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A Delicate Balance: Rethinking the Physician's Role in Physician Aid-in-Dying

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This Note considers the current framework of states' death with dignity laws and analyzes physicians' views of the legal standards to determine whether the current procedures in death with dignity states adequately protect the patient's interests. Aid in Dying (AID) legislation attempts to balance individual privacy interests with state interests: obtaining an ideal balance is the state legislature's goal and is the topic of much advocacy. This Note examines the current laws from a medical perspective and considers how physicians, as the ones implementing the laws, view their role and the legislative safeguards.

Part I reviews the history of AID through Supreme Court cases and concludes that AID is not a recognized constitutional right, and so legislation prohibiting or regulating AID is within the discretion of state legislators. Part II examines the state interests that are implicated by AID and physician concerns with legislation meant to protect those interests. Part III provides suggestions that states could implement to address physician concerns, including increased physician training, increased physician reporting requirements, and increased government oversight.

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INTRODUCTION

Physician aid-in-dying (AID) has become a hot topic in recent years.¹ The United States has historically criminalized all forms of suicide, including assisted suicide.² However, in 1997, Oregon became the first state to legalize AID in its Death with Dignity Act.³ The enactment of this Act sparked vigorous debate within

1. Kathryn Houghton, *Getting a Prescription to Die Remains Tricky Even as Aid-in-Dying Bills Gain Momentum Across the U.S.*, TIME (Mar. 29, 2021, 9:00 AM), <https://time.com/5950396/aid-in-dying-2021/> [<https://perma.cc/WB2C-T3KY>]; Christian M. Wade, *Emotional Pleas Heard for Physician-Assisted Suicide*, SALEM NEWS (Oct. 4, 2021), https://www.salemnews.com/news/emotional-pleas-heard-for-physician-assisted-suicide/article_b1f1f46a-22dd-11ec-9293-3352f3a698c0.html [<https://perma.cc/6EYG-A39S>].

2. As a preliminary issue, physician aid-in-dying (AID), or assisted suicide, must be distinguished from euthanasia. Euthanasia is “the administration of a lethal agent by another person to a patient for the purpose of relieving the patient’s intolerable and incurable suffering.” AM. MED. ASS’N, CODE OF MEDICAL ETHICS § 5.8 (2016), <https://www.ama-assn.org/system/files/2019-06/code-of-medical-ethics-chapter-5.pdf> [<https://perma.cc/3UT5-QZDQ>]. Euthanasia is separated into active and passive euthanasia. See Alejandro Gutierrez-Castillo, Javier Gutierrez-Castillo, Francisco Guadarrama-Conzuelo, Amado Jimenez-Ruiz & Jose Luis Ruiz-Sandoval, *Euthanasia and Physician-Assisted Suicide: A Systematic Review of Medical Students’ Attitudes in the Last 10 Years*, 13 J. MED. ETHICS & HIST. MEDICINE, no. 22, 2020, at 1, 2. “Active euthanasia” involves a physician administering a lethal dose of medication, and “passive euthanasia” involves withdrawing life-sustaining treatment. *Id.* Physician aid-in-dying, on the other hand, occurs “when a physician facilitates a patient’s death by providing the necessary means and/or information to enable the *patient* to perform the life-ending act.” AM. MED. ASS’N, *supra*, at § 5.7 (emphasis added). The key distinction is that during AID the patient themselves ingest a lethal dose of medication, while euthanasia consists of another person’s actions that affect the patient. The distinction implicates issues of mental competency and agency and results in major legal differences. This Note will focus solely on AID.

3. *Oregon*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/states/oregon/> [<https://perma.cc/BN3D-6K2Q>] (last visited Sept. 1, 2022).

the legal, medical, and political fields regarding the appropriate reach and effect of this type of legislation.⁴

Many scholarly articles and books thoroughly discuss whether AID should be legalized in all fifty states. Proponents of AID argue that assisted dying should be recognized as a fundamental right protected under the Liberty Clause of the Fourteenth Amendment.⁵ They claim AID is a fundamental right because choosing how to die while maintaining autonomy is extremely personal and an extension of the right to privacy established in *Griswold v. Connecticut* and *Roe v. Wade*.⁶ Many works have engaged in a constitutional analysis of AID laws, arguing that a patient's right to autonomy, choice, and control outweighs any state interest.⁷ Proponents of AID claim that the ability to choose to die and end irreversible suffering should be an option available to a limited population who meet certain qualifications.⁸ Opponents of AID have two major arguments: that killing, in any form, is wrong and that legalizing AID opens the door to the risk of abuse through expansion of AID medical procedures.⁹ Those with this view reference the long history of criminalizing all forms of killing, arguing that all life is valuable and legalizing assisted suicide would undercut the ethical foundation of law and medicine.¹⁰

This Note does not address whether AID should be legalized—other scholars have discussed this question thoroughly¹¹—and does not engage in an ethical debate¹² or a policy discussion. Rather, this Note focuses on assisted suicide as a *medical* procedure. As with other medical procedures, proper state regulation of AID involves balancing the state interests against the patient's individual interests. AID legislation includes safeguards, such as an age limit, mental capability requirement,

4. See generally EMILY JACKSON & JOHN KEOWN, *DEBATING EUTHANASIA* (Peter Cane ed., 2012); SUSAN STEFAN, *RATIONAL SUICIDE, IRRATIONAL LAWS: EXAMINING CURRENT APPROACHES TO SUICIDE IN POLICY AND LAW* (Patricia A. Zapf ed., 2016).

5. See, e.g., Erwin Chemerinsky, *Washington v. Glucksberg Was Tragically Wrong*, 106 MICH. L. REV. 1501 (2008); Katherine A. Chamberlain, Note, *Looking for a "Good Death": The Elderly Terminally Ill's Right to Die by Physician-Assisted Suicide*, 17 ELDER L.J. 61 (2009).

6. See, e.g., Tom L. Beauchamp, *The Right to Privacy and the Right to Die*, 17 SOC. PHIL. & POLY 276, 287 (2000) (arguing assisted suicide is a way to respect a person's autonomy and privacy interests); Chemerinsky, *supra* note 5, at 1507. Although the 2022 Supreme Court decision in *Dobbs v. Jackson Women's Health*, 597 U.S. ___ (2022), overturned *Roe*, the right to privacy remains intact through other binding precedent cases including *Griswold v. Connecticut*, 381 U.S. 479 (1965). It remains to be seen how the *Dobbs* decision will affect the discourse involving the right to die.

7. See, e.g., Kathryn L. Tucker, *In the Laboratory of the States: The Progress of Glucksberg's Invitation to States to Address End-of-Life Choice*, 106 MICH. L. REV. 1593, 1606 (2008); Margaret P. Battin, *Physician-Assisted Dying and the Slippery Slope: The Challenge of Empirical Evidence*, 45 WILLAMETTE L. REV. 91, 94 (2008).

8. See, e.g., John Coggon, *The Wonder of Euthanasia: A Debate that's Being Done to Death*, 33 OXFORD J. LEGAL STUD. 401, 404 (2013) (referencing JACKSON & KEOWN, *supra* note 4).

9. See Battin, *supra* note 7, at 95; Coggon, *supra* note 8, at 408.

10. Coggon, *supra* note 8, at 409 (referencing John Keown's argument in *EUTHANASIA, ETHICS AND PUBLIC POLICY: AN ARGUMENT AGAINST LEGISLATION* (2002)).

11. See sources cited *supra* notes 4, 7.

12. See Steven D. Smith, *De-Moralized: Glucksberg in the Malaise*, 106 MICH. L. REV. 1571 (2008) (discussing legal moralism in the context of assisted dying).

and licensing and reporting requirements for the physicians,¹³ that are meant to ensure any application of AID happens in a reasonable, non-arbitrary manner. However, as is the case with any regulation of a profession, legislators are not experts—the practitioner is. It is physicians who are tasked with implementing legislative policies in the field. Because physicians have the expertise and experience with assisted dying policies, questions involving the appropriateness of legislative regulations, the implementation of legislation, or the legislation's integration with or impediment of well-established medical practices should be answered by physicians. Unfortunately, recent surveys of physicians reveal that most physicians lack the training to make the medical judgments required by AID legislation,¹⁴ meaning the legislative process does not sufficiently protect individual patients against arbitrary or unreasonable use of AID. At the same time, physicians are not lawmakers, so their opinions must be considered in light of the broader context of policy and social welfare that is the purview of legislators to achieve an ideal balance of state and individual interests through AID regulation.

This Note considers physician qualifications, physician opinions on legalization, and ongoing concerns regarding the implementation of the current legislative framework.¹⁵ Part I briefly considers the legal history of AID and the current legal authority. Part II analyzes the merits of a state's interests in AID and explains physician concerns with the relevant legislative safeguards. Part III provides suggestions states can implement to address these concerns, including additional procedural obligations that would increase physician reporting and training requirements that fill legislative gaps. These suggestions rightfully place the burden of preventing abuse on physicians, as physicians have the most power in the physician-patient relationship and are the ones who determine whether a patient is qualified for AID.

13. See e.g., OR. REV. STAT. §§ 127.865, 127.855, 127.815, 127.885 (2020). Attending physicians must ensure that all the documentation required by the statute is filled out and filed in compliance with the law throughout the process of AID. The physicians must fill out and file compliance forms with the Center for Health Statistics for each patient, and the Department of Human Services annually reviews records regarding AID. See *infra* note 165.

14. Peter T. Hetzler III, James Nie, Amanda Zhou & Lydia S. Dugdale, *A Report of Physicians' Beliefs About Physician-Assisted Suicide: A National Study*, 92 YALE J. BIOLOGY & MED. 575, 581 (2019); Leslie Kane, *Life, Death, and Painful Dilemmas: Ethics 2020*, MEDSCAPE (Nov. 13, 2020) <https://www.medscape.com/slideshow/2020-ethics-report-life-death-6013311> [<https://perma.cc/3LS4-NHQL>].

15. Most of the concerns regarding the current framework revolve around the risk of abuse of vulnerable populations. Battin, *supra* note 7, at 97–99. Scholars disagree on the extent to which these risks have been realized in Oregon and other AID states, and there is not much empirical data by which to form a satisfying conclusion. See generally Tucker, *supra* note 7 (arguing that the Oregon legislative safeguards sufficiently protect residents against abuse); Battin, *supra* note 7 (relying on data collected from Oregon to conclude there is no evidence of abuse of vulnerable groups). But see Herbert Hendin & Kathleen Foley, *Physician-Assisted Suicide in Oregon: A Medical Perspective*, 106 MICH. L. REV. 1613 (2008) (arguing that the available data is insufficient to form a conclusive opinion and legitimate concerns remain regarding the safeguards).

I. THE LEGAL HISTORY OF PHYSICIAN AID IN DYING AND THE "RIGHT TO DIE"

There are three main Supreme Court cases that shaped the legal history of AID and address the so-called "right to die" that is implicated by AID. First, in *Cruzan v. Missouri Department of Health*, the United States Supreme Court addressed whether there is a right to refuse life-sustaining medical treatment (i.e., a "right to die").¹⁶ The Supreme Court ultimately found that the right to refuse medical treatment could be found under the Fourteenth Amendment's protection for liberty,¹⁷ noting that intrusions into bodily autonomy, such as medical treatment, implicate "substantial liberty interests."¹⁸ However, it is a well-established principle that individual liberty interests at times must yield to statutory regulation that serves a legitimate state interest.¹⁹ Thus, to determine whether a patient's constitutional right to liberty has been violated, the Court balanced certain state interests against the interests of the patient.²⁰ *Cruzan* established that questions involving life and death, and the associated medical treatment, are "deeply personal" and implicate liberty interests that must be evaluated by balancing state interests and the patient's interests.²¹ While not addressing AID directly, *Cruzan* paved the way for the second relevant Supreme Court case: *Washington v. Glucksberg*, 521 U.S. 702, 723 (1997).

