WHAT'S THE COST OF LIVING IN OREGON THESE DAYS?—A FRESH LOOK AT THE NEED FOR JUDICIAL PROTECTIONS IN THE DEATH WITH DIGNITY ACT

INTRODUCTION

An Oregon resident engaged in a fight for her life in her battle against cancer.[1] But when Barbara Wagner received a letter in May 2008, she learned her new obstacle would be her home state.[2] Ms. Wagner, a sixty-four-year-old, low-income Oregon resident, learned her lung cancer returned after a two-year remission.[3] Her physician wrote a prescription for medication that studies have shown increases the one-year survival expectancy of cancer patients by 9.7 percent.[4] But Lane Individual Practice Associates ("LIPA"), administrators of the Oregon Health Plan in Ms. Wagner's county, denied funding for her prescription.[5] Instead, the Oregon Health Plan offered her funding for comfort care that included the option of a lethal prescription.[6] In response to the letter, Ms. Wagner said, "'To say to someone, we'll pay for you to die, but not pay for you to live, it's cruel . . . . I get angry. Who do they think they are?'"[7]

Ms. Wagner's story is not an isolated incident. Randy Stroup, a fifty-three year old Oregon resident, was also denied treatment funding under the Oregon Health Plan and, likewise, learned that the State would offer to pay for a lethal prescription.[8]

Fortunately, after a swell of publicity, the Oregon Health Plan offered to provide the medications they desired, and both are alive to tell their stories.[9] The stories of Ms. Wagner and Mr. Stroup reveal a scary truth about the Death with Dignity Act[10]—its safeguards are inadequate. A person forced to choose between excruciating pain or a lethal prescription is left with no meaningful choice at all. The state has a duty to provide a mechanism to protect its citizens from being put in that

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1 *See* Tim Christie, *A Gift of Treatment*, REGISTER-GUARD (Eugene, Oregon), June 3, 2008, at A1.

2 *Id.*

3 *Id.*

4 *Id.*

5 *Id.*

6 *Id.*

7 *Id.*

8 Dan Springer, *Oregon Offers Terminal Patients Doctor-Assisted Suicide Instead of Medical Care*, FOXNEWS.COM, July 28, 2008, http://www.foxnews.com/story/0,2933, 392962,00.html.

9 *Id.*; Christie, *supra* note 2.

10 Death with Dignity Act, OR. REV. STAT. §§ 127.800–.897 (2007).

position. Unfortunately, based on the aforementioned scenarios, this duty is being ignored. In fact, certain circumstances looming in the not-too-distant future actually increase the likelihood that a citizen will be placed in that situation.

With the rise of the largest senior citizen population in our nation's history on the horizon, as well as the increased cost of health care for both state and private industries, a judicial review process to oversee the Death with Dignity Act is essential to protect senior citizens against its potential abuses. In order to show the purpose and process of adjudicating Death with Dignity Act procedures, this Note unfolds in four parts. Part I explains the circumstances, both present and future, creating the potential for improper use of the Death with Dignity Act. Part II explains why the Death with Dignity Act, as presently written, does not provide adequate safeguards to protect citizens in light of those circumstances. Part III proposes an adjudicative procedure that a state may enact in order to provide sufficient protection for its citizens. Finally, Part IV provides the method for adjudicating Death with Dignity Act cases by using the example of the judicial bypass procedure for minors seeking an abortion. With a process of judicial review as a check on the procedures of the Death with Dignity Act, a state can confidently ensure the protection of patients, as well as the integrity of health care providers.

I. THE DEATH WITH DIGNITY ACT HAS BEEN AROUND OVER A DECADE—SO WHAT'S THE PROBLEM?

A. The Progress of the Death with Dignity Act

In 1994, the citizens of Oregon passed the Death with Dignity Act by citizen's initiative.[11] The Death with Dignity Act offered certain qualified patients the opportunity to choose to end their lives by obtaining a prescription from their physicians for lethal medication.[12] The purpose of the Act was to provide qualified patients an opportunity to meet their ends quickly and painlessly, as an alternative to the long and painful process they would otherwise endure.[13] Since its passage, the issue of physician-assisted suicide has been subjected to numerous legal challenges, yet it remains unscathed and in full force and effect in the

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[11] Associated Press, *Oregon Voters Allow Assisted Suicide for the Terminally Ill*, L.A. TIMES, Nov. 11, 1994, at A34. Despite its passage, the Death with Dignity Act did not actually take effect until 1997, when an issue as to its constitutionality was decided by the U.S. Supreme Court. *See infra* note 14.

[12] § 127.8805.

[13] *See* § 127.805(1).

states that allow it.[14] Though public opinion on this subject is divided, recent polls show a majority of citizens approve and accept its presence.[15]

In fact, a few more states appear to be heading toward a similar version of the Death with Dignity Act. Washington State citizens recently passed Initiative 1000 in the November 4, 2008 election, allowing qualified citizens an opportunity to choose death by lethal prescription.[16] Some Wisconsin legislators also have sponsored a similar bill in the state legislature.[17] In Montana, a state district court judge found a "right to die" in the state's constitution.[18] Based on its majority support and its spread to other states, it appears the Death with Dignity Act is here to stay.[19]

B. The Potential Problems for the Death with Dignity Act

Despite its legal successes, numerous practical challenges to its ability to remain limited in application are approaching. There are two major circumstances that will likely lead to an increase in the use of the Act, and, therefore, increase the likelihood of abuses. First, the significant increase in the senior citizen population will place a considerable strain on the state, the medical profession, and individuals that will likely open the door to more states enacting a Death with Dignity Act. Second, the skyrocketing costs of providing health care will cause all those involved to undertake a system of "rationing" that may push toward greater use of the Death with Dignity Act.

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[14] *See* Vacco v. Quill, 521 U.S. 793, 808–09 (1997) (permitting states to decide whether to ban physician assisted suicide); Washington v. Glucksberg, 521 U.S. 702, 735–36 (1997) (holding that the debate over physician assisted suicide should continue because Americans are engaged in an earnest and profound debate); Lee v. Oregon, 107 F.3d 1382, 1392 (9th Cir. 1997) (dismissing the case for lack of Article III jurisdiction).

[15] Joseph Carroll, *Public Divided over Moral Acceptability of Doctor-Assisted Suicide*, GALLUP, May 31, 2007, http://www.gallup.com/poll/27727/Public-Divided-Over-Moral-Acceptability-DoctorAssisted-Suicide.aspx.

[16] Janet I. Tu, *Assisted Suicide Measure Passes*, SEATTLE TIMES, Nov. 4, 2008, at A3 (citing 2008 INITIATIVE MEAS. 1000, of Nov. 4, 2008 (Wash.), *available at* http://wei.secstate.wa.gov/osos/en/Documents/I1000-Text%20for%20web.pdf).

[17] Ryan J. Foley, *Assisted Suicide Bill Debated; Testimony Hot at First Such Hearing in Decade*, WIS. ST. J. (Madison), Jan. 24, 2008, at D1.

[18] Baxter v. State, No. ADV-2007-787, 2008 Mont. Dist. LEXIS 482, ¶ 51 (Mont. Dist. Ct. Dec. 5, 2008) (citing MONT. CONST. art. II, §§ 4, 10).

