1-1-1994

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LEGAL KILLING: THE IMMINENT LEGALIZATION OF A PHYSICIAN'S AFFIRMATIVE AID-IN-DYING

I. INTRODUCTION

I will follow that method of treatment which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest such counsel; furthermore, I will not give to a woman an instrument to produce abortion.¹

The Hippocratic Oath expressly provides that a physician should serve solely as healer—not killer.² If a physician is provided with the simple solution of killing his or her sick patients, he or she may have less incentive to perform the more arduous, time-consuming, and possibly fruitless task of curing. Judeo-Christian thought corroborates the oath: "Thou shalt not kill."³

Although some physicians have almost certainly covertly ignored the oath's mandate for centuries, only recently has support for the oath's rejection become overt. Proposals labeled "Death with Dignity,"⁴ "Aid-In-Dying,"⁵ "Physician-Assisted Death,"⁶ or "Physician-Assisted Suicide"⁷ seek to legal-

³. Deuteronomy 5:17.
⁴. See Californians Against Human Suffering, The California Death with Dignity Act (1992). Submitted to the general voting populace as Proposition 161, the initiative failed by a margin of 54% to 46%. Key Proposition Results by County, San Jose Mercury News, Nov. 4, 1992, at 17EL.
⁶. Dr. Ronald B. Miller, Lecture at Hoag Memorial Hospital (Oct. 23,1992) (audio cassette available in the library of Hoag Memorial Hospital, Newport Beach, CA).

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ize a physician’s assistance in dying. Whatever the language, no modern jurisdiction has yet declared the process legal.\textsuperscript{8}

The physician-assisted death topic is fascinating because it involves important legal, social, moral, and religious issues. The range of views is as diverse as it is broad. There are those who believe in a right of self-determination where autonomy and choice give one complete control over one’s body.\textsuperscript{9} On the other hand, society has traditionally discouraged non-natural death.\textsuperscript{10} Whatever the opinion, the possibility that the physician could, without legal recourse, affirmatively act to terminate the life of his or her patient with a needle, gas mask, or some other instrument is unprecedented. Legalizing such an act conflicts with the historical discouragement of suicide and suicide assistance, thus moving into previously uncharted territory. It is certainly advisable to stop and explore such a revolutionary idea before it is legalized.

This comment focuses on the legal issues arising from a statutory proposal to legalize physician-assisted death. While the courts have had ample chance to review a patient’s

\textsuperscript{8} The Netherlands has not officially declared the process legal, but its courts will not prosecute when certain rules are followed. See, e.g., M.A.M de Wachter, Ph.D., Active Euthanasia in the Netherlands, 262 JAMA 3316, 3318-19 (Dec. 15, 1989); cf. G. Van Der Wal, Euthanasia and Assisted Suicide. I. How Often is it Practised by Family Doctors in the Netherlands? 9 FAM. PRAC. 130 (1992); G. Van Der Wal, Euthanasia and Assisted Suicide. II. Do Dutch Family Doctors Act Prudently? 9 FAM. PRAC. 135 (1992). The Netherlands’ lower house of parliament recently promised immunity to physicians who follow certain euthanasia guidelines, “[b]ut physicians who fail to satisfy the guidelines could still face criminal charges and . . . up to 12 years in prison.” Tamara Jones, Netherlands Law Sets Guidelines for Euthanasia, L.A. TIMES, Feb. 10, 1993, at A1, A8. The action of the lower house is subject to two governmental formalities (approval by the upper house of parliament and receipt of the crown seal) before it becomes law in early 1994. Dutch Lawmakers Approve Rules for Doctor-Assisted Mercy Killings, ORANGE COUNTY REG., Feb. 10, 1993, at A14. The Dutch law will require a voluntary, well informed, and enduring request by the patient. Jones, supra, at A8. It also will require that a second physician be consulted, and that each doctor submit a fully documented report on each case to the district coroner. Id. The coroner will then submit a report to the local prosecutor, who will summarily close the case upon a finding that all the requirements were satisfied. Id.


\textsuperscript{10} See Daniel Callahan, When Self-Determination Runs Amok, HASTINGS CENTER REP. 52, (Mar.-Apr. 1992). Callahan notes the “long-standing effort to limit the circumstances under which one person can take the life of another, from efforts to control the free flow of guns and arms, to abolish capital punishment and to more tightly control warfare.” Id.
choice to withdraw medical treatment, it is rare for the courts to rule on a patient's choice to have his or her doctor affirmatively put him or her to death. The difference between passive euthanasia and active euthanasia is largely uncharted; this comment explores the potential for the legalization of physician-assisted death, one form of active euthanasia, and the resulting ramifications.

First, the background section of this comment examines the reasons compelling the legalization of physician-assisted death. The court cases that have acknowledged or assumed one's right to die are then presented. While these cases involve only the withdrawal of treatment, the background section proffers the next step beyond withdrawal of treatment—legalized active euthanasia. In particular, California's failed Proposition 161, the Death with Dignity Act, would have legalized physician-assisted death. The analysis section examines this proposition, its language and legal requirements, the reasons why the voters rejected it, and possible modifications. The comment proposes alterna-


12. The Michigan case of Dr. Jack Kevorkian and his suicide machines has gained much media attention. See, e.g., Nancy Gibbs, Mercy's Friend or Foe?, TIME, Dec. 28, 1992, at 36. Dr. Kevorkian's case is inapposite to the matter at hand. This comment explores the legalization of physician-assisted death through statutory means. Dr. Kevorkian acted on the cusp of statutory law, and the Michigan legislature altered its law in order to prohibit him from assisting patients in suicide. Id. at 37.

13. Euthanasia is "[t]he act or practice of painlessly putting to death persons suffering from incurable and distressing disease as an act of mercy." BLACK'S LAW DICTIONARY 554 (6th ed. 1990). Passive euthanasia normally entails the omission of treatment. For example, passive euthanasia includes "the disconnection of life-support equipment without which one cannot live." DEREK HUMPHRY, FINAL EXIT, THE PRACTICALITIES OF SELF-DELIVERANCE AND ASSISTED SUICIDE FOR THE DYING 3 (1992). Active euthanasia involves affirmative steps directed towards ending life. Id. This comment focuses on physician-assisted dying, a form of active euthanasia.

14. See discussion infra part II.A-C.

15. See discussion infra part II.D.

16. See discussion infra part II.E.


18. See discussion infra part III.A.

19. See discussion infra part III.A., IV.
tives necessary to make the Proposition socially palatable and summarizes these proposals in a checklist.

In short, this comment explores the safeguards that may be necessary to impel a majority to vote for physician-assisted death. After reviewing the safeguards, the analysis turns to the court’s role in reviewing such a statute. This comment ultimately concludes that the authors should draft such proposals carefully so as to minimize coercive forces and insulate a patient’s choice. Providing alternatives such as hospices and local advisory boards will help to minimize coercion and to increase respect for all groups subject to physician-assisted death.

II. BACKGROUND

Three phenomena account for the recent movement to legalize physician-assisted death. First, modern medical advancements have resulted in longer, but often painful, costly, and undesirable lives; many patients would rather not endure such an artificially prolonged death, but instead prefer an immediate end. Second, there is greater acceptance of suicide, at least in part because of the specter of artificially prolonged lives. Third, modern emphasis on patient autonomy, coupled with greater acceptance of a patient’s right to choose suicide, has compelled a broader population to question the Hippocratic Oath’s absolute prohibition of physician-assisted death.

20. See discussion infra part IV.
21. See discussion infra part V.
22. This concept is often referred to as a dignified death, or “death with dignity.” See discussion infra part V (proposed factors to consider when legalizing physician-assisted death). See also Cruzan v. Director, Mo. Dep’t of Health, 497 U.S. 261, 302 (1990) (Brennan, J., dissenting) (arguing “Nancy Cruzan is entitled to choose to die with dignity.”).
23. In a field poll taken two months prior to the vote on the California proposition, voters who were read a summary of the measure favored it by a margin of 68% to 24%. Robert Reinhold, California to Decide if Doctors Can Aid in Suicide, N.Y. TIMES, Oct. 9, 1992, at A1, A10. Although it was ultimately discarded, the California proposition garnered the support of 46% of the electorate. Key Proposition Results by County, SAN JOSE MERCURY NEWS, Nov. 4, 1992, at 17EL.
A. Modern Technology and the Prolonged Death

In many circumstances, death is now viewed as a technical phenomenon rather than a natural process. Since World War II, respiratory ventilators, dialysis machines, heart and kidney transplantation, artificial hearts, artificial blood, and artificial skin have greatly improved the ability to sustain life despite the failure of bodily functions. Whereas the majority of deaths previously resulted from communicable diseases such as influenza, pneumonia, and tuberculosis, modern deaths are more likely to result from degenerative diseases: "Modern medicine has gotten the population past life threatening diseases and to the point at which death more commonly comes from gradual bodily failure than from sudden infection. Its success has, in turn, increased life expectancy thereby increasing the elderly, more frail population." The transformation from a vibrant human into a frail object can be humiliating and undignified. The frail patient is more likely to find an offer of death with dignity attractive.

Modern technology's prolongation of death has not only increased the population of frail patients but has also increased medical costs. Health care has grown fifty percent faster than the rest of the economy, and at about $800 billion in expenditures, it may be America's largest industry. Medical care has nearly tripled from 5.3% of gross national product in 1960 to a full 13% in 1992.

In particular, terminally ill patients account for a disproportionately high percentage of these medical costs: "[T]he United States spends two percent of its gross domestic prod-

24. See HUMPHRY, supra note 13, at 3. Humphry explains that at least one-half of all deaths occur after the decedent has spent time connected to a machine. Id.
26. Id. at 69.
29. See Alexander, supra note 25, at 71.
uct (about $115 billion) on medical expenses for people in their last six months of life.” At least one study found that “the use of resources for dying patients exceeds resources used for other high cost patients,” and statistics kept by the Massachusetts General Hospital have consistently shown an inverse relationship between favorable prognosis and expenditure. In sum, medical costs have jumped enormously, mostly stemming from care of patients with little or no chance of recovery.

B. Greater Acceptance of Suicide

The effect that modern technology has had in making death a prolonged, painful, and costly process has caused us to re-think our traditional views regarding suicide. Under the common law, suicide was regarded as self-murder and therefore was punishable as a felony. Statutes prohibiting suicide and suicide assistance remain on the books in modern jurisdictions, but it is now more common for the police to ignore the matter or for courts to ignore statutory law and allow punishment to give way to policy.

At least one court has explained suicide as traditionally illegal because it is viewed as “irrational self-destruction.”

31. Flanigan, supra note 28, at D1, D4. This article asserts that there is a “tug of war” between older and younger generations for resources. Id. The elderly are winning, currently using more than 25% of the federal budget, and medical expenses will continue to force this number upwards. Id. The younger generations, however, must sacrifice part of their paycheck for the elderly; it is estimated that President Clinton’s plan to mandate employer-paid health insurance premiums will take $1,000 from the annual paychecks of middle-class people. Id.

32. Alexander, supra note 25, at 71 (quoting S.A. Schroeder, J.A. Showstack & H.E. Roberts, Frequency and Clinical Description of High-Cost Patients in 17 Acute-Care Hospitals, 300 NEW ENG. J. MED. 1306 (1979)).

