

Considering Competency: The Need for States' *Death with Dignity* Statutes to Establish Competency Committees

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Nine¹ states and the District of Columbia have statutes which legalize physician-assisted death (PAD),² the process by which a “physician provid[es], at the patient’s request, a prescription for a lethal dose of medication that the patient can self-administer by ingestion, with the explicit intention of ending life.”³ In the United States, this practice is confined to patients suffering from terminal illnesses⁴ who are “mentally competent.”⁵ Despite some guidance on what the word “competent” means, however, the term has proved incredibly difficult to understand in practice.⁶

This Note argues that states’ PAD laws should statutorily create medical committees which research and, from time to time, promulgate clinical criteria in order to guide physicians who choose to participate in PAD. Part

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1. The states are California, Colorado, Hawaii, Maine, New Jersey, New Mexico, Oregon, Vermont, and Washington. *See infra* app. at tbl.1. Montana has no statute addressing physician-assisted death, but its supreme court has ruled that nothing in its own Constitution or statutes deems the practice illegal. *See Baxter v. Montana*, 224 P.3d 1211, 1221 (Mont. 2009).

2. *See In Your State*, DEATH WITH DIGNITY, <https://deathwithdignity.org/states/> [<https://perma.cc/M4D5-2F8V>].

3. *Statement on Physician-Assisted Dying*, AM. ACADEMY OF HOSPICE & PALLIATIVE MED. (June 24, 2016), <http://aahpm.org/positions/pad> [<https://perma.cc/QH68-QVQN>].

4. *See* Timothy E. Quill & Bernard Sussman, *Physician-Assisted Death*, THE HASTINGS CTR. (Sept. 23, 2015), <https://www.thehastingscenter.org/briefingbook/physician-assisted-death/> [<https://perma.cc/U7D3-ZLMG>].

5. *See id.*

6. *See infra* Part II.

I will trace PAD's historical background in the United States; Part II will offer some insight into the current problem that a patient competency evaluation might entail; and Part III will outline how and why medical committees could help physicians administer aid in an environment rife with uncertainty. Although this Note takes no side in the moral debates over PAD, it recognizes that states either have PAD statutes on the books or are considering such statutes in the future. As such, this Note serves to suggest necessary safeguards for a burgeoning medical-legal landscape.

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INTRODUCTION

Terminally ill individuals in ten states and the District of Columbia may currently request a prescription for end-of-life medication, provided they meet certain clinical criteria.⁷ The eligibility requirements are often stringent, and include, among other things, “being an adult, [a] state resident, mentally capable, able to self-administer and ingest the medications, and having a terminal diagnosis with a prognosis of six months to live.”⁸ Although there is room for debate, many of these criteria are easy for physicians to determine, save one: mental competence. What exactly does this term mean? And does it—indeed, *should* it—mean something different in an end-of-life scenario?

Both questions have turned out to be quite difficult to answer. Regarding the first question, “[l]egal standards for decision-making capacity for consent to treatment vary somewhat across jurisdictions, but generally . . . embody the abilities to communicate a choice, to understand the relevant information, to appreciate the medical consequences of the situation, and to reason about treatment choices.”⁹ With respect to the second question—whether end-of-life circumstances make a difference in defining mental competence—some scholars have posited that “[i]n practice, the stringency of the test applied varies directly with the seriousness of the likely consequences of patients’ decisions,”¹⁰ thus implying a higher degree of “competence” necessary for more serious decisions. But despite these attempts to resolve the questions, “there are currently no formal practice guidelines from

7. See *Frequently Asked Questions*, DEATH WITH DIGNITY, [hereinafter “FAQ”] <https://deathwithdignity.org/resources/faqs/#:~:text=Death%20with%20dignity%2C%20or%20medical,protect%20both%20patients%20and%20physicians> [https://perma.cc/3Y96-FKLP]. These requests are governed by statutes in all relevant states/districts save Montana (Montana’s supreme court allows the practice, but there is no statute on the books). See *Montana*, DEATH WITH DIGNITY, <https://deathwithdignity.org/states/montana/> [https://perma.cc/XB49-FXXJ].

8. FAQ, *supra* note 7. It should be noted that this is a summary of state law as provided by an end-of-life non-profit. Requirements differ by state, but the quoted list provides a generally reliable overview of many states’ requirements. Importantly, each state requires that a requesting patient be competent.

9. Paul S. Appelbaum, M.D., *Assessment of Patients’ Competence to Consent to Treatment*, 357 N. ENGL. J. MED. 1834, 1835 (2007). These four criteria have come to dominate the approach to competency assessments.

10. *Id.* at 1835; see also Samuel N. Doernberg et al., *Capacity Evaluations of Psychiatric Patients Requesting Assisted Death in the Netherlands*, 57 PSYCHOSOMATICS 556, 557 (2016) (“An especially important issue in the assessment of capacity is where to set the threshold for capacity.”).

professional societies for the assessment of a patient's capacity to consent to treatment."¹¹

The present-day landscape is a scattered hodgepodge of practices, views, and ideologies. Some states allow PAD, and some do not. The states that do allow PAD have somewhat consistent language across their statutes, but they are not the same.¹² And, perhaps most importantly, physicians, psychologists, and scientists across the spectrum offer widely divergent views on what competency means, what a competency assessment ought to look like, and what factors should be prioritized over others. This Note traces the history of the right to die movement in the United States; illuminates certain problems that arise during physician competency assessments; and takes the novel position that state statutory schemes should include competency committees which from time to time promulgate guidelines to aid physicians in their competency assessments.