In 1997, the Supreme Court in *Glucksberg* directly addressed whether AID should be recognized as a constitutional right under the Liberty Clause of the Fourteenth Amendment.²² The Court again framed the question as one of substantive due process, but instead of balancing the state interests with the patient's interests, the Court considered whether the right was "deeply rooted in this Nation's history and tradition."²³ Pointing to centuries of history and tradition that prohibited and criminalized suicide, the Court concluded the right to suicide

16. *Cruzan ex rel. Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 269, 277 (1990). The Court first addressed whether the right existed at all, then continued to analyze whether a mentally incompetent person's guardian could exercise that right for the incompetent person. *Id.* at 280. Around the same time, there was national attention on the issue of euthanasia and physician-assisted suicide brought about by Dr. Jack Kevorkian, who illegally helped over a hundred people die. Melvin I. Urofsky, *Do Go Gentle into That Good Night: Thoughts on Death, Suicide, Morality, and the Law*, 59 ARK. L. REV. 819, 826 (2007).

17. *Cruzan*, 497 U.S. at 278.

18. *Id.*

19. *See, e.g.*, *Jacobson v. Massachusetts*, 197 U.S. 11 (1905) (upholding a state regulation that allowed mandatory vaccinations).

20. *Cruzan*, 497 U.S. at 271. The state interests articulated were the "preservation of life, the protection of the interests of innocent third parties, the prevention of suicide, and the maintenance of the ethical integrity of the medical profession." *Id.*

21. *Id.* at 281.

22. *Washington v. Glucksberg*, 521 U.S. 702, 723 (1997). Plaintiffs brought suit against Washington State, arguing that the state's ban on assisted suicide was unconstitutional on its face. The plaintiffs argued that AID should be protected as a fundamental liberty right under the Fourteenth Amendment, and any state legislation that limited or prohibited AID could not place an undue burden on patients wishing to exercise their right.

23. *Glucksberg*, 521 U.S. at 721. The Court concluded the right at issue was whether there is a constitutionally protected right to commit suicide, "which itself includes a right to assistance in doing so." *Id.* at 723.

and the right to assisted suicide were not fundamental liberty interests.²⁴ The *Glucksberg* Court specifically distinguished AID from the refusal of medical treatment found in *Cruzan*, holding that, although AID and the refusal of medical treatment are both personal decisions, they are not legally protected in the same way.²⁵

Although some scholars argue *Glucksberg* was incorrectly decided and the Supreme Court may overrule it in the future,²⁶ it remains good law and AID—or the right to die—is not a constitutionally protected privacy right. However, the third Supreme Court case, *Gonzalez v. Oregon*, expressly authorized state legislatures to legalize or criminalize AID by upholding the validity of Oregon’s Death with Dignity Act.²⁷ In *Gonzalez*, the Court held that state legislators had the authority to define the scope of the medical profession, which included legalizing AID.²⁸ The Supreme Court recognized that states have the authority to legalize AID, even if *Glucksberg* refused to recognize a fundamental right to die. Together, *Gonzalez* and *Glucksberg* show that the legality, and thus the accessibility, of AID is a matter of state law: state legislatures have the authority to either legalize or prohibit AID.²⁹

24. *Id.* at 728. After concluding assisted dying was not constitutionally protected as a fundamental right, the Court reviewed the Washington statute under a rational basis standard. *Id.* Because there were several state interests implicated, the Court ultimately upheld the Washington statutory ban on AID. *Id.*

25. *Id.* at 725.

26. Richard S. Myers, *The Constitutionality of Laws Banning Physician Assisted Suicide*, 31 BYU J. PUB. L. 395, 396 (2017) (pointing out that *Obergefell v. Hodges*, decided almost two decades later in 2015, used a different substantive due process analysis than *Glucksberg*—one that did focus on autonomy—and using *Obergefell*’s divergence from history and tradition to argue that the Supreme Court may reverse *Glucksberg* if given the chance); see also Chemerinsky, *supra* note 5 (arguing that deciding how to die is integral to autonomy and should be considered a fundamental constitutional right). But see Yale Kamisar, *Forward: Can Glucksberg Survive Lawrence? Another Look at the End of Life and Personal Autonomy*, 106 MICH. L. REV. 1453, 1453 (2008) (arguing that it is unlikely *Glucksberg* will be overruled because it does not “stigmatize any politically vulnerable group” and recognizing a constitutional right to AID would be difficult to define).

27. *Gonzales v. Oregon*, 546 U.S. 243 (2006). A dispute arose regarding whether AID could be considered a legitimate medical purpose. The Controlled Substances Act (CSA), a federal law that classifies various substances, requires certain substances to only be issued “for a legitimate medical purpose.” *Id.* at 254. Physicians acting in accordance with Oregon’s Death with Dignity Act prescribe drugs that fall under Schedule II of the CSA; thus, these drugs must be used for a legitimate medical purpose. In 2001, the U.S. Attorney General issued an Interpretive Rule of the CSA stating that assisting suicide is not a legitimate medical purpose and physicians that did so would be in violation of the CSA. *Id.* Oregon challenged this interpretation, and the Supreme Court ultimately struck down the U.S. Attorney General’s Interpretive Rule and upheld Oregon’s definition of “legitimate medical purpose.” *Id.* at 275.

28. *Id.* at 271, 275; see also Stephanie M. Richards, *Death with Dignity: The Right, Choice, and Power of Death by Physician-Assisted Suicide*, 11 CHARLESTON L. REV. 471, 480–83 (2017) (explaining the Court’s reasoning as it applied to the Attorney General’s authority and the state’s authority to regulate the medical field).

29. See Urofsky, *supra* note 16, at 827.

As of writing, nine states and the District of Columbia have legalized AID as a medical procedure.³⁰ Putting aside the states that still prohibit AID, the rest of this Note will consider whether states that have legalized AID have done so in a reasonable manner. Statutes that legalize AID attempt to strike a balance between state and individual interests.³¹ The next Part will examine the various state interests implicated in the regulation of AID, the legislation meant to balance those interests, and physician concerns with the legislative requirements.

II. STATE INTERESTS IN REGULATING PHYSICIAN AID IN DYING AND RELATED PHYSICIAN CONCERNS

Within the context of AID, the state's interests are maintaining the integrity of the medical profession, preserving life, protecting vulnerable residents, and preventing a slippery slope.³² An individual patient's interests are privacy and maintaining dignity and autonomy in dying.³³ AID legislation attempts to protect both the state's interests and the individuals' interests. This Part will consider whether physicians, as implementors of the legislation and administrators of AID, believe that the legislation sufficiently achieves the balance it attempts to strike.

To begin, this Part examines the legislation and the steps states have taken to safeguard patient interests. All AID states follow similar frameworks: AID patients are limited to citizens of the state who are at least eighteen years old,³⁴ have a medical diagnosis of six months or less to live,³⁵ and are mentally capable of making the decision to seek AID.³⁶ The patient must make two separate oral requests for

30. *State Statute Navigator*, DEATH WITH DIGNITY, <https://deathwithdignity.org/resources/state-statute-navigator/> [<https://perma.cc/2JGY-HKWT>] (last visited Sept. 1, 2022) (listing California, Colorado, District of Columbia, Hawaii, New Jersey, Maine, New Mexico, Oregon, Vermont, and Washington).

31. See Richards, *supra* note 28, at 489.

32. *Washington v. Glucksberg*, 521 U.S. 702, 728–33 (1997).

33. There is much debate regarding what interests patients have in AID. For the purposes of this Note, I will assume that the patient is interested in AID to maintain their control and autonomy. See Kirsten Weir, *Assisted Dying: The Motivations, Benefits, and Pitfalls of Hastening Death*, 48 *MONITOR ON PSYCH.*, no. 11, Dec. 2017, at 26; Angela Morrow, *Reasons for Requesting Physician-Assisted Suicide*, VERYWELL HEALTH (Mar. 23, 2020), <https://www.verywellhealth.com/reasons-for-seeking-physician-assisted-suicide-1132378?print> [<https://perma.cc/AK2Q-NZGJ>].

34. OR. REV. STAT. § 127.800 (2018); CAL. HEALTH & SAFETY CODE § 443.1(a) (West 2022); WASH. REV. CODE § 70.245.010(1) (2008); COLO. REV. STAT. § 25-48-102(1) (2016); D.C. CODE § 7-661.01(13) (2017); HAW. REV. STAT. ANN. § 327L-1 (West 2019); VT. STAT. ANN. tit. 18, § 5281 (2013); 2021 N.M. Laws 132 § 2(A) (2021); N.J. STAT. ANN. § 26:16-3 (West 2019); ME. REV. STAT. ANN. tit.22, § 2140(2)(A) (2019).

35. OR. REV. STAT. § 127.800 (2018); CAL. HEALTH & SAFETY CODE § 443.1(r) (West 2022); WASH. REV. CODE § 70.245.010(13) (2009); COLO. REV. STAT. § 25-48-103(1)(a) (2016); D.C. CODE § 7-661.01(16); HAW. REV. STAT. ANN. § 327L-1 (West 2019); VT. STAT. ANN. tit. 18 § 5281 (2013); 2021 N.M. Laws 132 § 2(J) (2021); N.J. STAT. ANN. § 26:16-3 (West 2019); ME. REV. STAT. ANN. tit. 22, § 2140(2)(M) (2019).

36. OR. REV. STAT. § 127.805 (2018); CAL. HEALTH & SAFETY CODE § 443.5(a)(1) (West 2022); WASH. REV. CODE § 70.245.020 (2009); COLO. REV. STAT. § 25-48-103(1)(b) (2016); HAW. REV. STAT. ANN. § 327L-5 (West 2019); VT. STAT. ANN. tit. 18, § 5283(a)(5)(B) (2013); 2021

AID as well as a written request.³⁷ The oral requests must be separated by a waiting period,³⁸ and the written request must be witnessed by two people, one of whom must be an independent person (i.e., not related to the patient and not a beneficiary after the patient's death).³⁹ The legislation tasks physicians with ensuring the patient has made an informed decision,⁴⁰ is free from undue influence,⁴¹ and is not depressed or otherwise possessing impaired judgment.⁴² Physicians' decisions are confirmed by a second physician.⁴³ Further, both physicians must file records

N.M. Laws 132 § 3(A) (2021); N.J. STAT. ANN. § 26:16-4 (West 2019); ME. REV. STAT. ANN. tit. 22, § 2140(6)(A) (2019). The Oregon Act defines "capable" as having "the ability to make and communicate health care decisions to health care providers." OR. REV. STAT. § 127.800 (2018). Similarly, the California Act defines "capacity to make medical decisions" as the "ability to understand the nature and consequences of a health care decision, the ability to understand its significant benefits, risks, and alternatives, and the ability to make and communicate an informed decision to health care providers." CAL. HEALTH & SAFETY CODE § 443.1(e) (2022).