33. Id. (citing Cullen, Ferrara, Briggs, Walker & Gilbert, Survival, Hospitalization Charges and Follow-up Results in Critically Ill Patients, 294 NEW ENG. J. MED. 1306 (1979); Silverman, The Therapeutic Intervention Scoring System: An Application to Acutely Ill Cancer Patients, 3 CRIT. CARE MED. 222 (1975); Civetta, The Inverse Relationship Between Cost and Survival, 14 J. SURG. RES. 265 (1973)).


35. See Catherine D. Shaffer, Criminal Liability For Assisting Suicide, 86 COLUM. L. REV. 348, 371.

36. Bartling v. Superior Ct., 209 Cal. Rptr. 220, at 226 (Ct. App. 1984) (emphasis added). Such language gives rise to the term “rational suicide.” The most vitriolic of critics contend that this term is an oxymoron: “The concept of rational suicide is elusive and controversial . . . . It is not a thing to do while one
Similarly, other courts have broadened the definition of a non-suicidal death by no longer distinguishing between extraordinary and ordinary care in medical cases.\textsuperscript{37} Although the prevention of suicide is still listed as a state interest,\textsuperscript{38} modern courts are more accepting of what was once labeled, and even punished, as suicide.\textsuperscript{39}

C. Patient Autonomy as Opposed to Physician Control

Concurrently with the increased acceptance of suicide, society and the courts have enlarged the individual's power to make autonomous decisions. In accordance with modern bioethics, the patient, not the doctor, controls what treatment he or she will or will not receive.\textsuperscript{40} Courts and legislatures require the physician to attain the patient's consent,\textsuperscript{41} recognize living wills\textsuperscript{42} and durable powers of attorney for health is not in one's best mind. Never kill yourself when you are suicidal.” Yeates Conwell, \textit{Rational Suicide and The Right to Die}, \textit{New Eng. J. Med.}, 1100, 1101 (1991).

37. See Rosenblum, \textit{supra} note 34, at 7-8. Ordinary means include all medicines, treatments, and operations that offer a reasonable hope of benefit and that can be obtained and used without excessive expense, pain, or other inconvenience. John A. Robertson, \textit{Involuntary Euthanasia of Defective Newborns: A Legal Analysis}, 27 STAN. L. REV. 213, 236 (1975). Extraordinary means include all medicines, treatments, and operations, that cannot be obtained or used without excessive expense, pain, or other inconvenience, or that, if used, would not offer a reasonable hope of benefit. \textit{Id.}


39. Rosenblum, \textit{supra} note 34, at 7-8. Rosenblum explains that the difference between ordinary and extraordinary treatment is the difference between beneficial, relatively painless treatment and nonbeneficial, painful treatment. \textit{Id.} When one refuses ordinary treatment, he is committing suicide. \textit{Id.} But when one refuses extraordinary treatment, he is not committing suicide. \textit{Id}. Instead, he is "merely acquiescing in imminent and inevitable death by avoiding a painful, nonbeneficial treatment." \textit{Id.} at 8. Therefore, courts should continue to distinguish between the two in order to prevent the proliferation of euthanasia and suicide. \textit{Id.}

40. Dr. Ronald B. Miller, Lecture at Hoag Memorial Hospital (Oct. 23, 1992) (audio-cassette available in the library of Hoag Memorial Hospital, Newport Beach, CA). \textit{See also} HUMPHRY, \textit{supra} note 13. Humphry explains that “physicians are now more likely to be seen as ‘friendly body technicians' and no longer as the rulers of one’s bodily health whose every piece of advice must be interpreted as a command.” \textit{Id.} at 19.


42. A living will is a document in which a decisionally capable person expresses in advance his or her wishes regarding medical treatment in the event that he or she becomes decisionally incapable at some time in the future. \textit{Coordinating Council on Life-Sustaining Medical Treatment Decision Making, Guidelines for State Court Decision Making in Life Sustaining Medical Treatment} 187 (1992) [hereinafter \textit{Medical Treatment}]. As of May, 1992,
care,\textsuperscript{43} and allow the patient to refuse life-sustaining medical treatment.\textsuperscript{44} Nonetheless, the law has yet to provide clear principles to govern the cases in which patients seek to take back control not only over their treatment, but over their deaths.

D. Case Law

1. In Re Quinlan

The seminal case allowing for withdrawal of treatment, or "passive euthanasia," is \textit{In re Quinlan}.\textsuperscript{45} The Quinlan court explored issues of guardianship,\textsuperscript{46} privacy,\textsuperscript{47} and religion\textsuperscript{48} as well as issues concerning medical standards, physician liability, and the role of a court in these types of cases.\textsuperscript{49} The court ultimately held that a guardian could substitute his or her judgment for an incompetent patient's judgment in choosing to withdraw the patient's medical treatment.\textsuperscript{50} Although the court noted that intervention by the judiciary would be rare and minimal in these cases, it did recommend the formation of medical ethics committees.\textsuperscript{51}

Karen Ann Quinlan was a twenty-two-year-old adult when she entered a "chronic persistent vegetative state."\textsuperscript{52} Although technically alive, she required a respirator in order

\begin{itemize}
\item 46 states and the District of Columbia had statutes authorizing living wills. \textit{Id.} at 8 n.22.
\item 43. A durable power of attorney is similar to a typical power of attorney in that a designated person is empowered to act on the patient's behalf. \textit{Id.} at 185. The "durable" element means that the power does not lapse if the patient becomes decisionally incapable. \textit{Id.} Thus, durable powers of attorney allow one to delegate medical decision-making authority. \textit{Id.} As of May, 1992, 42 states and the District of Columbia had statutes authorizing a durable health care power of attorney. \textit{Id.} at 9 n.25.
\item 46. \textit{Id.} at 670-71.
\item 47. \textit{Id.} at 662-64.
\item 48. \textit{Id.} at 661-62.
\item 49. \textit{Id.} at 664-70.
\item 51. \textit{Id.} at 672.
\item 52. \textit{Id.} at 654. One who is in a "chronic persistent vegetative state . . . 'remains with the capacity to maintain the vegetative parts of neurological function but no longer has any cognitive function.'" \textit{Id.} (citation omitted).
\end{itemize}
to assist her breathing, and her prognosis for recovery was "extremely poor—she [would] never resume cognitive life." Karen was totally unaware of her surroundings, although she developed "sleep-wake" cycles at which time she would blink and cry out. Karen's father, Joseph, was appointed guardian and was granted power to authorize the removal of her respirator.

The Supreme Court of New Jersey recognized an unwritten constitutional right of privacy in both the New Jersey and Federal Constitutions. The court held that this right of privacy governs a patient's decision to terminate medical treatment in much the same way that it governs a woman's decision to terminate pregnancy.

Since Karen's own right of privacy would allow her to order treatment withdrawn were she not incompetent, the court determined that her guardian and family were to render their "best judgment... as to whether she would exercise [her right] in these circumstances." This is known as "substitute judgment."

Despite the guardian's efforts, the court concluded that Ms. Quinlan's physicians had correctly refused to withdraw treatment based on then-existing medical standards and practices. The court, however, refused to follow such medical standards, which it depicted as strongly influenced by the

53. Id. at 655.
54. Id. at 654.
55. The trial court denied him this power. In re Quinlan, 355 A.2d 647, 670 (N.J. 1976), cert. denied, 429 U.S. 922 (1977). The trial judge believed in bifurcation of guardianship whereby Mr. Quinlan could only attain guardianship over his daughter's property, but not over her person. Id. at 670. Under the principle of stewardship, guardianship over one's person is reserved for God. Id. Such bifurcation of guardianship has "roots deep in the common law." Id.
56. Id. at 663 (citing N.J. CONST., art. I, par.1. (1947)).
57. Id. at 663-64.
58. Id. at 664.
59. "Substitute judgment" is a legal standard for surrogate decision-making. MEDICAL TREATMENT, supra note 42, at 184, 187. By this standard, the surrogate makes the decision on the basis of what is known about the patient's personal values and preferences. Id. This is a more subjective standard than the "best interests" standard, under which the surrogate makes the decision from the point of view of a hypothetical "reasonable person" on the basis of objective, socially shared criteria. Id.
"modern proliferation of substantial malpractice litigation and the possibility of criminal sanctions."

As a solution to such fears of liability impeding a physician's work, the court authorized the establishment of hospital "ethics committees" or similar consultative bodies. Such bodies, the court reasoned, diffuse the professional responsibility for a decision. The court stated:

[S]uch a system would be protective to the hospital as well as the doctor in screening out, so to speak, a case which might be contaminated by less than worthy motivations of family or physician. In the real world and in relation to the momentous decision contemplated, the value of additional views and diverse knowledge is apparent.

The Quinlan court concluded that judicial proceedings would not necessarily be required in future cases. When the judiciary does not interfere, the court noted, the doctor-patient relationship is strongest. Moreover, the goal of a quick resolution is hindered by the time-consuming judicial process.

Although the court stated that the judiciary would not necessarily intervene in future cases, it did set some guidelines. The primary guideline focused on consensus between the treating physician and the ethics committee. As long as the physicians and consultative body agreed that there would be "no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state," the life-support system could be withdrawn and there would be no civil or criminal liability on the part of any participant, including guardian, physician, hospital, or others.

61. Id. at 666-67.
62. Id. at 672.
63. Id. at 669.
64. Id.
66. Id.
67. Id. at 672.
68. Id. at 666-69, 671, 672.
69. See id. at 671-72.
71. Id.
Thus, the *Quinlan* court allowed for a consultative body to determine the possibility of a patient breaking out of a coma. In the absence of such a "reasonable possibility," physicians may follow the decision of a patient's guardian who is exercising "substituted judgment" in ordering the patient's treatment withdrawn.\(^7\) The United States Supreme Court refused to review the matter,\(^7\) and the controversy over the "right to die" continued.\(^7\)

2. Cruzan v. Missouri Department of Health: The Right to Die

The Supreme Court of the United States considered the question of a constitutional "right to die" for the first time in *Cruzan v. Missouri Department of Health*.\(^7\) In *Cruzan*, most of the justices either acknowledged or assumed there is a "right to die" under certain circumstances.\(^7\) The right, however, was not considered absolute, and the Court ultimately held that a state could require "clear and convincing" evidence of a patient's wishes where a guardian is seeking to discontinue nutrition and hydration.\(^7\)

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72. *Id.* at 671.
73. *Id.* at 672.
75. *Id.*
76. See *id.* at 279.
77. *Id.* at 265. The "clear and convincing" standard for the withdrawal of life support was formulated initially by the Missouri Supreme Court. *Id.* (quoting *Cruzan v. Harmon*, 760 S.W.2d 408, 411 (Mo. 1988) (en banc)). The state court created the standard after confronting the following unfortunate and uncertain facts. Nancy Beth Cruzan was 25 years old when she suffered severe injuries in an auto accident that left her in a persistent vegetative state. *Cruzan*, 497 U.S. at 266 n.1. See also supra note 52 for a description of "vegetative state." When it became apparent that Nancy had no chance of regaining her cognitive capacities, her parents sought to terminate her artificial nutrition and hydration. *Cruzan*, 497 U.S. at 267. Despite the wishes of Nancy's parents, the employees of the hospital demanded court approval before they would discontinue the artificial feeding. *Id.* at 268. The Missouri trial court subsequently granted such approval and ordered the removal of Nancy's feeding tube. *Id.* The trial court determined that no state interest could be found to outweigh Nancy's "fundamental right" to direct the withdrawal of medical procedures, especially when that right was supplemented by her earlier conversations with a friend that she would not want to continue her life in such a state. *Id.*

A closely divided Missouri Supreme Court, however, reversed the trial court's ruling. *Id.* The court found Nancy's remarks to her friend "unreliable for the purpose of determining her intent" and demanded "clear and convincing evidence" of her wishes before they would allow her guardians to exercise "sub-
Writing the majority opinion for the Court, Chief Justice Rehnquist cited the common law doctrine of informed consent to buttress the notion that a competent individual has a right to refuse life-sustaining medical treatment when there is clear and convincing evidence that his or her wish is to refuse treatment. The Court reasoned that this right, however, springs not from one's right of privacy, as the Quinlan court determined, but from a Fourteenth Amendment liberty interest inferable from prior Supreme Court decisions.

