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Medical Aid in Dying Legislation: Recommendations in the Interests of Health Care Providers and Patients

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I. INTRODUCTION

In the summer of 2019, New Jersey became the eighth jurisdiction to pass legislation authorizing qualified, terminally ill patients to self-administer prescribed lethal medication.[1] The Garden State began its efforts in 2014 when Governor Chris Christie pledged to veto any bill legalizing aid in dying.[2] New Jersey finally found success when Governor Phil Murphy signed the Medical Aid in Dying for the Terminally Ill Act (the "Act"). Maine followed shortly thereafter, increasing the total to nine jurisdictions that have aid in dying legislation.[3]

Since the enactment of New Jersey's Act, a New Jersey Department of Health report shows that twelve terminally ill patients utilized the legislation in 2019.[4] Seven of those individuals were diagnosed with some type of terminal cancer and three suffered from a neuro-degenerative disease.[5] One patient suffered from a pulmonary disease, and the other had a gastrointestinal disorder.[6] These patients had to satisfy a number of stringent requirements in order to eventually self-administer the medication. While New Jersey and the other jurisdictions are in the minority in the country for those that allow medical aid in dying ("MAID"), these jurisdictions do not make it easy for patients to utilize the procedure.

Because MAID is such a contentious matter, the statutes that authorize such practice are carefully drafted and filled with safeguards. The legislation is based on patient autonomy and self-

[1] N.J. STAT. ANN. § 26:16-1 (2019)
[2] Niraj Chokshi, *Christie may face a decision on assisted suicide in New Jersey* (November 19, 2014) THE WASHINGTON POST https://www.washingtonpost.com/blogs/govbeat/wp/2014/11/19/christie-may-face-a-decision-on-assisted-suicide-in-new-jersey/.
[3] MAINE REV. STAT. 22 § 2140 (2019).
[4] The Office of the Chief State Medical Examiner, *New Jersey Medical Aid in Dying for the Terminally Ill Act 2019 Data Summary* https://www.state.nj.us/health/advancedirective/documents/maid/2019_MAID_DataSummary.pdf
[5] *Supra.*
[6] *Supra,* note 4.

determination, as well as a purpose to minimize undignified and painful deaths.[7] The states have a compelling interest in strictly regulating MAID in order to protect and preserve human life and the public welfare. Each state has regulated the process slightly differently but with the same goal of giving terminally ill patients the option to end their lives peacefully while also assuring safety. The statutes are all similar in nearly every provision, yet the seemingly minor differences spark interest and could even strike an intense debate. All things considered, the differences in provisions from jurisdiction to jurisdiction may not yield drastically different results, but if the legislatures aim to maximize safety and minimize any wrongdoing, there are certain provisions that should be prioritized.

This paper will first describe the basics and background of MAID by outlining the main provisions included in each statute and the judicial history of aid in dying. This paper will then discuss the most recent litigation challenging MAID statutes. Next, this paper will provide a more in-depth analysis of the common provisions of all state statutes, pointing out the more critical portions. Last, this paper will recommend elements that should be included in every state statute in order to guarantee safety and to limit the risk of invalidation through litigation. Those recommendations include accounting for a patient's mental illness, such as depression. This paper also recommends that all healthcare providers should be entitled to prohibit participation in the MAID process, as well as a requirement that healthcare providers who opt-out of the process must provide the patient with a source of information on MAID and transfer the relevant medical records to a willing healthcare provider.

II. BACKGROUND

A. *The Basics of Medical Aid in Dying Statutes*

[7] Amanda M. Thyden, *Death with Dignity and Assistance: A Critique of the Self-Administration Requirement in California's End of Life Option Act*, 20 Chap. L. Rev. 421, 423 (2017).

The terminology for this phenomenon varies. A few terms that are widely used include "physician assisted suicide," "mercy killing," or "death with dignity." This paper will refer to the practice of prescribing life-ending medication to a qualified, terminally ill patient as "medical aid in dying" or "MAID," as this is the title of many state statutes, including New Jersey's Act.

Terminally ill patients seek MAID as an option to relieve suffering. For those who suffer from diseases or conditions that take away independence and any enjoyment of life from the patient, MAID offers an opportunity to relieve the pain and die with comfort and dignity. Examples of illnesses that drive patients to utilize this process include various forms of cancer, neurological diseases, gastrointestinal diseases and other terminal diagnoses. MAID statutes provide a clear exception to the criminal prohibitions on assisted suicide that exist nationwide.[8]

Eight states in the country, plus the District of Columbia, established processes for terminally ill, qualified patients to seek a prescription for lethal medication to self-administer. In addition to these nine jurisdictions, Montana authorized MAID through a judicial decision.[9] The Montana Supreme Court established that "a physician who aids a terminally ill patient in dying is not directly involved in the final decision or the final act."[10] The majority of the country still prohibits any form of assisted suicide, however, it could certainly be argued that the number of jurisdictions that make the effort to carefully permit MAID through detailed legislation will continue to grow.

