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Death with Dignity: Governance of the Most Personal of Decisions

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Death with Dignity: Governance of the Most Personal of Decisions

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I. Introduction

As medical science progressed to a point where people live longer than they desire, a movement arose demanding the right for a competent and informed person to end their life on their own terms.¹ In November of 1997 Oregon became the first state to allow citizens to legally end their own life in certain situations of terminal illness.² Oregon may have been first because of its tradition of individualism, progressive thinking and citizen involvement in community affairs.³ My home state, New Jersey, is now considering implementing its own Death With Dignity Act heavily influenced by the Oregonian original, introduced by Assemblyman John Burzichelli on September 27, 2012.⁴ As a citizen of New Jersey, I am left with the question, what types of governance are appropriate to regulate such a personal, individual issue and what role should the government play? Oregon chose, and New Jersey is now potentially copying, to leave government out of the policing role, and instead simply lay a foundation of protective procedure

¹ *Cruzan v. Director, Mo. Dept't of Health*, 497 U.S. 261, 270 (1990) (Brennan, J., dissenting) (“Medical technology has effectively created a twilight zone of suspended animation where death commences while life, in some form, continues.”); Tom L. Beauchamp, *The Justification of Physician-Assisted Deaths*, 29 IND. L. REV. 1173, 1175 (1996) (“[L]etting a patient die by accepting a valid refusal to continue in life is directly analogous to helping a patient die by accepting a valid request rather than forcing the patient to continue in life.”).

² O.R.S. 127.800-897; Raphael Cohen-Almagor & Monica G. Hartman, *The Oregon death with Dignity Act: Review and Proposals for Improvement*, 27 LEGIS. 269, 270-71 (2001). Oregon originally approved by ballot initiative the Death With Dignity Act in 1994. However, a constitutional challenge delayed implementation until another ballot initiative in 1997. See *Lee v. Oregon*, 891 F. Supp. 1439 (D. Or. 1995), enforcing 891 F. Supp. 1421 (D. Or. 1995); Kim Murphy, *Voters in Oregon Strongly Endorses Assisted Suicide*, L.A. TIMES, Nov. 5, 1997, at A1.

³ Susan Hedlund, *Death with Dignity: The Oregon Experience*, THE FORUM (2005), available at http://www.adec.org/AM/Template.cfm?Section=Resources_and_Links&Template=/CM/ContentDisplay.cfm&ContentID=1417; Carol A. Pratt, *Efforts to Legalize Physician-Assisted Suicide in New York, Washington and Oregon: A Contrast Between Judicial and Initiative Approaches – Who should Decide?*, 77 OR. L. REV. 1027, 1100 (1998) (“Demographically, Oregonians are recognized as placing a high value on personal choice and autonomy.”).

⁴ Assembly, No. 3328, 215th Leg. (N.J. 2012); Times of Trenton Editorial Board, *N.J. Death with Dignity Act deserves serious consideration*, NJ.com (Oct. 02, 2012, 6:52 AM), http://www.nj.com/times-opinion/index.ssf/2012/10/editorial_nj_death_with_dignit.html.

as well as annual reporting which ensures some moderate level of monitoring.⁵ Oregon's model seems to be an appropriate balance between allowing individual autonomy and protecting terminally ill patients from doctors and from themselves.

II. How Should a State Decide: Legislation, Judicial, Initiative

States may obtain some form of a right to die through three processes. Each has its own advantages and disadvantages in terms of how the governance structure is decided, what that structure will look like and the acceptance of the governance structure by the citizens of the state.

Montana citizens obtained their right to die through a court decision⁶, which led to a rather drastic difference in experience from Oregon and Washington. The legislature has not been able to decide on any governance structure, leaving Montana with a right to die but no procedural process or standard of care.⁷ The legislature actually tried to statutorily overrule the court more times than they tried to pass any kind of regulations regarding physician assisted suicide.⁸ Montana serves as an example as to why obtaining a right to die through the courts is inefficient, and simply leads to more conflict.

In order to efficiently impellent physician assisted suicide, the right along with procedures should be codified from the start. Therefore, legislatures seem to be the most appropriate method of implementing death with dignity. Despite evidence of majority support⁹

⁵ O.R.S. 127.800-897; Assembly, No. 3328, 215th Leg. (N.J. 2012) *available at* http://www.njleg.state.nj.us/2012/Bills/A3500/3328_I1.PDF.

⁶ *Baxter v. Montana*, 354 Mont. 234 (2009).

⁷ DEATH WITH DIGNITY NATIONAL CENTER, *History*, <http://www.deathwithdignity.org/history>.

⁸ *Id.*

⁹ The Right to Die, *ECONOMIST*, Sept. 17, 1994 at 14; Mark O'Keefe & Tom Bates, *The Freedom to Die*, *OREGONIAN* (Portland), Jan. 5, 1997, at B1 (reporting independent polls by the National Conference of Catholic Bishops and The Washington Post showing over 50% of Americans favor legalizing physician assisted suicide).

state legislatures remain reluctant to pass any kind of death with dignity legislation.¹⁰ In many cases, legislatures actually shifted to actively blocking initiatives rather than pushing them through.¹¹ This passivity is perceived to be motivated more by survival, avoidance of controversial issues, rather than ideology.¹² New Jersey is but one of at least ten States considering some form of death with dignity legislation, but only two, Oregon and Washington, legalized physician assisted suicide.¹³

If the courts are inefficient and legislatures unwilling, then the onus falls upon the people. Oregon and Washington passed their Death with Dignity Acts through ballot initiatives.¹⁴ Voter initiatives are not without their criticisms. They are sometimes considered tools for the majority to impose its will over the rights of minorities.¹⁵ Other times, voter initiatives are regarded as puppets of special interest groups.¹⁶ However, evidence suggests that legislatures share many of the process flaws attributed to initiatives, and often legislatures are not any more knowledgeable than voters on some proposed laws.¹⁷ Oregon demonstrates how voter initiatives can be

¹⁰ Pratt, *supra* note 3 at 1117.