Determining that one has a right based on liberty, however, does not end the inquiry; the next step is to balance the individual's "liberty interests against the relevant state interests." The Court determined that a state has an "unqualified interest" in protecting and preserving human life. Moreover, the Cruzan majority reasoned that the state should consider other interests besides the preservation of life. Since the choice between life and death is a "deeply personal decision of obvious and overwhelming finality," the Court determined that Missouri could seek to safeguard

78. Cruzan, 497 U.S. at 273.
79. Cruzan v. Missouri Dep't of Health, 497 U.S. 261, 278 (1990) (citing Jacobson v. Massachusetts, 197 U.S. 11, 24-30 (1905)). While the trial court termed the right a "fundamental" one, Rehnquist refused such language. The Court does not protect liberty interests as strongly as it protects fundamental rights, and Rehnquist's test, therefore, might be viewed as a lower-level scrutiny where an ad-hoc multifactor balancing test is required. See id.
80. Id. at 279 (quoting Youngberg v. Romeo, 457 U.S. 307, 321 (1982)).
81. By "unqualified," Rehnquist meant that the state would not have to make judgments about the "quality" of life that a particular individual may enjoy. Id. at 282.
82. The Court found this state interest evidenced by the fact that the majority of states have laws imposing criminal penalties on one who assists another to commit suicide. Id. at 280.
83. Id. at 271.
abuses of that personal element of choice; "the state need not remain neutral in the face of an informed and voluntary decision by a physically-able adult to starve to death."\textsuperscript{85} It was constitutional, then, for Missouri to impose a heightened evidentiary standard.

The state was allowed to protect its interests in preserving life and ensuring that a decision to die was personal by requiring "clear and convincing evidence" that a competent patient/person would have chosen to die.\textsuperscript{86} This standard of proof reflects a "societal judgment about how the risk of error should be distributed between litigants."\textsuperscript{87} The Court went on to rationalize its allocation of risk:

The more stringent the burden of proof a party must bear, the more that party bears the risk of an erroneous decision. We believe that Missouri may permissibly place an increased risk of an erroneous decision on those seeking to terminate an incompetent individual’s life-sustaining treatment. An erroneous decision not to terminate results in a maintenance of the status quo; the possibility of subsequent developments such as advancements in medical science, the discovery of new evidence regarding the patient’s intent, changes in the law, or simply the unexpected death of the patient despite the administration of life-sustaining treatment, at least create the potential that a wrong decision will eventually be corrected or its impact mitigated. An erroneous decision to withdraw life-sustaining treatment, however, is not susceptible of correction.\textsuperscript{88}

Missouri’s "clear and convincing evidence" standard, upheld in \textit{Cruzan}, requires the individual’s wishes to be adduced from his or her statements while he or she was competent.\textsuperscript{89} Chief Justice Rehnquist's opinion stated that parents, no matter how loving and caring, do not have a right of "substituted judgment"; there is no automatic assurance that a family member’s choice will match that of the patient.\textsuperscript{90}

Despite the Court’s rejection of "substituted judgment," Justice O'Connor wrote a separate concurrence in order to

\textsuperscript{85} \textit{Id.} at 285.
\textsuperscript{86} \textit{Id.} at 286-87.
\textsuperscript{87} \textit{Id.} at 283.
\textsuperscript{88} \textit{Id.}
\textsuperscript{90} \textit{Id.}
emphasize that the Court was not deciding conclusively whether a state should abide by the "substituted judgment" of a surrogate decision-maker. She concluded that a state may be constitutionally required to heed a surrogate in order to protect a patient's liberty interest. She also explained that the *Cruzan* decision ruled only on the constitutionality of one state's practices and that the "task of crafting appropriate procedures for safeguarding incompetents' liberty interests is entrusted to the 'laboratory' of the States."

Justice Scalia's concurrence had a short message: "[T]he federal courts have no business in this field." He reasoned that "the Constitution has nothing to say about the subject" of suicide, which has traditionally been the business of the state. He did proceed, however, to colorfully describe his belief that there is no fundamental right to suicide, as assisted suicide "is declared by the law to be murder, irrespective of the wishes or the condition of the party to whom the poison is administered." Moreover, Scalia did not distinguish between active and passive euthanasia: "It would not make much sense to say that one may not kill oneself by walking into the sea, but may sit on the beach until submerged by the incoming tide." He concluded that the Court could no better decide this issue than "nine people picked at random from the Kansas City telephone directory," and that "it is up to the citizens of Missouri to decide, through their elected representatives, whether that wish will be honored." The only constitutional limit on the state's interest in requiring an individual to preserve his own life would be the Equal Protection Clause, "which requires the

91. *Id.* at 289 (O'Connor, J., concurring).
92. *Id.*
95. *Id.* at 300.
96. *Id.* at 293.
97. *Id.* at 296 (citing *Blackburn v. State*, 23 Ohio St. 146, 163 (1873)).
98. *Id.* at 296.
100. *Id.* at 293.
democratic majority to accept for themselves and their loved ones what they impose on you and me.”

Justice Rehnquist’s opinion, Justice O’Connor’s clarification, and Justice Scalia’s deferential view were opposed in two separate dissents by Justice Brennan (joined by Justice Marshall and Justice Blackmun) and Justice Stevens. Justice Brennan’s dissent found that Nancy Cruzan had a “fundamental right to be free of unwanted artificial nutrition and hydration.” As with the interference with any fundamental right, the state should be subjected to a strict-scrutiny standard by which the Court would ensure there is a compelling state interest and that the statute is narrowly tailored to effectuate only that interest. Here, Justice Brennan found there is not a compelling state interest:

Missouri does not claim, nor could it, that society as a whole will be benefited by Nancy’s receiving medical treatment. No third party’s situation will be improved and no harm to others will be averted.

The only state interest asserted here is a general interest in the preservation of life. But the State has no legitimate general interest in someone’s life, completely abstracted from the interest of the person living that life, that could outweigh the person’s choice to avoid medical treatment.

In sum, the lack of a sufficiently important state interest would prove fatal when strictly scrutinized, and as Justice Brennan described, Nancy was entitled to “die with dignity.”

Justice Stevens, in his dissent, agreed that the state had little interest in this matter. He explained that the Court should not distinguish life from liberty; that is,

[i]f Nancy Cruzan’s life were defined by reference to her own interests, so that her life expired when her biological existence ceased serving any of her own interests, then her constitutionally protected interest in freedom from

101. Id. at 300.
102. Id. at 302.
103. See id. at 302, 312-13, 317.
105. Id. at 302.
106. Id. at 331 (Stevens, J., dissenting). Stevens wrote that the majority erred in permitting the state’s “abstract, undifferentiated interest in the preservation of life to overwhelm the best interests of Nancy Beth Cruzan.” Id.
unwanted treatment would not come into conflict with her constitutionally protected interest in life.\textsuperscript{107} In short, he determined that the patient's best interests should prevail over any general state policy.

In their final analyses, all of the Cruzan Justices except for Justice Scalia either acknowledged or assumed a "right to die" in certain circumstances. The Court, however, neither made an absolute right nor set forth an absolute test. Instead, the Court ruled that, under Nancy Cruzan's specific facts, a state could require "clear and convincing evidence" of a patient's wishes where a guardian seeks to discontinue nutrition and hydration.\textsuperscript{108} The Court, then, was willing to defer to the state. In the next section, this comment examines state-level determinations made by two California appellate courts.\textsuperscript{109}

3. The California Cases: Bouvia and Bartling

The California appellate courts have been particularly liberal in deferring to an individual's choice over the interests of the state or any physician.\textsuperscript{110} These courts have stated that "the patient's interests and desires are the key ingredients of the decision-making process . . . . W]henever possible, the patient himself should then be the ultimate decisionmaker."\textsuperscript{111} For these courts, the motive of the patient is irrelevant; "[i]f a right exists, it matters not what 'motivates' its exercise."\textsuperscript{112}

In Bartling v. Superior Court,\textsuperscript{113} a seventy-year-old patient who suffered from five different non-terminal diseases requested that he be removed from a respiratory ventila-

\textsuperscript{107.} Id. at 351.
\textsuperscript{108.} Id. at 286-87.
\textsuperscript{109.} The decisions reviewed are Bouvia v. Superior Ct., 225 Cal. Rptr. 297 (Ct. App. 1986) and Bartling v. Superior Ct., 209 Cal. Rptr. 220 (Ct. App. 1984).
\textsuperscript{110.} The courts have based this deference on a right of privacy implicit in the United States Constitution and explicit in the California Constitution. See CAL. CONSTR. art. I § 1; Rochin v. California, 342 U.S. 165 (1952) (cited in Bouvia, 225 Cal. Rptr. at 306).
\textsuperscript{111.} Bouvia, 225 Cal. Rptr. at 301 (citing Cobbs v. Grant, 502 P.2d 1 (Cal. 1972)). The patient's decision would not be subject to the approval of an ethics committee: "We find nothing in the law to suggest the right to refuse medical treatment may be exercised only if the patient's motives meet someone else's approval." Id. at 306.
\textsuperscript{112.} Id.
\textsuperscript{113.} 209 Cal. Rptr. 220 (Ct. App. 1984).
He had executed a "living will," a durable power of attorney for health care, and a declaration stating his knowledge of the consequences of turning off the ventilator. The court held that the right of a competent adult to refuse medical treatment is protected under both the California and Federal Constitutions and must not be abridged. The right to have life-sustaining treatment discontinued is not limited to patients who are comatose or terminally ill. The court further held that the right of Mr. Bartling, as a competent adult, to refuse unwanted medical treatment was not outweighed by any combination of the following state interests: the preservation of life, the need to protect innocent third parties, the prevention of suicide, and maintainence of the ethics of the medical profession.

The same high level of deference to the individual led another California appellate court to recognize Elizabeth Bouvia's right to hasten her death by refusing medical treatment despite the fact she was not terminally ill, had no great physical discomfort, could have lived another fifteen to twenty years on the life-sustaining equipment, and had lived with her cerebral palsy since birth. Ms. Bouvia may have also been influenced by depression resulting from a rash of tragic events suffered immediately prior to her decision.