B. *The Constitutional Backdrop*

There are multiple issues that surround this phenomenon, mostly constitutional. First, courts were faced with the question of whether a right to terminate medical treatment exists. This

[8] Thaddeus Mason Pope, *Legal History of Medical Aid in Dying: Physician Assisted Death in U.S. Courts and Legislatures*, 48 N.M.L. Rev. 267, 272 (2018).
[9] *Baxter v. State*, 224 P.3d 1211 (Mont. 2009).
[10] *Id.* 1214.

topic was popularized by *Cruzan v. Director, Missouri Department of Health*[11] and *Schiavo ex rel. Schindler v. Schiavo*[12], two cases that involved the right to refuse medical treatment and a standard of proof required for incompetent patients. In 1990, Chief Justice Rehnquist defined the right narrowly rather than establishing a right to die.[13] After balancing state interests, the *Cruzan* Court held that the Fourteenth Amendment of the United States Constitution does not forbid Missouri's procedural requirements of clear and convincing evidence to prove that a patient in a persistent vegetative state would want to terminate treatment.[14] The *Schiavo* court affirmed a lower court's decision that withholding nutrition and hydration from an incapacitated person based on the clear and convincing evidence standard was not unconstitutional.[15]

The issues developed when states took action to expressly prohibit assisted suicide. Courts no longer dealt with the right to terminate medical treatment and focused on whether there is a right to "pull the plug." In *Washington v. Glucksberg*, physicians who assisted terminally ill patients and other gravely ill patients challenged a Washington state statute that prohibited assisted suicide.[16] The state also permitted the withholding or withdrawal of life-sustaining treatment at a patient's direction. The legal issue was whether there is a fundamental right for competent people to seek physician assisted suicide.[17] The Court held that this right is not fundamental as assisted suicide is not historically or traditionally recognized.[18] The state has a legitimate interest in protecting and preserving life, protecting the integrity and ethics of the medical profession as well

[11] 497 U.S. 261 (1990).
[12] 403 F.3d 1289 (11th Cir. 2005).
[13] *Cruzan*, at 269.
[14] *Id.* at 288.
[15] *Schiavo*, at 1296.
[16] *Washington v. Glucksberg*, 521 U.S. 702, 706 (1997).
[17] *Id.* at 724.
[18] *Id.*

as protecting vulnerable groups of people.[19] The ban on assisted suicide was found as rationally related to these legitimate state interests.[20]

In the same year, the Court considered whether a New York state law banning physician assisted suicide violated the Equal Protection Clause by treating all competent persons in the final stages of a fatal illness differently.[21] In *Vacco*, causation and intent were the basis of the distinction between the act of terminating life-sustaining treatment compared to the act of providing treatment that will end one's life.[22] When a patient refuses a life-sustaining treatment, death is caused by the underlying fatal disease.[23] Conversely, when a patient consumes a lethal medication administered by a physician, death is caused by that medication.[24] The Court recognized a distinction between letting a patient die and more directly causing that patient's death.[25] For these reasons and because of the state's legitimate interests, the New York state statute did not violate the Equal Protection Clause.[26]

Throughout these cases, it is important to note the way the Court frames the right, whether it is broad or narrow. As it stands today, there is no right to physician assisted suicide but there is a right to refuse life sustaining nutrition or medication. Also significant is the distinction established in *Vacco* between those who are terminally ill and request a drug to assist their death and those who withdrawal life support systems. The nine individual jurisdictions use these cases as a basis to create legislation that is constitutional. The legislatures must be careful not to frame the statutes as permitting the promotion or assistance of suicide because a fundamental right in

[19] *Id.* at 731.
[20] *Id*. at 733.
[21] *Vacco v. Quill*, 521 U.S. 793, 797 (1997).
[22] *Id*. at 801.
[23] *Id.*
[24] *Id*.
[25] *Id*.
[26] *Id*. at 808.

assisted suicide is not recognized. States have more creatively drafted legislation allowing doctors to prescribe lethal medication only if certain requirements are met and the medication is self-administered by the patient, avoiding any form of euthanasia, voluntary or involuntary.

C. *Common Provisions of State MAID Statutes*

Oregon was the first state to authorize MAID in 1995 and has drafted such a thorough statute that it serves as a model for the eight jurisdictions that followed.[27] Oregon's statute was amended in 1999 to expand and clarify particular provisions, and again in 2017.[28] Some critics argue that the Oregon statute and the others that nearly duplicate it are so riddled with safeguards that it makes it virtually impossible to actually use the statute.[29] However, the legislatures are obligated to account for every potential danger in this process and address methods to avoid those dangers in the statute. With a matter as significant as ending one's life, safeguards should be welcomed.