[19] President Barack Obama has sought to reform the health care industry. One of the proposals put forward by the House of Representatives includes "end-of-life" counseling. America's Affordable Healthcare Act of 2009, H.R. 3200, 111th Cong. § 1233(a)(1)(B) (2009). Though not an explicit step toward a federal Death with Dignity Act, the fact that the government has an interest in "end-of-life" through the counseling provision is one step closer to such a program.

1. The Increasing Size of the Elderly Population

In the near future, the senior citizen population in the United States will experience a rapid growth. According to the Census Bureau, the "Baby Boomers" generation should reach age sixty-five by the year 2030.[20] Citizens sixty-five and older will increase from 39,000,000 in 2010 to 69,000,000 in 2030, accounting for twenty percent of the population.[21] Likewise, the eighty-five and older demographic will grow significantly. In fact, this age group will grow faster than any other age group, as it is projected to double in size by 2025 and increase fivefold by 2050.[22]

Based on a measurement known as "the elderly dependency ratio," the Census Bureau projects that elderly dependence will reach record levels in the coming years.[23] The dependency ratio is determined by calculating how many children and elderly people exist compared to every 100 people of working age.[24] The elderly dependency ratio will increase from 21.2 in 2010 to 35.7 by 2030, representing a number almost equivalent to the child dependency ratio.[25]

So what is the relevance of this information to the Death with Dignity Act? According to Oregon's Death with Dignity Act Annual Report, the overwhelming majority of participants are fifty-five and older with fifty-one percent over the age of sixty-five.[26] With such a significant increase in the elderly population across the country, it is reasonable to infer that the Death with Dignity Act will also increase in use, possibly expanding beyond Oregon and Washington to a majority of states. If such an expansion takes place, then opportunities for improper use of the Death with Dignity Act will be enlarged.

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[20] JENNIFER CHEESEMAN DAY, U.S. CENSUS BUREAU, CURRENT POPULATION REPORTS P25-1130, POPULATION PROJECTIONS OF THE UNITED STATES BY AGE, SEX, RACE, AND HISPANIC ORIGIN: 1995–2050, at 1 (U.S. Government Printing Office, Washington D.C. 1996), *available at* http://www.census.gov/prod/1/pop/p25-1130/p251130.pdf.

[21] *Id.*

[22] *Id.*

[23] *Id.* at 7.

[24] For example, if there were 25 children, 25 elderly, and 100 working age people, the dependency ratio would be 50. "Children," for purposes of this ratio, are between zero and seventeen years of age. "Elderly" is defined as sixty-five or older. "Working age" is defined as being between the ages of eighteen and sixty-four. *Id.*

[25] *Id.*

[26] OR. DEP'T. OF HUMAN SERVS., OREGON'S DEATH WITH DIGNITY ACT 2007, at 2–3 (2008) [hereinafter OREGON REPORT], *available at* http://egov.oregon.gov/DHS/ph/pas/docs/year10.pdf.

2. The High Costs of Health Care

The high costs of health care present a problem in need of an immediate remedy. Total health care spending is expected to increase from $2.3 trillion in 2007 to $4.1 trillion by 2016, accounting for 20% of the nation's gross domestic product.[27] According to the Census Bureau, in 2007, 45.7 million people lived in the United States without health insurance.[28] Though that number represents a decrease in uninsured individuals from the previous year, it does not reflect an increase in private health insurance.[29] Rather, the use of government provided health insurance rose, growing from 80.3 million in 2006 to 83 million recipients in 2007.[30] The pressure to revamp health care is so strong that it nearly dominated the most recent presidential campaigns.[31]

President Barack Obama believes that health care "should be a right for every American," according to his response to a question in one of the 2008 presidential debates.[32] He believes that a nation as large and rich as America should be able to provide insurance coverage for everyone.[33] But with the hike in private health care costs, coverage for everyone will likely mean an increased burden on the state or federal government to provide some form of universal insurance coverage for the uninsured.[34]

Unfortunately, the current burden the government shoulders in its attempt to provide health care assistance is reaching unbearable levels. Though both Medicare and Social Security programs face possible exhaustion of funds, Medicare's rapid decline is expected to be the first to suffer.[35] With the high costs of health care, the government will spend more on Medicare benefits than it will take in from payroll taxes.[36] In order to prevent the exhaustion of Medicare, the government can

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[27] John A. Poisal, et al., *Health Spending Projections Through 2016: Modest Changes Obscure Part D's Impact*, 26.2 HEALTH AFF., w242, w242–43 (2007).

[28] CARMEN DENAVAS-WAIT, ET AL., U.S. CENSUS BUREAU, CURRENT POPULATION REPORTS P60-235, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2007, at 19 (U.S. Government Printing Office, Washington D.C. 2008), *available at* http://www.census.gov/prod/2008pubs/p60-235.pdf.

[29] *Id.*

[30] *Id.*

[31] *See, e.g.*, Commission on Presidential Debates, Second McCain-Obama Presidential Debate (Oct. 7, 2008), http://www.debates.org/pages/trans2008c.html.

[32] *Id.*

[33] *Id.*

[34] *See, e.g.*, America's Affordable Health Choices Act of 2009, H.R. 3200, 111th Cong. (2009) (explaining that the purpose of the bill is "[t]o provide affordable, quality health care for all Americans and reduce the growth in health care spending.").

[35] SOC. SEC. & MEDICARE BDS. OF TRS., SUMMARY OF THE 2009 ANNUAL REPORTS 2 (2009), *available at* http://www.ssa.gov/OACT/TRSUM/tr09summary.pdf.

[36] *Id.*

increase taxes dramatically, cut more than half of the program's spending, or implement some combination of these two options.[37]

Because of the political damage a tax increase causes, the more likely course of action includes finding areas where decreases in spending will be feasible. The states' funding limitations will inevitably lead to a system of health care rationing. Of course, this rationing leads to economic determinations of treatment and tough decisions as to who will receive funding, as well as to what degree. For low income, elderly individuals in particular, who are unable to afford private health insurance and are suffering from a terminal disease, the risk is especially high that the state will not be able to fund the needed prescriptions and treatment that may be required. But politicians understand that they cannot allow the low-income, elderly citizens suffer through a terminal disease without taking some measure to make their end as comfortable as possible. So how does the government purport to provide care and a sense of dignity to our terminally ill seniors while cutting back on Medicare expenditures? Say hello to the Death with Dignity Act. Through the Death with Dignity Act, the government offers itself the opportunity to provide a health care cost cutting mechanism while claiming to provide the terminally ill an opportunity to retain dignity and a pain free end.

Some are probably thinking that such an idea is preposterous and would never enter into a person's thought process. Remember the story of Ms. Wagner?[38] Why is someone like her denied funding for her prescription but offered a lethal prescription? According to the medical director of Oregon's Division of Medical Assistance Program, "'We can't cover everything for everyone . . . . Taxpayer dollars are limited for publicly funded programs. We try to come up with policies that provide the most good for the most people.'"[39] The purpose of this Note is not to argue that there is anything necessarily wrong with this quote but to show economic efficiency does play a role in the decision making processes for governmental health care providers, even in Death with Dignity Act cases. With limited funding for government programs, the high costs of health care, and the largest increase of senior citizens in years, the Death with Dignity Act will likely find a place on the law books of most states, adding more opportunities for its abuse.