¹¹ *Id.*

¹² *Id.*

¹³ DEATH WITH DIGNITY NATIONAL CENTER, *Advocates*, <http://www.deathwithdignity.org/advocates/national>.

¹⁴ DEATH WITH DIGNITY NATIONAL CENTER, www.deathwithdignity.org.

¹⁵ Julian N. Eule, *Judicial Review of Direct Democracy*, 99 YALE L.J. 1503, 1505 (1990); Pratt, *supra* note 3 at 1118.

¹⁶ Clayton P. Gillette, *Plebiscites, Participation, and Collective Action in Local Government Law*, 86 MICH. L. REV. 930 (1988); Pratt, *supra* note 3 at 1118.

¹⁷ Pratt, *supra* note 3 at 1119; Jack L. Landau, *Interpreting Statutes Enacted by Initiative: An Assessment of Proposals to Apply Specialized Interpretive Rules*, 34 WILLAMETTE L. REV. 487, 514 (1998); John Copeland Nagle, *Direct Democracy and Other Hastily Enacted Statutes*, 1996 ANN. SURVEY AM. L. 535, 544-45 (1996). Nagle concludes that the differences between direct democracy and legislative processes are “real but exaggerated.”

effective, especially when dealing with controversial issues without a discernible “minority” group.¹⁸

Proponents of the voter initiative to legalize physician assisted suicide in Oregon were members of the “majority group,” non-terminally ill people. In general, proponents around the United States of physician assisted suicide are non-terminally ill people.¹⁹ Neither the Oregon DWDA’s sponsors, nor the majority of Oregonians who voted to legalize physician assisted suicide, nor the majority of Americans who support physician assisted suicide knew or know at the time of the vote whether they would ever be terminally ill and would therefore benefit from a Death with Dignity act. Importantly, the Oregon DWDA grants, rather than limits, a right to the minority group of terminally ill patients.

Well funded special interest groups actually opposed physician assisted suicide. In both the initiative and referendum elections in Oregon, large institutional lobbies opposing physician assisted suicide, such as the Roman Catholic Church, the Mormon Church, the AMA and Right to Life groups outspent supporters of physician assisted suicide.²⁰ While these lobbies effectively influenced the Oregon legislature to try and repeal the Oregon Act, they were not effective in influencing the electorate.²¹ The 1994 and 1997 elections on physician assisted suicide reflected the individual choice of Oregon voters.

Oregon serves not only as a model of governance for physician assisted suicide, but also as a model for how a State should decide whether to legalize and how to regulate physician

¹⁸ Nick Krieger, a citizen of Oregon and student at Seton Hall University School of Law, stated in an interview that he thought the Oregon DWDA was a good illustration of the ballot initiative process. Interview with Nick Krieger, Student, Seton Hall University School of Law, in Newark, N.J. (Nov. 20, 2012).

¹⁹ DEATH WITH DIGNITY NATIONAL CENTER, <http://www.deathwithdignity.org>.

²⁰ Pratt, *supra* note 3 at 1122.

²¹ *Id.*

assisted suicide. The issue seems perfect for the voter initiative process. The majority of Americans support a right to die, but legislators do not seem to be willing, as a collective, to agree. Therefore, it might be wise for citizens and legislators, such as Assemblyman John Burzichelli of New Jersey, to submit their DWDA proposals to a voter initiative. Assemblyman Burzichelli chose to include the citizens in New Jersey to the fullest extent allowed (in New Jersey) by submitting the bill to a voter referendum after legislative approval.²²

III. Current Models of Governance

Oregon is not the only state to have adopted, in some manner, a right to die. Washington copied the Oregon model of a statute enacted through a ballot initiative. Montana also allows self-administered suicide for terminally ill patients, however not through statute. Instead, the Montana Supreme Court found a right to die with dignity within the State's criminal code. All three provide examples of State experimentation with governance of a patient's ability to end their life when faced with terminal illness.

A. The Oregon Model: The Original Death With Dignity Act

The Oregon Death With Dignity Act (hereinafter DWDA) essentially establishes a procedural process for a terminally ill patient's acquisition of a prescription for drugs which will end that patient's life. As always, a few key definitions are needed in order to avoid confusion.

According to Oregon's DWDA, capable means that in the opinion of a court, the patient's

²² Assembly, No. 3328, 215th Leg. (N.J. 2012) ("The bill will only become operative if approved by the voters in a Statewide referendum"). The trend for supporters of physician assisted suicide is to submit the bills to a state ballot initiative, or at least to a referendum following legislative approval. The former takes all pressure off the legislators, while the later takes some pressure off legislators from making a decision on such a controversial issue. *See also* House Bill 3884 (Mass. 2011), *available at* <http://www.malegislature.gov/Bills/187/House/H03884> (Initiative petition of Marcia Angell for the passage of a death with dignity act which failed to pass. Although the initiative failed, it does show the trend and preference currently for proponents of physician assisted suicide for voter initiatives).

attending physician, consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.²³ An informed decision is a decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of his or her medical diagnosis, his or her prognosis, the potential risks associated with taking the medication to be prescribed, the probable result of taking the medication to be prescribed and the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.²⁴ Finally, a terminal disease is an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.²⁵

The only person who may initiate a request for medication is an adult who is capable, has been determined by the attending and consulting physician to be suffering from a terminal disease, and has voluntarily expressed his or her wish to die.²⁶ The patient must make two oral requests before making a third written request.²⁷ At the second request, the physician must offer the patient an opportunity to rescind the request.²⁸ No less than fifteen days may elapse between the patient's initial oral request and the writing of a prescription and no less than forty-eight hours may elapse between the written request and the writing of a prescription.²⁹

²³ O.R.S. 127.800.