The main safeguards that are included in every state statute include patient qualifications, voluntariness, patient capacity or competence, informed decision-making, second medical opinions, witnesses, written and oral requests as well as waiting periods.[30] The other eight statutes certainly piggy-back off of Oregon's legislation to some extent.[31] Within each of these main provisions lies some minor differences from state-to-state that should be accounted for.

i. Patient Qualifications

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[27] OR. REV. STAT. ANN. § 127.800 (2017).
[28] *Id*; Thaddeus Mason Pope, *Legal History of Medical Aid in Dying: Physician Assisted Death in U.S. Courts and Legislatures*, 48 N.M.L. Rev. 267, 278 (2018) (also noting the express authorization of physicians to dispense lethal medications, relieving the responsibility from pharmacists who wish to refrain).
[29] *Id*. at 276.
[30] Carol A. Pratt, *Efforts to Legalize Physician-Assisted Suicide in New York, Washington and Oregon: Contrast Between Judicial and Initiative Approaches – Who Should Decide?*, 77 Or. L. Rev. 1027 (1998).
[31] Pope, *supra* note 28, at 280-83 (stating that Colorado, Washington, California, Vermont, and Washington, D.C. closely model Oregon's statute).

As for patient qualifications, all nine jurisdictions require the patient to be an adult with a terminal disease, which means the disease cannot be cured and the patient's condition will not improve.[32] The life expectancy for a terminally ill patient must be six months or less.[33] This requirement serves to avoid wrongful deaths where a patient may actually have a chance of recovery. The patient must also be a resident of the state. Nearly all MAID legislation requires proof of residency by demonstrating factors such as possession of a state driver's license, registration to vote in the state, or evidence that the patient owns or leases property in the state.[34] California and New Jersey include a filing of a tax return as evidence of residency as well.[35] Proof of residency helps protect against "MAID tourism," or patients who travel to one of the nine jurisdictions to utilize the MAID process because it is not legal in their home jurisdiction. To be qualified, a patient must also be "capable." The statutes generally define "capable" to mean that the patient has the ability to understand the nature and consequences of the situation at hand and has the ability to make an informed decision.[36] This provision will be emphasized and further analyzed in Section IV of the paper.

ii. Voluntariness

The next safeguard, voluntariness, mainly addresses the patient's ability to rescind his or her request as well as potential undue influence. Every statute includes a provision that allows a patient, at any time, to rescind the request for lethal medication.[37] The statutes also require

[32] OR. REV. STAT. ANN. 127.800 §1.01 (2017); WASH. REV. CODE ANN §70.245.190(1)(d) (2016); VT. STAT. ANN. tit. 18 § 5285(a)(10) (2016); COLO. REV. STAT. § 25-48-102(16) (2016); N.J. STAT. ANN. § 26:16-3 (2019).
[33] *Id*.
[34] Zachary Gureasko, *The Expansion of the "Right to Die": Physician-Assisted Suicide, Concepts of State Autonomy & The Proper Political Process for Legalization*, 1 Belmont Health L.J. 59 (2017); *See also* COLO. REV. STAT. § 25-48-102(14) (2016).
[35] CAL. CODE REGS. 1.85 § 443.2 (2015); N.J. STAT. ANN. § 26:16-11 (2019)
[36] CAL. CODE REGS. 1.85 § 443.1(e) (2015);
[37] OR. REV. STAT. 127.810 §3.07 (2017); WASH. REV. CODE ANN §70.245.100 (2016); COLO. REV. STAT. § 25-48-105 (2016); D.C. Code § 7-661.03(a)(6) (2016); VT. STAT. ANN. tit. 18 § 5283 (2016); N.J. STAT. ANN. § 26:16-10 (2019); ME. STAT. ANN. tit. 418 § 2140.21 (2019).

attending physicians to offer the patient an opportunity to rescind after the patient makes the request for lethal medication.[38] Physicians are required to verify that the patient is acting voluntarily and is not being unduly influenced.[39] Voluntariness also speaks toward the health care provider's ability to decline to participate in any part of the process for any moral, ethical or religious reason.[40] The healthcare provider opt-out provisions will be discussed in further detail in Section IV.

iii. Witnesses

Witness restrictions help to assure that the patient is acting voluntarily. When the patient signs and completes his or her written request for lethal medication, two witnesses must be present in order to attest that the patient is competent, acting voluntarily, and not being coerced or under undue influence.[41] At least one witness may not be a relative of the patient, may not be entitled to any portion of the patient's estate upon his or her death, and may not be "[a]n owner, operator, or employee of the health care facility where the qualified patient is receiving medical treatment or is a resident."[42] Most states also restrict the attending physician from acting as a witness.[43] A number of states include a provision requiring an individual of a long-term care facility with qualifications specified by the Department of Human Services to serve as a witness only if the patient is a patient of the long-term care facility at the time of the written request.[44]