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37 *Id.*

38 *See supra* notes 2–9 and accompanying text.

39 *See* Christie, *supra* note 2, at A1.

II. HOW ARE THE SAFEGUARDS ENFORCED?—DOES THE PHRASE "BECAUSE I SAID SO" WORK ANYMORE?

In light of the increased potential for abuse of the Death with Dignity Act, it is important to assess the strength of the purported safeguards provided by the statute. The adequacy of the safeguards offered by the Death with Dignity Act has received mixed reviews. Some claim that the statutory protections alone are sufficient to prevent lethal prescriptions from improperly getting into the hands of patients.[40] The basis of this argument rests on the theory that if no actual evidence of abuse, coercion, or misuse of the Death with Dignity Act is produced, then the safeguards are in fact adequate.[41] But such an argument is insufficient, especially when the statute does not require objective investigation into the procedures and physicians involved in the Death with Dignity Act process. For this reason, others argue that the statute, while stating protections against and punishments for abuse, is void of any real enforcement mechanism.[42] There are three main statutory safeguards that can be evaluated for their adequacy to protect a potential Death with Dignity Act patient: capacity, voluntary choice, and terminal disease.

A. Do You Know What You Are Asking Me to Do?—The Capacity Requirement

First, the Death with Dignity Act provides, as a safeguard, the requirement that a patient seeking a lethal prescription be "capable."[43] "Capable" is defined as the patient's "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."[44] The determination of capacity rests on the "opinion of a court or . . . the patient's attending physician or consulting physician, psychiatrist or psychologist."[45] Capability of a patient hinges on whether the "patient may be suffering from a psychiatric or

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[40] *See, e.g.*, Kathryn L. Tucker, *In the Laboratory of the States: The Progress of* Glucksberg's *Invitation to States to Address End-of-Life Choice*, 106 MICH. L. REV. 1593, 1602, 1605 (2008) (citing OR. REV. STAT. § 127.805 (2007)) (claiming that the safeguards of the Oregon Death with Dignity Act have been successful).

[41] *Id.* at 1605 (quoting William McCall, *Assisted-suicide Cases Down in '04* COLUMBIAN (Vancouver, Wash.), Mar. 11, 2005, at C2).

[42] See generally Susan R. Martyn & Henry J. Bourguignon, *Now Is the Moment to Reflect: Two Years of Experience with Oregon's Physician-Assisted Suicide Law*, 8 ELDER L.J. 1 (2000) [hereinafter Now Is the Moment] (explaining that the Death with Dignity Act's enforcement mechanisms are weak and amorphous).

[43] § 127.805(1).

[44] § 127.800(3).

[45] *Id.*

psychological disorder or depression causing impaired judgment."[46] Though the statute provides the option of a court determination of capability,[47] it requires the patient's physician to make the initial determination of capacity.[48] Once the physician is satisfied that the patient is capable, the physician must refer the patient to another consulting physician, who then gives a second opinion about the patient's capability.[49] According to the statute, if either the attending or consulting physician is suspicious about the capacity of the patient, she is required to refer the patient to a psychologist or psychiatrist for counseling.[50] A good faith determination of capability by the physicians satisfies this safeguard.[51]

This process, however, has no mechanism for determining whether a physician's determination of capability is accurate. Although the statute requires a report from the attending and consulting physicians that the patient is capable,[52] there is no requirement as to how much information should be provided. Also, physicians are not specifically required to report how they reached their conclusions.[53] There is no requirement that the physician investigate into the determination of the patient's mental history, even as to whether the patient has tried to commit suicide in the past. The scariest fact about this "safeguard" is that a physician is shielded from liability for an incorrect finding of capability, even if she is mistaken or negligent, because the physician is only required to make a "good faith" effort in her determination.[54] Of course, there is no definition of "good faith" in the statute that can be used to check the intentions or performance of this safeguard.

Physicians are not adequately trained to decide whether a patient is suffering from a mental disorder or depression, especially to the extent that it is needed to show "impaired judgment."[55] In a recent survey, twenty-eight percent of physicians, by their own admissions, questioned their abilities to determine whether a patient requesting a lethal prescription is in fact capable of making such a decision.[56] This statistic

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[46] § 127.825.

[47] § 127.800(3).

[48] § 127.815(1)(a).

[49] § 127.815(1)(d).

[50] § 127.825.

[51] § 127.885(1).

[52] § 127.855(3).

[53] *Id.*

[54] § 127.885(1).

[55] Raphael Cohen-Almagor & Monica G. Hartman, *The Oregon Death with Dignity Act: Review and Proposals for Improvement*, 27 J. LEGIS. 269, 283 (2001).

[56] *Id.* (citing Melinda A. Lee, et al., *Legalizing Assisted Suicide—Views of Physicians in Oregon*, 334 NEW ENG. J. MED. 310, 312–13, (1996)).

rises in importance in light of a study revealing that twenty percent of patients seeking a lethal prescription suffer from symptoms of depression.[57] In fact, when patients receive treatment for their depression, some of them decide not to follow through with the lethal process.[58] But there are other impairments to a patient's capacity that physicians are likely to miss. In addition to depression, a patient's judgment may be "impaired" by alcoholism or drug use (especially in the case of a terminally diseased patient), thus rendering the patient incapable of seeking a lethal prescription.[59] The fear of oncoming, excruciating pain can also cloud the judgment of a patient. If, however, she receives the needed pain relief information and medication, a study reveals that she will be less likely to follow through with the lethal prescription.[60] Competency is difficult enough for a psychiatrist to determine, as proven by a survey that found only six percent of psychiatrists confidently assert the ability to determine the capacity of a patient seeking a lethal prescription.[61]

Even assuming that a physician has an ability to discern certain characteristics of mental instability in their patients, counseling referral has steadily declined since the inception of the Death with Dignity Act. In 2007, not one patient who requested a lethal prescription was referred to psychological or psychiatric counseling.[62] That same year, the Death with Dignity Act saw a record number of participants.[63] Perhaps every patient was capable. But, because of the lack of an enforcement mechanism, no one will ever know.

B. Are You Sure?—The Requirement of Voluntary Choice

The Death with Dignity Act requires that a patient voluntarily express a wish to die.[64] Two oral requests must be made with a fifteen day waiting period between them.[65] The patient must also make a written request.[66] There is a forty-eight hour waiting period requirement

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[57] Linda Ganzini, et al., *Physicians' Experiences with the Oregon Death with Dignity Act*, 342 NEW ENG. J. MED. 557, 562 (2000) [hereinafter *Physicians' Experiences*].

[58] *Id.*

[59] Herbert Hendin & Kathleen Foley, *Physician-Assisted Suicide in Oregon: A Medical Perspective*, 106 MICH. L. REV. 1613, 1621 (2008); *see also Now Is the Moment*, *supra* note 42, at 14 (quoting David Orentlicher, *From the Office of the General Counsel: Physician Participation in Assisted Suicide*, 262 J. AM. MED. ASS'N 1844, 1845 (1989)).