37. OR. REV. STAT. § 127.840 (2020); CAL. HEALTH & SAFETY CODE § 443.3(a) (West 2022); WASH. REV. CODE § 70.245.090 (2009); COLO. REV. STAT. § 25-48-104(1) (2016); D.C. CODE § 7-661.02(a) (2017); HAW. REV. STAT. ANN. § 327L-2 (West 2019); VT. STAT. ANN. tit. 18, § 5283(a) (2013); N.J. STAT. ANN. § 26:16-10.a (West 2019); ME. REV. STAT. ANN. tit. 22, § 2140(11) (2019).

38. Most waiting periods are fifteen days. OR. REV. STAT. § 127.850 (2020); WASH. REV. CODE § 70.245.110 (2009) (a proposed amendment to the Washington statute provides for a waiting time of seventy-two hours. H.B. 1141, 2021 Leg., 2021 Reg. Sess. (Wa. 2021)); COLO. REV. STAT. § 25-48-104(1) (2016); D.C. CODE § 7-661.02(a) (2017); VT. STAT. ANN. tit. 18, § 5283(a) (2013); N.J. STAT. ANN. § 26:16-10.a (West 2019); ME. REV. STAT. ANN. tit. 17-A § 2140(11). In an amendment effective January 1, 2022, California changed the waiting period from fifteen days to two days. CAL. HEALTH & SAFETY CODE § 443.3(a) (West 2022); S.B. 380, 2021 Leg., 2021-2022 Reg. Sess. (Cal. 2021); Bernard J. Wolfson, *New California Law Eases Aid-in-Dying Process*, CAL. HEALTHLINE (Dec. 3, 2021, 1:00 PM), <https://californiahealthline.org/news/article/new-california-law-eases-aid-in-dying-process/> [<https://perma.cc/45NK-CEU3>]. Hawaii has a waiting period of twenty days, but a bill has been proposed to change it to fifteen days. HAW. REV. STAT. ANN. § 327L-9 (2019); S.B. 839, S.B. 839, 31st Leg., 2021 Reg. Sess. (Haw. 2021).

39. OR. REV. STAT. § 127.810 (2022); CAL. HEALTH & SAFETY CODE § 443.3(b)(3) (West 2022); WASH. REV. CODE § 70.245.030 (2009); COLO. REV. STAT. § 25-48-104(2) (2016); D.C. CODE § 7-661.02(b)(1) (2017); HAW. REV. STAT. ANN. § 327L-3 (West 2019); VT. STAT. ANN. tit. 18, § 5283(a) (2013); 2021 N.M. Laws 132 § 3(H); N.J. STAT. ANN. § 26:16-5 (West 2019); ME. REV. STAT. ANN. tit. 22, § 2140(5)(C) (2019).

40. OR. REV. STAT. § 127.830 (2022); CAL. HEALTH & SAFETY CODE § 443.5(a)(2) (West 2022); WASH. REV. CODE § 70.245.070 (2009); COLO. REV. STAT. § 25-48-110 (2016); D.C. CODE § 7-661.03(a)(9) (2017); HAW. REV. STAT. ANN. § 327L-7 (West 2019); VT. STAT. ANN. tit. 18, § 5283(a)(5)(C) (2013); 2021 N.M. Laws 132 § 2(C); N.J. STAT. ANN. § 26:16-7 (West 2019); ME. REV. STAT. ANN. tit. 17-A § 2140(9) (2019).

41. OR. REV. STAT. § 127.815 (2020); CAL. HEALTH & SAFETY CODE § 443.5(a)(4) (2022); WASH. REV. CODE § 70.245.040(1)(d) (2009); COLO. REV. STAT. § 25-48-106(1)(g) (2016); D.C. CODE § 7-661.03(a)(1)(C) (2017); VT. STAT. ANN. tit. 18, § 5283(a)(5)(D) (2013); 2021 N.M. Laws 132 § 2(D); N.J. STAT. ANN. § 26:16-6 (West 2019); ME. REV. STAT. ANN. tit. 22, § 2140(6)(E) (2019).

42. OR. REV. STAT. § 127.825 (2022); CAL. HEALTH & SAFETY CODE § 443.5(a)(1)(A)(iii) (West 2022); WASH. REV. CODE § 70.245.060 (2009); COLO. REV. STAT. § 25-48-108 (2016); D.C. CODE § 7-661.04 (2017); HAW. REV. STAT. ANN. § 327L-6 (West 2019); VT. STAT. ANN. tit. 18 § 5283(a)(8) (2013); 2021 N.M. Laws 132 § 4; N.J. STAT. ANN. § 26:16-8 (West 2019); ME. REV. STAT. ANN. tit. 22, § 2140(8) (2019).

43. OR. REV. STAT. § 127.820 (2022); CAL. HEALTH & SAFETY CODE § 443.5(a)(3) (West 2022); WASH. REV. CODE § 70.245.040(1)(d) (2009); COLO. REV. STAT. § 25-48-107 (2016);

of the patient's requests, the diagnosis, the determination that the patient met the qualifications, and any other medical documentation made throughout the process.⁴⁴

On their face, these many legislative safeguards seem to guarantee that individuals who die from AID have done so through a careful, precise process that appropriately balances individual autonomy with the state interests in preserving life and protecting vulnerable populations. In reality, however, there is an ongoing debate among scholars⁴⁵ and physicians⁴⁶ regarding whether the safeguards actually achieve a proper balance.

A. Maintaining the Integrity of the Medical Profession

The first state interest implicated by AID is ensuring the integrity of the medical profession. This is possibly the most complicated interest brought up by the *Glucksberg* Court because it involves defining the scope and purpose of an entire profession. *Gonzales* upheld a state's regulation of medicine, implying that the state legislature is best suited to establish these boundaries.⁴⁷ While the legislative process may realistically be the best manner by which to establish legal guidelines and safeguards, input from medical professionals is essential to truly understand whether AID should fall within the scope of the medical field and how it should be implemented. Therefore, this Note considers recent surveys of physicians' opinions on AID and whether it is appropriately legalized as a medical procedure.

1. Arguments in Opposition to AID as a Medical Procedure

There are two main arguments against establishing AID as a legitimate medical procedure: first, that medicine is the art of healing and assisting dying is diametrically opposed to that purpose, and second, that authorizing physicians to

D.C. CODE § 7-661.03(a)(3) (2017); HAW. REV. STAT. ANN. § 327L-5 (West 2019); VT. STAT. ANN. tit. 18, § 5283(a)(7) (2013); N.J. STAT. ANN. § 26:16-6.a(4) (West 2019); ME. REV. STAT. ANN. tit. 22, § 2140(7) (2019).

44. OR. REV. STAT. § 127.855; CAL. HEALTH & SAFETY CODE § 443.5(a)(10)–(11) (West 2022); WASH. REV. CODE § 70.245.120 (2009); COLO. REV. STAT. § 25-48-111 (2016); D.C. CODE §§ 7-661.05, 7-661.06 (2017); HAW. REV. STAT. ANN. § 327L-12 (West 2019); VT. STAT. ANN. tit. 18, § 5283(a)(14)–(15) (2013); 2021 N.M. Laws 132 § 9; N.J. STAT. ANN. § 26:16-10.d (West 2019); ME. REV. STAT. ANN. tit. 22, § 2140(14) (2019).

45. See Tucker, *supra* note 7, at 1603 (“The experience in Oregon has demonstrated that a carefully drafted law does not place patients at risk.”); Battin, *supra* note 7, at 104 (arguing empirical data collected from Oregon shows no evidence of abuse of vulnerable populations). *But see* Hendin & Foley, *supra* note 15, at 1614 (“The evidence strongly suggests that these safeguards are circumvented in ways that are harmful to patients.”); Wendy E. Hiscox, *Physician-Assisted Suicide in Oregon: The ‘Death with Dignity’ Data*, MED. L. INT’L 197, 199 (2007) (“Further inquiry, however, suggest that the safeguards are largely ineffective.”); José Pereira, *Legalizing Euthanasia or Assisted Suicide: The Illusion of Safeguards and Controls*, 18 CURRENT ONCOLOGY, at e38, e38 (2011).

46. Hetzler et. al, *supra* note 14; *Polling on Voter Support for Medical Aid in Dying*, COMPASSION & CHOICES (Feb. 24, 2022), <https://compassionandchoices.org/resource/polling-medical-aid-dying/> [<https://perma.cc/X95A-ARNT>].

47. *Gonzales v. Oregon*, 546 U.S. 243, 270–71 (2006).

assist dying would detrimentally affect the physician-patient relationship.⁴⁸ The first argument, articulated in *Glucksberg* and *Gonzales*, is based on the traditional understanding of medicine and the fear that physician cooperation in assisted dying would undermine the medical purpose of healing.⁴⁹ In fact, the American Medical Association filed an amicus brief to the *Glucksberg* Court in 1996, arguing against finding a constitutional right to AID.⁵⁰ The brief states, “[t]he power to assist in intentionally taking the life of a patient is antithetical to the central mission of healing that guides [the medical profession].”⁵¹ Consider the original Hippocratic Oath, written in the fifth century B.C. by ancient Greek healers, in which physicians swear not to “prescribe a deadly drug” or otherwise aid a patient in dying.⁵² If one accepts the view that the bounds of medicine include only healing, then it follows that AID would fall outside the medical profession. However, the definition of medicine is not so clear-cut.

With the passage of time, physicians’ understanding of “do no harm” has evolved. The modern Hippocratic Oath, as written in 1964, does not include the language in the original that bans physicians from prescribing deadly drugs.⁵³ Instead, the Oath states, “If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness.”⁵⁴ The changes to the Hippocratic Oath reflect a common theme: the understanding of the purpose and scope of medicine and the physician’s role evolve with time and the advancement of technology.⁵⁵ These changes cause even more questions about the proper scope of the medical profession, questions that are implicated in the AID discussion. As will be discussed below, recent studies

48. Chamberlain, *supra* note 5, at 81–82.

49. See *Gonzales*, 546 U.S. at 272; *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997).

50. Brief of Am. Med. Ass’n, Am. Nurses Ass’n, & the Am. Psychiatric Ass’n, et al. as Amici Curiae in Support of Petitioners at 4, *Washington v. Glucksberg*, 521 U.S. 702 (1997) (No. 96-110), 1996 WL 656263, at *1.

51. *Id.*; see also Daniel P. Sulmasy, Ilora Finlay, Faith Fitzgerald, Kathleen Foley, Richard Payne & Mark Siegler, *Physician-Assisted Suicide: Why Neutrality by Organized Medicine Is Neither Neutral Nor Appropriate*, 33 J. GEN. INTERNAL MED. 1394, 1396 (2018) (“Medicine’s central task is to heal . . . it makes no sense to claim that patients have been healed by having assisted them in ending their lives.”).

52. *Physician Oaths*, AAPS, <https://www.aapsonline.org/ethics/oaths.htm#lasagna> [https://perma.cc/LRC3-PNY4] (last visited Sept. 1, 2022).

53. Peter Tyson, *The Hippocratic Oath Today*, PBS SOCAL: NOVA (Mar. 26, 2001), <https://www.pbs.org/wgbh/nova/article/hippocratic-oath-today/> [https://perma.cc/BHW7-B5X8].