iv. Request Procedures

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[38] *Id.*
[39] N.J. STAT. ANN. § 26:16-10 (2019); OR. REV. STAT. 127.805 §2.01 (2017); D.C. Code § 7-661.03(a)(1)(C) (2016).
[40] *Id.*
[41] OR. REV. STAT. 127.810 §2.02 (2017); WASH. REV. CODE ANN §70.245.030 (2016); COLO. REV. STAT. § 25-48-104 (2016); CAL. CODE REGS. 1.85 § 443.3(b) (2015); N.J. STAT. ANN. § 26:16-5 (2019); ME. STAT. ANN. tit. 418 § 2140.21 (2019); VT. STAT. ANN. tit. 18 § 5283 (2016).
[42] *Id.*
[43] CAL. CODE REGS. 1.85 § 443.3(b) (2015); COLO. REV. STAT. § 25-48-104(2)(c) (2016); WASH. REV. CODE ANN §70.245.030 (2016); D.C. Code § 7-661.02(b)(4) (2016); OR. REV. STAT. 127.810 §2.02 (2017); N.J. STAT. ANN. § 26:16-5 (c) (2019);
[44] OR. REV. STAT. 127.810 §2.02 (2017); WASH. REV. CODE ANN §70.245.030 (2016).

As for the request procedures, both written and oral requests are mandated under the statutes.[45] Most states require at least one oral request and one written request to his or her attending physician. The oral request must be reiterated to the physician fifteen days after the first oral request.[46] It is at that time when an attending physician is typically required to offer the patient an opportunity to rescind.[47] In New Jersey and Maine, at least 48 hours shall pass between the date the patient signed the written request and the date the attending physician writes a prescription under the statute.[48] These waiting periods serve as safeguards and give patients an opportunity to consider all information provided by the attending or consulting physician, to notify next of kin, and to take time to solidify his or her decision. After reviewing the common provisions of MAID state statutes, one can see how carefully the process is drafted to ensure safety and preservation of human life as well as protection of the integrity and ethics of the medical profession, as laid out by the Court in *Washington v. Glucksberg.*[49]

III. RECENT LEGAL CHALLENGES

The historical legal challenges centered mainly around whether there is a fundamental right for competent people to seek physician assisted suicide. This narrow definition of the right was not recognized to be fundamental by the Supreme Court.[50] The Court also dealt with the distinction between death caused by refusal of life sustaining nutrition versus death caused by medication administered by a physician and why the former is authorized but the latter is not. Since then, the nine MAID jurisdictions have succeeded in passing legislation that allows terminally ill patients

[45] *Supra*, at § 3.06 (2017).
[46] Gureasko, *supra* note 34, at 72 (Vermont's "various waiting periods and methods of requesting the prescription, as well as the physician's role in the process, bear a striking resemblance to the related statutes" in Oregon and Washington.).
[47] *Supra*.
[48] N.J. STAT. ANN. § 26:16-10 (2019); ME. STAT. ANN. tit. 418 § 2140.13 (2019).
[49] 521 U.S. 702, 731 (1997).
[50] *Id*.

to die in dignity while prohibiting physician assisted suicide and euthanasia. Today, these jurisdictions face new issues in court.

A. *Legal Challenge to New Jersey's Legislation*

Litigation ensued in New Jersey just a few months after Governor Murphy signed the Act to allow qualified terminally ill patients to self-administer aid-in-dying medication.[51] Dr. Yosef Glassman alleged that the Act violated a fundamental right to defend life, First Amendment rights, as well as equal protection and due process, among other things.[52] The litigation focused on the plaintiff's argument that the Act violated the Administrative Procedure Act ("APA") by failing to promulgate rulemaking and therefore the plaintiff may suffer harm from the significant change in the law.[53] The appellate court held that the lower court failed to properly balance the factors required for an injunction.[54]

Judge Arnold Natali, writing for the appellate court, stated that the "plaintiff failed to establish that injunctive relief was necessary to prevent irreparable harm and preserve the status quo."[55] There was no evidence that the plaintiff was burdened by a request to implement the provisions of the Act. Furthermore, Judge Natali pointed out the Act's unambiguous language rendered participation by physicians entirely voluntary.[56] The Act only requires that healthcare providers who, based on religious or other moral bases, opt not to treat patients under the Act shall transfer the patient's medical records to another healthcare provider. The court declined to acknowledge that the transfer of medical records is a matter of constitutional import. Additionally,

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[51] *Joseph Glassman, M.D. v. Gurbir S. Grewal, New Jersey State Attorney General*, No. AM-707-18T3, slip op. at X (N.J. Super. Ct. App. Div. Aug. 23, 2019).
[52] *Supra.*
[53] *Supra.*
[54] Bruce D. Greenberg, *The Appellate Division Elaborates on the* Crowe v. DeGioia *Standard for Preliminary Injunctive Relief* NEW JERSEY APPELLATE LAW (August 28, 2019) http://appellatelaw-nj.com/the-appellate-division-elaborates-on-the-crowe-v-degioia-standard-for-preliminary-injunctive-relief/.
[55] *Supra,* note 51.
[56] *Supra,* note 51.

the language of the Act is clear in that the legislature did not intend to await administrative rulemaking nor was rulemaking necessary.[57] While this opinion is not yet officially reported, it is useful for states to determine what challenges may arise from MAID statutes by health care providers and what to include in MAID statutes in order to avoid litigation.