[60] *Physicians' Experiences*, *supra* note 57, at 560.

[61] Linda Ganzini, et al., *Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide*, 153 AM. J. PSYCHIATRY 1469, 1473 (1996).

[62] OREGON REPORT, *supra* note 26, at 4.

[63] *Id.* at 1.

[64] OR. REV. STAT. § 127.805(1) (2007).

[65] § 127.840.

[66] *Id.*

between the written request and the writing of the lethal prescription.[67] The physician is required to suggest that the patient contact her next of kin, though the patient is not required to do so.[68] The statute provides that a patient may change her mind at any time.[69] In seeking to protect the voluntariness of the decisions, anyone who "coerces or exerts undue influence" on a person seeking a lethal prescription under the Death with Dignity Act will be found guilty of a felony.[70] Again, physicians decide whether the patient is making a voluntary decision and must make a report of that finding.[71] As long as the decision is made in good faith, the physician is free of liability.[72]

Though this decision rests on the physician, the statute provides no guidelines as to how the physician is to make that determination. The physician is not required to question family members to determine if familial coercion is present. Neither is she required to inquire into the financial ability of the patient to determine if the patient is making her decision based on a lack of means. The physician could simply ask if the patient is being coerced and, upon receiving a satisfactory answer, decide that the patient is making a voluntary decision.[73] Upon receiving a satisfactory answer, the physician has performed a "good faith" determination of voluntariness.[74]

To claim that this statutory safeguard sufficiently protects patients from coercion is absurd. Coercion and undue influence come in many forms and are often difficult to discover. The most obvious form of coercion is family pressure, especially for the elderly.[75] One of the reasons a person seeks a lethal prescription is because she feels she is a burden to her family.[76] Though at first such a reason rings of nobility on behalf of the elder member, the reasons why the elder member feels that way are worth investigating. It could be that the family members are putting pressure on her in order to hasten their ability to acquire the elder member's inheritance. This danger significantly increases in states, like Wisconsin, that do not deny inheritance rights to family

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67 § 127.850.

68 § 127.835.

69 § 127.845.

70 § 127.890(2).

71 § 127.855(3).

72 § 127.885(1).

73 *See* § 127.815(1)(a) (regarding attending physician responsibilities).

74 § 127.885(1).

75 Hendin & Foley, *supra* note 59, at 1624–25 (citing Erin Hoover Barnett, *A Family Struggle: Is Mom Capable of Choosing to Die?*, OREGONIAN, Oct. 17, 1999, at G01).

76 *Id.* at 1625.

members who assist in the suicide of a family member.[77] Despite these possibilities, the physician is not required to investigate a patient's family before writing a lethal prescription.

Additionally, financial constraints may cause a patient to feel they have no real choice except to "choose" a lethal prescription. Elderly citizens who cannot work, are alone, and have no family to depend on, do not have the means to pay for expensive medical treatment. When the state refuses to pay for treatments but offers to pay for a lethal prescription, a patient in fear of the oncoming pain and suffering associated with the disease will naturally feel compelled to choose the latter.[78] A more subtle form of coercion lies in the hands of the patient's physician. If the physician suggests to a patient that she should take a lethal prescription, the patient may feel compelled to take it.[79] After all, this is the person the patient trusts and relies on to seek her best interest.[80] If the patient happens to have a physician, paid by the state under some publicly funded health care plan, who encourages the patient to take a lethal prescription, that patient may feel that taking the prescription is the best option.[81] Clearly, there are numerous opportunities for coercion that the statutory safeguards are impotent to prevent.

C. How Sick Are You?—The Terminal Disease Requirement

The Death with Dignity Act requires that a patient must be suffering from a "terminal disease."[82] "Terminal disease" is defined as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months."[83] The attending physician makes the initial diagnosis of the disease, followed by a confirmation by the consulting physician.[84] Of course, as long as the physician exercises "good faith" in the analysis of a patient's illness, the Death with Dignity Act shields her from liability.[85]

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77 *See* Ryan J. Foley, *Kin Who Assist in Suicide Can Inherit; Ruling Thought to Be 1st of Its Kind in U.S.*, CHI. TRIB., Sept. 26, 2008, at 7 (citing Lemmer v. Schunk (*In re* Estate of Schunk), 2008 WI App 157, 760 N.W.2d 446 (Wis. Ct. App. 2008)) (discussing the litigation that arose due to a law prohibiting one who unlawfully kills another from inheriting from the person (citing WIS. STAT. § 854.14 (Supp. 2008))).

78 Susan R. Martyn & Henry J. Bourguignon, *Physicians' Decisions About Patient Capacity: The Trojan Horse of Physician-Assisted Suicide*, 6 PSYCHOL. PUB. POL'Y & L. 388, 397 (2000) [hereinafter *Physicians' Decisions*].

79 *Now Is the Moment*, *supra* note 42, at 28.

80 *Id.*

81 Cohen-Almagor & Hartman, *supra* note 55, at 293–94.

82 OR. REV. STAT. § 127.805(1) (2007).

83 § 127.800(12).

84 § 127.815(1)(a), (d).

85 § 127.885(1).

Obviously, a physician cannot know the precise moment when a patient with a terminal disease will die. Thus, the statute places the "within reasonable medical judgment" caveat within the definition for terminal disease.[86] The purpose behind this is to prevent physicians from "mercy" killing and to make sure that no more lethal prescriptions are granted than are necessary.[87] Because this portion of the statute purports to be a safeguard, at a minimum, it should place some tangible, documentary requirements on the physician.[88] For this reason, a guideline suggests that physicians extensively document a patient's disease, prognosis, the written request or video equivalent for the lethal prescription, the conversations between the physician and patient, the physician's offer to rescind at the patient's request, discussions between the patient and her family, and a psychological report of the patients capability.[89] Fortunately, the statute does require documentation of some of the suggestions above by the physician.[90] But even if the physician is wrong or negligent in her diagnosis, no liability will befall her.[91] Therefore, this safeguard evinces weakness and a lack of an actual enforcement mechanism.

III. ORDER IN THE COURT—I'LL HAVE A LETHAL PRESCRIPTION UNDER THE DEATH WITH DIGNITY ACT

Though the statutory safeguards are inadequate, the Death with Dignity Act need not be scrapped. In fact, there are some areas in which the Death with Dignity Act could expand so long as there is an actual safeguard mechanism to enforce its protections.[92] Rather, the Death with Dignity Act should offer an objective safeguard process beyond the reach of the Oregon Health Plan. This Note proposes that the best method to ensure that the safeguards are enforced is actually mentioned in the

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[86] § 127.800(12).

[87] *See Now Is the Moment*, *supra* note 42, at 8 (citing § 127.805(1)).

[88] Cohen-Almagor & Hartman, *supra* note 55, at 297.

[89] *Id.*

[90] § 127.815(1)(a), (d); § 127.855.

[91] § 127.885(1); *see also Now Is the Moment*, *supra* note 42 at 32.