²⁴ *Id.*

²⁵ *Id.*

²⁶ O.R.S. 127.805.

²⁷ O.R.S. 127.840.

²⁸ *Id.*

²⁹ O.R.S. 127.850.

Oregon requires that the written request be made similar to a provided form.³⁰ The form must be signed, dated and witnessed by at least two individuals, one of which may not be a relative or an employee at the facility where the patient is receiving care or a person to receive anything in the estate.³¹ The process of formalizing the written request bears striking resemblance to the onerous traditional procedures for signing and finalizing a will.

The patient's attending physician has several specific responsibilities. The attending must make sure the patient is informed, recommend that the patient notify next of kin and counsel the patient about the importance of having another person present when taking the medication.³² A second consulting physician must confirm the diagnosis of terminal disease and verify that the patient is making a voluntary and informed decision.³³ Medication to end life may not be prescribed until the person is confirmed to not be suffering from a psychiatric or psychological disorder or depression causing impaired judgment.³⁴

Oregon also places a burden on the government to collect annual data regarding compliance with the DWDA.³⁵ Any health care provider, upon dispensing medication pursuant to the DWDA, must file a copy of the dispensing record with the Oregon Department of Human Services. ("OHS").³⁶ The OHS must collect this information, but keep it private.³⁷ However, the OHS must also release annually a statistical report of the information received regarding the DWDA.³⁸

³⁰ O.R.S. 127.810. The sample form can be found at O.R.S. 127.897.

³¹ O.R.S. 127.810.

³² O.R.S. 127.815.

³³ O.R.S. 127.820.

³⁴ O.R.S. 127.825.

³⁵ O.R.S. 127.865.

³⁶ *Id.*

³⁷ *Id.*

³⁸ *Id.*

B. The Washington Model: If it Aint' Broke, Don't Fix It

In November 4, 2008 Washington passed its own Death with Dignity Act through Ballot Initiative 1000.³⁹ The Washington act was inspired and influenced by the Oregon DWDA. In fact, the Washington Act is nearly identical to the Oregon DWDA and does not differ in any material way.⁴⁰ Therefore, at least one state, and its citizens through the ballot initiative, approve of the governance structure of the Oregon DWDA.

Relevantly, New Jersey decided to follow Washington's example and follow Oregon's example. The New Jersey proposed DWDA is also nearly identical to Oregon's.⁴¹

C. The Montana Model: A Judicial Approach

In Montana, a terminally ill Robert Baxter suffering from lymphocytic leukemia asked his doctors for a lethal dose of medication which he could self-administer.⁴² The physicians brought a case claiming the Montana homicide statute was not constitutional, alleging that patients had a right to die with dignity under the Montana Constitution.⁴³ The Montana Supreme Court ruled that rather than a constitutional issue, a patient's consent to physician aid in dying constitutes a valid statutory defense to a charge of homicide against the physician pursuant to Mont. Code Ann. §45-2-211.⁴⁴

Montana's homicide statute establishes consent as a defense, stating that the "consent of the victim to conduct charged to constitute an offense or to the result thereof is a defense."⁴⁵ Using this language, the Montana Supreme Court held that "a terminally ill patient's consent to

³⁹ Janet Tu, *Death with Dignity act passes*, THE SEATTLE TIMES (November 5, 2008) available at http://seattletimes.com/html/nationworld/2008352350_assistedsuicide05m.html.

⁴⁰ R.C.W. 70.245.010 – 904.

⁴¹ Assembly, No. 3328, 215th Leg. (N.J. 2012)

⁴² Baxter, *supra* note 6 at 237.

⁴³ *Id.* at 237-38.

⁴⁴ *Id.* at 237; M.C.A. §45-2-211.

⁴⁵ M.C.A. §45-2-211.

physician aid in dying constitutes a statutory defense to a charge of homicide against the aiding physician when no other consent exceptions apply.”⁴⁶

Several bills have been introduced to the Montana legislature in response to the Court’s ruling.⁴⁷ One was based on the Oregon and Washington DWDAs and tried to codify and put some structure around the Court’s decision.⁴⁸ Two others attempted to overturn the court’s ruling. All three bills failed to be passed.⁴⁹ As such, Montana still does not have any standard of care or procedure with regards to its citizen’s right to die.

Montana’s path to a right to die, though interesting, provides little guidance on appropriate governance for the issue. Other than the existence of the right, nothing is set in stone regarding the substance and procedure of how a patient may obtain life-ending medication. Therefore, Montana does not provide a good example of governance regarding prescribing terminally ill patients with life-ending medication.

With Montana out, and with Washington and New Jersey copying Oregon, the only United States example available is the Oregon DWDA.

D. The Swiss Model: Active Policing

Switzerland allows assisted suicide through its criminal code.⁵⁰ The criminal code states that “a person who, for selfish reasons, incites someone to commit suicide or who assists that person in doing so will, if the suicide was carried out or attempted, be sentenced to a term of

⁴⁶ Baxter, *supra* note 6 at 251. The Court drew implied legislative support from Montana’s Terminally Ill Act, which allows the taking away of, or refraining from giving life-sustaining medical treatment. The Court believed the Terminally Ill Act demonstrated an intent to a right for patients to have their end of life wishes followed.

⁴⁷ DEATH WITH DIGNITY NATIONAL CENTER, *History*, <http://www.deathwithdignity.org/history>.