I. HISTORICAL BACKGROUND

In 1991, Dr. Timothy E. Quill published an article in the *New England Journal of Medicine*¹³ describing his encounters with an anonymous patient given the pseudonym "Diane." Diane had acute myelomonocytic leukemia, and "[b]one pain, weakness, fatigue, and fevers began to dominate her life."¹⁴ But the article was not a simple case vignette about cancer; instead, Dr. Quill

11. Appelbaum, *supra* note 9, at 1838.

12. For a comparison of each state statute's definition of competency, see *infra* app. at tbl.1.

13. See Timothy E. Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 *NEW ENG. J. MED.* 691 (1991). Equally significant and perhaps even more notorious was the conduct of Dr. Jack Kevorkian. Dr. Kevorkian was found guilty of second-degree murder after a video of himself injecting a patient with amyotrophic lateral sclerosis was aired by *60 Minutes*. See Fred Charatan, *Dr. Kevorkian Found Guilty of Second Degree Murder*, 318 *BMJ* 962 (1999), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1174693/#> [<https://perma.cc/Q75D-RVA6>]; see also William Clairborne, *Kevorkian, Arguing Own Defense, Asks Jury to Disregard Law*, *WASH. POST* (Mar. 26, 1999), <https://www.washingtonpost.com/archive/politics/1999/03/26/kevorkian-arguing-own-defense-asks-jury-to-disregard-law/df142079-a9b1-4182-adad-0d7789250f29/> [<https://perma.cc/4KAW-9VA5>] ("Kevorkian . . . angrily opposed the inclusion of the manslaughter option, declaring, '[t]he prosecution has charged me with first-degree murder. I don't think they should back down. That's cowardice.'). Indeed, Dr. Kevorkian was described as "possibly the best known and most controversial proponent of assisted suicide." *Kevorkian v. Am. Med. Ass'n*, 602 N.W. 2d 233, 235 (Mich. Ct. App. 1999). Needless to say, the political and cultural status quo of assisted suicide in the 1990s was charged.

14. Quill, *supra* note 13, at 693.

admitted that he prescribed barbiturates¹⁵ for what he and Diane officially agreed to call treatment of her “insomnia,” but which in reality was meant to assist her in ending her own life.¹⁶ Dr. Quill wrote: “Although I did not assist in her suicide directly, I helped indirectly to make it possible, successful, and relatively painless.”¹⁷ He then wondered “how many families and physicians secretly help patients over the edge into death in the face of such severe suffering.”¹⁸

At the time Dr. Quill published his article, such action was not an official part of any doctor’s medical practice. Indeed, the legal landscape that constituted the backdrop of Dr. Quill’s actions was much less sympathetic than his anecdote suggests.¹⁹ In fact, no state permitted PAD, and some states, including Dr. Quill’s state of practice, New York, criminalized the practice by statute.²⁰

15. Barbiturates are “[d]epressant drug[s] used to help sleep, relieve anxiety, muscle spasms, and prevent seizures.” *Barbiturates*, DRUG ENFORCEMENT ADMINISTRATION, <https://www.dea.gov/factsheets/barbiturates#:~:text=Depressant%20drug%20used%20to%20help,Seconal%C2%AE%2C%20or%20Nembutal%C2%AE> [https://perma.cc/AM36-ZZE7].

16. See Quill, *supra* note 13, at 693.

17. *Id.* at 694.

18. *Id.*

19. In truth, the social atmosphere was more nuanced than what Dr. Quill might have preferred. See, e.g., Bill Broadway, *The Dilemma of Assisted Suicide*, WASH. POST. (Dec. 3, 1994), <https://www.washingtonpost.com/archive/local/1994/12/03/the-dilemma-of-assisted-suicide/a669ccf1-196e-4957-86ed-a0123a59386d/> [https://perma.cc/BUC4-KSU5] (“The legalization of assisted suicide creates a pastoral dilemma for some clergy, especially those who sympathize with people who want their lives to end because of agonizing, debilitating illness.”); Don Colburn, *Should Doctors Assist Patients in Dying?*, WASH. POST (Feb. 1, 1994), <https://www.washingtonpost.com/archive/lifestyle/wellness/1994/02/01/should-doctors-assist-patients-in-dying/8497d3a2-02c5-4205-be66-9bb6ef0ed736> [https://perma.cc/U73D-PABX]; Ronald Dworkin, *Opinion, When Is It Right to Die?*, N.Y. TIMES (May 17, 1994), <https://www.nytimes.com/1994/05/17/opinion/when-is-it-right-to-die.html> [https://perma.cc/8KB6-EHP6]; Janny Scott, *Suicide Aid Focus Turns to California*, L.A. TIMES (Nov. 7, 1991), <https://www.latimes.com/archives/la-xpm-1991-11-07-mn-1407-story.html> [https://perma.cc/QXV3-34UJ]. The attitudes of the medical and legal communities were likewise internally discordant. See, e.g., J. David Velleman, *Against the Right to Die*, 17 J. MED. & PHILOSOPHY 665, 673 (1992) (“In order to avoid doing harm, then, we are sometimes required, not only to withhold options, but also to take the initiative for withholding them.”); John A. Powell & Adam S. Cohen, *The Right to Die*, 10 ISSUES L. & MED. 169 (1994); Cavin P. Leeman, *Depression and the Right to Die*, 21 GEN. HOSPITAL PSYCHIATRY 112, 114 (1999) (“So how can we safeguard patients’ rights to refuse treatment while we also protect their best interests against their own incompetent decisions? . . . There probably is no absolute way out of this dilemma.”); Seth F. Kreimer, *Does Pro-Choice Mean Pro-Kevoorkian? An Essay on Roe, Casey, and the Right to Die*, 44 AM. U. L. REV. 803, 807 (1995) (“Assisted suicide presents our society with a fearsome dilemma.”).