[92] For instance, the Death with Dignity Act as currently written would not allow an Alzheimer's patient to participate because it is not reasonable to assume that a patient will die within six months when the disease is diagnosed. *See* § 127.800(12) (defining a terminable disease as a disease that will "produce death within six months"). Further, a patient within six months of death will likely not have the capability required under the Death with Dignity Act. *See* § 127.800(3) (defining capability). In addition, the fact that a person writes a "living will" authorizing participation in the Death with Dignity Act is not sufficient to allow participation as currently written. *See* § 127.805 (requiring a person to express her wish to die). With the appropriate enforcement of safeguards, opponents of the Death with Dignity Act may be willing to expand the statute's applicability, at least to cover this undignified disease.

statute, though only referred to once and seemingly glossed over.[93] A process of judicial review over the Death with Dignity Act provides the best option to ensure that each of the protections and procedures are followed. A state that enacts an adjudicative review process will ensure protection of its citizens, as well as the integrity of the medical profession, by providing a mechanism to prevent misuse of the Death with Dignity Act.

A. The Experience Factor—Courts Have Already Processed the Safeguards in Other Settings

1. A Court Can Distinguish Whether You Understand What You Are Asking

The courts offer a tested system for determining the capability of a patient to request a lethal prescription under the Death with Dignity Act. The judicial process has extensive experience in making competency determinations for various issues and people groups. Across the nation, judges determine the competency of those with mental incapacity, children, and the elderly.[94] Courts often have the final say as to the competency of one of these people groups to enter into a contract, make a will, or even to commit a crime.[95] Often, these cases present difficult factual scenarios requiring sophisticated decision-making. For the most part, these tough choices are placed before judges who render decisions based on the law, the facts of the particular cases, and all the evidence presented.

One of the more difficult and extensive issues courts decide is especially pertinent to the Death with Dignity Act—the doctrine of informed consent. Based on the statutory language, an argument can be made that the very definition of "capability" within Oregon's Death with Dignity Act comes from the state's rule regarding informed consent.[96] There are two necessary components that a patient must show to claim informed consent was not obtained. First, the patient must prove that the physician did not "explain . . . [i]n general terms the procedure or treatment to be undertaken; . . . alternative procedures or methods of treatment, if any; and [the] . . . risks, if any, to the procedure or treatment."[97] Though the initial explanation can be in general terms, the

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[93] *See* § 127.800(3) (regarding capability).

[94] *See, e.g.*, FED. R. EVID. 601.

[95] *Id.*

[96] *Compare* OR. REV. STAT. § 127.800(7) (2007) (defining "informed decision" for purposes of the Death with Dignity Act) *with* § 677.097 (explaining the procedure for a physician to obtain "informed consent" of a patient). This Note will use Oregon's law regarding informed consent in explaining its meaning and application.

[97] § 677.097.

physician also must ask if the patient wants a more detailed explanation; and upon receiving an answer in the affirmative, the physician must give a more detailed explanation of either the procedure or the alternatives unless it would be detrimental to the patient.[98] Second, the patient must show that the lack of explanation by the physician caused the injury.[99] In determining whether the failure to warn causes injury, the issue is whether the particular patient would have consented to the treatment if she had been properly informed of all material risks or alternatives.[100]

Although physicians ordinarily are trusted to use reasonable judgment in deciding whether a patient can give informed consent, the special situation created by the Death with Dignity Act does not lend itself to the usual informed consent procedure. Many physicians, by their own admissions, are not confident in their abilities to determine the capability of a Death with Dignity Act participant.[101] Additionally, some of the participants may suffer from symptoms of depression, rendering them incapable of participating in the Death with Dignity Act.[102] Most importantly, whether that particular Death with Dignity Act patient would have changed her mind if the physician had explained the availability of feasible alternatives will be difficult to unveil for several reasons. First, the Death with Dignity Act does not require the physician to explain how she determined the patient's capability or even how much she explained about the procedure or alternatives. Second, the patient, upon review of the procedure, will likely have died as a result of the prescription, leaving only second guessing as to what that particular patient might have done. Thus, the safer course to protect patients from improper or negligent determinations of capability is to allow courts to review the attending and consulting physicians' determinations of capability before allowing the patient to receive a prescription. The courts have more experience in determining capacity and can use it to ensure that a person is truly able to understand the gravity of her decision to participate in the Death with Dignity Act.

2. A Court Can Distinguish Whether You Are Sure This Is What You Want to Do

Courts also provide an able medium for recognizing the difficult situations when coercion and undue influence may be present in a

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[98] *Id.*

[99] *See, e.g.*, Arena v. Gingrich, 748 P.2d 547, 550 (Or. 1988) (discussing cause).

[100] *Id.* This test is subjective, rendering what an objective, reasonable person would do irrelevant. *Id.*

[101] Cohen-Almagor & Hartman, *supra* note 55, at 283.

[102] *See Physicians' Experiences*, *supra* note 57, at 562.

patient's decision to use the Death with Dignity Act. The court system has a wealth of experience in uncovering coercion and undue influence involving issues such as contracts, wills, and criminal proceedings.[103] In addition, cases involving coercion from family pressure, salesmen, and even physicians come before the judiciary.[104] Again, these cases are very fact-specific, depending heavily on the circumstances which a physician who does not investigate beyond the consultation with the patient is likely to miss.

Even assuming good intentions, physicians lack the training to detect coercion and undue influence. Even if they had such training, it would be unlikely that a physician could recognize coercion or undue influence based upon a couple of consultations with the patient.[105] Coercion and undue influence hide well from even the most trained eye. In fact, physicians themselves may play a role in coercing the patients into making the decision to end their lives.[106] When a physician tells a patient that she can suffer in pain for the remainder of her years or can take a lethal prescription as a painless alternative, one can hardly doubt that a patient who hears such words of hopelessness will give extra credence to the suggestion by her trusted doctor.[107] Additionally, the Health Maintenance Organizations ("HMOs") and other state-run health programs may be involved, whether intentionally or not, in coercing patients to end their lives through the Death with Dignity Act.[108] After all, Ms. Wagner and Mr. Stroup might not have been around to tell their stories had they not spread the news throughout the media about the letters they received denying treatment.[109] How do we know that no other such letters were sent out? Who else may have felt there was no hope but did not have the means or support to seek out help or counsel? All we have is the word of the state health department that everything is fine.

A court proceeding, however, could require the patient to prove that the decision is in fact voluntary by producing evidence that a physician is currently not required to unearth. Using its extensive experience in

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[103] *See, e.g.*, Wayne v. Huber (*In re* Wayne's Estate), 294 P. 590 (Or. 1930); Checkley v. Boyd, 14 P.3d 81 (Or. Ct. App. 2000).

[104] *See, e.g.*, Shaw v. Kirschbaum, 653 A.2d 12 (Pa. Super. Ct. 1994); Crawford Chevrolet, Inc. v. McLarty, 519 S.W.2d 656 (Tex. Civ. App. 1975).

[105] *Physicians' Decisions*, *supra* note 78, at 396.

[106] *Now Is the Moment*, *supra* note 42, at 49.

[107] *Id.*

[108] *Physicians' Decisions*, *supra* note 78, at 397 (citing *Lethal Drug Abuse Prevention Act of 1998: Hearing on H.R. 4006 Before the Subcomm. on the Constitution of the H. Comm. on the Judiciary*, 105th Cong. 17 (1998) (statement of N. Gregory Hamilton, Physicians for Compassionate Care)).