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ SCHWEIZERISCHES STRAFGESETZBUCH art. 115 (Switz.); Stephen J. Ziegler, *Collaborated Death: An Exploration of the Swiss Model of Assisted Suicide for its Potential to Enhance Oversight and Demedicalize the Dying Process*, 37 J.L. MED. & ETHICS 318, 322 (2009).

imprisonment of up to five years.”⁵¹ However, a person so charged may avoid conviction by proving that they were “motivated by the good intentions of bringing about a requested death for the purposes of relieving suffering.”⁵² Because assisted suicide in Switzerland is facilitated through the criminal code, the police investigate every death.⁵³

IV. What Level and Type of Governance is Appropriate From Government

Government has many governance options available when dealing with medical issues. However, the United States federal and state governments decided to take a back seat to regulation of the medical field. Physicians are largely left to their own devices. Oregon chose to continue this tradition in regards to physician assisted suicide.

A. Oregon’s Form of Governance

Oregon removes the state from the process of a physician prescribing a lethal dose of medication. For the most part, the law simply provides a procedural framework for physicians and patients to ensure an informed decision by a competent terminally ill patient. For example, rather than a government official or agency overseeing the initial request, the Oregon DWDA simply requires two verbal requests followed by a written request, with the whole interaction occurring between doctors and patients.⁵⁴ The government sets up the procedure, then steps away. This one example is a microcosm of the entire governance structure set up by the Oregon DWDA.

Oregon’s decision to not to actively police or investigate each lethal prescription demonstrates the most extreme removal of the government from the process. The act does not set

⁵¹ STGB art. 115.

⁵² RAYMOND WHITLING, *A NATURAL RIGHT TO DIE: TWENTY-THREE CENTURIES OF DEBATE* (2002).

⁵³ Ziegler, *supra* note 50 at 323-24.

⁵⁴ O.R.S. 127.840.

up any active form of investigation or monitoring of the physicians or the patients.⁵⁵ Instead, the Oregon DWDA creates a passive method of monitoring, leaving the doctors largely to their own devices unless an egregious mistake is made.

The Oregon DWDA requires the Oregon Department of Human Services to monitor compliance with the law.⁵⁶ However, the OHS essentially collects information simply to determine how many individuals receive the prescriptions, how many ultimately take the medication and assess whether or not the procedural safeguards built into the Act are being followed.⁵⁷ Further, the sole responsibility for monitoring the DWDA rests with the OHS.⁵⁸

There are three reporting requirements. First, within seven calendar days of writing a prescription for medication to end the life of a qualified patient, the attending physician must send the following completed, signed and dated documentation to OHS: the patient's completed written request for medication to end life, a compliance form supplied by the OHS, a consulting compliance form supplied by the OHS and a psychiatric/psychological consultant's compliance form supplied by the OHS if an evaluation was performed.⁵⁹ Second, within 10 calendar days of a patient's ingestion of lethal medication obtained pursuant to the DWDA, or death from any other cause, the attending physician must complete the "Oregon Death with Dignity Act Attending Physician Interview" form supplied by the OHS.⁶⁰ The Attending Physician Interview

⁵⁵ Ziegler, *supra* note 50 at 322.

⁵⁶ O.R.S. 127.865; ROBIN LUNGE, OREGON'S DEATH WITH DIGNITY LAW AND EUTHANASIA IN THE NETHERLANDS: FACTUAL DISPUTES (2004), *available at* http://www.leg.state.vt.us/reports/04death/death_with_dignity_report.htm#Section4; Katrina Hedberg, *Oregon Department of Human Services Reporting*, in THE OREGON DEATH WITH DIGNITY ACT: A GUIDEBOOK FOR HEALTH CARE PROFESSIONALS (Patrick Dunn & Bonnie Reagan eds., 2007).

⁵⁷ Hedberg, *supra* note 56.

⁵⁸ Lunge, *supra* note 56.

⁵⁹ O.A.R. 333-009-0020; Hedberg, *supra* note 56.

⁶⁰ O.A.R. 333-009-0020; Hedberg, *supra* note 56.

form is a very simple survey form to determine the circumstances surrounding the death of the patient. For example, the form asks questions such as on what day the patient consumed the lethal dose of medication, and who was present at the patient's death.⁶¹ The form is filled out by the attending physician on his or her own, not by any OHS investigator who actually interviews the physician.

Finally the third reporting requirement mandates that within ten days of dispensing medication pursuant to the DWDA, the dispensing health care provider must submit a copy of the "Pharmacy Dispensing Record" form supplied by the OHS.⁶² Information to be reported on this form includes the patient's name and date of birth, the prescribing physician's name and phone number, the dispensing health care providers name, address and phone number, medication dispensed and quantity, the date the prescription was written and the date the medication was dispensed.⁶³

The OHS simply receives administrative information through their data collection process. The agency ensures the proper procedures were followed, and nothing more. No regulation of the specific conversation between the attending physician, consulting physician and the patient (so long as physician provides the patient with information so that patient may make an informed decision).⁶⁴ Strikingly, there seems to be no monitoring on the part of the OHS

⁶¹ Attending Physician Interview Form, *available at* <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/mdintdat.pdf>.

⁶² O.A.R. 333-009-0020; Hedberg, *supra* note 56.

⁶³ O.A.R. 333-009-0020; Hedberg, *supra* note 56; Pharmacy Dispensing Record form, *available at* <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/pharform.pdf>.

⁶⁴ O.A.R. 333-009-0020; Hedberg, *supra* note 56.

regarding the necessity of a psychiatrist or psychologist.⁶⁵ The Oregon DWDA, and the resulting reporting regulations, trust the attending and consulting physician to make that call on their own, without any real policing (besides, of course, the threat of a medical malpractice lawsuit).

The Oregon method may be contrasted by the Swiss method of monitoring. In Switzerland each case of assisted death must be investigated by the police to determine if the suicide was in compliance with the law.⁶⁶ If patients believe the process of death should be demedicalized and the government should have a policing role, the Swiss method seems superior. However, if patients believe in a strong doctor-patient relationship and keeping government out of the practice of medicine and out of their end of life wishes, then the Oregon method appears to be the stronger option.