 Nonetheless, the court valued Bouvia's decision that her existence had become meaningless and determined that "[i]f her right to choose may not be exercised because there remains to her, in the opinion of the court, a physician or some committee, a certain arbitrary number of years, months, or
days, her right will have lost its value and meaning." 125 The court asked:

Who shall say what the minimum amount of available life must be? Does it matter if it be 15 to 20 years, 15 to 20 months, or 15 to 20 days, if such life has been physically destroyed and its quality, dignity and purpose gone? As in all matters lines must be drawn at some point, somewhere, but that decision must ultimately belong to the one whose life is in issue. 126

The Bouvia court, like the Bartling court before it, determined that this was not a legal issue: The patient's right to choose "is not a conditional right subject to approval by ethics committees or courts of law. It is a moral and philosophical decision that, being a competent adult, is [the patient's] alone." 127

In his concurrence, Justice Compton expressed his disgust with the fact that Bouvia had to go through the courts in order to assert her absolute right. 128 He reasoned that if the state had not threatened physicians with penal sanctions, the process for Ms. Bouvia could have been much smoother, as her physicians could have simply acted in accordance with the Hippocratic Oath rather than acting in fear of potential legal repercussions. 129 His reading of the Oath was such that a doctor would effectuate a reasonable balance between his or her own obligation to heal and his or her obligation to preserve life. 130

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126. Id. at 305.
127. Id.
128. Id. at 307-08 (Compton, J., concurring).
129. Id.
130. Bouvia v. Superior Ct., 225 Cal. Rptr. 297, 308 (Ct. App. 1986 (Compton, J., concurring). Justice Compton noted the precise language of the Hippocratic Oath which states, "I will give no deadly medicine to anyone if asked." Id. (citation omitted). But, he believed that the Oath's portion about a physician using his or her best abilities and judgments overrides that express statement. Id. Commentator Richard Benton notes that perhaps the words of the Oath are not to keep a physician from killing under all circumstances. RICHARD G. BENTON, DEATH AND DYING 42 (1978) (quoting G. Cant, Deciding When Death is Better than Life, TIME, July 26, 1973, at 36-37). In fact, the words may have been designed initially "to keep the physician from becoming an accomplice of palace poisoners or of a man seeking to get rid of a wife." Id.
The lesson of the California appellate court cases is that no criminal or civil liability will be imposed if a party honors a competent, informed patient's refusal of medical service. But, the Bouvia court was quick to distinguish refusal from affirmative or active euthanasia, which is "far different" from the mere omission of a doctor while his or her patient asserts his or her constitutional rights.

E. The Next Step: Legalization of Physician-Assisted Death

Because most of the justices on the Cruzan Court and the California appellate courts, as well as a large segment of the population, are receptive to passive euthanasia, this comment analyzes the likely next step—active euthanasia in the form of physician-assisted death. Over the past two years, voters in Washington and California have narrowly defeated initiatives that would make it legal for a physician to affirmatively aid his or her patient in dying. After the California proposition was defeated, many felt that the voters were not opposed to the overall concept of a physician aiding a patient in dying, but they were simply opposed to the language of the initiative.

1. Case in Point: California's Proposition 161

As with any proposition in California, the supporters of Proposition 161 gained access to the ballot by collecting the requisite number of petition signatures. The language printed on the petition matched that of the ballot. Early
polls showed that Proposition 161 would certainly pass,\textsuperscript{137} but as election day neared, the margin narrowed and the initiative was ultimately defeated by a margin of fifty-four to forty-six percent.\textsuperscript{138} Traditionally liberal voting populaces supported the initiative, while traditionally conservative populaces did not.\textsuperscript{139}

The authors of the Proposition clearly recognized people's fears and made an attempt to respond to them. In the preamble, the authors stated that the purpose of the Act was "to provide mentally competent, terminally ill adults the legal right to voluntarily request and receive physician aid-in-dying."\textsuperscript{140} They explained that such a right springs from one's right of self-determination: "The right to choose to eliminate pain and suffering, and to die with dignity at the time and place of our own choosing when we are terminally ill is an integral part of our right to control our own destinies."\textsuperscript{141}

This right of physician-assisted death was a response to modern medical technology, which has artificially prolonged life "beyond natural limits."\textsuperscript{142} Such a prolongation of life should be remedied because it caused the loss of dignity and increased pain and suffering for both the patient and family "while providing nothing medically necessary or beneficial to the patient."\textsuperscript{143} In essence, the right of physician-assisted suicide was to make death as "painless, humane and dignified" as possible.\textsuperscript{144}

Such a right, however, would not be without limits. The authors explained that the Proposition provided "solid protection against abuse."\textsuperscript{145} In particular, the Proposition required that in order "to ensure that the rights of others are

\begin{footnotes}
\footnotetext{137}{See supra note 23.}
\footnotetext{138}{See supra note 23.}
\footnotetext{139}{Merely 39.7\% of the voters in San Bernardino County and 41.8\% of the voters in Orange County voted in favor of the proposition. Ewell, supra note 135 at 17EL. In more liberal counties, clear majorities voted in favor of the proposition: 60.8\% in San Francisco and 56.3\% in Santa Cruz. Id.}
\footnotetext{140}{CALIFORNIANS AGAINST HUMAN SUFFERING, THE CALIFORNIA DEATH WITH DIGNITY ACT, § 2525.1 (1992).}
\footnotetext{141}{Id.}
\footnotetext{142}{Id.}
\footnotetext{143}{Id. The authors perceived physician-assisted death as a dignified response; receiving aid-in-dying is not to be denigrated to the status of "suicide" or "mercy killing." Id. §§ 2525.16, 2525.23.}
\footnotetext{144}{Id. § 2525.1.}
\footnotetext{145}{CALIFORNIA BALLOT PAMPHLET, GENERAL ELECTION, NOV. 3, 1992, at 34 (1992).}
\end{footnotes}
not affected," there would have to be: (1) a six-month terminal condition; (2) a voluntary choice; and (3) two physicians insulated from liability.

The Act required the patient to have a six-month terminal condition, defined in the proposed statute as "an incurable or irreversible condition which will . . . result in death within six months or less" as determined by two physicians, one of whom is the patient's primary attending physician.

Once the patient was deemed to have a six-month terminal condition, doctors could help implement his or her voluntary choice to die. In an attempt to ensure the voluntariness of the choice, the drafters required that the patient be (1) mentally competent and (2) free from coercive pressures.

The patient should be mentally competent when signing a witnessed revocable directive requesting that a physician aid him or her in death. The Proposition did not define mental competence, nor did it require the patient to undergo a psychological examination. Instead, the determination of a patient's mental competence could be made by the patient's physicians, regardless of their psychological training. The request by the patient must have been made on more than one occasion (an "enduring" request), but there

147. Id.
148. Id. § 2525.2(j).
149. Id. The Voluntary Directive to Physicians, to be signed by the patient, broadens the definition of terminal in order to include terminal conditions and illnesses. Id. at 9. See also infra text accompanying notes 178-180 discussing the possible implications of this broader definition.
150. CALIFORNIANS AGAINST HUMAN SUFFERING, THE CALIFORNIA DEATH WITH DIGNITY ACT, Id. §§ 2525.4; 2525.9.
151. Id. §§ 2525.3; 2525.8; 2525.18.
152. Id.§ 2525.3 (1992).
153. Id. at § 2525.13. "An attending physician who is requested to give aid-in-dying may request a psychiatric or psychological consultation if that physician has any concern about the patient's competence, with the consent of a qualified patient." Id. (emphasis added).
154. Id. (Since the physician is not required to seek a psychiatric or psychological evaluation of the patient, he or she presumably is left with the task of judging a patient's competence. The Proposition does not discuss training the physician in the art of psychological evaluation.)
155. Id. § 2525.2(i) ("Enduring request" means a request for aid-in-dying, expressed on more than one occasion.").
was not any required "cooling-off" period between such requests.\textsuperscript{156}

To protect the patient from coercion, the Act tried to forbid "inducement" or "coercion" of the patient by family members or insurance companies for whom the patient may have become a burden.\textsuperscript{157} To allay the voters' fears of coercion, the Act provided:

No patient may be pressured to make a decision to seek aid-in-dying because that patient is a financial, emotional, or other burden to his or her family, other persons, or the state. A person who coerces, pressures, or fraudulently induces another to execute a Directive under this title is guilty of a misdemeanor, or if death occurs as a result of said coercion, pressure or fraud, is guilty of a felony.\textsuperscript{158}

In addition, the processing of the directive and actual administration of aid-in-dying could occur without any family member witnessing or even having knowledge.\textsuperscript{159} A similar section specifically addressed concerns regarding insurance companies.\textsuperscript{160} No insurance company could change its rate structure or extension of coverage in response to the insured's choice regarding physician-assisted death.\textsuperscript{161} No insurer could require or prohibit any person from executing a directive as a condition to being insured.\textsuperscript{162} Such a conditional insurer would be guilty of a misdemeanor.\textsuperscript{163}

Nonetheless, there was no provision for a reviewing medical committee or advisory board to determine whether the patient was competent and not under coercion.\textsuperscript{164} In fact, the final certification was to be made by two independent physicians, one of whom was the patient's attending physician, from any field of medicine, regardless of their level of train-
These physicians purportedly would be immune from liability. In fact, all health care professionals acting in accordance with any part of Proposition 161 were purported to be insulated from liability. No claims of criminal liability or unprofessional conduct would attach to the health care provider who acted in accordance with “reasonable medical standards in administering aid-in-dying.”

As part of the reasonable physician’s job, the Act would have required a physician to certify that the directive was properly executed and witnessed. As treatment continued, the physician would be required to determine whether the directive had or had not been revoked in one of the three ways specified by the Act. The physician would have to determine when it is necessary, based on written or oral statements of his or her patient, to execute a new directive.

Once the procedure took place, the physician would list the underlying illness as the cause of death. Hospitals would be required to make annual reports to the state department of health services regarding the total number of cases, the patient’s age, and the type of illness. No record would tie the occurrence of the procedure to the individual.

Proposition 161’s requirements were varied and complex. The validity of each requirement, or safeguard, is a matter of

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165. “‘Attending physician’ means the physician selected by, or assigned to, the patient who has primary responsibility for the treatment and care of the patient.” CALIFORNIANS AGAINST HUMAN SUFFERING, THE CALIFORNIA DEATH WITH DIGNITY ACT § 2525.2(a) (1992). “‘Physician’ means a physician and surgeon licensed by the Medical Board of California.” Id. § 2525.2(e).

166. Id. § 2525.9.

167. Id. (“No physician, health care facility, or employee of a health care facility who, acting in accordance with the requirements of this title, administers aid-in-dying to a qualified patient shall be subject to civil, criminal, or administrative liability therefore.”).

168. Id. § 2525.15.

169. Id. § 2525.14.

170. A directive could be revoked at any time, without regard to the patient's mental state or competency, by any of the following methods: (1) mutilation of the paper on which it was written, (2) written revocation expressing an intent to revoke, or (3) oral communication expressing an intent to revoke. Id. § 2525.5.

171. Id. § 2525.5 (1992).


III. ANALYSIS

Views about choice are most likely to mirror views about physician-assisted death. At one extreme are those who believe a choice to short-circuit life is never valid, and these people will never accept physician-assisted death. At the other extreme are those who strongly favor an individual's freedom of choice and will accept this choice under almost all circumstances. For these people, there is a presumptive validity that the choice to pursue a physician's aid-in-dying is a free choice; potentially influential factors, such as the desire to avoid high medical costs and becoming a burden on one's family, will not disqualify the choice.