[109] *See supra* notes 2–9 and accompanying text.

deciding these cases, the court provides a method to show that the patient voluntarily decided to accept the option of a lethal injection. Should the court determine that either a physician, family member, HMO, or other entity coerced or unduly influenced a patient's decision, the court can deny the patient's ability to receive a lethal prescription before a life is wrongfully taken.

B. Dead or Alive—The Court's Objectivity Regarding the Outcome

Another benefit to using a court proceeding to enforce the protections of the Death with Dignity Act is the objectivity it brings to the issue. Hot button issues, such as the Death with Dignity Act, often force people to take sides. Of course, people who have an interest in the procedure are more likely to make decisions beneficial to their side.[110] Those who have an interest in preventing the procedure will render decisions that will either limit or eliminate the problem as they see it. Usually, these decisions are self-centered based on the belief system held by the proponent or opponent of the issue, with one side feeling it is "winning" and the other side believing it is "losing."[111]

This is especially true with the Death with Dignity Act. One side argues that the Death with Dignity Act is a necessary addition to the legal and political system because it offers a "compassionate" end to a life of suffering and an opportunity to give individuals control over their own lives.[112] Decision makers in this camp are likely to push for the use of the Death with Dignity Act with few to no limits.[113] Even in the difficult cases, proponents of the Death with Dignity Act might make decisions that serve their own interests rather than their patients' interests.[114] HMOs and state-run health programs have a stake in the use of the Death with Dignity Act as well.[115] They claim to uphold individual rights and a better economy for all, yet they also send out

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[110] *See Now Is the Moment*, *supra* note 42, at 10 (quoting THE OREGON DEATH WITH DIGNITY ACT: A GUIDEBOOK FOR HEALTH CARE PROFESSIONALS 8, 63 (Patrick Dunn & Bonnie Reagan eds., 1998)).

[111] *See id.*

[112] Tucker, *supra* note 40, at 1611.

[113] *See id.*

[114] Hendin & Foley, *supra* note 59, at 1628–30 (citing George Eighmey, Oregon's Death with Dignity Act: Health Care Professionals Speak Out on Its Impact, Remarks at the Nineteenth Annual Meeting of the Council on Licensure, Enforcement, and Regulation (Sept. 3, 1999), *quoted in* N. Gregory Hamilton, *Oregon's Culture of Silence*, *in* THE CASE AGAINST ASSISTED SUICIDE: FOR THE RIGHT TO END-OF-LIFE CARE 175, 184–85 (Kathleen Foley & Herbert Hendin eds., John Hopkins Paperbacks ed. 2004)).

[115] *See Physicians' Decisions*, *supra* note 78, 397 (citing *Lethal Drug Abuse Prevention Act of 1998: Hearing on H.R. 4006 Before the Subcomm. on the Constitution of the H. Comm. on the Judiciary*, 105th Cong. 17 (statement of N. Gregory Hamilton, Physicians for Compassionate Care)).

letters offering lethal prescriptions as an option to those who request life-sustaining treatment.[116] But why should anyone expect less? There are a large number of people who have to be treated and money is tight, especially in the present economy. And with the influx of the largest senior citizen community coming, money will be even tighter. Obviously, if a patient's determination of either capacity or voluntariness is left to one of these proponents, they will more than likely make a decision favorable to their economic needs.

Also, physicians have a stake in the use of the Death with Dignity Act by their patients. Physicians are extremely busy with numerous patients with numerous needs.[117] Obviously, caring for every patient who seeks care from the physician is a difficult and overwhelming task, especially when the patient is suffering from a terminal disease.[118] While a physician has a duty to "do no harm," a physician also must consider a patient's financial limits and not use frivolous attempts of treatments they know are unlikely to work. These conflicting duties force physicians into making determinations that may be more in their best interest than their patients', as they fear liability. Offering the Death with Dignity Act to a patient may free more time for a physician to treat other patients who have, in the physician's opinion, higher chances of survival. Additionally, a physician is free from liability under the Death with Dignity Act, while any other mistakes in treatment may subject him to malpractice.[119] Thus, the Death with Dignity Act is an attractive option for a physician to use to protect himself while seemingly offering his patients an alternative to a life of suffering. Therefore, a physician may have an interest in pushing the patient to make the choice to end her life.

A court procedure offers an objective perspective to each of the procedures in the Death with Dignity Act. The final outcome of the decision made by the court is of no moment to a judge. The judge's only role is to ensure that the law is followed properly and, if violated, to give punishment. Despite personal opinions or prejudices, the judge has a duty not to herself or to her positions, but to the law. Her job is simply to look at the evidence presented by the potential participant and make a determination that every aspect of the Death with Dignity Act is properly and thoroughly observed. Should a judge decide that she cannot make a fair judgment in a matter, she can simply recuse herself from the proceeding, deferring to the judgment of another judge.

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116 *See supra* notes 2–6 and accompanying text.

117 *Now Is the Moment*, *supra* note 42, at 47.

118 *Id.*

119 OR. REV. STAT. § 127.885(1) (2007).

Opponents of this suggestion may argue that a judge who holds a "right to life" position or is a "conservative ideologue" will either refuse all petitions from patients seeking a lethal prescription, decide all of those cases favorably to her position, or that judges may continually recuse themselves so that a potential Death with Dignity Act candidate may not be able to receive a lethal prescription.[120] The beauty of the adjudicative system, however, is that it provides a finding of fact which can serve as the basis for an appeal. If a judge uses her position to advance her own agenda, it is the job of the appellate courts to review and reverse those decisions and hold those judges accountable. Another argument may be that the length of time required might moot the case because the patient seeking assistance under the Death with Dignity Act may pass away before an appeal can be granted. But this argument does not make sense for two reasons. First, if the Death with Dignity Act is only used by a limited number of people, as the proponents of the Death with Dignity Act suggest, the strain on the judicial system should be minimal at all levels.[121] Second, if the patient were to die within the fifteen day period, which is recommended below as the suggested judicial period, one could hardly argue that the Death with Dignity Act was needed to prevent a long and tortuous period of suffering, which debunks the major argument advanced for its passage.[122] Nevertheless, the judicial system provides an adequate avenue of objective decision-making to the Death with Dignity Act and would serve as a protection against the agendas of all parties involved.

C. Prescribe Properly or Prepare for Prison—The Court's Actual Mechanism for Enforcement

Currently, the Death with Dignity Act provides no real mechanism for enforcement of its provisions. The statute makes it a felony to willfully change a request for medication intending to cause a patient's death.[123] Coercion or undue influence to take a lethal prescription is also a felony.[124] Additionally, the Death with Dignity Act claims that it does not in any way limit civil liability for "negligent conduct or intentional misconduct."[125] Proponents of the Death with Dignity Act claim that

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[120] A similar argument has been made in the context of the judicial bypass procedure for minors seeking to obtain an abortion without parental consent. Lauren Treadwell, Note, *Informal Closing of the Bypass: Minors' Petitions to Bypass Parental Consent for Abortion in an Age of Increasing Judicial Recusals*, 58 HASTINGS L.J. 869, 883 (2007).