B. *Legal Challenge to Vermont's Legislation*

Vermont's Patient Choice at End of Life Act ("Act 39") was similarly challenged. In *Vt. Alliance for Ethical Healthcare, Inc. v. Hoser*, various religious health care providers and physicians argued for an injunction to enjoin the Chair of the Vermont Board of Medical Practice from initiating any disciplinary proceeds that may arise from a refusal to inform patients of the options under Act 39.[58] The legal challenge focused on whether healthcare providers are required to counsel for assisted suicide in a manner that may be inconsistent with their religious beliefs.[59] More specifically, the question became whether the informed consent requirements create a conflict between the legal requirements of medical practice and the health care providers' personal convictions which include an aversion to enable assisted suicide.[60]

The court determined that because both the Vermont Attorney General and the plaintiffs agree that if a patient requests help from a healthcare provider under Act 39, a referral to a website is sufficient to satisfy the informed consent requirements.[61] The plaintiffs did not insist that silence on their part was necessary in order for them to abide by their personal and religious convictions.[62] Because the risk of actual harm of disciplinary action was found to be highly remote due to the consensus that a website referral would sufficiently inform patients of their options, the court held

[57] *Supra*, note 51.
[58] 274 F.Supp. 3d 227, 231 (D. Vt. 2017).
[59] *Id*. at 238.
[60] *Id*. at 234.
[61] *Id.* at 235.
[62] *Id.*

that the plaintiffs lacked standing.[63] This case raises the question of what exactly are the minimum requirements for health care providers who opt out.

C. *Legal Challenge to California's Legislation*

In 2018, a challenge to California's End of Life Option Act also failed for lack of standing.[64] One of the legal challenges in *People ex rel. Becerra v. Superior Court*, was whether plaintiff-physicians who belong to a professional organization that promotes medical ethical standards are harmed by the requirement to diagnose a patient with a terminal disease. The argument reasoned that in diagnosing a patient with a terminal disease, the plaintiff-physicians make that patient eligible to receive lethal medication which impacts their "professional obligations and duties to clients."[65]

The court was also faced with a challenge regarding conflicting provisions. California's Act allows a health care provider to prohibit its employees from participating in MAID but there is no rule *against* prohibiting an employee from providing information or a referral.[66] In other words, under the statute, a "health care provider" cannot be subject to discipline for providing information or a referral but it was not shown that "the Act provides a similar safe harbor for the *employee* of a health care provider (unless the employee is also a health care provider)."[67]

In addressing the first claim, the court explained that when a physician diagnoses a patient with a terminal illness, that patient is not automatically eligible and must still satisfy a number of requirements in the statute.[68] The health care provider who diagnoses the patient is not in any way responsible for the patient's later use in MAID. The physicians must also comply with the

[63] *Id.* at 239.
[64] *People ex rel. Becerra v. Superior Court*, 240 Cal. Rptr. 3d 250 (Cal. Ct. App. 2018).
[65] *Id.* at 264.
[66] *Id*. at 265.
[67] *Id*.
[68] *Id.*

American Medical Association Code of Medical Ethics ("Code of Medical Ethics") which establishes a duty on the physician to communicate an honest diagnosis. Compliance with the Code of Medical Ethics might make the physicians uncomfortable, knowing the patient may eventually be qualified under the MAID legislation, but this is not sufficient to confer standing.[69]

As for the second challenge, the court explained that even if the Act allows health care providers to prohibit employees from participating in the MAID process but does not expressly allow employees to provide information on MAID and referrals to patients, the plaintiff-physicians did not allege that they even employ health care providers or that their employees wish to provide information and referrals against the wishes of the plaintiff-physicians.[70] Therefore, the plaintiff-physicians lacked standing. Although standing requirements were not satisfied here, a question remains as to what the minimum requirements are for health care providers who choose to prohibit MAID in their facilities and the employees of such facilities.

MAID legislation and bans on assisted suicide initially faced due process and equal protection challenges. Today, MAID statutes are largely challenged on the basis of a physician's moral or religious rights not to participate. Thus far, the challenged statutes have been carefully drafted to survive litigation. In order to prevent a risk of future legal challenges, there are particular provisions that require attention.