Presumably, most of the California voters fall somewhere between these extremes. While some of those who opposed the initiative fell within the extreme group arguing that this practice should never be allowed, many of the opponents questioned the procedure based on the lack of precise language and safeguards that could serve to protect the efficacy and voluntariness of the decision. A more carefully drafted statute with more significant safeguards would probably compel this group to vote in favor of a proposition for the legalization of physician-assisted death. This section analyzes these concerns and the probable judicial response.

175. Religious groups are strongly opposed to active euthanasia. See Rabbi Mark S. Miller, Rosh Hashanah Sermon (Oct. 23, 1992) (Temple Bat Yam, Newport Beach, CA) (transcript available in the library of Temple Bat Yam).

176. How free a choice can be is really a matter of philosophical debate. A Marxist view that the individual's choice is a product of the social institutions around him precludes the conclusion that there is any free choice. See June R. Carbone, The Role of Contract Principles in Determining The Validity of Surrogacy Contracts, 28 SANTA CLARA L. REV. 581, 593 n.44 (1988) (citing Margaret Jane Radin, Market Alienability, 100 HARV. L. REV. 1849, 1932-33 (1987)). This comment addresses the belief that our social institutions and practices can be shaped in order to properly influence one's decisions.

A. The Legal Requirements of Proposition 161

Presumably, most of the legal requirements of Proposition 161 were formulated with the wary voter in mind. While the vote fell short for this Proposition, perhaps the right mix of safeguarding requirements could sway the voters to approve a new proposition in a forthcoming election. To formulate this "right mix," one should first analyze the logic and political attractiveness of the various legal requirements.

1. The Requirement of a Six-Month Terminal Condition

There are quite a few loopholes in the language requiring a six-month terminal condition. First, although the Proposition simply refers to a terminal condition, the directive the patient must sign refers to either a "terminal condition or illness." This inconsistency, as well as the generally ambiguous statutory language, leads one to wonder whether the physicians determining that a patient is to die within six months are to make their estimate considering that the patient is receiving life-sustaining treatment or without considering such life-prolonging treatment.

Second, the Act does nothing to stop courts from extending this procedure to non-terminal patients. Certainly one of the greatest fears the Proposition's opponents have is the extension of this procedure to non-terminal patients. Although "terminal" is the listed requirement, the stated objectives of the Act are "death with dignity" and "avoidance of pain." Such objectives require the Act to encompass a broader group than just the terminally ill. For instance, the disabled, and those with Alzheimer's disease, would then have to be covered if the drafters' stated objective were the true objective.

Instead of drafting requirements in tune with their true objective, the authors make an arbitrary categorization: terminal within six months. Presumably, this is done to please the wary voter. Most likely, however, the hope of the initiative supporter is to break through the stigma against active euthanasia and make it socially acceptable so that eventually

178. See supra text accompanying notes 148-150.
180. See supra text accompanying notes 142-144.
other people besides the terminally ill can exercise voluntary euthanasia.\textsuperscript{181} A physician's aid-in-dying could become the "reasonable standard" rather than the rare exception.\textsuperscript{182}

2. The Requirement of a Voluntary Choice

As noted, the stated purpose of Proposition 161 was "to provide mentally competent, terminally ill adults the legal right to voluntarily request and receive physician aid-in-dying."\textsuperscript{183} The authors of Proposition 161 emphasized the voluntariness of the procedure for both physicians and patients.\textsuperscript{184} Yet, there is serious doubt as to whether the safeguards requiring mental competence\textsuperscript{185} and forbidding coercion\textsuperscript{186} would adequately ensure that a patient's choice is voluntary.

a. Mental Competence

The very nature of degenerative illnesses brings into question whether a "competent" choice can ever be made. One can easily argue that it is ridiculous to speak of "competence" when the patient has recently been diagnosed with a terminal illness because the mental distress of such an event precludes rational thought. To be competent is to be "adequate for the purpose."\textsuperscript{187} The mental distress one suffers after a diagnosis of terminal illness can make him inadequate, at least temporarily, for the purpose of determining whether to end his life. Psychological elements—depression, hopelessness, and delirium—certainly influence one's thoughts, and some argue that "suicidal ideation is limited to those who are significantly depressed."\textsuperscript{188}

\textsuperscript{181} Humphry, \textit{supra} note 13, at 140 (1991) (explaining that others contend physician-assisted death for Alzheimer's patients is justified); cf. Mary Ann Seawell, \textit{Historian: Stop Abetting Suicide for Disabled People}, STANFORD OBSERVER, Sept.-Oct. 1992, at 12 (fearing the inclusion of physical disabilities within the term "terminal illness").
\textsuperscript{182} Rosenblum, \textit{supra} note 34, at 29-31.
\textsuperscript{183} See \textit{supra} text accompanying notes 140-141.
\textsuperscript{184} In the Act's declaration of purpose, the authors mention the word "voluntary" no fewer than four times. See \textit{Californians Against Human Suffering, The California Death with Dignity Act} § 2525.1 (1992).
\textsuperscript{185} Id. §§ 2525.2(h), 2525.3.
\textsuperscript{186} Id. §§ 2525.8, 2525.18.
\textsuperscript{187} American Heritage Dictionary 271 (New College ed. 1980).
In addition to the mental factors, physical factors such as pain could interfere with one's competence. If untreated, persistent physical pain will surely affect a patient's view about the quality of his life and, in turn, will influence his choice about suicide or physician-assisted suicide. As observed, "[o]ne common statement made by patients is that their pain is so severe that they are unable to deal with the issue of mortality, interfering with their ability to develop coping mechanisms to deal with the dying process."189 Those arguing that competence is impossible to achieve after a diagnosis that one is terminally ill will argue that those patients who did not make an advanced directive are never qualified to make a choice regarding physician-assisted suicide. To these people, competence is the key to making a decision regarding the decision to end one's own life.190 It would follow, then, that the decision would have to be made before the diagnosis of terminal illness.191

Although there are those who believe competence is the key, the modern approach, as supported by California case law, seems to minimize its importance. For example, the Bartling court determined that a depressed alcoholic, who vacillated in his choice to die, was still mentally competent at the point he decided to withdraw treatment.192 In accordance with the California courts' de-emphasis on competence, Proposition 161 would not have required any psychological examination; the physician's analysis would be sufficient in determining a patient's competence.193 California courts have not been overly concerned with the issue of competence.

The California courts, then, equate consciousness with competence. To speak of competence as a strict safeguard is a fallacy, because the California courts are likely to deem any choice made by a conscious patient to be a competent

189. Id. at 294.
190. But cf. HEIFETZ & MANGEL supra note 1 (arguing that a determination of competence will be too broad-sweeping and that one should never be denied physician-assisted death simply because he or she is deemed incompetent).
191. Through the living will and durable power of attorney, most states allow such an advanced decision for treatment withdrawal. See supra notes 42-43.
192. See supra text accompanying notes 113-119.
193. Ordinary physicians, however, lack training in psychology and are traditionally poor at making such determinations. Dr. Ronald B. Miller, Lecture at Hoag Memorial Hospital (Oct. 23, 1992) (audio-cassette available in the library of Hoag Memorial Hospital, Newport Beach, CA).
choice. Further, one need not even be conscious, because a third-party surrogate can make the choice for him or her.

i. The Third-Party Surrogate Decision

As a matter of course, medical personnel, friends, or family make judgments for the incompetent patient that are substituted for those judgments the patient would have made if competent. But the doctrines of "substituted judgment" and "best interests" compel the third party to implement exactly what that particular patient or a hypothetical reasonable patient would choose under the particular circumstances of the particular illness. The argument in favor of surrogate decision-making is that the patient's "right to choose" will be lost if a third party is not allowed to implement it for the patient.

Nonetheless, there are strong arguments against surrogate decision-making. It is not a true exercise of choice. As Professor Rosenblum observed, "the sine qua non of a right to 'choose' anything is cognitive ability to choose." The Massachusetts Supreme Court attacked the doctrine of substituted judgment as a legal fiction and a "cruel charade." The court stated:

The substituted judgment doctrine fails to recognize that a competent patient makes a medical decision with respect to a particular treatment, at a particular time, with relation to how it affects his particular condition. This cannot be truly substituted by reliance on vague, usually remote, statements made by the person at a different time and place, in a different condition, without regard to any particular treatment. This is especially so with statements made in the peak of health. What is clear on a moment's reflection is that people change their minds about

196. See supra note 59.
197. Rosenblum, supra note 34, at 19.
198. Id.
199. Id. at 18 (quoting In re Moe, 432 N.E.2d 712, 724 (Mass. 1982) (Nolan, J., dissenting).
treatment, depending on the time and their condition and the treatment.  

Although Proposition 161 did not include a provision regarding surrogates, it is important to discuss surrogates here because their role will certainly be vital if such legislation is passed. While California's Natural Death Act provides only for withdrawal of life-sustaining procedures in instances of a terminal condition or permanent unconscious condition, the courts have readily extended such withdrawal to non-terminal, conscious patients.

Similarly, the courts might ignore the distinction between a terminal/non-terminal or conscious/non-conscious patient in allowing for third-party decisions in the area of physician-assisted suicide. Proposition 161 does nothing to ensure that a court will make the proper distinctions, nor does it ensure that third parties will be barred from ordering a physician to affirmatively aid in the patient's death. In sum, the California courts do not strictly require competence, and any voter believing that mental competence is a strict requirement or that third parties are excluded from the process has been tricked by the language of Proposition 161. Similarly, the next section demonstrates how the promise of a coercion-free procedure is equally flawed.

b. Coercive Pressures on the Patient

Despite the drafters' linguistic forays regarding a lack of coercion of the patient, no amount of safeguarding language can make physician-assisted death a coercion-free procedure. The mere legality of such physician aid-in-dying is coercive in itself. When patient A seeks aid-in-dying, that patient’s decision may have an effect on the decision of patient B lying in the next hospital bed. When patient B sees that the health care professionals are freed from the burden of caring for patient A and that patient A's family is free to go on with their lives instead of making daily visits to the dying relative, he or she may be affected. Certainly it can be debated whether there is justice in the health care professionals

200. Id. at 19.
201. CAL. HEALTH & SAFETY CODE § 7185.5 (West 1991).
203. See supra text accompanying note 158.
and family being freed from their burden, but to make the assertion that the process is coercion-free is preposterous:

Will we not sweep up, in the process, some who are not really tired of life, but think others are tired of them; some who do not really want to die, but who feel they should not live on, because to do so when there looms the legal alternative of euthanasia is to do a selfish or cowardly act? Will not some feel an obligation to have themselves ‘eliminated’ in order that funds allocated for their terminal care might be better used by their families, or financial worries aside, in order to relieve their families of the emotional strain involved?\textsuperscript{204}

One may be inclined to dispose of this argument because any decision is based on outside factors such as courage, money, and the effect on loved ones. But one can envision disproportionate use by the poor, because their decisions may be affected more by the cost of care.\textsuperscript{205} Moreover, the decision here is an irrevocable one, so external forces affecting one’s thought process must be minimized.