54. *Id.*

55. Another significant change to the Hippocratic Oath is the removal of language that prohibits physicians from assisting in abortion. The original Oath swears not to “give a woman a pessary to procure abortion,” *Physician Oaths*, *supra* note 52, but that language is completely removed in the modern version, replaced with the language regarding life and death, Tyson, *supra* note 53. The modern version of the Oath was written in 1964, *id.*, showing how changes in public sentiment and professional actions result in the evolution of formal professional standards, such as the Oath. More to the point, currently, public sentiment and professional actions are changing regarding AID, and if the same pattern occurs as it did regarding abortion, professional standards regarding AID may soon change as well.

show that physician opinions on AID are changing, mirroring the recent trend in public sentiment to legalize AID.⁵⁶

The second argument against including AID as a legitimate medical purpose is the idea that the foundation of the physician-patient relationship is the trust the patient has in the physician to cure them.⁵⁷ As law professor Melvin Urofsky put it, “Medical ethicists and others worry that if the doctor becomes a dispenser of death, this will adversely affect the doctor-patient relationship, destroying the trust that is essential to good care.”⁵⁸ Those with this concern do not want to encourage patients to seek out AID when other treatments are available.⁵⁹ Once again, accepting this argument requires defining the purpose of medicine in a very specific way, one which may not be appropriate to every physician-patient relationship. Each patient has individual needs and goals, and a physician has an obligation to do what is in the best interests of the patient. Terminally ill patients may expect and desire their physician to explain *all* of their end-of-life (EOL) options, including AID.

As long as physicians communicate and fully explain to their patients what EOL options are available, it is unlikely the physician-patient relationship would be damaged. However, it is essential to guarantee that the patient understands the different types of EOL care available, and the physician is best suited to ensure this information is imparted.⁶⁰ If the patient understands all the EOL options and still chooses to seek AID, “a physician who assists suicide does not undermine the doctor-patient relationship because such care fulfills her patient’s wishes and maintains, not violates, her patient’s trust.”⁶¹ In fact, a serious discussion about AID as an option for terminally ill patients “demonstrate[s] a commitment to the patient’s well-being right up until the moment of death,” a commitment consistent with the physician’s role.⁶²

This broader definition of the physician’s role means that AID is not outside the realm of medical practice. Additionally, even with this broader definition of

56. See, e.g., Hetzler et al., *supra* note 14, at 577. For statistics on Americans’ opinions about assisted dying, see COMPASSION & CHOICES, *supra* note 46 (showing results of Medscape and Gallup polls that conclude 74% of residents and 55% of physicians agree that medical aid in dying should be legalized); see also Megan Brenan, *Americans’ Strong Support for Euthanasia Persists*, GALLUP (May 31, 2018), <https://news.gallup.com/poll/235145/americans-strong-support-euthanasia-persists.aspx> [<https://perma.cc/T7JW-BVSE>] (showing that in 2018, 65% of Americans thought AID should be legalized).

57. Sulmasy et al., *supra* note 51, at 1396; Chamberlain, *supra* note 5, at 81–82.

58. Urofsky, *supra* note 16, at 832.

59. Sulmasy et al., *supra* note 51, at 1396.

60. David Orentlicher, Thaddeus Mason Pope & Ben A. Rich, *Clinical Criteria for Physician Aid in Dying*, 19 J. PALLIATIVE MED. 259, 260 (2016) (listing the different EOL care available: hospice, management of symptoms, discontinuing life-prolonging treatment, palliative sedation to unconsciousness, and voluntarily ceasing to eat or drink); see also AM. MED. ASS’N, *Opinions on Caring for Patients at the End of Life*, in *AMA CODE OF MEDICAL ETHICS*, *supra* note 2.

61. Chamberlain, *supra* note 5, at 82.

62. Urofsky, *supra* note 16, at 833.

medicine, physicians are under no obligation to actively participate in AID.⁶³ All AID statutes explicitly say that no health care provider is required to participate in AID, rather, it is entirely voluntary.⁶⁴ Physicians are not subject to any liabilities for participating or refusing to participate. Therefore, if both physician and patient are not opposed to AID, then there is no reason to assume physician participation in AID would destroy trust.

In short, both arguments in opposition to AID as a legitimate medical procedure are based on premises that are not universal—that medicine is the art of healing only and that AID undermines the physician-patient relationship as doctors become “dispensers of death.”⁶⁵ Both physicians and patients can, and do, disagree with these premises. In fact, recent surveys of physicians show a clear difference of opinion on whether AID should be legalized.

2. Physician Views on AID Remain Divided

Medical professionals are fiercely divided on the topic of physician aid in dying. Some hold to the traditional view that hastening death is incompatible with the role of the physician, while others believe that AID is an appropriate medical purpose. The American Medical Association (AMA) recognizes the differences in opinion, stating that “[t]houghtful, morally admirable individuals hold diverging, yet equally deeply held, and well-considered perspectives about physician-assisted suicide.”⁶⁶ Regardless of a physician’s position on AID, the AMA continues on to assure the public that both “supporters and opponents share a fundamental commitment to values of care, compassion, respect, and dignity.”⁶⁷

Recent studies have shown that physician opinions about AID are slowly becoming more favorable, though clear division still remains.⁶⁸ A study done by Medscape in 2020 asked 5,130 U.S. doctors whether AID should be legalized for terminally ill patients.⁶⁹ Fifty-five percent of the doctors said “yes,” 17% said “no,”

63. *Id.*; Chemerinsky, *supra* note 5, at 1511 (“Each doctor can and would decide for himself or herself whether to assist a person in dying.”).

64. OR. REV. STAT. § 127.885(4) (2003) (“No health care provider shall be under any duty . . . to participate in the provision . . . of medication [to AID patients.]”); HAW. REV. STAT. ANN. § 327L-19 (West 2019); D.C. CODE § 7-661.10 (2017); VT. STAT. ANN. tit. 18, § 5285 (2013); COLO. REV. STAT. § 25-48-117 (2016) (“A health care provider may choose whether to participate in providing medical aid-in-dying to an individual in accordance with this article.”); CAL. HEALTH & SAFETY CODE § 443.14(e) (West 2022) (“Participation under this part shall be voluntary.”); N.J. STAT. ANN. § 26:16-17.c (West 2019); WASH. REV. CODE § 70.245.190 (2009) (“Only willing health care providers shall participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner.”); 2021 N.M. Laws 132 § 7(C) (“No health care provider who objects . . . shall be required to participate in [AID].”); ME. REV. STAT. ANN. tit. 22, § 2140(21) (2019) (“Nothing in this Act requires a health care provider to provide medication.”).

65. Urofsky, *supra* note 16.

66. AM. MED. ASS’N, CODE OF MEDICAL ETHICS § 5.7.

67. *Id.*

68. Hetzler et al., *supra* note 14; COMPASSION & CHOICES, *supra* note 46.

69. Kane, *supra* note 14.

and 28% said it would depend on the situation.⁷⁰ This is a 9% increase over the response in 2010, where 46% of doctors supported medical aid in dying.⁷¹ Similarly, in a 2019 survey of 188 doctors, 60% thought AID should be legalized and 69% thought it should be decriminalized.⁷² However, only 25% of respondents indicated they would be willing to perform AID, either because of religious/spiritual beliefs or a lack of training.⁷³ Furthermore, only 49% agreed that the medical profession should endorse AID as a “morally valid medical option,” drawing a distinction between legalization and moral endorsement of AID.⁷⁴ While this particular study had a small sample size, when combined with the Medscape survey, it is clear that physicians are deeply divided on the topic of AID.

The change in physician opinion to be more favorable towards AID parallels recent trends in voter support. A 2018 Gallup poll of American voters showed 65% of respondents believed AID should be legalized.⁷⁵ Approval for AID and euthanasia has steadily increased since 1966 when voters were first polled on this issue (the approval rate was 52% at that time).⁷⁶ However, because the medical field remains so divided and public opinion is changing so slowly, there is no clear conclusion to be drawn as to whether AID should be considered a legitimate medical purpose on a national level. Thus, deference to the democratic process through state legislation—as held in *Gonzales*—is still appropriate.⁷⁷ Unfortunately, a recent study of physicians shows that the current legislative framework is ineffective, and the medical profession has strong concerns about how the states go about protecting their interests and the interests of AID patients.⁷⁸

B. Preserving Life

As a threshold matter, for the purposes of weighing a state's interest, it is imperative to distinguish between suicide *per se* and AID. AID is more complicated than suicide *per se*, as it involves hastening a death that will naturally occur relatively soon. As such, the state interest implicated is not one of preventing suicide, but of preserving the life of terminally ill individuals until death naturally occurs.⁷⁹

70. *Id.*

71. COMPASSION & CHOICES, *supra* note 46.

72. Hetzler et al., *supra* note 14, at 577.

73. *Id.*

74. *Id.* at 581 tbl.4; *see also* Brenan, *supra* note 56 (“A slim majority of Americans (54%) currently think doctor-assisted suicide is morally acceptable, and 42% think it is morally wrong.”); *Moral Issues*, GALLUP, <https://news.gallup.com/poll/1681/moral-issues.aspx> [<https://perma.cc/RSC4-SKDQ>] (last visited Aug. 26, 2022) (showing results from a 2020 poll that 51% of respondents believe doctor-assisted suicide is morally acceptable).

75. Brenan, *supra* note 56.

76. *Id.*

77. This deference does not impose unwanted obligations on physicians because physicians are not required to participate in AID. *See* sources cited *supra* note 64.

78. *See, e.g.*, Hetzler et al., *supra* note 14.

79. *See* Chemerinsky, *supra* note 5, at 1510 (“[T]he question is much more specific: does the state have a compelling interest in preventing terminally ill patients from being assisted in their death?”)

Therefore, my analysis will focus on the interest in preserving life, with the understanding that in this context the prevention of suicide *per se* is not relevant to this discussion.

It is well-established that states have a legitimate interest in preserving the life of residents. This can be seen through the history of U.S. laws that criminalize actions that result in death.⁸⁰ For instance, in *Cruzan*, the Supreme Court pointed out that “[a]s a general matter, the States—indeed, all civilized nations—demonstrate their commitment to life by treating homicide as a serious crime.”⁸¹ Additionally, suicide *per se* was a crime in the English courts during the eighteenth and nineteenth centuries, a view that was adopted in the American colonies and persisted for many years.⁸² Although suicide *per se* has been decriminalized, the state’s interest in life continues to be shown through courts’ condemnation of suicide as a “public wrong” and through laws that ban assisting suicide.⁸³ As shown in *Glucksberg*, the United States has a long history of prohibiting assisted suicide.⁸⁴

While it is obvious states have an interest in preserving life, it is important to note that this interest is not absolute. There are qualifications and exceptions to the preservation of life that make it clear the state’s interest can be outweighed by other interests. For instance, the most obvious qualification has been discussed above: the *Cruzan* Court held it acceptable for life-sustaining treatment to be withheld from patients.⁸⁵ Voluntary refusal of medical treatment is naturally antithetical to the preservation of life, yet the state interest yielded in favor of autonomy.⁸⁶ In *Cruzan*, the Court acknowledged that the strength of a state’s

Phrased this way, the argument collapses into the prior point that the state has a compelling interest in safeguarding life.”).