20. See *Vacco v. Quill*, 521 U.S. 793, 797 n.1 (1997) (referencing N.Y. Penal Law § 125.15, which prohibits the intentional aiding of another in committing suicide); see also WASH. REV. CODE. 9A.36.060 (2023) (“A person is guilty of promoting a suicide attempt when he or she knowingly causes or aids another person to attempt suicide.”).

Various legal battles concerning PAD arose during the 1990s.²¹ Finally ruling on the issue in 1997, the U.S. Supreme Court held in *Washington v. Glucksberg*²² that “Washington’s prohibition against ‘caus[ing]’ or ‘aid[ing]’ a suicide . . . d[id] not” offend the Fourteenth Amendment to the United States Constitution.²³ In a separate opinion issued the very same day, the Court held that “New York’s prohibition on assisting suicide . . . d[id] not” violate the Equal Protection Clause of the Fourteenth Amendment.²⁴ The decisions taken together “effectively foreclosed subsequent challenges to state restrictions [concerning PAD] on federal constitutional grounds.”²⁵

But that was not the end of the matter. Chief Justice Rehnquist ended his opinion in *Glucksberg* by noting Americans’ engagement in an “earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide” and qualified the Courts’ holding by “permit[tin]g th[e debate about PAD] to continue, as it should in a democratic society.”²⁶ Justice O’Connor’s concurrence was more explicit. Understanding that “[f]or many, the last days will be spent in physical pain and perhaps the despair that accompanies physical deterioration and a loss of control of basic bodily and mental functions,”²⁷ she went on to note, quite poignantly, that “[t]here is no reason to think the

21. See, e.g., *Compassion in Dying v. Washington*, 62 F.3d 299 (9th Cir. 1995); *Lee v. Oregon*, 107 F.3d 1382 (9th Cir. 1997).

22. 521 U.S. 702 (1997).

23. *Id.* at 705–06 (second and third alterations in original).

24. *Vacco*, 521 U.S. at 797. Respondents had argued that “because New York permits a competent person to refuse life-sustaining medical treatment, and because the refusal of such treatment is ‘essentially the same thing’ as physician-assisted suicide, New York’s assisted-suicide ban violates the Equal Protection Clause.” *Id.* at 798 (citation omitted). The Supreme Court rejected this argument on both constitutional and logical grounds. First, the Court held that “neither New York’s ban on assisting suicide nor its statutes permitting patients to refuse medical treatment treat anyone differently from anyone else or draw any distinctions between persons. *Everyone*, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; *no one* is permitted to assist a suicide.” *Id.* at 800. But the Court also fundamentally disagreed with the proposition that refusing life-sustaining treatment and administering end-of-life medication were the same; the Court held that “when a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication.” *Id.* at 801.

25. Lois A. Weithorn, *Psychological Distress, Mental Disorder, and Assessment of Decisionmaking Capacity Under U.S. Medical Aid in Dying Statutes*, 71 HASTINGS L. J. 637, 646 (2020).

26. *Glucksberg*, 521 U.S. at 734.

27. *Id.* at 736 (O’Connor, J., concurring).

democratic process will not strike the proper balance between the interests of terminally ill, mentally competent individuals who would seek to end their suffering and the State's interests in protecting those who might seek to end life mistakenly or under pressure."²⁸

After *Glucksberg*, Oregon's Death with Dignity Act was officially implemented on October 27, 1997, by voter initiative following a fresh series of legal battles.²⁹ Oregon's law was challenged once more before the Supreme Court in 2006,³⁰ this time under the theory that physicians who prescribed end-of-life drugs to their patients were in violation of the federal Controlled Substances Act (CSA), "notwithstanding a state law permitting the procedure."³¹ The Court, in a 6–3 decision, held that "CSA's prescription requirement does not authorize the Attorney General to bar dispensing controlled substances for assisted suicide in the face of a state medical regime permitting such conduct."³² From then on, the law has been clear: states may, but need not, allow for PAD within their states, subject to their own statutory requirements and restrictions.

Various states soon followed Oregon's lead. Washington eventually legalized PAD in 2009,³³ followed by Vermont³⁴ in

28. *Id.* at 737 (O'Connor, J., concurring).

29. See *Oregon Death with Dignity Act History*, COMPASSION & CHOICES, <https://compassionandchoices.org/in-your-state/oregon/history> [https://perma.cc/79QC-HR8X]. Measure 16 actually established Oregon's Death with Dignity Act in 1994. See Linda Ganzini, *Death with Dignity Law*, OREGON ENCYCLOPEDIA, https://www.oregonencyclopedia.org/articles/death_with_dignity_law/#.Yyyt6ezMJhE [https://perma.cc/DW2T-S4XS] (last updated Sept. 12, 2022). Implementation was delayed, however, by a federal injunction. See *id.*

30. See *Gonzales v. Oregon*, 546 U.S. 243, 248 (2006).

31. *Id.* at 248–49.

32. *Id.* at 274–75.

33. See *Death with Dignity Act*, WASH. STATE DEPT' OF HEALTH, <https://doh.wa.gov/data-and-statistical-reports/health-statistics/death-dignity-act> [https://perma.cc/JDX4-L9TH].

34. See Paris Achen, *Permanent Version of Vt. Assisted Suicide Bill Signed*, USA TODAY (May 20, 2015), <https://www.usatoday.com/story/news/nation/2015/05/20/permanent-version-of-vt-assisted-suicide-bill-signed/27675289/> [https://perma.cc/EG4W-Q6SY]; see also Patient Choice at End of Life, VT. STAT. ANN. tit. 18, §§ 5281–5293 (West 2023).