[121] Tucker, *supra* note 40, at 1604 (citing OREGON REPORT, *supra* note 26, at 1) ("[T]he reports demonstrate that use of physician-assisted dying is limited.").

[122] *See id.* at 1611.

[123] § 127.890(1).

[124] § 127.890(2).

[125] § 127.890(3).

these safeguards offer sufficient incentive to deter misuse of the statute.[126]

But how does the Death with Dignity Act propose to enforce these safeguards? It does not. As one author stated, the Death with Dignity Act "has no teeth."[127] The Death with Dignity Act requires information to be gathered by the physician in order to report it to the state health department.[128] Of course, not every patient's information is reviewed by the health department. The department only seeks a sampling of the patients for reporting purposes.[129] Moreover, the statute does not allow any information taken pursuant to the Death with Dignity Act to be revealed to the public.[130] The only information revealed under the Death with Dignity Act are the statistics gathered by the state health department upon reviewing a sample of the reports.[131]

Without the requisite knowledge, a patient's family cannot possibly know whether a family member wrongfully received a lethal prescription. The criminal authorities will never learn whether a family member coerced a patient into going through with the Death with Dignity Act for monetary reasons. The state health department cannot deduce wrongdoing from the forms turned in from the physicians because the physicians are not required to give details as to how they reached their decisions. They are only required to make good faith efforts in compliance with the provisions, which does not require any measure of specificity of the capacity, voluntariness, or the illness of the patient.[132] Most importantly, a physician who wrongfully prescribes a lethal prescription, whether intentionally or negligently, is immune from liability under the statute.[133] So, even if a family member were to learn that the physician made a mistake in deciding that the particular patient had capacity, the physician would be free from liability as long as she made her determination in good faith.[134] How is the measure of good faith decided? The statute is silent on that issue. It appears that as long as she complies with the requirements set forth in the statute, she has satisfied the requirements necessary to avoid liability.[135] Because the information received pursuant to the reporting requirement to the health department is not open to the public, there is no apparent method

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126 *See, e.g.*, Tucker, *supra* note 40, at 1602 (citing § 127.805(1)).

127 *Now Is the Moment*, *supra* note 42, at 53.

128 § 127.855.

129 § 127.865(1)(a).

130 § 127.865(2).

131 § 127.865(3).

132 § 127.885(1).

133 *Id.*; *see also Now Is the Moment*, *supra* note 42, at 32.

134 *Id.*

135 *See* § 127.815 (regarding physician responsibilities).

by which to obtain proof of wrongdoing surrounding the Death with Dignity Act process.[136] And because of the immunity provision, physicians are exempt from both civil and criminal liability, as long as they make a good faith effort.[137] Thus, the statutory provisions have no mode of true enforcement under the current statute.

A court proceeding has the power to properly enforce the safeguard provisions of the Death with Dignity Act. Prior to receipt of the lethal prescription, a patient can produce evidence before the court proving that she is capable and that her decision has not been improperly influenced by another. Additionally, the judge can look at whether the physician properly determined the capacity or voluntariness to petition for a lethal prescription. If a physician or health provider wrongfully or negligently granted a patient a lethal prescription, the court would allow the patient or patient's family a method of recourse against the physician or health provider. Of course, the court can either allow damages for civil liability or can even enjoin the physician from writing or the patient from obtaining a lethal prescription. By allowing for these options, the safeguards of the Death with Dignity Act will have a more adequate enforcement mechanism to protect patients from receiving a improper lethal prescription.

IV. BORROWING FROM *BELLOTTI*—THE MODE OF THE DEATH WITH DIGNITY ACT BYPASS PROCEDURE

The adjudicative process necessary to enforce the safeguards of the Death with Dignity Act can be achieved with relative simplicity. This process need not be a long proceeding or consume massive resources of the judicial system. This proceeding and all of its appeals can be accomplished within the fifteen day waiting period required before a lethal prescription may be given to the patient.[138] Additionally, this process need not be expensive for a patient seeking to obtain a lethal prescription. The overarching goal of this process is to make a simple determination, prior to the actual filling of the prescription, that the patient is in fact capable of making a voluntary decision, and that there is no wrongdoing on the part of any person involved in the patient's decision making process. A successful example of this type of process is found in the realm of abortion rights. The Supreme Court allows minors seeking an abortion without parental consent to obtain an abortion under certain circumstances through the mechanism of a judicial bypass procedure.[139] In order to ensure a proper adjudicative procedure for the

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[136] § 127.865(2); *see also Now Is the Moment*, *supra* note 42, at 32.

[137] § 127.885(1).

[138] § 127.850.

[139] Bellotti v. Baird, 443 U.S. 622, 643 & n.22 (1979) (Powell, J., plurality opinion).

Death with Dignity Act, legislatures must consider several aspects regarding the process of enforcing the Death with Dignity Act in order to provide the most efficient and protective system possible.

A. For the Executive or Judicial Branch—Any Judicial Bypass Proceeding Is Better than Nothing

In deciding the process of the Death with Dignity Act adjudicative proceeding, the first consideration a legislature must decide is whether the hearing should take place before a court or an administrative agency. In the abortion realm, the Supreme Court permits a state to conduct the judicial bypass procedure through an administrative agency.[140] The reasoning behind this alternative seems to be that the constitutional rights of children, though equal in theory, may be treated differently in practice.[141]

The same may not, however, be said for an adult system that is similar in nature. The Court grants adults their constitutional rights to the fullest extent of the law. The fact that there is no adjudicative process at all may suggest that any such hearing might survive constitutional muster. There certainly are some advantages to using an administrative hearing. The rules of evidence certainly do not apply in these hearings,[142] leaving more opportunities to present evidence of a patient's capability or voluntariness. Second, an administrative hearing may be easier to access and calendar than placing such hearings in the court system. The primary advantage of the administrative adjudication is efficiency.

There is, however, an obvious disadvantage to such a proceeding. An administrative agency is connected with the state executive department, whose decisions may be influenced by an executive who has the budget as a main concern. Should a hearing officer receive pressure from the chief executive, a patient's or physician's compliance with the safeguards of the Death with Dignity Act may be conveniently swept under the rug in order to lessen the burden of a state health care plan. But despite an administrative hearing's disadvantages, an administrative hearing or a court proceeding would at least add a necessary element by placing a burden of proof prior to a patient's obtainment of a lethal prescription.

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[140] *Id.*

[141] *See id.* at 635 (comparing the juvenile court system with the adult criminal justice system).

[142] Schuler v. Comm'r of Soc. Sec., 109 F. App'x. 97, 102 (6th Cir. 2004) (citing Cline v. Sec'y of Health, Educ. & Welfare, 444 F.2d 289, 291 (6th Cir. 1971)).