B. What do the Numbers Say about Oregon's Governance of Physician Assisted Suicide

The Oregon DWDA requires the OHS to obtain data regarding the use of the Act by physicians to issue prescriptions for self-administered lethal doses of medications and to submit an annual, public report.⁶⁷ Since the law was passed, a total of 935 people have had DWDA prescriptions written and 596 patients died from ingesting medications prescribed under the DWDA.⁶⁸ Deaths from DWDA prescriptions steadily increased from sixteen in 1998 to seventy-one in 2011.⁶⁹ Most (94.1%) patients died at home and most (96.7%) were enrolled in hospice

⁶⁵ O.A.R. 333-009-0020; Hedberg, *supra* note 56.

⁶⁶ Ziegler, *supra* note 50 at 323-24.

⁶⁷ O.R.S. 127.865; OREGON HEALTH AUTHORITY, *Annual Reports*, <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>.

⁶⁸ 2011 Summary. These numbers are far lower than the number of deaths through Do Not Resuscitate orders. See footnote 108.

⁶⁹ Oregon Public Health Division, Oregon's Death with Dignity Act 2011 summary, *available at* <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year14.pdf>.

care either at the time the DWDA prescription was written or at the time of death.⁷⁰ The three most frequently mentioned end-of-life concerns in 2011 were decreasing ability to participate in activities that made life enjoyable (90.2%), loss of autonomy (88.7%) and loss of dignity (74.6%).⁷¹ Only one of the seventy-one DWDA patients who died during 2011 was referred for formal psychiatric or psychological evaluation.⁷² Sixty-two physicians wrote the 114 prescriptions provided during 2011.⁷³

During 2011, no referrals were made to the OHS for failure to comply with DWDA requirements. Between 2006 and 2010, fourteen referrals were made to the Board of Medical Examiners or to OHS for failing to comply with the DWDA requirements.⁷⁴ None of these referrals were found to be violations of good faith compliance, and none of the physicians were sanctioned for unprofessional conduct regarding the DWDA.⁷⁵ Ten of these referrals were made in 2006, when the standardized forms were created or revised.⁷⁶

The data shows no cause for concern in regards to physician malfeasance. The evidence suggests Oregon was correct in granting physicians deference, and allowing the health care community to self-regulate with regard to DWDA compliance. Of course, because of the lack of policing, physicians may provide physician assisted suicide without reporting it. However, with legalization under the DWDA, physicians lack significant motivation to not report and risk

⁷⁰ *Id.*

⁷¹ *Id.*

⁷² *Id.*

⁷³ *Id.*

⁷⁴ Oregon Public Health Division, Oregon's Death with Dignity Act 2011-2006 summaries, *available at* <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>.

⁷⁵ *Id.*

⁷⁶ Oregon Public Health Division, Death with Dignity Forms, *available at* <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/pasforms.aspx>.

sanction. Only one disturbing trend appeared after analysis of the reasons terminally ill patients chose to end their life using the DWDA.

In the first report, a relatively low proportion of married persons participating led to concerns that socially isolated patients might be more likely to use physician assisted suicide than patients with better social support.⁷⁷ However, after obtaining a larger sample size through years two and three, an increasing proportion of married participants showed that the proportions of married, widowed, divorced or never married physician assisted suicide patients resembled those seen amongst other Oregonians dying from similar diseases.⁷⁸

Another trend detected with the DWDA data collected by the OHS actually led to better health care quality. Physicians consistently reported that concerns about loss of autonomy and decreased ability to participate in activities that make life enjoyable were important motivating factors.⁷⁹ This realization led doctors and other medical providers to explore with patients their fears and wishes around end-of-life care, and to make patients aware of other options.⁸⁰ Often, once a patient's concerns have been addressed by the provider, he or she may choose not to pursue physician assisted suicide.⁸¹ The availability of physician assisted suicide has driven doctors to address other end-of life care options more effectively, and physicians report that since the passage of the DWDA they have made efforts to improve their knowledge of the use of

⁷⁷ Oregon Public Health Division, Oregon's Death with Dignity Act 1998 summary, *available at* <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year1.pdf>.

⁷⁸ Oregon Public Health Division, Oregon's Death with Dignity Act 2000 summary, *available at* <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year3.pdf>.

⁷⁹ Oregon Public Health Division, Oregon's Death with Dignity Act 2004 summary, *available at* <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year7.pdf>.

⁸⁰ *Id.*

⁸¹ *Id.*

pain medications in the terminally ill, to improve their recognition of psychiatric disorders such as depression and to refer patients more frequently to hospice.⁸²

C. Federal Governance of Medicine

The privacy and autonomy of the doctor-patient relationship in the United States remains sacrosanct and protected by law and tradition.⁸³ Protecting the confidentiality of doctor-patient communications results in societal health benefits such as accurate diagnosis and treatment due to increased disclosure for a promise of secrecy.⁸⁴ Furthermore, The Supreme Court of the United States enshrined the right to privacy within the penumbra of rights found within the United States Constitution.⁸⁵ Americans value individuality and autonomy. Typically, American citizens do not welcome the government into their private lives, and as a reflection Congress saw fit to limit the governments intrusion into the practice of medicine.

Congress entrusted the Food and Drug Administration to regulate food, drugs and cosmetics.⁸⁶ However, Congress explicitly stated that “nothing in this chapter shall be construed to limit or interfere with the authority of a health care practitioner to prescribe or administer any legally marketed device to a patient for any condition or disease within a legitimate health care practitioner-patient relationship.”⁸⁷ The Food Drug and Cosmetic Act clearly shows, at least at the federal level, the intention of the government to remove itself from the practice of medicine. Instead, the physician is left in control and the doctor-patient relationship held in high regard.