2015,³⁵ Colorado,³⁶ California,³⁷ and the District of Columbia³⁸ in 2016, Hawaii in 2018,³⁹ New Jersey in 2019,⁴⁰ and New Mexico in 2021.⁴¹ At the time of this writing, Florida, Michigan, and Pennsylvania are considering similar statutes.⁴² Public support concerning the right to die in the United States is strong; “[a]n overwhelming majority supports laws that give patients the right to decide whether they want to be kept alive through medical treatment.”⁴³

Importantly, PAD is the subject of debate in many international jurisdictions as well, often with different contours, policy implications, and protocols. For instance, Belgium legalized euthanasia in 2002⁴⁴ in a law much more liberal than that of any

35. The Act first passed in 2013, but some of its main provisions (e.g., the mandatory waiting period) were only made permanent in 2015. See Achen, *supra* note 34.

36. See *Colorado*, COMPASSION & CHOICES, <https://www.compassionandchoices.org/in-your-state/colorado> [<https://perma.cc/GN6G-JSFJ>]; see also Colorado End-of-life Options Act, COLO. REV. STAT. ANN. §§ 25-48-101–23 (West 2023).

37. See *California End of Life Option Act*, KAISER PERMANENTE, <https://healthy.kaiserpermanente.org/southern-california/health-wellness/life-care-plan/end-of-life-option-act> [<https://perma.cc/727Q-L9FY>]; see also End of Life Option Act, CAL. HEALTH & SAFETY CODE §§ 443.1–.22 (West 2023).

38. See *Death with Dignity Act of 2016*, DC HEALTH, <https://dchealth.dc.gov/page/death-dignity-act-2016> [<https://perma.cc/52CS-3DEG>]; see also Death with Dignity, D.C. CODE ANN. § 7-661.01–.16 (West 2023).

39. See Jessica Gillespie, *Hawaii’s Our Care, Our Choice Act*, NOLO, <https://www.nolo.com/legal-encyclopedia/death-with-dignity-hawaii.html> [<https://perma.cc/LHL3-M24E>] (last updated Jan. 31, 2022); see also Our Care, Our Choice Act, HAW. REV. STAT. ANN. §§ 327L-1–25 (West 2023).

40. See Jessica Gillespie, *New Jersey’s Medical Aid in Dying for the Terminally Ill Act*, NOLO, <https://www.nolo.com/legal-encyclopedia/new-jersey-s-aid-dying-the-terminally-ill-act.html> [<https://perma.cc/9GT2-3RNN>] (last updated Feb. 1, 2022); see also The New Jersey Aid in Dying for the Terminally Ill Act, N.J. STAT. ANN. § 26:16-1 (West 2023).

41. See *New Mexico*, COMPASSION & CHOICES, <https://compassionandchoices.org/in-your-state/new-mexico> [<https://perma.cc/3Z83-2FRV>]; see also Elizabeth Whitefield End-Of-Life Options Act, N.M. STAT. ANN. § 24-7C (West 2023).

42. See *In Your State*, *supra* note 2.

43. *Strong Public Support for Right to Die*, PEW RSCH. CTR. (Jan. 5, 2006), <https://www.pewresearch.org/politics/2006/01/05/strong-public-support-for-right-to-die/> [<https://perma.cc/HBJ2-CGUT>] (noting that although public support is strong for the right to die generally, “[t]he public is deeply divided over legalizing physician-assisted suicide”). Another study published in 2023 stated that, according to a 2018 Gallup Poll, 72 percent of Americans agreed that physicians should have the ability to help terminally ill patients die, see Gerald P. Koocher et al., *Medical Assistance in Dying (MAiD): Ethical Considerations for Psychologists*, 54 PRO. PSYCH.: RSCH. & PRACT. 2, 3 (2023), but highlighted the point that semantics are significant: i.e., that number dropped to 65 percent if the words “commit suicide” appeared in the survey, and only 54 percent of respondents described PAD as morally acceptable, see *id.* at 3.

44. See Sarah Mroz et al., *Assisted Dying Around the World: A Status Quaestionis*, 10 ANNALS PALLIATIVE MED. 3540, 3542 (2021), <https://pubmed.ncbi.nlm.nih.gov/32921084/> [<https://perma.cc/8UBT-NH24>].

U.S. state. For one, euthanasia involves a doctor actually administering medication, whereas PAD involves a doctor *prescribing* medication to a patient with instructions on how to self-administer the dose.⁴⁵ Perhaps even more noteworthy, Belgium's law does not require that a patient be terminally ill; it only requires that the patient be in a "medically futile condition of constant and unbearable physical *or mental* suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident."⁴⁶ Belgium's approach therefore includes patients who suffer primarily or only from certain mental, and not physical, conditions.

Other countries have PAD laws on the books as well. Switzerland decriminalized assisted suicide in 1942,⁴⁷ and the Netherlands and Luxembourg both legalized the practice in the 2000s.⁴⁸ Canada has amended its criminal code to "create exceptions from the offences of culpable homicide, of aiding and of administering a noxious thing, in order to permit medical practitioners and nurse practitioners to provide medical assistance in dying,"⁴⁹ and Colombia's courts have allowed assisted suicide.⁵⁰