It is wrong for the drafters to assert that the patient makes her choice alone. The patient will, at the least, converse generally about the procedure with her family. Mere mention of cutting short the dying relative’s life will certainly strain the family-patient relationship, which in turn will affect the decision-making process. Moreover, the family members may not be in their clearest states of mind at this time:

\textit{[I]f the patient is maintained at home, many frustrations and physical demands may be imposed on the family by the advanced illness. There may develop extreme weakness, incontinence and bad odors. The pressure of caring for the individual under these circumstances is likely to


\textsuperscript{205} The poor may make for the hardest cases as they do not employ estate planners who direct them to file durable powers of attorney and living wills before the onset of problems. While the wealthy may be able to mandate physician aid-in-dying in an anticipatory directive, the poor will be left to use the voluntary directive. The directive, however, occurs only after the onset of problems. At that point, it will be more likely that one’s competence is called into question than if the directive had been made before the onset of problems. Thus, it may be possible that the poor could be more restricted in their desire for physician aid-in-dying.
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arouse a resentment and, in turn, guilt feelings on the part of those who have to do the nursing.\textsuperscript{206}

The notion that "bad odors" will cause the family to pressure their relative into terminating his life may appear extreme at first glance, but weakness, incontinence, and bad odors can be humiliating and harrowing because they signify one's loss of bodily control. For many patients, such developments in the context of a fatal illness represent a significant loss of dignity that may be the tipping point for them and their families. One cannot deny that the stresses and strains of sickness are a burdensome reality in need of some amelioration. A lethal injection, however, may be too accessible and too extreme a solution.

Not only is the family a concern, but so is the insurance company. The authors of Proposition 161 claimed that their initiative would be insulated from insurance structures.\textsuperscript{207} Yet, it is a truism that insurance policies influence our actions. One area in which the insurance company could have particular influence is in defining the reasonable medical standards a physician must follow when administering physician aid-in-dying.

Suppose a patient lives only five months after being diagnosed as terminally ill, and the doctor, in the insurance company's mind, did not advise clearly and convincingly enough on physician aid-in-dying. The insurance company may attempt to recover damages from the physician for the "superfluous" medical costs of those five months. What is even more likely is that insurance companies will compose rate schedules that set fixed prices for treatment of a given illness. For those illnesses where physician-assisted suicide is a legal alternative, rates will be set low enough to create an incentive for hospitals and physicians to encourage physician-assisted death. These are just a few of the ways in which insurance companies could coerce physicians into giving stronger advice on physician aid-in-dying. Insurance companies, then, may have a large role in framing the next section's topic: reasonable medical standards.

\textsuperscript{206} Kamisar, supra note 204, at 121 (citing Zarling, \textit{Psychological Aspects of Pain in Terminal Malignancies}, in \textit{Management of Pain in Cancer} 211, 211-12 (Schiffrin ed. 1956)).

\textsuperscript{207} See supra text accompanying notes 160-163.
3. The Requirements of the Physician: Medical Standards and Immunity

As noted previously, Proposition 161 provided that a patient is qualified to receive a physician's aid-in-dying after she has been diagnosed as having a terminal condition by any two physicians, as long as one is the patient's attending physician.208 The Act purported to immunize a physician from civil, criminal, or administrative liability if she acts in accordance with the Act. No physician is to be required to take any action contrary to "reasonable medical standards."209

a. The Two Physicians

Proposition 161 required that two physicians certify the patient's request to die.210 The attending physician is required to certify the patient's wishes, presumably because that physician knows the patient best.211 As she has remained with and followed the development of the patient's sickness, she will be best qualified to determine whether or not the patient is making a competent, informed choice.

The attending physician, however, is not a calculating robotic mechanism of objectivity. Instead, the physician is affected by the stresses and strains and emotional attachments that develop over the course of dealing with a patient's illness. Certainly a physician's own depression resulting from feelings of failure will affect her decision to certify the patient's directive.212 At least one study shows a correlation between the physician's level of involvement with the patient and her willingness to accept suicide by that patient.213

208. See supra text accompanying notes 165-167.
210. See supra text accompanying notes 165-166.
211. See supra text accompanying notes 165-166.
212. One commentator noted:
[A] doctor may react more emotionally and less objectively than in any other area of medical practice. His deep concern may make him more pessimistic than is necessary. As a result of the feeling of frustration in his wish to help, the doctor may have moments of annoyance with the patient. He may even feel almost inclined to want to avoid this type of patient.

Kamisar, supra note 204, at 122 (citing Zarling, Psychological Aspects of Pain in Terminal Malignancies, MANAGEMENT OF PAIN IN CANCER 211, 213-214 (1956)).
There may be a further problem in that neither of the two physicians need be an expert in working with the terminally ill. The only hurdle is that one physician must be licensed by the California Medical Board.\textsuperscript{214} It takes no great stretch of the imagination to envision a system where below-average or young doctors are attracted to this potentially lucrative practice:

If the range of skill and judgment among licensed physicians approaches the wide gap between the very best and the very worst members of the bar—and I have no reason to think it does not—then the minimally competent physician is hardly the man to be given the responsibility for ending another's life.\textsuperscript{215}

Tracking statistical data, such as which physicians are most inclined to offer the aid-in-dying, will be difficult.\textsuperscript{216} The reporting requirements of the Act are minimal,\textsuperscript{217} and there will be no way to tie the occurrence of the procedure to an individual patient or physician.

A further problem is that physicians must make legal determinations. The physician will have to determine when it is necessary, based on written or oral statements of his patient, to execute a new directive.\textsuperscript{218} Not all physicians will take time away from their medical studies or practice to learn the subtleties of the Act in order to make the proper legal determinations.

The obvious alternative is to allow only specially trained and licensed physicians to certify and carry out the procedure. Limiting the number of certified practitioners would facilitate the state's role as watchdog. Training these physicians on everything from the legal requirements of the Act to how to psychologically evaluate a patient would make it more likely that the Act's requirements were followed. Proposition 161, however, does not require or even suggest such training. Certainly, a physician will need to learn how to advise his patient, how to determine his patient's competence, and how

\textsuperscript{214} See supra note 165.

\textsuperscript{215} Kamisar, supra note 204, at 124.

\textsuperscript{216} See Alexander, supra note 25, at 67. Professor Alexander comments on the difficulty in attaining statistical data for patients who have had treatment withdrawn. Id. at 69.

\textsuperscript{217} See supra text accompanying notes 172-174.

\textsuperscript{218} See supra text accompanying notes 170-171.
to best estimate what diseases will likely kill a person within six months.

The problem with requiring a special license, however, is that the patient's primary physician may not be licensed. This results in a loss of the intimate doctor-patient relationship that our society encourages. The license requirement would leave the unlicensed physician without the flexibility and access to all treatments needed in order to be a full-service health care provider. As the physicians' activities are limited, their patients' respect will wane.

Allowing any two generally licensed physicians to carry out the aid-in-dying is improper. We must limit the number of physicians engaging in this new practice and make sure they are properly trained in the proper legal and medical requirements. Any detrimental effect on the intimacy of the doctor-patient relationship will be minimal in relation to the benefits gained in having a limited set of knowledgeable practitioners carrying out a patient's desire to end his or her life. After their training, these practitioners will be held accountable for their failure to act in accordance with the set of "reasonable medical standards" they have learned.

b. Reasonable Medical Standards

The Act sets questionable medical standards. First, it is unreasonable for a physician to estimate the length of one's life; it is practically a cliche for a patient to survive beyond any estimation made by his physician. Second, it is improper for a physician to declare his patient unworthy of further treatment, because the physician's traditional role is to strive constantly to find a cure for that which has previously been deemed incurable.²¹⁹ Third, it is unclear whether a physician must disclose the availability of the procedure. Non-disclosure would emasculate the statute, but required disclosure would certainly interfere with the doctor-patient relationship, as the patient is certain to view his situation and his physician differently after the physician brings up the topic.²²⁰ Finally, although the Act calls for physicians to act

²¹⁹. See Kamisar, supra note 204, at 125. The counter to this argument is that one who seeks aid-in-dying will be so far into his disease that a general cure for his disease could still not solve his ailment. Id. at 126.

in accordance with reasonable medical standards, the lesson of past cases is that the medical profession will heed court-approved standards.\textsuperscript{221} A forecast of the court standards, then, is in order.

c. Physician Liability: The Role of the Courts

Proposition 161 claimed to immunize the physician from any sort of liability.\textsuperscript{222} In light of the “modern proliferation of substantial malpractice litigation and the . . . possibility of criminal sanctions,”\textsuperscript{223} as well as the courts’ involvement in the withdrawal cases, it is difficult to trust such broad-sweeping immunization. The courts will most likely fail to keep their hands off this area.

Assuming that the Act, if passed, is deemed valid under both the California and Federal Constitutions, there are various legal causes of action that could be brought to challenge the Act. Considering the requirement that physicians follow unspecified “reasonable” medical standards, such as determining a patient’s competence and precisely estimating when a patient has six months to live, the physician’s role is “deceptively risky.”\textsuperscript{224} First, an allegation that the physician failed to act “in accordance with” the Act subjects him or her to criminal prosecution or civil liability.\textsuperscript{225} The doctor, hospital, and support personnel could be subject to criminal prosecution for homicide or assisted suicide. The civil litigation could encompass wrongful death, medical malpractice, and breach of fiduciary duty.\textsuperscript{226} Interestingly enough, a “wrongful living” tort could be brought against the physician who fails to properly disclose the availability of the procedure.\textsuperscript{227} Regulatory proceedings could also subject the physician to penalties against medical licenses and hospital privileges. Assuming the Act is upheld as constitutional, then, the road for physicians and health care professionals will not be liability-free.

\textsuperscript{221} See supra note 11. The withdrawal-of-treatment cases reached the courts because physicians acted in accordance with their medical standards, and the patient requested that the court modify these standards.
\textsuperscript{222} See supra text accompanying notes 166-168.
\textsuperscript{224} Llewellyn, supra note 220, at 26.
\textsuperscript{225} CALIFORNIANS AGAINST HUMAN SUFFERING, THE CALIFORNIA DEATH WITH DIGNITY ACT § 2525.9 (1992).
\textsuperscript{226} Llewellyn, supra note 220, at 26.
\textsuperscript{227} See Rosenblum, supra note 34, at 27-28.
This assumption of constitutionality is further explored in the next section.

B. *The Constitutionality of the Act: The Bouvia and Bartling Standard*

The primary difference between the withdrawal of treatment taking place in the *Bouvia* and *Bartling* courts and physician-assisted death is that the former allows the natural dying process to take place, while the latter short-circuits the dying process. Whether or not the courts will accept a statutory legalization of *active* euthanasia is a matter of speculation, but it is most likely that they would. California courts tend to follow statutory law in the “right to die” area, support patient autonomy, and may ultimately heed the Act’s language declaring that physician-assisted death is not suicide.228 The strength or lack of strength in the safeguards would probably be deemed immaterial.

The courts have shown a tendency to follow the policy of statutory law. In the *Bouvia* and *Bartling* cases, the courts were swayed by the policy of California’s Natural Death Act.229 In fact, the Natural Death Act would buttress the argument in favor of Proposition 161, as it provides that adult persons have a “fundamental right to control the decisions relating to the rendering of [their] own medical care.”230 On the other hand, one could argue that the courts were not willing to rule in favor of withdrawal only because to rule otherwise would allow intrusions into one’s constitutional right of privacy.231 No such intrusions exist, however, in the case of voluntary active euthanasia.