⁸² *Id.*

⁸³ Ziegler, *supra* note 50 at 323; Joseph Glenn White, *Physicians’ Liability for Breach of Confidentiality: Beyond the Limitations of the Privacy Tort*, 49 S.C. L. REV. 1271 (1998).

⁸⁴ White, *supra* note 83 at 1272-73.

⁸⁵ *Griswold v. Connecticut*, 381 U.S. 479 (1965).

⁸⁶ 21 U.S.C. §301 – 399F.

⁸⁷ 21 U.S.C. §396.

Another example of the United States' policy of letting medicine regulate itself is the Joint Commission. A private, non-profit organization, the Joint Commission is a national system for monitoring healthcare quality.⁸⁸ The Joint Commission provides a voluntary accreditation process that sets performance measures which must be met by participating providers before receiving the Joint Commission's accreditation.⁸⁹ The Joint Commission's accreditation is highly sought after because the Centers for Medicare and Medicaid Services deem a hospital's accreditation as a sufficient indication that the hospital meets the Centers for Medicare and Medicaid Services conditions for participation, allowing a hospital to receive Medicare and Medicaid payments.⁹⁰ Yet again, Congress chose to entrust regulation of the practice of medicine, this time in hospitals, to the practitioners themselves.

D. Is the Oregon Model Appropriate, or Should the Government Take More Control

By foregoing any form of policing, investigation or even requiring any type of self-regulation through committees Oregon placed a lot of faith in its physicians. Although the OHS does facilitate some monitoring, the monitoring program simply collects what amounts to administrative data.⁹¹ No independent committee of doctors reviews the data.⁹² Doctors are trusted to regulate themselves and simply report the result to the OHS. If people fear doctors covering up or pushing their patients to a decision they would not normally make, perhaps they would prefer the Swiss method.⁹³

⁸⁸ The Joint Commission, *About the Joint Commission*,

http://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx.

⁸⁹ Teresa Schreffler, *Systems Approaches to Improving the Quality of Healthcare: Strengths, Weaknesses, and the Ideal Model of Medical Error Reporting*, 53 U. KAN. L. REV. 1249 (2005).

⁹⁰ *Id.* at 1260.

⁹¹ O.A.R. 333-009-0020; Hedberg, *supra* note 56.

⁹² O.A.R. 333-009-0020; Hedberg, *supra* note 56.

⁹³ Ziegler, *supra* note 50.

It seems, however, the Oregon method does a better job of balancing the interests of the three parties involved. The State regulates procedures to protect patients and ensure informed decisions from competent individuals. Doctors retain their autonomy and ability to practice medicine in the best interest of their patients, without government influence. Terminally ill patients are able to obtain medication to bring death with dignity privately, with just a discussion with their doctors and their families. The balance struck can satisfy all parties, and deprives none of their traditional role. The private relationship between a doctor and patient remains undisturbed. Although, through the reporting requirements, the government does obtain some medical information, The Oregon DWDA wisely limits the intrusion to essential data needed to watch for possible disturbing trends. The reporting, coupled with the required procedures, allows the government to ensure to some degree that the patient makes an informed decision and that the patient does not suffer from any psychological impairment without unnecessary intrusion into the medical process. Additionally, although the government does not police the process, it does keep track of some vital statistics in order to spot any detrimental trends and to monitor compliance with the procedural safeguards. Most importantly, a terminally ill patient may obtain death with dignity, without embarrassing intrusions into one of his or her most private decisions ever made in their life.

E. Oregon's Success With the Citizens: An Anecdotal Example

At least one Oregonian agrees with the State of Oregon's regulation of physician assisted suicide. Nick Krieger, a law student at Seton Hall University School of Law, took the time to sit down with me and answer a few questions regarding Oregon's DWDA. Mr. Krieger was born in Oregon and lived there his entire life until coming to law school in New Jersey in 2010.⁹⁴ Mr.

⁹⁴ Nick Krieger Interview, *supra* note 18.

Krieger supported the ballot initiative, and continues to support the Oregon DWDA.⁹⁵ He believes strongly in personal choice, indicative of the general Oregonian culture.⁹⁶ Mr. Krieger emphatically supports the government allowing people to make personal choices without interference.⁹⁷

When asked about the government's role in regulating a patient's decision to end their life, Mr. Krieger championed the Oregon model.⁹⁸ He made clear that he does not support any form of licensing or specific physician approval method originating from the government.⁹⁹ However, Mr. Krieger does think that procedural standards are necessary to make sure people are making informed decisions.¹⁰⁰ He concluded by stating that he likes that Oregon empowered people to make their own decision, but understands that the government needs to regulate that power somehow.¹⁰¹

Though anecdotal, Mr. Krieger likely voices the thoughts of many Americans. Individualism became a core part of American ideology, incorporating the influences of New England Puritanism, Jeffersoniansim and the philosophy of natural rights.¹⁰² American individualism embodies traditional American values such as personal freedom.¹⁰³ As such, state governments may be hard pressed to insinuate themselves into such a personal decision as the choice to end one's life when suffering from terminal illness. The Oregon model tailors itself to

⁹⁵ *Id.*

⁹⁶ Nick Krieger Interview, *supra* note 18; Hedlund, *supra* note 3; Pratt, *supra* note 3 at 1100 (“Demographically, Oregonians are recognized as placing a high value on personal choice and autonomy.”).

⁹⁷ Nick Krieger Interview, *supra* note 18.

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

¹⁰² ENCYCLOPEDIA BRITANNICA ONLINE, *Individualism*, <http://www.britannica.com/EBchecked/topic/286303/individualism>.

¹⁰³ *Id.*

both the American tradition of doctor-patient confidentiality and individualism. While other, more intrusive methods, such as the Swiss method of police investigation, may be appropriate for other countries, the Oregonian model may be the best method for government regulation of physician assisted suicide in the United States.