45. See Angela Morrow, *What Is Euthanasia?*, VERYWELLHEALTH, <https://www.verywellhealth.com/what-is-euthanasia-1132209> [https://perma.cc/2Q5R-LARR] (last updated May 2, 2023). Euthanasia is illegal throughout the United States. See *Medical Aid in Dying Is Not Assisted Suicide, Suicide or Euthanasia*, COMPASSION & CHOICES, <https://www.compassionandchoices.org/resource/not-assisted-suicide> [https://perma.cc/D84K-3XM2]. The different legal treatments might be a result of who remains in ultimate control of a person's death, balanced against America's strong inclination toward patient autonomy. See, e.g., Nicola Davis, *Euthanasia and Assisted Dying Rates Are Soaring. But Where Are They Legal?*, GUARDIAN (July 15, 2019) <https://www.theguardian.com/news/2019/jul/15/euthanasia-and-assisted-dying-rates-are-soaring-but-where-are-they-legal> [https://perma.cc/WTW6-MVFL] ("The main difference between euthanasia and assisted suicide is who performs the final, fatal act,' said Richard Huxtable, professor of medical ethics and law at the University of Bristol. Euthanasia refers to active steps taken to end someone's life to stop their suffering and the 'final deed' is undertaken by someone other than the individual, for example a doctor. If the person concerned has requested this, it falls under the term 'voluntary euthanasia.' Assisted suicide is about helping someone to take their own life at their request—in other words the final deed is undertaken by the person themselves."). Thus, having patients perform the act in question, rather than the doctor themselves, might reflect the fact that Americans are more concerned with the patient actually being in control.

46. ADF INT'L, *20 Years of Euthanasia in Belgium: After Almost 30,000 Lives Lost, What Can We Learn?* (May 25, 2022), <https://adfinternational.org/20-years-euthanasia/> [https://perma.cc/PS9V-QVCV] (emphasis added).

47. See Mroz et al., *supra* note 44, at 3543 tbl.1.

48. See *id.*

49. Act of June 17, 2016, S.C. 2016, c 3 (Can.) (amending the Criminal Code and related other Acts to permit medical practitioners and nurse practitioners to provide medical assistance in dying).

50. See Mroz et al., *supra* note 44, at 3544 tbl.1.

Indeed, and as Professor Thaddeus Pope notes, America's experience with these questions predates much more contemporary scholarship and debate around PAD.⁵¹ Ohio considered a bill in 1906 titled, "An Act Concerning Administration of Drugs etc. to Mortally Injured and Diseased Persons,"⁵² which "applied to 'any person of lawful age and of sound mind . . . so ill of disease that recovery is impossible or who is suffering great pain or torture.'"⁵³ Iowa considered a similar bill the same year,⁵⁴ as did Nebraska in 1937.⁵⁵ Professor Pope argues that interest in PAD reemerged in the late 1980s and early 1990s, partly as a "logical extension of the then newly established right to refuse life-sustaining treatment."⁵⁶ To wit, some have even questioned whether there are any real, substantive differences between the refusal of such treatment and PAD requests.⁵⁷

Note that even in 1906, a necessary prerequisite to receiving such drugs was being "of sound mind."⁵⁸ In fact, various scholars and academics have voiced myriad concerns relating to the difficulty inherent in attempting to define mental competency long before Oregon's law went into effect.⁵⁹ In any event, the current

51. See Thaddeus Pope, *Legal History of Medical Aid in Dying: Physician Assisted Death in U.S. Courts and Legislatures*, 48 N. M. L. REV. 267, 275 (2018).

52. *Id.*

53. GIZA LOPES, DYING WITH DIGNITY: A LEGAL APPROACH TO ASSISTED DEATH 20 (2015) (emphasis added) (citation omitted).

54. See Pope, *supra* note 51.

55. See *id.* at 275–76.

56. *Id.* at 276.

57. See Katherine A. Chamberlin, *Looking for a 'Good Death': The Elderly Terminally Ill's Right to Die by Physician-Assisted Suicide*, 17 ELDER L. J. 61, 61 (2009) ("Because the end result of refusing life-sustaining treatment and physician-assisted suicide is the same—the death of the terminally ill patient—there is no substantive basis for distinguishing between the two."); *but cf. supra* note 45 (a list of sources arguing why the practices are substantively different regardless of the fact that the results are the same).

58. See LOPES, *supra* note 53.

59. See, e.g., Leon R. Kass, *Is There a Right to Die?*, 23 HASTINGS CTR. REP. 34, 36–37 (1993) ("Does a senile person have a 'right to die' if he [or she] is incapable of claiming it for him [or her]self? Do I need to be able to claim *and act* on such a right in order to have it, or can proxies be designated to exercise my right to die on my behalf? If the right to die is essentially an expression of my autonomy, how can anyone else exercise it for me?"); Jonathan Brant, *The Right to Die in Peace: Substituted Consent and the Mentally Incompetent*, 11 SUFFOLK U. L. REV. 959, 959 (1977) (statement by then-assistant attorney general of Massachusetts Jonathan Brant) ("[C]ourts have both the power and the duty to substitute their consent for an incompetent patient where his [or her] constitutional right to privacy is being invaded by extremely painful, futile medical procedures designed to extend existence."); William A. Kraus, *The Incompetent Developmentally Disabled Person's Right of Self-Determination: Right-to-Die, Sterilization and Institutionalization*, 15 AM. J. L. & MED. 333, 333 (1989) (arguing that the developmentally disabled have the right to terminate life-sustaining treatment).

reality is that many states have adopted PAD laws, are considering PAD laws, or might adopt PAD laws in the near future. With nine states and the District of Columbia already having passed their own versions of Death with Dignity statutes,⁶⁰ Justice O'Connor's statement about the "proper balance" concerning a patient's competency remains as pertinent now as it was then.