80. See, e.g., 18 U.S.C. §§ 1111–1112 (criminalizing homicide and manslaughter).

81. *Cruzan ex rel. Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 280 (1990).

82. *Washington v. Glucksberg*, 521 U.S. 702, 711–12 (“[F]or over 700 years, the Anglo-American common-law tradition has punished or otherwise disapproved of both suicide and assisting suicide.”).

83. *Id.* at 714.

84. *Id.* at 715–19 (“Attitudes toward suicide itself have changed since [English common-law], but our laws have consistently condemned, and continue to prohibit, assisting suicide.”).

85. *Cruzan*, 497 U.S. at 261.

86. Many proponents of AID argue that the distinction between removing life-sustaining treatment and prescribing medication for assisted dying is unreasonable. See, e.g., Coggon, *supra* note 8, at 406; Chamberlain, *supra* note 5, at 72 (“The U.S. Supreme Court’s distinction between refusing life-sustaining treatment and physician-assisted suicide is both arbitrary and unconstitutional.”). There are other laws in the United States that show the state’s interest in life is not unqualified. For instance, despite a majority of states prohibiting homicide (and, historically, suicide), there are also laws allowing capital punishment. Today, the death penalty is still legal in twenty-seven states, the federal government, and the military. DEATH PENALTY INFO. CTR., FACTS ABOUT THE DEATH PENALTY (2022), <https://documents.deathpenaltyinfo.org/pdf/FactSheet.pdf> [<https://perma.cc/B7DS-HWUL>]. Granted, the circumstances surrounding the death penalty are very different than those involving AID—the criminal context of punishment versus the medical context of autonomy in dying—but nevertheless the persistence of capital punishment shows that there are, and have been, circumstances where a state’s interest in preserving life is outweighed by other interests.

interest in preserving life fluctuates depending on the context. The state's interest is "greatest when an affliction [is] curable"⁸⁷ and weakens as "the prognosis dims."⁸⁸

Within the context of AID, the state strikes a balance between its interest in preserving life and preserving individual autonomy by requiring patients seeking AID to have a prognosis of at most six months to live.⁸⁹ This requirement takes into consideration the fact that the state interest is likely weak, as the "affliction[s]" in question are not "curable," but the strict regulations still preserve the life of citizens until the final months. However, physicians have articulated doubts regarding whether a six-month diagnosis can be made accurately. In a national survey of physicians, only 18% of physician respondents agreed that physicians can "predict with certainty" whether a patient has six months or less to live.⁹⁰ Similarly, Berger and Terry, representing organizations that work on behalf of those with disabilities, expressed a concern that it is "nearly impossible" to accurately predict the time of death, pointing to disabled persons who have lived for years after an inaccurate diagnosis.⁹¹

In practice, the 2020 data summary from Oregon shows 3.3% of patients (8 of 245) who died from lethal medication outlived the six-month prognosis.⁹² That is, they received the medication but did not take it immediately, and then outlived the six-month estimated prognosis. Obviously, this does not show how many people who *did* ingest the medication would have lived longer than six months.⁹³ Vermont notes that 4 of 52 patients likely survived past the 2019 reporting period, as the Health Department had not received a death report for those patients.⁹⁴ Similarly, Washington notes that its Department of Health did not receive the death certificates of 12 of 334 patients in 2020.⁹⁵ In its 2020 report, Colorado reports a maximum time duration between prescription and date of death of eleven

87. *Cruzan*, 497 U.S. at 271.

88. *Id.* at 270 (quoting *In re Quinlan*, 355 A.2d 647 (N.J. 1976)).

89. See sources cited *supra* note 35.

90. Hetzler et al., *supra* note 14, at 581; see also Hendin & Foley, *supra* note 15, at 1633 ("The majority of Oregon physicians, when surveyed, were not confident they could make [an accurate] prediction [of six months or less to live]."); Hiscox, *supra* note 45, at 199.

91. Helena Berger & Clyde Terry, *When Insurance Companies Refuse Treatment "Assisted Suicide" Is No Choice at All*, AAPD (Jan. 24, 2017), <https://www.aapd.com/when-insurance-companies-refuse-treatment-assisted-suicide-is-no-choice-at-all/> [<https://perma.cc/SR4J-339Z>].

92. PUB. HEALTH DIV., CTR. FOR HEALTH STATS., OREGON DEATH WITH DIGNITY ACT 2020 DATA SUMMARY 11 (2021) [hereinafter OR. DATA SUMMARY].

93. See Robert Preston, *Physician-Assisted Suicide—A Clean Bill of Health?* 123 BRIT. MED. BULL. 69, 74 (2017) (noting that the period between the first request for AID and death from ingestion is sometimes more than six months).

94. AGENCY OF HUM. SERVICES, VT. DEP'T OF HEALTH, REPORT CONCERNING PATIENT CHOICE AT THE END OF LIFE 4 (2018) [hereinafter VT. DATA SUMMARY].

95. CTR FOR HEALTH STAT., WASH. STATE DEP'T OF HEALTH, 2020 DEATH WITH DIGNITY ACT REPORT 13 (2021) [hereinafter WASH. DATA SUMMARY].

months.⁹⁶ Further, data from California includes individuals who were prescribed the medication in prior years but ingested it in the most recent report.⁹⁷ Though the prescription date is not reported, it is likely at least some of those patients outlived the six-month diagnosis. After all, if the medication was prescribed in 2018, but the patient did not die until the medication was ingested in 2019, there is a likelihood that the time between prescription and ingestion was more than six months.

On the other hand, data collected from states that have legalized AID and that record the cause of death shows the percentage of individuals who died of their underlying illness before ingestion of drugs (and before the six-month prognosis). California reports 14.6% of those seeking AID died from the underlying disease,⁹⁸ Hawaii reports 34.8%,⁹⁹ Vermont 35%,¹⁰⁰ Washington 12.2%,¹⁰¹ and Oregon 18%.¹⁰² Thus, the data shows that there is evidence of patients dying before and after the predicted six-month timeline. This means that the current regulation may or may not appropriately balance the state interest in preserving life with individual interest in autonomy and dignity in dying.

Unfortunately, there is little the state can require that would increase accuracy or certainty of patients' prognoses. Diagnosis and prognosis are wholly within the scope of the physician's expertise, and state action cannot decrease the margin of error. However, this uncertainty about accuracy is an important point to take note of when drafting legislation: a shorter prognosis requirement, such as a three-month prognosis, may be appropriate to reduce the risk of ending life prematurely. This type of decision is one for the democratic process and is beyond the scope of the discussion here. For the purposes of this Note, the important fact is that physicians have noted a concern, backed up by data, that the required six-month diagnosis is not always accurate. This means that the current legislative framework may not be properly protecting the state's interest in preserving life.

C. *Protecting Vulnerable Populations*

The next state interest implicated by AID is protecting vulnerable populations against abuse of AID. The concern is that vulnerable populations—particularly the elderly, disabled, and poor—might be pressured to seek AID when alternative

96. CTR. HEALTH & ENVIRON. DATA, COLO. DEP'T OF PUB. HEALTH & ENVIRON., COLORADO END-OF-LIFE OPTIONS ACT, YEAR FOUR 2020 DATA SUMMARY, WITH 2017-2020 TRENDS AND TOTALS 4 (2020) [hereinafter COLO. DATA SUMMARY].

97. See, e.g., CAL. DEP'T OF PUB. HEALTH, CALIFORNIA END OF LIFE OPTION ACT 2019 DATA REPORT 3 (2020) [hereinafter CAL. DATA SUMMARY] (noting that thirty-four individuals with prescriptions from prior years ingested the medication during 2019).

98. *Id.*

99. OFFICE OF PLAN., POL'Y & PROGRAM DEV., DEP'T OF HEALTH, REPORT TO THE THIRTIETH LEGISLATURE STATE OF HAWAII 1 (2020) [hereinafter HAW. DATA SUMMARY].

100. VT. DATA SUMMARY, *supra* note 94, at 4.

101. WASH. DATA SUMMARY, *supra* note 95, at 5.

102. OR. DATA SUMMARY, *supra* note 92, at 5.

methods of EOL care are available.¹⁰³ The *Glucksberg* Court stated there was a “real risk of subtle coercion and undue influence in end-of-life situations.”¹⁰⁴ Specifically, the Court worried that the elderly, poor, or disabled would feel pressured to seek out AID “to spare their families the substantial financial burden of end-of-life health-care costs.”¹⁰⁵ The Court decried this potential undue influence, asserting that the “suicidal impulses” of these populations should “be interpreted and treated the same way as anyone else’s.”¹⁰⁶ In other words, the state fears that the desire of vulnerable individuals to seek AID could be motivated by external pressures, such as familial or financial influence, rather than a genuine desire for autonomy in dying. To alleviate this fear, AID legislation requires that physicians ensure patients make an informed decision,¹⁰⁷ are free from undue influence,¹⁰⁸ and are not afflicted by impaired judgment.¹⁰⁹

Proponents of AID rely heavily on data that shows patients using AID are generally insured and highly educated to rebut the risk of coercion.¹¹⁰ The argument seems to assume that educated patients are more capable of understanding their options and are less vulnerable to pressure or coercion. Similarly, if the patients have health insurance, they will not be financially pressured. The data, however, does not support this assumption. According to the most recent data reports, 100% of AID participants in Oregon¹¹¹ and 97% in Washington were insured,¹¹² and 71.8%¹¹³ and 76%¹¹⁴ had at least a college-level education.¹¹⁵ However, these patient

103. *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997); Sulmasy et al., *supra* note 51, at 1396.

104. *Glucksberg*, 521 U.S. at 732.

105. *Id.*

106. *Id.*

107. OR. REV. STAT. § 127.810 (2022); CAL. HEALTH & SAFETY CODE § 443.3(b)(3) (West 2022); WASH. REV. CODE § 70.245.030 (2009); COLO. REV. STAT. § 25-48-104(2) (2016); D.C. CODE § 7-661.02(b)(1) (2017); HAW. REV. STAT. ANN. § 327L-3 (West 2019); VT. STAT. ANN. Tit. 18, § 5283(a) (2013); 2021 N.M. Laws 132 § 3(H); N.J. STAT. ANN. § 26:16-5 (West 2019); ME. REV. STAT. ANN. Tit. 22, § 2140(5)(C) (2019).

108. OR. REV. STAT. § 127.830 (2022); CAL. HEALTH & SAFETY CODE § 443.5(a)(2) (West 2022); WASH. REV. CODE § 70.245.070 (2009); COLO. REV. STAT. § 25-48-110 (2016); D.C. CODE § 7-661.03(a)(9) (2017); HAW. REV. STAT. ANN. § 327L-7 (West 2019); VT. STAT. ANN. Tit. 18, § 5283(a)(5)(C) (2013); 2021 N.M. Laws 132 § 2(C); N.J. STAT. ANN. § 26:16-7 (West 2019); ME. REV. STAT. ANN. Tit. 17-A § 2140(9) (2019).

109. OR. REV. STAT. § 127.815 (2020); CAL. HEALTH & SAFETY CODE § 443.5(a)(4) (West 2022); WASH. REV. CODE § 70.245.040(1)(d) (2009); COLO. REV. STAT. § 25-48-106(1)(g) (2016); D.C. CODE § 7-661.03(a)(1)(C) (2017); VT. STAT. ANN. Tit. 18, § 5283(a)(5)(D) (2013); 2021 N.M. Laws 132 § 2(D); N.J. STAT. ANN. § 26:16-6 (West 2019); ME. REV. STAT. ANN. Tit. 22, § 2140(6)(E) (2019).