B. Can You Prove It?—The Burden of Proof in the Death with Dignity Act Bypass Procedure

Another aspect of the proposed Death with Dignity Act adjudicative process that must be considered is the burden of proof that will be sufficient to show safeguards are adequately observed. States vary in their burdens of proof in their abortion judicial bypass procedures.[143] The Supreme Court allows states to require a minor to prove maturity or best interest by a clear and convincing evidence standard.[144] Some only require a minor prove their maturity by a preponderance of the evidence, meaning only some evidence that proves a minor is more likely than not mature enough to make the decision to have an abortion.[145]

In states using the clear and convincing evidence standard in the abortion judicial bypass cases, several reasons are advanced for its use that may render this standard the best for a legislature to require in Death with Dignity Act cases. Clear and convincing evidence is a measure of proof that will cause the trier of fact to have "'a firm belief or conviction'" about the claims a person is seeking to prove.[146] This standard, according to the Supreme Court, is constitutional because the hearing is ex parte, the minor may be represented by counsel, and there is no rebuttal testimony.[147] Similarly, a patient seeking to establish capacity or voluntariness can be performed ex parte, with the option of assistance of counsel, and no adverse testimony. Additionally, the stakes are much higher in Death with Dignity Act cases where a patient, unlike a fetus,[148] cannot be argued to be anything other than a human life. The Death with Dignity Act is a mechanism to bring a person's life to an end. Regardless of the stance one has on abortion, a person who is alive enough to seek a prescription is a living person. Therefore, a higher standard should at least be strongly considered by legislatures for use in Death with Dignity Act adjudicative proceedings.

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[143] *Compare* TEX. FAM. CODE ANN. § 33.003(i) (Vernon 2008) (requiring the minor to demonstrate "by a preponderance of the evidence" that she "is mature and sufficiently well informed") *with* OHIO REV. CODE ANN. § 2151.85(C) (LexisNexis 2007) (requiring that the minor must prove allegation of maturity, pattern of abuse, or best interests "by clear and convincing evidence").

[144] Ohio v. Akron Ctr. for Reprod. Health, 497 U.S. 502, 515–16 (1990).

[145] *In re* Jane Doe, 19 S.W.3d 249, 251 (Tex. 2000) (quoting TEX. FAM. CODE ANN. § 33.003(i)).

[146] *Akron Ctr. for Reprod. Health*, 497 U.S. at 516 (quoting Cross v. Ledford, 120 N.E.2d 118, 123 (Ohio 1954)).

[147] *Id.*

[148] *See, e.g.*, Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 914 (1992) (Stevens, J., concurring in part and dissenting in part) ("[T]he state interest in *potential* human life is not an interest *in loco parentis*, for the fetus is not a person." (emphasis added)).

Even with this higher standard of proof, a patient can easily satisfy the burden necessary to prove the safeguards have been properly enforced. Of course, a patient can testify to her capacity and voluntariness in seeking a lethal prescription under the Death with Dignity Act. Additionally, a patient can present testimony from the physician that all aspects of the Death with Dignity Act were properly complied with. Though in person testimony is preferable, the legislature can allow a physician to testify by affidavit. If affidavit testimony is allowable, the legislature should require the physician to specifically articulate the methods used to obtain his determination so that the requisite safeguards are satisfied. This process will be a strong incentive for a physician to exercise care in his decisions and methods when involving a Death with Dignity Act candidate. Under this process, a patient can be ensured that he will be protected when his time to make this decision comes.

C. Who Foots the Bill?—A Look at the Public/Private Funding of the Death with Dignity Act Bypass Procedure

The benefits of an adjudicative process to enforce the safeguards of the Death with Dignity Act are worth any cost. That being said, this process need not be an expensive enterprise. Obviously, some may argue that public funds should not be expended in any way to the termination of human life, much like the argument made against funding abortions.[149] Though this argument is likely a moot point,[150] there is no reason why public funding would be necessary for such an endeavor. The court costs can be paid by patients seeking to obtain a lethal prescription. Having a patient pay this fee and making it a non-refundable payment, will result in two indirect benefits. First, the patient will have to cautiously consider whether she really wants to obtain the medication after having to pay a court fee. Additionally, the patient's family members may be less enthusiastic about a procedure that may leave them with less of an inheritance, however meager it may be. Placing the costs of the adjudicative process on the potential Death with Dignity Act candidate will ensure that the public is not funding a procedure it deems immoral while causing the patient to take added caution before entering into the Death with Dignity Act process.

Naturally, opponents to this idea may argue that such a requirement would serve as a chilling effect toward those who are less fortunate. But legislatures can provide a waiver of court costs for

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[149] *See, e.g.*, Harris v. McRae, 448 U.S. 297, 301 (1980) (citing Hyde Amendment, Pub. L. 96-123, § 109, 93 Stat. 923, 926 (1979)) (regarding the public funding of abortions).

[150] Obviously the states with a Death with Dignity Act already offer public funding for a lethal prescription as Ms. Wagner and Mr. Stroup learned from their letters.

indigent patients who can prove they are unable to pay anything, much like the waiver provision in the abortion judicial bypass cases.[151] Also, the argument used by proponents of the Death with Dignity Act is that the poor do not use the Death with Dignity Act in such a manner as to suggest it is dangerous to them.[152] Based on the report put out by the Oregon Health Plan, the majority of Death with Dignity Act candidates are well-educated, middle-class citizens.[153] If that is true, then there should be no fear that an adjudicative process cost would prevent a terminally ill patient from seeking a lethal prescription. Therefore, a reasonable court fee imposed on the patient allows for the necessary funding to provide an adequate enforcement mechanism of the Death with Dignity Act's safeguards.

CONCLUSION

An adjudicative process is necessary to adequately enforce the safeguards of the Death with Dignity Act. This process is necessary to prevent wrongdoing on the part of any person or entity involved with the Death with Dignity Act. Especially with the rise of the largest group of senior citizens in our nation's history and the skyrocketing costs of health care, the danger that an elderly patient may be unwittingly coerced into accepting a lethal prescription through the Death with Dignity Act is sufficiently high to demand such protective measures. Every state that considers adoption of the Death with Dignity Act should add this adjudicative process to its statute. The adjudicative proceeding should not be complicated or costly, but it should be efficient and adequate to ensure the safeguards are met.

Ms. Wagner and Mr. Stroup are examples of the possible dangers inherent in the lack of enforcement of the Death with Dignity Act's safeguards. What would have been the result if they had not contacted the media and brought negative attention to the Oregon Health Plan's suggestion that they might pay for a lethal prescription, but not pay for treatment? Would the safeguards of the Death with Dignity Act protect them as currently enforced? Would the state be held responsible for improper influence? How would anyone know the reasons they accepted the medication if the physician did not have to so specify? Unless state

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[151] Planned Parenthood League of Mass. v. Bellotti, 641 F.2d 1006, 1111 (1st Cir. 1981) (citing 1980 Mass. Acts 793–96).

[152] Tucker, *supra* note 40, at 1603–04 (citing Margaret P. Battin et al., *Legal Physican-Assisted Dying in Oregon and the Netherlands: Evidence Concerning the Impact on Patients in "Vulnerable" Groups*, 33 J. MED. ETHICS. 591, 591 (2007); CTR. FOR DISEASE PREVENTION & EPIDEMIOLOGY, OR. HEALTH DIV., DEP'T OF HUMAN RES., OREGON'S DEATH WITH DIGNITY ACT: THE FIRST YEAR'S EXPERIENCE 7 (1999), *available at* http://egov.oregon.gov/DHS/ph/pas/docs/year1.pdf).

[153] OREGON REPORT, *supra* note 26, at 2.

legislatures enact these safeguards, these questions will remain unanswered.

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