II. ANALYSIS OF THE PROBLEM

Over 100 years ago, Justice Cardozo, then sitting on the New York State Court of Appeals, wrote that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his [or her] own body."⁶¹ Such an endorsement of personal autonomy has strong support throughout American case law.⁶² Indeed, although the concept of physical suffering might seem to be the primary reason patients request PAD, the Fifth Annual Report on Oregon's Death with Dignity Act found that patient requests for lethal medications

stemmed from multiple concerns related to autonomy and control at the end of life. The three most commonly mentioned end-of-life concerns during 2002 were: loss of autonomy, a decreasing ability to participate in activities

60. See Death with Dignity Act, OR. REV. STAT. ANN. §§ 127.800–897 (West 2023); Death with Dignity Act, WASH. REV. CODE ANN. § 70.245 (West 2023); Colorado End-of-life Options Act, COLO. REV. STAT. ANN. §§ 25-48-101–23 (West 2023); Death with Dignity, D.C. CODE ANN. § 7-661.01–.16 (West 2023); Patient Choice at End of Life, VT. STAT. ANN. tit. 18, §§ 5281–5293 (West 2023); End of Life Option Act, CAL. HEALTH & SAFETY CODE §§ 443.1–.22 (West 2023); Our Care, Our Choice Act, HAW. REV. STAT. ANN. §§ 327L-1–25 (West 2023); Death with Dignity Act, ME. REV. STAT. ANN. tit. 22, § 2140 (West 2023); The New Jersey Aid in Dying for the Terminally Ill Act, N.J. STAT. ANN. § 26:16-1 (West 2023); Elizabeth Whitefield End-Of-Life Options Act, N.M. STAT. ANN. § 24-7C (West 2023); see also *In Your State*, supra note 2 (canvassing the current status of each state's legislative efforts, breaking states into categories including "States Considering Death with Dignity This Year/Session," "No Active Legislation," "Legislation Enacted, Amendment Passes," "States With a Death with Dignity Statute," "Active Legislation Under Threat," and "Amendment Pending.").

61. *Schloendorff v. Soc'y of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914).

62. See, e.g., *Stewart v. Super. Ct.*, 224 Cal. Rptr. 3d 219, 236 (2017) ("First, and as we have stressed throughout, the right to autonomy in medical decisionmaking is uniquely fundamental. . ."); *State ex rel. Schuetzle v. Vogel*, 537 N.W.2d 358, 360 (N.D. 1995) ("A person's interest in personal autonomy and self-determination is a fundamentally commanding one. . ."); *In re Nora D.*, 485 P.3d 1058, 1065 (Alaska 2021) ("More generally, the common law recognizes that important interests of dignity, self-determination, *autonomy*, and privacy are implicated by an individual's ability to make personal medical decision.") (emphasis added).

that made life enjoyable, and losing control of bodily functions. . . .⁶³

Said one prominent Oregon psychiatrist: “Being in control and not dependent on other people is the most important thing from them in their dying days.”⁶⁴ And some of the statutes have acknowledged this; New Jersey, for example, declares in its “[l]egislative findings and declarations” section that it “[r]ecogniz[es its] long-standing commitment to individual dignity . . . and the fundamental right of competent adults to make health care decisions.”⁶⁵ But myriad sources, including some of the ones just cited, are adamant that this autonomy right is not absolute.⁶⁶ The Supreme Court in *Cruzan v. Director, Missouri Department of Health* identified a non-exhaustive list of pertinent state interests—including “the preservation of life, the protection of the interests of innocent third parties, the prevention of suicide, and the maintenance of the ethical integrity of the medical profession”⁶⁷—that must be weighed against the manifestly important autonomy interests of patients. Justice O’Connor’s balancing maxim, then, was not simply a philosophical musing; it was an accurate summation of the uniquely American approach to personal autonomy that has echoed throughout this country’s history.

Indeed, the focus on that *proper balance* between personal autonomy and the interests of the State is borne out in the medical literature. It is axiomatic in medical ethics that “the

63. Office of Disease Prevention & Epidemiology, *Fifth Annual Report on Oregon’s Death with Dignity Act*, DEP’T OF HUM. SERVS, at 5 (2003), <https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/documents/year5.pdf> [<https://perma.cc/W3TD-8D55>].

64. Bonnie Steinbock, *The Case for Physician Assisted Suicide: Not (Yet) Proven*, 31 J. MED. ETHICS 235, 235 (2005) (citation omitted).

65. N.J. STAT. ANN. § 26:16-2(a) (2019). For an interesting and opposite perspective that the existence of these choices actually cuts *against* autonomy, see Thomas Søbirk Petersen & Morten Dige, *Critique of Autonomy-Based Arguments Against Legalising Assisted Dying*, 37 BIOETHICS 165, 165 (2023) (“[W]hen terminally ill patients who experience suffering make a request for assisted dying they are either not competent, and therefore, there is no autonomy to respect, or the mere legislation of [PAD] would change the situation in ways that are incompatible with the patient making an autonomous choice.”) (footnote omitted).

66. See, e.g., *Vogel*, 537 N.W.2d at 360 (holding a person’s interest in personal autonomy is not absolute); *In re Nora D.*, 485 P.3d at 1066 n.53 (citing *Cruzan v. Dir.*, Mo. Dep’t of Health, 497 U.S. 261, 279 (1990)) (noting that the personal autonomy right is not absolute and must be balanced against the relevant state interest).

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

determination of whether patients are competent is critical in striking a proper balance between respecting the autonomy of patients who are capable of making informed decisions and protecting those with cognitive impairment.”⁶⁸ Determining whether requesting patients are competent is, therefore, paramount.⁶⁹ In PAD settings, where the stakes are life and death, the decision is even more consequential.

