there's no vacillation.

What about revocability? Obviously these requests should be revocable, and certainly if we are talking about people who can self-administer medication, they can easily revoke their requests by not taking the medication. Nonetheless, I think it's important to tell people of their right to revoke, so that they don't feel somehow that their caregivers will be disappointed in them if they change their minds.

Privacy and confidentiality are two important issues implicated here. Clearly, patients have a right to privacy. That to me means that the patient can be encouraged to discuss this decision with others, including family members, but can't be forced to do so. Under the Oregon plan, one of the things physicians must do is encourage their patients to talk with their families. Such a conversation, however, cannot be a condition, it seems to me. In some cases imposing such a requirement could prove very violative of a patient's right to privacy. What about confidentiality? In all these schemes the procedural protections call for a number of people to be aware of a patient's desire for physician assistance with suicide. All of the care givers and others involved with this practice must be required to treat this kind of information with the same respect that they treat other medical information and keep it confidential.

What about official governmental record keeping? Most of the proposals deal with that issue. They create a method for reporting to a state health department or some other agency charged with monitoring the frequency with which physician assisted suicide is administered, what kinds of individuals are seeking it, and that sort of thing. One suggestion that's been made about this kind of reporting is that all information should be reported essentially anonymously, perhaps with one coded identifier that could, under exigent circumstances, link the information to the patient.

Protections for physicians and other health care providers are essential. Others who must be protected include, for example, the pharmacist who fills the prescription. Certainly, prescriptions for particular medications would trigger some suspicions in the pharmacist about the use to be made of this medication, so the pharmacist must be included. Protection should also be extended to other health care providers, nurses and others who might be present at the time the patient administers self-medication. Most of the proposals create immunity from liability for those who act in good faith according to the procedures set up in the statute. I don't know that such provisions are essential because the whole existence of the scheme suggests that people who act according to the statute have done nothing wrong. But because we've gotten into the habit of putting immunity provisions into virtually every piece of this sort of legislation, it's likely that health care providers would demand it here.

What about institutional conscience objections? We see these kinds of things

cropping up in other types of legislation. While I certainly believe that individuals are entitled to their conscience objections and may refuse to participate on moral or religious or other grounds if that's their view. For example, a physician can simply say no and refer the patient to someone else. As far as institutions being entitled to prohibit certain practices within their walls, I'm more dubious. I think that probably that sort of provision will end up in any statutes that are enacted, although I'm not really sure they are necessary or desirable. Having a conscience is a human attribute, not an institutional attribute, but I suspect institutional conscience provisions will be included. If so, the institutions must be required to provide notice of their policies to health care providers and patients.

Let me sum up, since we're running out of time. This debate is going to be with us for some time, no matter what the Supreme Court does. Even if it grants certiorari and reverses the lower courts, the questions won't go away. The landscape will simply change a little bit.

And I'll just state one opinion on this whole debate. I firmly believe that what Doctor Quill did for his patient Diane was a compassionate and courageous act. Such an act should not be a crime, and if in fact the New York statutes can be construed to define what Doctor Quill did as a crime, I think those statutes are immoral as well as unconstitutional.

Of course stating such an opinion only begins to address the issues. Many subsidiary points are up for discussion and debate, and the debate will probably take us into the next century. Thank you for your attention.

## APPENDIX

### Outline

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## Bibliography

### **Physician-Assisted Suicide**

Compassion in Dying v. State of Washington, 79 F.3d 790 (9th Cir. 1996) (en banc).

Quill v. Vacco, 80 F.3d 716 (2d Cir. 1996).

Ann Alpers & Bernard Lo, Physician-Assisted Suicide in Washington: A Bold Experiment, 274 JAMA 483 (1995).

David A. Asch, The Role of Critical Care Nurses in Euthanasia and Assisted Suicide, 334 New Eng. J. Med. 1374 (1996).

Jerald G. Bachman, Kirsten H. Alcser, David J. Doukas, Richard L. Lichtenstein, Amy D. Corning & Howard Brody, Attitudes of Michigan Physicians and the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia, 334 New Eng. J. Med. 303 (1996).

Anthony L. Back, Jeffrey I. Wallace, Helene E. Starks & Robert A. Pearlman, Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses, 275 JAMA 919 (1996).

Charles H. Baron, Clyde Bergstresser, Dan W. Brock, Garrick F. Cole, Nancy S. Dorfman, Judith A. Johnson, Lowell E. Schnipper, James Vorenberg & Sidney H. Wanzer, A Model State Act to Authorize and Regulate Physician-Assisted Suicide, 33 Harv. J. Legis. 1 (1996).

Melinda A. Lee, Heidi D. Nelson, Virginia P. Tilden, Linda Ganzini, Terri A. Schmidt & Susan W. Tolle, Legalizing Assisted Suicide -- Views of Physicians in Oregon, 334 New Eng. J. Med. 310 (1996).

Bernard Lo, Improving Care Near the End of Life: Why Is It So Hard?, 274 JAMA 1634 (1995).

Timothy E. Quill, Death and Dignity: A Case of Individualized Decision Making, 324 New Eng. J. Med. 691 (1991).

Timothy E. Quill, Christine Cassel & Diane Meier, Care of the Hopelessly Ill" Proposed Clinical Criteria for Physician-Assisted Suicide, 327 New Eng. J. Med. 1380 (1992).

Colleen Scanlon, Euthanasia and Nursing Practice -- Right Question, Wrong Answer, 334 New Eng. J. Med. 1401 (1996).

A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT),

274 JAMA 1591 (1995).

New York State Task Force on Life and the Law, When Death is Sought (1994).