110. Tucker, *supra* note 7, at 1604.

111. OR. DATA SUMMARY, *supra* note 92, at 10.

112. WASH. DATA SUMMARY, *supra* note 95, at 5.

113. OR. DATA SUMMARY, *supra* note 92, at 9.

114. WASH. DATA SUMMARY, *supra* note 95, at 8.

115. Similarly, 89.9% of California AID participants had insurance and 74.4% had at least a college-level education. CAL. DATA SUMMARY, *supra* note 97, at 7, 9. Seventy-eight percent of Colorado AID participants had at least a college-level education. COLO. DATA SUMMARY, *supra* note 96, at 4–5.

characteristics are not dispositive: despite their insurance and education, 53.1% of participants in Oregon and 58.6% of participants in Washington felt they were a burden on their family or their caregivers.¹¹⁶ Although the main reasons individuals in these states—the only states to report on the reasons AID was pursued—sought out AID was a loss of autonomy (93.1% in Oregon and 89.6% in Washington) and the loss of ability to engage in activities making life enjoyable (94.3% in Oregon and 90.6% in Washington),¹¹⁷ 53.1% and 58.6% are significant numbers, reflecting a genuine concern that the system may not be properly protecting patients from undue influences.¹¹⁸

Physicians echo the concerns raised by analysis of the data. While physicians are required to inform their patients of their diagnosis, prognosis, the feasible alternatives to assisted suicide, the risks of the lethal medication, and the probable result of taking said medication,¹¹⁹ there is no guidance for physicians on explaining *how* different EOL options can address the patients' specific EOL concerns. For instance, physicians are not trained to communicate how palliative care may alleviate pain or how hospice care may make patients feel like less of a burden.¹²⁰ In addition to the lack of guidance, there is no oversight or review of patient-physician interactions to ensure adequate informing occurs.¹²¹ Therefore, even highly educated patients could remain ignorant as to the alternative EOL options available.¹²²

Further, although physicians are the best suited to inform patients about their EOL options (even if not all physicians are knowledgeable about the details), they do not have the knowledge necessary to determine whether there are undue familial or financial influences on the patient.¹²³ For instance, there have been cases where insurance companies favor covering AID over alternative treatments.¹²⁴ Physicians

The other states that reported this data had a small sample size, so I have not included the information here, as the above-listed data is representative of the trends.

116. OR. DATA SUMMARY, *supra* note 92, at 12; WASH. DATA SUMMARY, *supra* note 95, at 10. Oregon and Washington were the only states that collected and published data about the reasons patients sought out AID.

117. OR. DATA SUMMARY, *supra* note 92, at 12; WASH. DATA SUMMARY, *supra* note 95, at 10.

118. *See* Preston, *supra* note 93, at 71–72. *But see* Battin, *supra* note 7, at 104 (arguing the data collected from Oregon shows there is no adverse effect on vulnerable groups).

119. OR. REV. STAT. § 127.815(1)(c) (2020); CAL. HEALTH & SAFETY CODE § 443.5(a)(2) (West 2022); WASH. REV. CODE § 70.245.040(1)(c) (2009).

120. *But see* Hendin & Foley, *supra* note 15, at 1619 (arguing available hospice care inadequately treats pain of terminally ill patients, meaning hospice care may not be a feasible alternative without physician intervention or systemic improvements).

121. Hendin and Foley also articulate a concern that physicians may “merely go through the motions of presenting the possibility of palliative care for their patients,” rather than engage in a meaningful explanation. Hendin & Foley, *supra* note 15, at 1616, 1618 (describing a conversation where a physician discussed alternative options in only three sentences and did not address patient anxieties about those treatments).

122. *See* Orentlicher, Pope & Rich, *supra* note 60, at 260.

123. Sulmasy et al., *supra* note 51, at 1396.

124. *See* Hetzler et al., *supra* note 14, at 581 (showing that forty-six percent of respondent physicians agreed that health insurance companies would cover assisted dying over more expensive,

have no way to know about these insurance decisions unless the patient tells them. Therefore, even insured patients may be financially pressured to seek AID over other EOL options.

Similarly, there is no government oversight of the administration of medication—there is no requirement that independent witnesses be present when the patient takes the drugs, though the statutes recommend it.¹²⁵ The concern is that this lack of oversight makes the AID procedure subject to abuse, as there is no way to guarantee the patients took the medication free of external pressure.¹²⁶ Physicians are ill-equipped to screen for these external influences, especially if the individual is a new patient, as circumstances beyond the patients' health are outside the scope of the physician's role.¹²⁷

Additionally, physicians participating in AID do not have a longstanding relationship with all their patients. Rather, some patients seek out the doctor specifically to request AID, and so have only two conversations with the physician. Oregon records the average duration of the patient-physician relationship. In 2020, the median length of the physician-patient relationship was eight weeks, ranging from a minimum of less than one week to a maximum of nineteen years.¹²⁸ Washington also used to record this information, though the most recent data summaries from 2019 and 2020 do not include it. However, in its 2018 report, Washington notes that 49.5% of patients had a relationship with their physician that was less than twenty-five weeks (118 of 238); 10.5% had relationships twenty-five to fifty-one weeks (25 of 238); and 37.8% (90 of 238) had a patient-physician

alternative treatments); *see also* Berger & Terry, *supra* note 91. *But see Refuting Misinformation About Death with Dignity*, DEATH WITH DIGNITY, <https://deathwithdignity.org/refuting-misinformation/> [<https://perma.cc/MV93-28GW>] (last visited Aug. 26, 2022).

125. *See, e.g.*, OR. REV. STAT. § 127.815(g) (2020) (stating that a physician should “counsel the patient about the importance of having another person present when the patient takes the medication,” but not requiring it). *See generally* Margaret K. Dore, “*Death with Dignity*”: *A Recipe for Elder Abuse and Homicide (Albeit Not by Name)*, 11 MARQUETTE ELDER’S ADVISOR 387 (2010).

126. Berger & Terry, *supra* note 91. However, the data shows that even though a witness is not required, health care providers are commonly present at the time of ingestion and death. For instance, in Oregon, around half of participants had a health care provider or volunteer present at time of death. OR. DATA SUMMARY, *supra* note 92, at 12. Washington’s 2018 Data Summary reports that 77% of participants had some health care provider present. CTR FOR HEALTH STAT., WASH. STATE DEP’T OF HEALTH, 2018 DEATH WITH DIGNITY ACT REPORT 13 (2019). California reports 47.9% of participants had a health care provider present at ingestion. CAL. DATA SUMMARY, *supra* note 97, at 6. Thus, the fact that witnesses are not required for ingestion is a problem that varies in severity across state lines. Still, the reality that half of the patients ingesting lethal medication do so without an official witness provides opportunities for abuse, which physicians can only counter if they are present.

127. Preston, *supra* note 93, at 74, 75 (“It is questionable, however, whether [doctors] are best-placed to make judgments such as whether an applicant for assisted suicide has a settled wish to die or is free from pressure.”); Sulmasy et al., *supra* note 51, at 1396 (“Yet most doctors have limited knowledge of their patients’ lives beyond the examination room—for example, what family dynamics are at work or what internal pressures may exist.”).

128. OR. DATA SUMMARY, *supra* note 92, at 12.

relationship longer than one year.¹²⁹ Washington reports that the minimum duration was less than one week, and the maximum was twenty-three years.¹³⁰

Because the average physician-patient relationship within the context of AID is relatively short, most physicians cannot accurately determine whether the patient is being pressured to seek AID.¹³¹ Nevertheless, the current system requires that physicians determine issues such as “what family or other dynamics might be at work in the background”¹³² without giving any guidance on how precisely to do so. In the cases where vulnerable populations *are* faced with external familial or financial pressures, the choice to seek out AID “becomes more like a duty to die.”¹³³ It is this abuse of the system that the state has an interest in preventing through regulation.

Finally, physicians have raised concerns about the protection of another vulnerable population: the mentally ill. Not all physicians have the expertise needed to identify when a patient is suffering from depression or another psychiatric illness.¹³⁴ Knowing when a patient is depressed is important because “it is potentially reversible” and may affect the patient’s decision to seek AID.¹³⁵ Studies show that depression is correlated with an interest in assisted suicide.¹³⁶ Under the current AID legislation, being depressed does not automatically make a patient ineligible for AID: finding that a patient is depressed “does not necessarily mean that the patient is incompetent.”¹³⁷ Mental competence, or capability, is separate from mental-health status. Oregon defines mental capability as whether a patient “has the ability to make and communicate health care decisions” to the physician.¹³⁸

129. CTR FOR HEALTH STAT., WASH. STATE DEP’T OF HEALTH, 2018 DEATH WITH DIGNITY ACT REPORT 12 (2019).

130. *Id.*

131. Hendin & Foley, *supra* note 15, at 1626 (“How can any physician be sure there is no coercion unless the physician has met the family and seen the interaction among them and with the patient?”).

132. Preston, *supra* note 93, at 74.

133. *Id.*

134. Hetzler et al., *supra* note 14, at 581 (showing that only 23% of physicians agree they are sufficiently trained to screen for depression); Battin, *supra* note 7, at 123–25 (discussing the debate regarding whether physicians are competent to screen for depression).

135. Ilana Levene & Michael Parker, *Prevalence of Depression in Granted and Refused Requests for Euthanasia and Assisted Suicide: A Systematic Review*, 37 J. MED. ETHICS 205, 205 (2011).

136. Hendin & Foley, *supra* note 15, at 1621, 1630–31; Hetzler et al. *supra* note 14, at 582. *See generally* Levene & Parker, *supra* note 135.

137. Hendin & Foley, *supra* note 15, at 1631 (quoting TASK FORCE TO IMPROVE THE CARE OF TERMINALLY-ILL OREGONIANS, THE OREGON DEATH WITH DIGNITY ACT: A GUIDEBOOK FOR HEALTH CARE PROVIDERS 30 (Kathleen Haley & Melinda Lee eds., 1st ed. 1998)).

138. OR. REV. STAT. § 127.800(3) (2020). A 2015 study determined which characteristics of patients were considered the most important by psychiatrists in AID evaluations. Shara M. Johnson, Robert J. Cramer, Brett O. Gardner & Matt R. Nobles, *What Patient and Psychologist Characteristics Are Important in Competency for Physician-Assisted Suicide Evaluations?*, 21 PSYCH., PUBLIC POL’Y & L. 420, 420 (2015). A patient’s cognitive ability, their appreciation of the situation (their rational understanding of the disorder and treatment), and their reasoning (the process by which the patient makes a decision) were significant predictors of a competence decision. *Id.* at 427–28.

Similarly, the California Act defines the “capacity to make medical decisions” as the “ability to understand the nature and consequences of a health care decision, the ability to understand its significant benefits, risks, and alternatives, and the ability to make and communicate an informed decision to health care providers.”¹³⁹ Being free from mental illness is not part of the equation. AID statutes recommend referral to a psychologist or psychiatrist only if the physician believes the patient is suffering from a psychiatric disorder that may “caus[e] impaired judgment,”¹⁴⁰ but the presence of a psychiatric disorder is not determinative—in other words, *just because a patient is depressed does not automatically mean his or her judgment is impaired*.