Every Death with Dignity statute requires that physicians make a determination that a requesting patient is competent before administering life-ending medication.⁷⁰ Although each state’s definition of competency varies slightly, all statutes generally provide that a competent patient is one who has the ability to make and communicate health care decisions to health care providers.⁷¹

But while the statutes do include certain clinical criteria, “the[y] provide insufficient guidance for physicians in their assessment of the patient’s decision-making process.”⁷² Physicians in especially borderline cases—for instance, those concerning patients with neurocognitive diseases such as Alzheimer’s or dementia, or those involving patients with serious mental illnesses that might affect cognition more broadly—generally *do not* come to any type of consensus. One study found that “capacity judgment[] . . . outcomes differed markedly for A[lzheimer] patients” and that “[p]hysicians as a group achieved . . . only 56% judgment agreement for the mild A[lzheimer] patients.”⁷³ The authors of

68. Appelbaum, *supra* note 9, at 1834.

69. The model Death with Dignity legislation recommends that state statutes use the word “capacity” instead of “competency.” See *Model Legislation*, DEATH WITH DIGNITY, 1, 1 n.2 (2022), https://deathwithdignity.org/wp-content/uploads/2021/12/2022-01-14_model-legislation-web.pdf [<https://perma.cc/3YHR-DE4M>]. This is because, argues the model legislation, “[c]ompetency is determined by judges and the courts, while questions of capacity are decided by physicians and other psychiatric and or/mental health consultants.” *Id.* (citing Raphael J. Leo, *Competency and the Capacity to Make Treatment Decisions: A Primer for Primary Care Physicians*, 1 PRIMARY CARE COMPANION TO THE J. CLINICAL PSYCHIATRY 131, 131–41 (1999)). But more recent medical scholarship has dismissed the distinction, arguing that courts have used the terms interchangeably for too long. See, e.g., Appelbaum, *supra* note 9, at 1834 (“The terms ‘competence’ and ‘capacity’ are used interchangeably in this article, since the oft-cited distinctions between them—competence is said to refer to legal judgments, and capacity to clinical ones—are not consistently reflected in either legal or medical usage.”).

70. See *infra* app. at tbl.1.

71. See *id.*

72. David Orentlicher et al., *Clinical Criteria for Physician Aid in Dying*, 19 J. PALLIATIVE MED. 259, 259 (2016).

73. Daniel C. Marson et al., *Consistency of Physician Judgments of Capacity to Consent in Mild Alzheimer’s Disease*, 45 J. AM. GERIATRICS SOC’Y 453, 455 (1997).

that study concluded that “[p]hysicians . . . currently appear to differ too widely in their conceptual understanding of competency, in their clinical approach to competency assessment, and in the different standards or thresholds they consciously or unconsciously apply in deciding competency.”⁷⁴ If the results of the study weren’t clear enough on their own, the authors asserted that their results “substantiate[d] a long-standing clinical concern, namely, that physician competency assessment is a subjective, inconsistent, and arguably idiosyncratic process.”⁷⁵

More recent scientific scholarship⁷⁶ only buttresses the view that, absent clear clinical guidance, many physicians are making personal judgment calls when it comes to competency determinations in PAD settings. For instance, one study found that psychologists who reported that someone in their personal life had attempted suicide were nearly three times as likely to declare a patient competent as those without such an experience.⁷⁷ Conversely, “those that reported someone in their personal life having *completed* suicide were less likely to declare the patient competent.”⁷⁸

A desire to see physician-assisted suicide legalized for personal use was “another factor found” to be positively correlated with competency determinations; in the words of the study, the “more willing clinicians were to support a family member [choosing PAD], the more likely they were to declare a patient competent.”⁷⁹ In a similar vein, a study conducted by the University of California, San Francisco Medical Center (UCSFMC) found that “psychiatrists’ views on the ethical permissibility of PAD influenced their personal opinions of the standards and thresholds for PAD, and

74. *Id.* at 456.

75. *Id.* (footnote omitted).

76. See, e.g., Shara M. Johnson et al., *What Patient and Psychologist Characteristics Are Important in Competency for Physician-Assisted Suicide Evaluations?*, 21 PSYCH., PUB. POL’Y, AND L. 420, 428 (2015); Frank Schweitser et al., *Assessment of Patient Decision-Making Capacity in the Context of Voluntary Euthanasia for Psychic Suffering Caused by Psychiatric Disorders: A Qualitative Study of Approaches Among Belgian Physicians*, 47 J. MED. ETHICS 1 (2021) (concluding that physicians assess decision-making capacity in different ways and that personal values and beliefs influence their approach); Samuel N. Doernberg et al., *Capacity Evaluations of Psychiatric Patients Requesting Assisted Death in the Netherlands*, 57 PSYCHOSOMATICS 556 (2016); James A. Bourgeois et al., *Physician-Assisted Death Psychiatric Assessment: A Standardized Protocol to Conform to the California End of Life Option Act*, 59 PSYCHOMETRICS 441 (2018).