IV. ANALYSIS

The nine MAID statutes have been drafted to account for legitimate state interests, as well as the interests of all parties involved. Nevertheless, there are particular provisions that should be standard across all nine jurisdictions but have not been adopted by some. Life is the most cherished gift. Where legislatures regulate MAID, every detail in every safeguard should be taken into

[69] *Id.* at 264-65.
[70] *Id*. at 265-66.

account to prevent potential dangers or misuse and to protect such sacred lives. This section will analyze which portions of which statutes should be revised or modeled on other states. This section will also recommend the regulations that should be enacted in order to protect the vulnerable lives of the terminally ill, as well as physicians and other health care providers. There are particular provisions that should be prioritized to prevent litigation.

A. *Is a Patient with Depression "Capable"?*

All nine jurisdictions establish a rule that requires the patient to be referred to a mental health care professional if appropriate.[71] Some provisions are less detailed than others. New Jersey's Act is vague in that it merely requires the attending physician to refer the patient to a mental health care professional if the attending or consulting physician opines that the patient may not be capable.[72] If a referral occurs, the attending physician shall not write a prescription for medication unless the mental health care professional determines that the patient is capable.[73] "Capable" is defined as "having the capacity to make health care decisions and to communicate them to a health care provider including communication through persons familiar with the patient's manner of communicating if those persons are available."[74]

The more thorough provisions specifically address whether the patient may suffer from depression or a psychiatric or psychological disorder that may cause impaired judgment.[75] It is important to account for depression and any psychiatric or psychological disorders because these conditions could cause mental instability or cause the patient to make rash decisions. Under New

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[71] ME. STAT. ANN. tit. 418 § 2140.8 (2019); N.J. STAT. ANN. § 26:16-6(a)(5) (2019); HAW. REV. STAT. § 327L-1 (2019); D.C. Code § 7-661.04 (2016); OR. REV. STAT. 127.825 §3.03 (2017); COLO. REV. STAT. § 25-48-108 (2016); WASH. REV. CODE ANN §70.245.060 (2016); VT. STAT. ANN. tit. 18 § 5283(a)(8) (2016); CAL. CODE REGS. 1.85 § 443.7 (2015).
[72] N.J. STAT. ANN. § 26:16-8 (2019).
[73] *Supra*.
[74] *Supra*. at § 26:16-3.
[75] H.R.S. § 327L-6 (2019); ME. STAT. ANN. tit. 418 § 2140.2 (2019); OR. REV. STAT. 127.825 §3.03 (2017); D.C. Code § 7-661.04 (2016); WASH. REV. CODE ANN §70.245.060 (2016).

Jersey's statute, depression is not specified as a qualification for capability, increasing the risk that a patient who suffers from depression may have an impaired ability to appreciate his or her decision. It is not uncommon for people to make irreversible decisions out of emotional depression when those decisions do not reflect their enduring convictions.[76] States must protect patients who are at risk of acting involuntarily or impulsively in making these irreversible decisions to end the patient's life.

Some have argued that mental disorders are not synonymous with incompetence.[77] Even if that is true, to allow any form of depression to alter a patient's decision to end their life when that decision may go against that patient's long-standing beliefs would have permanent and unfixable consequences. It has been argued that regardless of whether a patient is diagnosed with depression, the focus should be only on whether the patient is competent.[78] Competence is sometimes defined as the ability to understand, appreciate, reason, and to communicate a choice.[79] A patient who is clinically depressed may likely lack the ability to appreciate the risks and benefits of MAID and any alternatives to MAID. Physicians should be required to account for the possibility of depression when determining whether the patient is capable or competent in order to guarantee that the patient appreciates his or her decision and to give the patient an opportunity for counseling.

The waiting periods established in MAID statutes can help provide the patient with more time to consider the irrevocable nature of his or her decision. However, these waiting periods, as well as the mandated offer of an opportunity to rescind by the physician, are not a guarantee that those who choose to proceed are not basing their decision off of feelings of depression or other

[76] Ronald Dworkin et al., *Assisted Suicide: The Philosophers' Brief*, N.Y. REV. BOOKS (Mar. 27, 1997), http://www.nybooks.com/articles/1997/03/27/assisted-suicide-the-philosophers-brief/.
[77] Candace T. Player, *Death with Dignity and Mental Disorder*, 60 Ariz. L. Rev. 115 (2018).
[78] *Id.* at 134.
[79] *Id.* at 139.

psychiatric or psychological disorders. In the interests of the MAID patients, depression or other psychiatric or psychological disorders should be included in reference to the patient's ability to make an informed decision.

These recommendations may only effect a very small portion of the population, considering all the other MAID requirements that patients have to satisfy. In 2016, twenty percent of MAID patients in Oregon did not even chose to take the prescribed lethal medication and died of other causes.[80] In Washington only four percent of patients were referred for a psychiatric or psychological evaluation in 2018.[81] Only twelve New Jersey residents utilized MAID in 2019.[82] Nevertheless, as mental health problems become more prevalent in the United States, and as the number of jurisdiction that allow MAID increases, the legislatures should protect patients seeking MAID who might be effected by depression or other psychiatric or psychological disorders.