V. Should Doctors be the Ones Issuing Lethal Prescriptions

Physicians commonly withhold treatment at the behest of their patients. Although this can be done at the oral request of the patient or their family, such an informal method can lead to confusion and conflict.¹⁰⁴ Perhaps the most famous case, Terri Schiavo's husband and parents fought a protracted legal battle over whether to remove life-sustaining treatment.¹⁰⁵ Although conflict existed between the husband and parents over who could decide Terri Schiavo's course of treatment (or lack thereof) never was it questioned whether the doctors could actually remove the life-sustaining treatment and in fact the removal was judicially enforced.¹⁰⁶

To avoid such conflict, states enforce Do Not Resuscitate orders signed before an emergency situation requiring doctors to withhold life-saving care.¹⁰⁷ Advance Directives for Health Care can set governmentally enforced directions for which situations the person would like to refuse care.¹⁰⁸ DNRs and Advance Directives demonstrate an acceptance by both individuals and governments with doctors literally harming a patient when the eventual outcome of that "harmful" action is actually desired.¹⁰⁹

¹⁰⁴ TERRI SCHIAVO LIFE & HOPE NETWORK, <http://www.terrisfight.org/>.

¹⁰⁵ TERRI SCHIAVO LIFE & HOPE NETWORK, *Timeline*, <http://www.terrisfight.org/timeline/>

¹⁰⁶ *Id.*

¹⁰⁷ STATE OF NEW JERSEY DEPARTMENT OF HEALTH, *Do Not Resuscitate Orders*, http://www.state.nj.us/health/ems/dnr_introduction.shtml

¹⁰⁸ STATE OF NEW JERSEY DEPARTMENT OF HEALTH, *Advanced Directives for Health Care*, http://www.state.nj.us/health/healthfacilities/documents/ltc/advance_directives.pdf

¹⁰⁹ Additionally, the number of Do Not Resuscitate orders, numbering around 18,000 in 2010 in Oregon, is much larger than the ninety six lethal medication prescriptions issued in 2010 in

While DNRs constitute a form of passive euthanasia, obtaining medication through the DWDA constitutes a form of active euthanasia.¹¹⁰ A valid refusal of care can be easily compared to a valid request for end of life medication through the DWDA.¹¹¹ Compliance with the refusal never seems to be an affront to traditional notions of physician morals, and how the death occurs from the refusal is irrelevant.¹¹² Because individuals and government are comfortable with doctors ceasing care leading to death, and because doctors have always been one of the few categories of people legally able to write a prescription, doctors seem to be the logical choice as to who should be issuing the lethal prescriptions pursuant to a state's DWDA.

VI. What Type of Governance is Appropriate From and Amongst Doctors: Can they be Trusted to Regulate Themselves

As discussed above, Oregon grants physicians significant autonomy in the process of a patient requesting life-ending medication.¹¹³ Doctors should have two roles: ensuring informed consent from a competent patient and providing access to the ability to end your own life through a prescription, but not actually pushing the button. Oregon's DWDA (and the DWDA proposed in New Jersey) codifies these roles. Although as discussed above¹¹⁴, it seems that at least within the United States the government removes itself from much of the process, other than setting the

Oregon.¹⁰⁹ Oregon Public Health Division, Oregon's Death with Dignity Act 2010 summary, *available at* <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year13.pdf>; Erik Fromme, *POLST Registry Do-Not-Resuscitate Orders and Other Patient Treatment Preferences*, J. AM. MED. ASS'N., Jan. 4, 2012, *available at* <http://jama.jamanetwork.com/article.aspx?articleid=1104816>.

¹¹⁰ Beauchamp, *supra* note 1 at 1176.

¹¹¹ *Id.* at 1187.

¹¹² *Id.*

¹¹³ *See supra* part IV(A).

¹¹⁴ *See supra* part IV.

procedural ground rules. However, the question remains whether doctors can be trusted with so much deference.

At least one reason to entrust doctors with responsibility may be because if not granted the deference, physicians will just engage in the practice of assisted suicide on their own. Informal surveys indicate that approximately one to two percent of deaths in the United States come from physician-assisted death in jurisdictions where it is illegal.¹¹⁵ In contrast, physician-assisted death may actually be less common in Oregon where the practice is legal, yet still left largely un-regulated.¹¹⁶

Another small, but comforting, reason doctors may likely be trusted to act on their own is their comfort level with patients discussing how they feel about the physician-assisted suicide. About ninety percent of Oregon physicians are at least somewhat comfortable discussing their opinion of the Death with Dignity Act with a patient who would ask.¹¹⁷ Free and unencumbered dialog between a physician and patient should foster trust within their relationship, and the fact that physicians are willing to have this conversation should inspire trust in the state government of Oregon to remain deferential to physicians.

Neither Oregon or Washington require a special private or in-house review committee created and managed by doctors in order to self-regulate.¹¹⁸ Physician practice groups and hospitals do not seem to have established any special review committees to specifically deal with DWDA requests. This lack of special attention actually makes sense in the Oregon DWDA

¹¹⁵ Timothy E. Quill and Jane Greenlaw, THE HASTINGS CENTER, *Physician Assisted Death*, <http://www.thehastingscenter.org/Publications/BriefingBook/Detail.aspx?id=2202>.

¹¹⁶ *Id.*

¹¹⁷ Linda Ganzini, *Oregon Physicians' Attitudes About and Experiences With End-of-Life Care Since Passage of the Oregon Death with Dignity Act*, J. AM. MED. ASS'N., May 9, 2001, available at <http://jama.jamanetwork.com/article.aspx?articleid=193817>.