Using the statutory law as well as the California Constitution, the courts have supported a patient’s rights of autonomy.232 As a caveat, however, the statutes that the courts rely on to assert a patient’s rights of control have considered

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231. CAL. CONST. art I, § 1.
232. See supra text accompanying notes 110-133.
only refusal of treatment, but say nothing about active euthanasia. Despite the failure of the statutes to explicitly mention active euthanasia, the courts would most likely continue to support a patient's right to autonomy.

Although the courts have been guided by the policies of state statutes and a patient's right to choose, they are still opposed to suicide. The Bouvia court reiterated that it is a crime to aid in suicide, and any affirmative conduct that allows another to kill himself is “far different” than the mere presence of a doctor while treatment is withdrawn. The Bouvia court refused to dwell on the suicide issue, and we cannot be sure whether “far different” applies to physician aid-in-dying so as to make it unconstitutional.

The Bartling court pointed out that the states have traditionally made suicide illegal in order to prevent “irrational self-destruction.” It would be simple for that court to argue, then, that the procedure in accordance with Proposition 161 is rational and therefore justified. After all, the purpose of the safeguards' requiring an enduring request and a competent patient is to make the decision to seek physician-assisted death look like a rational decision, which as the drafters are quick to point out, is therefore “not suicide.”

It is preposterous to declare that physician-assisted death is not suicide; the patient intends to die and “sets the death producing agent in motion with the intent of causing his own death.” But a court using the Bartling analysis may overlook that and deem this type of suicide rational. Although the courts have repeatedly shown a distaste for suicide, their tendency to abide by state statutes and support a

233. The Natural Death Act asserts that a patient has a fundamental right to control medical decisions “including the decision to have life-sustaining procedures withheld or withdrawn in instances of a terminal condition.” CAL. HEALTH & SAFETY CODE § 7185.5 (West 1991). California’s Administrative Code asserts that a patient is to actively participate in medical decisions and “to the extent permitted by law, this includes the right to refuse treatment.” CAL. CODE REGS. tit. 22, § 70707(6) (West 1991).


patient's choice may outweigh any case against the "rational" type of suicide proposed by Proposition 161.

Once the courts accept the general procedure, it is unlikely that they will be bothered by arguments that a patient lacked mental competence or that coercive pressures existed. As noted, the Bartling court was not influenced by Mr. Bartling's vacillation, depression, or alcoholism.\textsuperscript{238} In Bouvia, the court was forthright in admitting that one's motive is irrelevant: "if a right exists, it matters not what 'motivates' its exercise."\textsuperscript{239} Hence, if there is a right to physician-assisted death, the court will not delve deeply into the issues of mental competence and coercive pressures.\textsuperscript{240}

Similarly, courts may not even be bothered by active euthanasia in the case of non-terminal illnesses. Just as they went beyond the statutory language in Bouvia and Bartling to allow withdrawal of treatment for competent, non-terminal patients,\textsuperscript{241} they may allow physician-assisted death for the same. After all, it would be deemed hypocritical to argue that a lethal injection is less humane than the legal method of a slow, painful death after the withdrawal of treatment.\textsuperscript{242}

Of course, relying on the language of these cases could be dangerous, as active euthanasia is so different from passive euthanasia that the rule of stare decisis may not apply. Moreover, the most learned judges have been known to mold their rationales to the facts before them, and in the face of a procedure that so drastically diverges from the practices in almost every jurisdiction in the world, they may reserve the right to formulate a new rationale that fits their ultimate conclusion. Perhaps judges will realize the danger of physician aid-in-dying\textsuperscript{243} and will then take time to analyze the

\textsuperscript{238} See supra text accompanying notes 113-119.
\textsuperscript{240} Once physician-assisted death is accepted as a right or a quasi-right, any imposed limits would be viewed as arbitrary. See Rosenblum, supra note 34, at 26. Compare the abortion area, in which the procedure was initially proposed only for the "hard cases" (rape, incest, gross genetic defect, and preservation of the mother's life), but soon reached far beyond; "hard cases" make up less than five percent of the 1.5 million abortions performed annually in the United States. Id. at 8 (quoting Torres & Forrest, Why Do Women Have Abortions? 20 Fam. Plan. Persp. 169 (1988)).
\textsuperscript{241} See supra text accompanying notes 110-133.
\textsuperscript{242} Rosenblum, supra note 35 at 24.
\textsuperscript{243} See discussion infra part III.C.
possibility of alternatives such as hospice care and advisory boards before making a final conclusion.

C. The Danger of Physician Aid-in-Dying

Although the abstract principle of allowing a dying patient to be freed from a painful, undignified life is attractive, making a specific proposal is something else altogether. When the authors of such a proposal fail to take care in its drafting, and the courts will interpret the language broadly so as to affect more than just those mentioned in the legislation, care must be taken.

The argument that there will be an inevitable extension of a broadly tailored policy on physician aid-in-dying has been termed the “wedge principle” or the “parade of horrors objection.” One author uses pre-Nazi Germany to show a society where movies and books were used to convince people to accept euthanasia for the severely and chronically sick. Such acceptance, the author surmises, desensitized people and made possible the eventual atrocities of the Nazis. Although this argument may shock some as extreme and aberrational, the importance of valuing and respecting the existence of life for all groups cannot be denied.

Three groups in particular are potentially subject to abuse: the disabled, the elderly, and the financially disadvantaged. One disabled historian points out that “equating disability with terminal illness reflects not a person’s medical condition but their devaluated social status.” It has also been pointed out that many of the elderly who wish to die would not wish to die if we made an effort to touch them: “[I]f we were to encourage their suicide, it would abrogate our responsibility to eliminate the reasons for such despair.” Respectful measures, as proposed in the next section, must be taken to help the disabled and elderly improve their situations before we do nothing more than act to terminate such undesirables.

244. See discussion infra part IV.A.
245. See discussion infra part IV.B.
246. See Kamisar, supra note 204, at 138.
247. Id. at 139-40. This parallels the present popularity of Derek Humphry’s best-seller advocating euthanasia. See Humphry, supra note 13, at 20.
248. Kamisar, supra note 204, at 140.
249. Seawell, supra note 181, at 12.
IV. PROPOSED ALTERNATIVES

Due to the lack of care in drafting Proposition 161 and the probable interpretation by California’s courts, which would make physician aid-in-dying a reasonable standard for more than just the terminally ill, alternatives must be explored. Since it is highly likely that we will face this practice someday, we must face it intelligently. The following alternatives must be promoted as policy in conjunction with the legalization of physician-assisted death. Hospices and aid-in-dying boards would not necessarily replace physician aid-in-dying, but could serve to complement the practice.

A. The Case for Eliminating Pain and Other Symptoms: The Hospice Alternative

Physicians have the potential to make significant advances in eliminating the pain, fatigue, depression, and hopelessness that influence a patient’s decision. The majority of physicians, however, do not receive the training they need to eliminate all the factors that compel a patient to seek a physician’s aid-in-dying.251 The World Health Organization recommends that governments procure a pain relief policy before considering active euthanasia legislation.252 Such a policy should involve hospice care.

A hospice is a place where caregivers and family members join together to help the patient live his or her final days free from pain and depression.253 While a hospital is generally considered a poor place in which to die, the hospice is an attractive alternative. Considering that increasing numbers of people are dying in hospitals as a result of the increase of death from degenerative diseases,254 policies should be implemented to support hospices.

The hospice benefits both the patient and his or her family. Freed from pain by virtue of pain-killing drugs, the patient may become a person again in his or her final few weeks. It is certainly more dignified for one to die calmly in the hospice environment rather than being forced to make an

251. Foley, supra note 188, at 289, 295. See also supra text accompanying notes 218-219 (discussing physician training).
252. Foley, supra note 188 at 289, 293.
253. See generally Jack M. Zimmerman, Hospice: Complete Care for the Terminally Ill ix-x (1981).
impulsive decision to terminate one's life while pained and fatigued in a hospital. Moreover, hospice patients can still contribute to society, and the possibility of recovery, however remote, always remains.

The hospice staff not only strives to help the patient, but it also helps the patient's family. One goal of the hospice is to make sure the patient dies on the best possible terms with his or her family. For this reason, family members can visit during any hour of the day and can participate directly in the nursing. One can easily follow the story of a woman who attempted to care for her husband at home before the psychological stress from the situation hardened her and made her ignore her husband's complaints. Once he entered a hospice, she was able to cope with his illness and give him the love he desperately needed. Making the patient whole again and bringing families together at the bedside is what the hospice does best.

Family members also benefit independently of the patient. They can interact with and learn from other families who are facing a similar predicament. Moreover, the family environment of the hospice allows the patient's family members to seek counseling from the hospice's staff members—even after the death of their loved one.

Although there are potential benefits for both the patient and his or her family, some believe many aspects of the hospice are inappropriate. One scholar, Colin Brewer, objects to the primarily religious nature of the hospice movement in Britain. He says that many of the British hospices are run

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255. There are four fears a patient has: (i) being sustained in a vegetative state against her wishes, (ii) suffering a lingering death tormented by pain, (iii) losing control, and (iv) being an intolerable burden on her family. David Rehm & Edward Martin, The Hospice Response to Proposals of Assisted Suicide, 75 RHODE ISLAND MED. J 127, 128 (March, 1992). These fears can be shared with the hospice practitioners and resolved so that suicide is no longer desired; “when the patient is offered physician-supervised palliative care . . . the suicide option is no longer necessary.” Id. at 128.

256. For instance, one patient translated an autobiography in a doctor's library from French to English. HEIFETZ & MANGEL, supra note 1, at 162-63.

257. See ZIMMERMAN, supra note 1, at 45.

258. See id.

259. HEIFETZ & MANGEL, supra note 1, at 155.

260. Id. at 164.


262. Id. at 206
by religious "totalitarian[s]" who cannot claim to be running a "truly human, flexible, and comprehensive service."\(^{263}\) He tells the story of a hospice patient, Mrs. N, who consistently requested an immediate death by pleading, "[y]ou wouldn't treat a puppy like this, would you?"\(^{264}\) In return, the religious caregivers consistently responded, "God is with you, Mrs. N" and refused to fulfill her wish to die.\(^{265}\) Brewer's ultimate conclusion is that "hospices are fine for those people who choose to die the hospice way," but others, like Mrs. N, deserve the option of a quick and merciful death.\(^{266}\) In other words, Brewer supports a two-headed view whereby hospices and voluntary active euthanasia co-exist.\(^{267}\)

Such a two-headed view is potentially problematic in two ways. First, the effect of a neighboring patient who gives in and accepts voluntary active euthanasia has a profound effect in making the patient think he or she, too, should free his or her family of a burden; the right to die becomes a duty to die.\(^{268}\) Brewer counters that just as fertility measures and abortion procedures take place at the same institution, so too can physician-assisted death take place in a hospice.\(^{269}\)

The two-headed view is potentially problematic in a second way. When physician-assisted death becomes legal, there is less incentive to create hospices, and those who do not choose the physician-assisted death will either be denied a hospice because there are none,\(^{270}\) or feel guilt if they do enter a hospice. Such guilt could counter the effectiveness of the hospice in providing a comfortable, guilt-free, pain-free death.

To avoid the problems of a two-headed system, the ideal hospice must promote compassionate pain-healing and tran-

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\(^{263}\) Id. at 209. See also HUMPHRY, supra note 13. Humphry writes that the religious-based hospices are more likely to be found on the East Coast of the United States, while the more "humanitarian" hospices are found on the West Coast. Id. at 35.