It is also possible that a patient with a terminal illness could suffer from depression due to the reality of his or her situation. Even if that is the case, it is in the state's interest to protect patients from allowing their condition to lead to suicidal thoughts. MAID statutes are meant to provide a dignified death for the terminally ill. At a minimum, a diagnosis of depression or a psychological impairment should force physicians to pause the MAID process and further examine whether the patient is fully competent and capable, with second or third opinions from psychologists or psychiatrists.

B. *Healthcare Provider Opt-Out Provisions and Facility Prohibitions*

[80] *Id.* at 154 (citing OR. Health Auth. Pub. Health Div., Oregon Death with Dignity Act Data Summary 2016 (2017) http://www.oregon.gov/oha/PH/Providerparnerresouces/evaluationresearch/deathwithdignityact/documents/yeye19.pdf).
[81] Katherine Hutchinson, PhD, MSPH, et al., *2018 Death with Dignity Act Report,* Washington State Department of Health (July 2019) https://www.deathwithdignity.org/wp-content/uploads/2020/02/2018-Report-WA-Death-with-Dignity-Act.pdf.
[82] *Supra*, at note 4.

Every statute includes a provision that generally allows healthcare providers to refuse to participate in the process. There is no duty on a healthcare provider to participate or to carry out the patient's request.[83] Washington State's Death With Dignity Act speaks in the affirmative, mandating that "[o]nly willing health care providers shall participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner."[84] California's statute also grants immunity to physicians who refuse to inform a patient of his or her right and decline to refer a patient to a physician who participates in MAID.[85]

Furthermore, some statutes give entire healthcare facilities the ability to opt out.[86] Health care providers may prohibit other health care providers from participating in MAID when on the premises of the prohibiting health care provider.[87] Some jurisdictions expand on that and allow prohibiting health care providers to issue sanctions or some sort of discipline if the prohibiting health care provider has given notice to the sanctioned health care provider.[88] New Jersey does not have a provision that expressly allows a health care provider to prohibit the participation in MAID on the premises of that facility. New Jersey simply relieves a health care provider from liability if the healthcare provider refuses to participate.[89]

As evinced by the recent legal challenges to state statutes, these provisions are critical. Not only are the opt-out provisions significant for the basic reason that no health care provider should

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[83] OR. REV. STAT. 127.885 §4.01 (2017); WASH. REV. CODE ANN §70.245.010, 70.245.190 (2016); D.C. Code § 7-661.10 (2016); VT. STAT. ANN. tit. 18 § 5284 (2016); COLO. REV. STAT. § 25-48-117 (2016); ME. STAT. ANN. tit. 418 § 2140.21 (2019); N.J. STAT. ANN. § 26:16-17 (2019); CAL. CODE REGS. 1.85 § 443.14(b) (2015);
[84] WASH. REV. CODE ANN §70.245.190(1)(d) (2016).
[85] CAL. CODE REGS. 1.85 § 443.14(e)(2) (2015);
[86] *Id.*; D.C. Code § 7-661.10(c) (2016);
[87] OR. REV. STAT. 127.885 §4.01(5) (2017); D.C. Code § 7-661.10(c) (2016); WASH. REV. CODE ANN §70.245.190(2)(b)(i) (2016); ME. STAT. ANN. tit. 418 § 2140.22 (2019); VT. STAT. ANN. tit. 18 § 5286 (2016); COLO. REV. STAT. § 25-48-118(1) (2016).
[88] ME. STAT. ANN. tit. 418 § 2140.22 (2019); WASH. REV. CODE ANN §70.245.190(2) (2016); D.C. Code § 7-661.10(d) (2016); VT. STAT. ANN. tit. 18 § 5286 (2016); COLO. REV. STAT. § 25-48-118(2) (2016).
[89] N.J. STAT. ANN. § 26:16-17 (2019).

be obligated to participate in MAID, these provisions help avoid litigation. As contentious as physician aid-in-dying is in the United States, no person or entity should be required to disregard moral, ethical, religious or other beliefs. In general, every statute accounts for the basic right to opt-out.

Equally important is a provision allowing entire healthcare facilities to prohibit physicians acting under the prohibiting provider's control from participating in MAID. Where a facility is owned and operated by a health care provider who has pronounced moral, ethical, or religious beliefs, that health care provider should be able to limit the use of MAID in its facility so long as notice is given. Legislation like New Jersey's, that does not expressly give health care facilities the right to prohibit MAID, is more likely to face litigation by religious facilities that do not support MAID.