¹¹⁸ O.R.S. 127.800-897; R.C.W. 70.245.010 – 904; O.A.R. 333-009-0020; Hedberg, *supra* note 56.

vision of end of life care. Oregon treats the prescribing of life-ending medication like any other medical procedure. The only difference is that Oregon partly codifies the standard of care for this particular medical situation by requiring certain procedures and reports to be made and followed.¹¹⁹ Therefore, unsurprisingly physicians and hospitals treat quality control just like any other process. Tracking of and punishment for non-compliance with the act flows from standard disciplinary channels.

Participation in the Oregon DWDA may involve a variety of health professionals who hold state licenses. Doctors write the prescriptions, but physician assistants, nurses, nurse practitioners, psychologists, social workers, pharmacists and emergency personnel are all licensed or certified professionals and may be involved in various capacities, other than writing the prescriptions, with the DWDA from direct patient care to counseling.¹²⁰ States created licensing boards to oversee, regulate and discipline these health care providers.¹²¹

State licensing boards treat non-compliance with the DWDA just like any other non-compliance with medical procedures or standard of care. To hold a state license confers upon the holder the obligation to practice in a competent, professional and legal manner.¹²² Should any health care professional become aware of non-compliance of the DWDA by a physician or other health care provider he or she must report that individual to the appropriate licensing board.¹²³ Likewise, should any health care professional become aware of a physician or other health care provider delivering any kind of substandard care, he or she must report that individual to the

¹¹⁹ O.R.S. 127.800-897; O.A.R. 333-009-0020; Hedberg, *supra* note 56.

¹²⁰ Kathleen Haley, *Responding to Professional Non-Compliance*, in *THE OREGON DEATH WITH DIGNITY ACT: A GUIDEBOOK FOR HEALTH CARE PROFESSIONALS* (Patrick Dunn & Bonnie Reagan eds., 2007).

¹²¹ *Id.*

¹²² *Id.*

¹²³ *Id.*

appropriate licensing board.¹²⁴ The rules do not change regardless of whether a health care provider provides service below the standard of care or whether a health care provider violates the precepts of the Death with Dignity Act. Physicians will self-monitor for compliance, and should a violation occur only then will a government agency be notified. The Oregon DWDA continues the tradition of only passively investigating the practice of medicine, relying and trusting the practitioners to self-regulate to a certain degree.

Licensees have always had to report other licensees who are medically incompetent, engage in unprofessional conduct or have a physical or mental impairment that affects their ability to safely practice their profession to the appropriate licensing or certifying board.¹²⁵ This is an old legal requirement, for health care professionals to report a fellow health care professional within their same discipline.¹²⁶ Failure to report may result in disciplinary action against the professional who knew of the inappropriate or illegal conduct. Additionally, a professional in a different discipline may be ethically required to report to the appropriate board. Reporting to a physician group, insurance carrier, hospital, clinic or an agency responsible for care (for example, in this case the OHS) may also be required.¹²⁷ These groups should be consulted independently regarding reporting obligations.¹²⁸

These rules have not changed after implementation of the Oregon DWDA. Health care practitioners must still engage in this self-regulation. For example, if a physician provides a lethal dose of medication to a clearly incompetent patient or to a patient who is not terminally ill, or a nurse administers an injection with the intent to kill rather than for comfort, a report must be

¹²⁴ *Id.*

¹²⁵ *Id.*

¹²⁶ Kathleen Haley, *supra* note 120.

¹²⁷ *Id.*

¹²⁸ *Id.*

filed with the respective licensing board.¹²⁹ Because the Oregon DWDA does not grant any policing power to the OHS, it is unlikely the OHS or the licensing board or any other governmental agency would find out unless some other health care practitioner or a member of the patient's family takes it upon their own initiative to file a report. Otherwise, the only other information the OHS receives are forms filed by the physician who administered the care, who obviously has an incentive to lie.¹³⁰ Failure to report in a timely fashion is considered non-compliance with the DWDA, and the OHS will report such a failure to the appropriate licensing board.¹³¹

Although the Oregon DWDA does seem to grant a lot of deference, authority and trust to the medical community, it really is not anything new. Therefore, assuming the traditional methods of self-regulation among the medical community currently provide an affective regulatory force, the same methods can be trusted to regulate Death with Dignity cases. Doctors want to heal patients, either in body or in mind. The Oregon DWDA system gives physicians more control, allowing them to treat patients as best they can in conformity with the patient's wishes. Doctors are in charge, and the outcome seems to benefit patients. The only reason not to entrust doctors with this responsibility is if the entire system of self-regulation for doctors and others who engage in the practice of medicine does not protect patients.

VII. Conclusion

New Jersey was wise to copy the Oregonian model for their own Death With Dignity Act. Oregon correctly balanced the competing state, physician and patient interests. The state lays a procedural protection net and collects data to spot any disturbing or dangerous trends.

¹²⁹ *Id.*

¹³⁰ O.A.R. 333-009-0020; Hedberg, *supra* note 56.

¹³¹ Haley, *supra* note 120.

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Physicians continue to operate with relatively little interference from government in the practice of medicine. Patients may obtain life ending medication with dignity and with relative privacy.

The only addition New Jersey might consider is a requirement that doctors not suggest physician assisted suicide. Though not currently in the proposed statute, this could be added either to the statute as an amendment, or adopted as a regulatory rule by whatever agency would eventually be tasked to regulate physician assisted suicide in New Jersey. Although there is no data suggesting doctor influence occurs at any substantial rate, this may simply be due to the limited amount and types of data collected. The impetus for physician assisted suicide should come from the individual, or at least only from family members or other people close with the patient. The attending physician should be impartial, and the physicians role should be limited, by statute, to ensuring the patient is competent, is making an informed decision and is aware of all available options.

Other than this one addition, New Jersey should strongly consider enacting what is essentially a copy of the governance structure of the Oregon Death With Dignity Act. Considering the historical resistance by legislators, supporters of a New Jersey Death With Dignity Act should pursue the method most likely to succeed, a voter referendum upon legislative approval.