Unfortunately, “physicians are not reliably able to diagnose depression, let alone to determine whether depression is impairing judgment.”¹⁴¹ In fact, because of the relatively short patient-doctor relationship, even psychiatrists doubt their ability to determine whether a patient is competent to choose AID. In an early (1999) study of Oregon psychiatrists, only 6% felt confident they could assess whether a patient’s judgment was impaired in these situations.¹⁴² Although this number may have increased in the last couple decades, the most recent data from Oregon still reveals worryingly low rates of psychiatric consulting: only 3 of 245 patients (1.2%) were referred for a psychiatric evaluation.¹⁴³ Colorado similarly reports that only 3 of 188 patients (1.6%) were referred for a psychiatric evaluation.¹⁴⁴ Washington’s 2020 Data Summary redacted the number of patients who were referred to psychiatric consulting under its Small Numbers Guidelines, meaning the amount of patients referred was so small as to be insignificant. In 2018, 10 patients (4%) in Washington were referred for a psychiatric evaluation.¹⁴⁵ The low rate of psychiatric referral is concerning, given the studies that show depression is linked with an interest in AID.¹⁴⁶ It is unknown how many individuals who ingested lethal medication were suffering from impaired judgment due to a psychiatric condition because physicians may not be sufficiently trained to determine such information.

139. CAL. HEALTH & SAFETY CODE § 443.1(c) (West 2022).

140. OR. REV. STAT. § 127.800(5) (2020); CAL. HEALTH & SAFETY CODE § 443.5(a)(4) (West 2022); WASH. REV. CODE § 70.245.040(1)(d) (2009); COLO. REV. STAT. § 25-48-106(1)(g) (2016); D.C. CODE § 7-661.03(a)(1)(C) (2017); VT. STAT. ANN. tit. 18, § 5283(a)(5)(D) (2013); 2021 N.M. Laws 132 § 2(D); N.J. STAT. ANN. § 26:16-6 (West 2019); ME. REV. STAT. ANN. tit. 22, § 2140(6)(E) (2019). Hawaii is the only AID state that requires a psychiatric evaluation before prescription. HAW. REV. STAT. § 327L-6 (West 2019).

141. Hendin & Foley, *supra* note 15, at 1621.

142. *Id.* at 1623; *see also* Levene & Parker, *supra* note 135, at 209; Hiscox, *supra* note 45, at 200 (“Additional problems arise from the fact that an attending or consulting physician need not have any training in performing an evaluation [of mental competence] . . .”).

143. OR. DATA SUMMARY, *supra* note 92, at 11. Similarly, Washington reports a 4% referral rate, and Colorado 2%. WASH. DATA SUMMARY, *supra* note 95, at 5; COLO. DATA SUMMARY, *supra* note 96, at 6.

144. COLO. DATA SUMMARY, *supra* note 96, at 6.

145. WASH. DATA SUMMARY, *supra* note 95, at 14; CTR FOR HEALTH STAT., WASH. STATE DEPT OF HEALTH, 2018 DEATH WITH DIGNITY ACT REPORT 12 (2019).

146. *See* sources cited *supra* note 136.

In sum, although the state purports to protect vulnerable populations through legislative safeguards, the requirements it imposes on physicians are illogical and ineffective. Physicians are ill-equipped to screen AID patients for external influences that might affect their decision-making due to the short doctor-patient relationship and the limited knowledge about the patient's life. Further, not all physicians have the experience or expertise to screen for depression, meaning there is an entire vulnerable population that is inadequately protected. The so-called safeguards have massive holes. Potential gap-filling solutions to these holes will be discussed in Part III.

D. Preventing a Slippery Slope

Similar to the interest in protecting vulnerable populations, the final state interest is preventing the extension of AID. The concern is that legislation allowing AID is only a few legislative amendments away from allowing voluntary or even involuntary euthanasia.¹⁴⁷ Those with this fear point to the Netherlands, where assisted death and euthanasia laws have gradually become more permissive.¹⁴⁸ They argue this shift is inevitable if AID is legalized. At the basis of this concern is the belief that the expansion of AID in any way is morally wrong and thus should be avoided.¹⁴⁹ While I will not discuss the moral arguments involved in the slippery slope discussion, it is important to note the motivation behind this fear and acknowledge that such a belief—that expansion is wrong—is not universal.¹⁵⁰ In fact, as seen in the Netherlands, many proponents of assisted death “think that the suffering that a person endures need not be the product of a *terminal* disease in order for it to be intolerable . . . [and] would like to see euthanasia and assisted suicide permitted in . . . a wider range of cases.”¹⁵¹

Regardless of the differing moral views, expansion of AID to euthanasia continues to be a lively debate within scholarly and legislative circles.¹⁵² The Oregon Death with Dignity Act has been enacted for over two decades and has not substantially expanded beyond its original structure.¹⁵³ However, there have been recent legislative debates about expanding the definition of “self-administer” and “ingest” to make it easier to qualify, as well as a proposal to include degenerative

147. Sulmasy et al., *supra* note 51, at 1397.

148. See David Benatar, *A Legal Right to Die: Responding to Slippery Slope and Abuse Arguments*, 18 CURRENT ONCOLOGY 206, 206 (2011); Mary J. Shariff, *Assisted Death and the Slippery Slope—Finding Clarity Amid Advocacy, Convergence, and Complexity*, 19 CURRENT ONCOLOGY 143, 144 (2012) (stating that the Netherlands allows euthanasia and AID for both physical and nonphysical suffering that is unbearable and incurable, even if not terminal).

149. See Benatar, *supra* note 148, at 206.

150. *Id.*

151. *Id.*

152. See Lydia S. Dugdale, Barron H. Lerner & Daniel Callahan, *Pros and Cons of Physician Aid in Dying*, 92 YALE J. BIOLOGY & MED. 747, 747 (2019).

153. Chemerinsky, *supra* note 5, at 1513.

conditions in the definition of “terminal.”¹⁵⁴ Some scholars also argue that publicity about AID can increase “suicide contagion,” noting a correlation between increased rates of suicide *per se* and AID.¹⁵⁵

Analyzing the slippery slope debate in depth is beyond the scope of this Note. Suffice to say that there are physicians who have concerns regarding suicide contagion and the expansion of AID procedures.¹⁵⁶ It is possible that evolving societal views on AID may result in a change or expansion of legislation, but such expansion would be the result of the democratic process—a long, drawn-out process during which both opponents and proponents have opportunities to be heard. The use of the democratic process would, ideally, curb any radical or arbitrary expansion of assisted dying.

As this Part has shown, the state has legitimate interests in its regulation of AID. The state also has the obligation to ensure the regulations in effect sufficiently meet these interests while simultaneously protecting the rights of its residents. Recent surveys of physicians show that the current regulations fail to sufficiently balance these interests and protect residents seeking AID. The next Part of this Note suggests some potential solutions to fill the above-listed legislative gaps.

III. POTENTIAL SOLUTIONS VIA STATE GUIDANCE AND PHYSICIAN TRAINING

Because Supreme Court holdings have authorized states to legalize and regulate AID, the state has the obligation to ensure the AID procedures are appropriately structured and reasonably balance the state interests with the individual's interest. Unfortunately, the current procedures may not adequately achieve this balance—lack of oversight has led to a failure to protect vulnerable individuals seeking AID.

A. Increase State Oversight

The first potential solution would be to increase state oversight of AID. This could be done by forming a government division or committee dedicated to AID exclusively. No state that legalized AID has a specific area of the government to oversee the program. Instead, private physicians conduct assisted suicide for qualifying patients and submit reports to the state health department.¹⁵⁷ The lack of involvement means the state does not have access to information about *how* the procedures are being implemented. The government has extensive discretion to

154. Dugdale, Lerner & Callahan, *supra* note 152, at 749.

155. *See, e.g.*, Sulmasy et al., *supra* note 51, at 1396.

156. *See, e.g.*, Dugdale, Lerner & Callahan, *supra* note 152.

157. This self-reporting structure is another concern in and of itself, as there is no way for the state to ensure reports are true and accurate, and no way for the state to enforce compliance. Hiscox, *supra* note 45, at 205 (“Arguably the biggest cause for concern lies in the fact that the system remains one of self-reporting and therefore the total incidence of abuse is not only unknown but unknowable, as is the true extent of [physician assisted suicide].”).

regulate the medical field, including AID,¹⁵⁸ and could monitor the use of AID more closely.¹⁵⁹ Creating a specific government division dedicated to AID regulation, monitoring, and enforcement would allow states to analyze the gathered data more closely, identify areas of concern in the current legislation, and take more efficient steps to fix problems.

Creating a specific governmental division is not a novel idea; in California, the Department of Public Health has six subdivisions, called Centers, which then also have subdivisions that deal with specific programs.¹⁶⁰ For instance, within the Center for Family Health there is a Genetic Disease Screening Program, a division dedicated to identifying and treating genetic and congenital disorders in newborns.¹⁶¹ This division further has three internal sections dedicated to the Program's mission. Such a structural organization would be incredibly helpful for regulating AID procedures: a separate division within the department of health of each state could create AID regulations, monitor implementation, and enforce reporting requirements. Allocating resources and personnel to AID programs specifically would allow states to keep a closer eye on implementation to ensure the legislation is achieving the ideal balance.

Increased state oversight could include surveying physicians about how many requests for AID were made, how many were denied, the reasons for denial, and whether those who were denied sought out a different physician.¹⁶² Gathering data on denial of AID would increase transparency regarding the decision-making process.¹⁶³ Analyzing reasons for denial of AID would allow states to determine how efficient physicians are at screening patients' eligibility and note any areas where the rate of or reasons for denials are inconsistent across different physicians. This additional data could give insight into the potential for "doctor shopping," where patients request AID medication from multiple physicians before finding one willing to prescribe it.¹⁶⁴

Increased oversight could also include more detailed reporting requirements from physicians. Currently, physicians fill out a simple compliance form that requires them to check boxes to confirm the patient meets all criteria, including

158. Hendin & Foley, *supra* note 15, at 1637; Preston, *supra* note 93, at 71 ("A fundamental problem here is the absence of an independent qualitative audit system . . . [T]here is no body charged specifically with scrutinizing the quality of the [physician] assessment process.").

159. Hiscox, *supra* note 45, at 202 (arguing the Oregon Department of Health should review the practice of AID more rigorously to ensure compliance).

160. *California Department of Public Health (CDPH) Programs*, CAL. DEP'T PUB. HEALTH, <https://www.cdph.ca.gov/Programs> [<https://perma.cc/N8HK-65P2>] (last visited Sept. 1, 2022).

161. *Genetic Disease Screening Program*, CAL. DEP'T PUB. HEALTH (Nov. 17, 2021), <https://www.cdph.ca.gov/Programs/CFH/DGDS/Pages/GDSP-Program-and-Services.aspx> [<https://perma.cc/MY3Z-6NDW>].