Facility prohibitions are not likely to hinder a patient's ability to seek the opportunity of MAID because a health care provider is generally required to transfer the patient's relevant medical records to another healthcare provider under most statutes.[90] Vermont's Patient Choice and Control at the End of Life Act ("Vermont's Act") does not require a physician to transfer medical records in the event that the physician elects not to participate in the provision of a lethal dose of medication to the patient.[91] Vermont's Act does not offer any details in regard to what an unwilling physician is required to do, which makes it susceptible to litigation similar to the *Hoser* case.[92] In order to improve the process, statutes should allow a health care provider to opt-out, but require that health care provider to provide the patient with at least some information on MAID and to transfer the patient's relevant medical records to a willing health care provider. So long as a health

[90] ME. STAT. ANN. tit. 418 § 2140.21 (2019); N.J. STAT. ANN. § 26:16-17(c) (2019); COLO. REV. STAT. § 25-48-113 (2016); CAL. CODE REGS. 1.85 § 443.14(e)(3) (2015);
[91] VT. STAT. ANN. tit. 18 § 5285-86 (2016).
[92] *Id.*

care provider who opts out of the MAID process is required to transfer medical records, a patient is nevertheless likely to receive treatment elsewhere.

A problem does arise in the circumstance where a patient's condition is so severe that it hinders his or her ability to physically change institutions. In this case, the patient's right to utilize MAID under the statute is diminished. Where a health care provider refuses to participate in MAID, an exception may be required for these patients. Perhaps a willing physician from an outside facility should be brought in to treat the patient. This counter argument addresses a complicated worst-case scenario that requires a more thoughtful resolution or a compromise beyond the scope of this paper.

In sum, at the very least, MAID legislation should not hold physicians liable who decline to participate in the process. In order to avoid legal challenges, every jurisdiction should also allow health care facilities to prohibit physicians from practicing MAID. In the interests of the patient, MAID statutes should require a health care provider who opts out to transfer the patient's medical records to another health care provider.

C. *Refusal to Inform and Refer*

In addition to the opt-out provisions for health care providers and the prohibitions by health care facilities, MAID legislation should address the refusal to inform a patient or refer the patient to another physician. As the Vermont litigation proves, it is not entirely clear the point at which a health care provider may draw the line when opting not to treat a terminally ill patient with respect to MAID. In the most extreme cases, a health care provider may vehemently disagree with any form of MAID and refuse to even refer a patient to another source or to provide a patient with information on MAID, as discussed above. California's Act addresses this by protecting healthcare

providers who refuse to inform a patient of his or her right to MAID and refuse to give the patient a referral.[93]

Although it could be argued that California's provision granting immunity to healthcare providers who refuse to inform a patient or refer a patient to a different healthcare provider is necessary to protect the interests of the healthcare providers who disagree with MAID, §443.14(e)(2) of California's Act goes too far. Allowing a physician to diagnose a patient with a terminal illness and thereafter excuse himself or herself from treating or even communicating with the patient thereafter will leave the patient in the dark, confused and abandoned. The patient should, at a minimum, be entitled to a referral. The physician should provide the patient with further information, such as a website on MAID, as agreed on in *Hoser*.[94]

The First Amendment rights and interests of healthcare providers who have moral, ethical, or religious beliefs that do not allow them to participate in any way in the MAID process are not violated. The assertion that the healthcare providers, such as the plaintiffs in *Becerra* and *Hoser,* face redressable injury under the MAID statutes that require them to refer a patient against their beliefs lacks merit. In the event that a patient later seeks to utilize the MAID process, the physician who opted out but who was required to provide the patient with a referral or other information, is not responsible in any way for the patient's choice to self-administer lethal medication. That patient still has to satisfy the other requirements and procedures in the MAID statute. To say otherwise is far too attenuated.

MAID statutes should not include immunity for health care providers who are unwilling to merely inform a terminally ill patient of a website or some other resource where that patient can research a potential MAID opportunity. California's §44.314(e)(2) does not give terminally ill

[93] CAL. CODE REGS. 1.85 § 443.14(e)(2) (2015).
[94] *Hoser*, at 232.

patients the information they are entitled to in these circumstances. Because these extreme circumstances of refusal are rather rare, it may not even be strictly necessary to amend existing MAID legislation but it could very well invite a legal challenge. If §443.14(e)(2) of California's statute is not amended, or if future jurisdictions adopt similar provisions, courts may end up having to balance a patient's interest in receiving information on MAID from the diagnosing physician or a health care provider's First Amendment interests.

V. CONCLUSION

The various safeguards in MAID legislation may seem onerous or difficult for a terminally ill patient to satisfy but they serve a necessary purpose of preserving life and protecting the integrity of the medical profession. There are currently a few particular provisions that require attention. The MAID statutes should account for whether a patient suffers from depression in order to guarantee that the patient's decision is not impaired. All health care providers should be granted the opportunity to opt-out of participating in MAID and facilities should be entitled to prohibit participation. Last, unwilling health care providers should, at a minimum, provide the patient with a source of information on MAID and transfer the patient's medical records to a willing health care provider. Legislatures should consider the recent legal challenges when carefully drafting future MAID statutes and account for these recommendations in order to better protect the interests of all parties involved.