\(^{264}\) Brewer, supra note 261, at 204.

\(^{265}\) Id. at 207.

\(^{266}\) Id. at 207.

\(^{267}\) Derek Humphry's Hemlock Society also supports such co-existence. See HUMPHRY, supra note 13.

\(^{268}\) Brewer, supra note 261, at 207.

\(^{269}\) Id. at 205.

\(^{270}\) In Holland, there are few hospices. Foley, supra note 188 at 289, 293. This can be attributed to the fact that accepting active euthanasia decreases the incentive to create hospices, or it can be attributed to the fact that the private individual in Holland has access to pain-killing drugs.
While privately run hospices are admirable, the state must be sure that people of all economic classes have access. The state can achieve this goal by setting up its own state-run facilities, or better yet, by ensuring that insurance companies will provide coverage for one’s stay in any hospice. If insurance companies are allowed to refuse coverage for hospice stays, the alternative of physician-assisted death becomes inordinately attractive for the financially disadvantaged.

Thus, hospices are an important part of the recommended pain-relief program. If both hospices and physician-assisted death are available, a patient will weigh the benefits of each. To make sure that one’s balancing is not improperly influenced by his or her lack of knowledge or by coercive pressures, an advisory board must be formed.

B. The Case for Proper Decision-Making: Advisory Boards

The drafters of Proposition 161 recognized the importance of collaborative decision-making in requiring that two independent physicians certify a patient’s request for aid-in-dying. But the “independence” of two physicians working in the same community is rare. Physicians tend to work in concert with others and rarely question one another’s professional judgment. In order to ensure that decision-making is truly collaborative, any proposal for physician aid-in-dying must include a provision for an advisory board.

Medical advisory boards are widely used by hospitals when allocating organs for transplant and when determining whether an experimental drug should be used on a particular patient. The interdisciplinary boards can be composed of physicians, ethics specialists, members of the clergy, and lawyers. Such diverse membership ensures that decisions will be made after consideration of all relevant ethical, moral, medical, and legal issues.

271. See supra text accompanying notes 165-166.
272. See Robertson, supra note 37, at 266 n.275.
273. See generally David C. Blake, The Hospice Ethics Committee: Health Cares’ Moral Conscience or White Elephant?, Hastings Center Rep. 6-11 (Mar.-Apr. 1992) (explaining the traditional functions of an ethics committee are three: (1) case review or consultation, (2) policy or guidelines development, and (3) education in the field of bio-ethics).
274. In Holland, the University Hospital of Utrecht recommends that doctors who are approached with a request for aid-in-dying are to protect themselves
1. Advantages of an Advisory Board

Collaborative decision-making serves two primary purposes: the board is used to ensure that the patient makes an informed, rational choice, and the board serves to protect the physician from liability. The board would make sure that the patient is fully exposed to information through the gathering of evidence and subpoenaing of witnesses. Dialogue regarding these issues would ensure that all possible options for a particular patient have been explored. While the Board deliberates, a "cooling-off" period is artificially manufactured for the patient, who can then reverse or revise what would otherwise be a hasty and irrevocable decision.

The existence of the board diffuses the responsibility for the physician as well. In light of the effect a doctor's close relationship may have on his or her decision-making, the board is important to ensure impartiality and to make sure that objectivity is not compromised. Without a board, a doctor is asked to play judge, a role for which he or she has not been trained. Without training, a doctor cannot identify, assess, and balance all the interests involved. Any one individual's decision will reflect his or her socio-economic class and personal biases. In sum, a decision-making body is from liability by reporting to a team consisting of the attending physician, the chief of service, and the head nurse. M.A.M de Wachter, supra note 8, at 3319 (1989). If this team reaches a unanimous agreement, then the issue is referred to the director of the hospital. If there is not a unanimous agreement, a consultative committee (to be nominated by the director) will make a final decision. For further information regarding recent legislation likely to take effect in 1994, see generally, supra note 8.


276. Such a waiting period had been advocated in order to diminish the influence of hyperbolic post-partum emotions in the event of parents considering involuntary euthanasia of defective newborns. Robertson, supra note 37, at 267 n.275. The Model Act also recommends a cooling-off period. See also Kurtz & Saks, supra note 5 at 125. Much of the disagreement with Proposition 161 can be attributed to the Act's failure to provide a waiting period. See CALIFORNIA BALLOT PAMPHLET, GENERAL ELECTION, Nov. 3, 1992, at 34 (1992) (rebuttal to argument in favor of Proposition 161).

277. See supra text accompanying notes 210-242.

278. See supra text accompanying notes 169-171; see also Robertson, supra note 38, at 264.

279. See Robertson, supra note 37, at 264.

280. Id.
better equipped than two quasi-independent physicians to make a dispassionate and socially desirable decision.281

2. Disadvantages of an Advisory Board

The disadvantage of the board is that it interferes with the patient's private decision. It may be inappropriate for investigators to be traipsing through the patient's hospital room during such a private time as his or her final days of life. Deliberation by the board prolongs the patient's death after he or she has already admitted that his or her life is not worth living.282 In short, the existence of the board means this will not be a purely private decision.

The board may also fail for other policy reasons. As each board at each hospital will make its decisions on a case-by-case basis, uniformity of decision will not be possible. Moreover, the board adds to the long list of committees that some believe already clog medical decision-making.283 Lastly, the board may be vulnerable to pressure to accept the physician's judgment. A proclivity to act in the hospital's interests rather than the patient's could lead to bias in the decision-making and an increase in hospital bureaucracy.284

3. The Likelihood of Boards Becoming Common Practice: Weighing the Advantages and Disadvantages

Without a statutory provision, it is unlikely that the California courts would recommend the formation of an aid-in-

281. Proposals for post-hoc review committees have also been made. See id. at 267. These mirror "tissue committees" of peer review. See id. In Holland, a proposal has been made to report each closed case to the coroner, who can then decide whether or not to send his findings along to the prosecutor. M.A.M. de Wachter, supra note 8, at 3316, 3319. The guidelines recently approved by Holland's lower house subsume this proposal. Jones, supra note 8, at A8. In light of the irrevocable finality of physician-assisted death, this comment encourages prevention of problems rather than post-hoc punishment.

282. The Model Act requires the board to meet within two business days following the request and to make its decision within seven days of the request, but in no event is the board to take more than 30 days. Kurtz & Saks, supra note 5, at 125 § 9-102.

283. See Robertson, supra note 38, at 264-65.

dying board. The Bouvia court explained that a board would be superfluous.\footnote{285 See supra text accompanying notes 126-127. But cf. In re Quinlan, 355 A.2d 647, 672 (N.J. Sup. Ct. 1976) (recommending the formation of a medical board). See also supra text accompanying notes 63-65.}

Perhaps the case of active euthanasia could be distinguished, however, in that more than just an individual's autonomous decision is at stake; issues of competence, coercion, physicians' roles, and society's traditional disgust for suicide abound. After all, the Bouvia court stated that cutting short one's life is "far different"\footnote{286 See supra text accompanying notes 133, 234.} from allowing the natural dying process to take place. When we legalize affirmative steps towards killing someone, there is a greater potential for interfering with the state's interest in preserving life.

Once we distinguish active euthanasia, the advantages of an advisory board can be seen to outweigh its disadvantages. Short time delays and slight interferences with the patient's privacy in his or her hospital room are a small price to pay for ensuring the protection of an individual's choice. The formation of an advisory board can help to ensure that the decision being made is truly rational and that the socially desirable outcome takes place. The drafters of Proposition 161 recognized a need for some level of collaborative decision-making here, and the existence of an advisory board ensures that the responsibility for the decision will be diffused.

V. CHECKLIST OF PROPOSALS

In the future, any policy maker, drafter, or voter considering a statute to legalize physician-assisted death should consider the following:

1.) The Statute's Objective: The state and its people have a strong interest in preserving life and in preventing desensitization to the taking of a life. Concomitant with any legalization of physician-assisted death, the state must promote attractive alternatives to the procedure. Moreover, appropriate safeguards must insulate one's choice from influential factors.

2.) The Statute's Directive: (i) The statute should provide for advanced directives, preferably made before the onset of illness, but subject to change at any time, and change should be encouraged; (ii) The specific request for physician-assisted
death must be made on two occasions; (iii) At least a 24-hour waiting period must separate the two requests.

3.) The Family: (i) A physician must ask the patient if he can notify a family member or friend; (ii) In the event the patient chooses a third party to be notified, the physician must take all reasonable measures to notify that person; (iii) In the event the patient does not want anybody notified, the physician must heed the patient's desire; (iv) In the event a patient chooses to have someone notified and that person strongly opposes the procedure, the physician must focus on his relationship with and knowledge of the patient in determining whether or not the procedure should be carried out.

4.) Terminal Illness Mandated: (i) The patient must be terminally ill; (ii) Under no circumstances will this procedure be extended to a person who is not terminally ill.

5.) Advisory Board: (i) Interdisciplinary advisory boards composed of physicians, ethicists, lawyers, or psychologists must be formed; (ii) Whenever the procedure is requested, the advisory board must be notified in order to make the determination that the statute's requirements are followed; (iii) Immediately after the patient makes his or her initial request, the board should begin its fact-finding process. The board must act under the rebuttable presumption that the patient has made a voluntary choice; (iv) The advisory board must act by majority vote within three days of the initial request.

6.) Physicians: (i) At least two physicians, in addition to those serving on the advisory board, must authorize the request; (ii) One of the authorizing physicians should be the patient's primary attending physician; (iii) The other physician must have at least ten years' experience in diagnosing terminal diseases and working with the terminally ill. This physician will be specially licensed after receiving training in how to advise the patient, how to best estimate when a patient is truly terminal, and how to determine whether the patient and physician have followed the legal requirements. This physician must be associated with a hospice program.

7.) Hospices: (i) Physician-assisted death is unavailable if the physician does not apprise the patient of the hospice alternative; (ii) Public and private insurance must fund hospice care as they would fund hospital care.
8.) **Insurance:** (i) Insurance companies must not actively promote physician-assisted death; (ii) Insurance companies do not have causes of action against physicians for pursuance or non-pursuance of physician-assisted death; (iii) Rate schedules for the care of the terminally ill must not diverge from the rate schedules composed for other forms of care.

Anyone facing a proposal attempting to legalize physician-assisted death should consider the areas listed above.

VI. **CONCLUSION**

This comment has explored the motivation for and possibility of physician-assisted death becoming law. In November of 1992, voters in California narrowly rejected Proposition 161, which would have legalized the practice. Before such a measure is proposed again, the language will have to be clearer to ensure against loopholes and provide safeguards against abuse. The near-victory for Proposition 161 indicates that the proper safeguards would have garnered a majority vote and that the time for legalized physician-assisted death is nearing. The courts will likely accept what the voters accept.

Neither the voters nor the courts, however, should ignore alternatives to physician-assisted death. Encouraging the use of hospices and the formation of advisory boards will ensure that the legal killing, as authorized by voters, is not abused. To ignore the alternatives is to make physician-assisted death the only option. When the state fails to encourage alternatives, it is implicitly supporting physician-assisted death while failing to maintain its interest in the preservation of life. A government that does not act to preserve the lives of its citizens is not a noble government.

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