162. Hendin & Foley, *supra* note 15, at 1637; Hiscox, *supra* note 45, at 206.

163. Hiscox, *supra* note 45, at 206.

164. *See id.* at 209–10.

being fully informed of the “feasible alternatives.”¹⁶⁵ The form requires that the patient is fully informed of his or her diagnosis and prognosis, the potential risks of AID, the probable result of AID, and the alternatives to AID, such as comfort care, hospice care, and pain control.¹⁶⁶ Some forms do not even include this informed consent requirement.¹⁶⁷ Increased oversight could include adding more detail to this reporting form, such as adding a checklist that contains material information on the alternative EOL options that the physician would have to discuss with the patient during the consultation. This addition would help the state make sure patients are receiving all essential information before making their final decision. The form could also include more detailed requirements to ensure the patient is acting voluntarily, such as requiring the physician to discuss familial and financial reactions to and repercussions of AID.

B. Require Continuing Medical Education Related to EOL Care

The second potential solution would be to require additional continuing education for participating physicians to keep them up to date on EOL options and treatment for terminally ill patients. Currently, only California and Oregon include continuing medical education (CME) requirements on the topic of treatment for terminally ill patients.¹⁶⁸ California has a one-time requirement that physicians complete twelve CME credits on pain management and EOL care.¹⁶⁹ However, this requirement can be met by either CME on treatment for terminally ill patients *or* by a CME course on the treatment for opiate-dependent patients.¹⁷⁰ The Oregon Medical Board requires one hour of continuing education on pain management

165. OR. DEP'T OF HEALTH, ATTENDING PHYSICIAN'S COMPLIANCE FORM (2022), <https://www.oregon.gov/oha/ph/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/at1form.pdf> [<https://perma.cc/4USZ-FE48>]; WASH. DEP'T OF HEALTH, ATTENDING PHYSICIAN'S COMPLIANCE FORM (2022), <https://www.doh.wa.gov/portals/1/Documents/Pubs/422-064-AttendingPhysicianComplianceForm.pdf> [<https://perma.cc/JC56-KH9Y>]; CAL. DEP'T OF PUB. HEALTH, ATTENDING PHYSICIAN'S CHECKLIST & COMPLIANCE FORM, https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/EOL_Attending_Physician_Checklist_and_Compliance_Form.pdf [<https://perma.cc/3L93-TBVW>] (last visited Sept. 1, 2022).

166. See, e.g., CAL. DEP'T OF PUB. HEALTH, *supra* note 165.

167. See, e.g., COLO. DEP'T OF PUB. HEALTH & ENVIRON., ATTENDING PHYSICIAN WHO PRESCRIBES MEDICAL AID-IN-DYING MEDICATION REPORTING FORM (2018), <https://cdphe.colorado.gov/center-for-health-and-environmental-data/registries-and-vital-statistics/medical-aid-in-dying#Reporting> [<https://perma.cc/HW92-LDWC>].

168. *State CME Requirements*, MEDSCAPE (Jan. 2019), <https://www.medscape.org/public/staterequirements> [<https://perma.cc/DB6H-2XJ5>]. Some states require CME on topics of pain management, palliative care, or prescribing controlled substances, but do not directly require CME on the topic of EOL care for the terminally ill. *Id*; see also David E. Weissman, *End-of-Life Physician Education: Is Change Possible?*, 1 J. PALLIATIVE MED. 401, 401 (1998) (“[C]ontinuing medical education (CME) programs aimed at improving end-of-life practice behavior are virtually nonexistent.”).

169. See *State CME Requirements*, *supra* note 168; *Continuing Medical Education*, MED. BD. CAL., https://www.mbc.ca.gov/Licensees/Continuing_Education/#Pain [<https://perma.cc/ZG78-4F8C>] (last visited Sept. 1, 2022).

170. *Continuing Medical Education*, *supra* note 169.

every two years, but does not require CME on EOL care.¹⁷¹ A related administrative rule states that education in pain management can be satisfied by CME in pain management or EOL care.¹⁷² Because the physicians can fulfill the requirement in alternative ways, there is no guarantee that physicians are educated and up to date on EOL care.¹⁷³ This could have a detrimental effect on AID implementation, as physicians are responsible for ensuring AID patients make an informed decision, which includes knowing alternative EOL options. If the physician is not knowledgeable about EOL options, then there is no way to guarantee the patient will be informed, undermining an important legislative safeguard.

To address this lack of physician education, state legislatures could coordinate with medical boards to require participating physicians to complete additional CME courses on EOL care and treatment for terminally ill patients.¹⁷⁴ The additional courses could count toward the required CME credits but would be required every renewal period, rather than only once.

Additional CME courses specifically on AID procedures and implementation could also be offered or required for participating physicians. These courses could address the topics of informed consent (including what information the patient needs to know), the possibility of external undue influences, potential depression or impaired judgment, and any other facts about implementation that would be helpful for physicians.¹⁷⁵

C. Publish Screening Guides

Finally, the state could promulgate guidance for physicians regarding how to screen for undue influence, pressures, and potentially depressed patients.¹⁷⁶ There is no data about how physicians are meant to screen for depression, so providing specific guidelines would increase certainty and transparency about the AID process. This could take the form of specific questionnaires meant to diagnose depression. For example, the Patient Health Questionnaire-9 (PHQ-9) is a common screening tool for depression.¹⁷⁷ It is a relatively short questionnaire, asking nine

171. *Continuing Education*, OR. MED. BD., <https://www.oregon.gov/omb/Topics-of-Interest/Pages/Continuing-Education.aspx> [<https://perma.cc/P7FB-UKZB>] (last visited Aug. 26, 2022).

172. OR. ADMIN. R. 409-050-0130 (2011), <https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=82144> [<https://perma.cc/EQ88-3Y8Y>].

173. *See generally* Amy M. Sullivan, Matthew D. Lakoma & Susan D. Block, *The Status of Medical Education in End-of-Life Care*, 18 J. GEN. INTERNAL MED. 685, 688 (2003) (showing results of a survey of medical students, residents, and faculty that show “few students and residents received, and few faculty provided, formal end-of-life education or training”).

174. *See* Weissman, *supra* note 168, for a discussion on how changing CME programs should be approached.

175. *See generally* Kathryn L. Tucker, *Aid in Dying: Guidance for an Emerging End-of-Life Practice*, 142 CHEST J. 218 (2012).

176. Orentlicher, Pope, & Rich, *supra* note 60, at 260 (“A number of mental health screening assessments are available for physicians to use in the office. For example, the Patient Health Questionnaire (PHQ-9) is a validated instrument for detecting and diagnosing depression.”).

177. Douglas M. Maurer, *Screening for Depression*, 85 AM. FAMILY PHYSICIAN 139, 141 (2012).

questions and taking around five minutes to complete, that has demonstrated high levels of accuracy in identifying mood disorders in adults.¹⁷⁸ There is also a depression-screening questionnaire targeted to adults older than sixty-five that may be applicable in AID contexts. This is the Geriatric Depression Scale, and there are versions with five, fifteen, and thirty questions.¹⁷⁹ These questionnaires also have high levels of accuracy and sensitivity.¹⁸⁰ In AID legislation, states could require that doctors use these or equivalent screening tools with every patient before writing a prescription, even if there is no indication of mental illness. The questionnaires could not take the place of a psychiatric referral, as physicians do not have the expertise to substitute their judgment for that of a psychiatrist. Rather, a questionnaire meant to diagnose depression could serve as a screening device, identifying patients who should be referred to psychiatrists for evaluation.

The state could also mandate psychiatric evaluation for every patient, but it is unclear whether such an action would be advisable and/or cost-effective. Mandatory psychiatric evaluations would make a long process even longer, making it more likely that patients would die before receiving a prescription. There is also no guarantee that a single psychiatric visit would be sufficient to determine legal mental competency.¹⁸¹

Similar guidance and screening tools could be used to detect undue influence. In 2016, scholars in California developed the California Undue Influence Screening Tool (CUIST) to determine whether an individual is experiencing external pressures.¹⁸² The CUIST screens for four things: (1) the individual's vulnerability, which includes physical health problems, emotional distress, or isolation; (2) the influencer's authority or position of power, which includes whether the influencer has access to or control over the individual's property; (3) the influencer's actions or tactics, such as whether the influencer manipulates the individual through false promises, isolation, or control over access to information; and (4) potential unfair or improper outcomes, such as economic loss and physical or mental deterioration.¹⁸³ The CUIST is meant to identify undue influences on an individual through a conversation. While some of the items on the CUIST may be outside physicians' expertise (such as the legal status of the influencer or the tactics used), there is no reason physicians cannot use this tool as a preliminary screening method. Further, physicians could receive training in how to use this tool as part of their CME requirements. Alternatively, states could modify the CUIST to better

178. *Id.* at 141–42.

179. *Id.*

180. *Id.*

181. Levene & Parker, *supra* note 135, at 209.

182. Mary Joy Quinn, Lisa Nerenberg, Adria E. Navarro & Kathleen H. Wilber, *Developing an Undue Influence Screening Tool for Adult Protective Services*, 29 J. ELDER ABUSE & NEGLECT 157, 157 (2017); Megan Richelsoff, *Undue Influence and Financial Exploitation*, 42 BIFOCAL 32, 32 (2020).

183. CAL. ELDER JUST. COAL. CALIFORNIA UNDUE INFLUENCE SCREENING TOOL (CUIST) (2016), https://www.elderjusticecal.org/uploads/1/0/1/7/101741090/final_cuist_5-27-2016_12.4.18.pdf [<https://perma.cc/TWW2-8ZDJ>].

align with physicians' expertise while retaining the essential elements of the screening tool.

If these additional oversight regulations are implemented, there will be more certainty that individuals seeking AID are doing so freely and fully informed about their decision. This will satisfy the state interest in preserving life and protecting vulnerable populations. It will also allow the individual's interest in autonomy in dying to be carefully balanced against the state interests. These additional reporting and training requirements would also address scholars' and physicians' concerns with implementation of AID regulations without placing additional burdens on the patients themselves.

CONCLUSION

The debate regarding the adequacy of AID procedures has been ongoing for decades, yet little real change has happened. This could be due to the passionate advocacy on both sides, which results in a stalemate of sorts. The inadequacy of the data collected also results in differing interpretations, making it difficult to form a decisive conclusion on whether the safeguards are adequate or not.¹⁸⁴ This indecisiveness makes it more difficult to advocate for changes to the procedures. Yet, by analyzing physician opinions on AID procedures, it is clear the medical field is not satisfied with the current safeguards. Because AID is predominantly a medical procedure and physicians have the most experience with implementation, physician concerns should be seriously considered and addressed by state legislatures.

Many scholars have argued that AID legislation's reporting requirements are insufficient and believe more extensive reporting would help prevent abuse of AID.¹⁸⁵ While there is no doubt additional reporting would give the state more information on which to base review of AID, reporting will not change the inadequacy of physician education and training. Certain judgments are simply outside physician expertise, such as screening for depression and influences, and the average physician is not required to be an expert on EOL care.¹⁸⁶ Therefore, to truly fill the gaps in the legislation, the state should require both additional reporting and additional education for physicians. This Note attempts to provide a starting point on which further educational, training, and reporting suggestions could build.

184. See generally Battin, *supra* note 7; Tucker, *supra* note 7. But see Hendin & Foley, *supra* note 15; Sulmasy et al., *supra* note 51; Hetzler et al., *supra* note 14.

185. Hiscox, *supra* note 45, at 202; Dore, *supra* note 125.

186. Hendin & Foley, *supra* note 15; Sulmasy et al., *supra* note 51; Hetzler et al., *supra* note 14.