77. See Johnson et al., *supra* note 76, at 428.

78. *Id.*

79. *Id.*

how they would evaluate a PAD-requesting patient.”⁸⁰ The study also found that, “[a]mong Oregon psychiatrists who opposed PAD but were willing to complete a mental health evaluation of a requesting patient, half indicated that even if the patient was *without a mental disorder and competent*, they would still try to prevent the patient from using a lethal prescription.”⁸¹

Another study canvassing physician perspectives,⁸² albeit in Belgium, found a “lack of physician[] knowledge in how to assess patient decision-making capacity.”⁸³ The authors also found widely differing views among physicians concerning the assessment of this capacity.⁸⁴ And another Belgian study found a disagreement rate of 12 percent amongst physicians over whether patients were competent.⁸⁵ The authors of this study found that “capacity discussions” by attending physicians were “relatively sparse,”⁸⁶ and that “requests from psychiatric patients d[id] not seem to receive a high level of scrutiny to ensure a high threshold for capacity, even in cases of disorders that are known to increase the risk of incapacity. . . .”⁸⁷

Scott Kim, a senior investigator in the Department of Bioethics at the National Institutes of Health, has voiced similar concerns.⁸⁸ He noted that some laws, including the laws at issue in this Note, “provide a nearly tautological or empty definition of incapacity as lacking the ability to make and communicate health care decisions,” or, to put it another way, “incapacity means you are incapable, which does not guide doctors and judges all that much.”⁸⁹

Perhaps equally troubling is the range in attitudes and perspectives that exists regarding how a patient’s particular disease, functional abilities, and prior ideations should inform a competency evaluation. As Professor James Toomey notes in his analysis of competency in senior citizens, “we need a normative

80. Bourgeois et al., *supra* note 76, at 442.

81. *Id.*

82. *See* Schweitser et al., *supra* note 76.

83. *Id.* at 5.

84. *See id.*

85. *See* Doernberg et al., *supra* note 76, at 560.

86. *Id.* at 562.

87. *Id.* at 563.

88. *See* Scott Y.H. Kim, *Competency, Decision-Making Capacity, and Voluntariness*, in PHYSICIAN-ASSISTED DEATH, SCANNING THE LANDSCAPE PROCEEDINGS OF A WORKSHOP 10, 11 (Nat’l Academies of Scis., Eng’g., and Med., 2018).

89. *Id.*

theory of *which types* of cognitive abilities matter and how *much* ability is required for a particular decision.⁹⁰ Important questions linger in the background of these conversations, often untethering scholars from certain baseline assumptions concerning competency. For example, is a patient with dementia even capable of requesting end-of-life medication?⁹¹ And if so, is there a point in the progression of their disease at which the requesting patient *loses* their ability to communicate a conscious choice? How about terminally ill patients with cognitive impairments?⁹² Or patients with significant past suicidality or major depressive disorder?⁹³ Or patients who are competent when they make their request and incompetent right before they receive their lethal dosages? These questions are not assumed to be easy, nor are they assumed to have right or wrong answers (even by those who write frequently and in-depth about the topic).⁹⁴ Instead, these questions serve to illuminate the inherent difficulty undergirding certain competency decisions, especially given conflicting scientific results and the absence of legislative guidance.

In fact, these questions are incredibly complex. Although most Death with Dignity statutes mention the presence of a “mental disorder” as a “trigger” for a psychiatric consult,⁹⁵ it is now

90. James Toomey, *How to End Our Stories: A Study of the Perspectives of Seniors on Dementia and Decision-Making*, 29 ELDER L. J. 1, 3 (2021).

91. See Scott Y.H. Kim et al., *Is This Person with Dementia (Currently) Competent to Request Euthanasia? A Complicated and Underexplored Question*, 47 J. MED. ETHICS 1 (2021); see also *id.* at 3 (“[One] doctor’s view is that one needs to have *very* advanced disease to lose decisional capacity.”).

92. See generally Megan S. Wright, *Equality of Autonomy? Physician Aid in Dying and Supported Decision-Making*, 63 ARIZ. L. REV. 157, 160 (2021) (“The exclusion of persons with decisional impairments from PAID has led some scholars to advocate for using advance directives for this end-of-life option.”).

93. Cf. Bourgeois et al., *supra* note 76, at 445 (“This conservative stance that past, well-remitted depressive disorder with suicide attempt would, in fact, be disqualifying was considered by some on the committee as excessive.”).

94. See, e.g., Toomey, *supra* note 90, at 3 (“There is no neurological answer to th[e] question [of the necessary and sufficient conditions of a legally recognizable decision]. There can’t be.”); see also Weithorn, *supra* note 25, at 687 (“How high must the levels of understanding, appreciation, and reasoning be to lead to a conclusion that the patient meets the legal criterion of capacity under the statute? In developing the [prominent capacity tests, its creators] expressly declined to set such thresholds, recognizing that such decisions are *policy* matters that reflect a number of considerations relevant to each treatment context or decision.”) (alterations in original).

95. See, e.g., OR. REV. STAT. ANN. § 127.825 (2013) (“If in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient for counseling.”); COLO. REV. STAT. § 25-48-108(2) (2016) (“If the attending physician or the consulting physician believes that the individual may not be mentally

understood that the “presumption that persons with mental disorders, mental disabilities, or cognitive impairments are per se incompetent to make treatment decisions ‘is obsolete.’”⁹⁶ In short, “[c]ognitive impairment alone cannot be determinative of decisional capacity to request PAD.”⁹⁷ Thus, each patient who makes a request for PAD represents a unique case, and accordingly requires a separate and individualized competency assessment.

Notably, these sparse guidelines exist in states where PAD has been legalized by statute. When Montana’s Supreme Court, for instance, found nothing in their own precedent or in Montana statutes indicating such practice was against the public policy,⁹⁸ PAD became legal against a backdrop of virtually no guidelines.⁹⁹

A lack of uniform guidance has significant consequences for the practical, on-the-ground application of these statutes. Indeed, one study looking at PAD in Oregon found troubling concerns of “doctor shopping,” in which 59 percent of patients in the first three years of the statute’s existence “requested a lethal prescription from more than one physician before finding a willing participant.”¹⁰⁰ The same study notes that a possible concern might be “the extent to which suicide advocacy groups are counseling and referring patients to willing doctors.”¹⁰¹ For instance, in 2003, Compassion in Dying, an end-of-life advocacy group, “orchestrated 33 of the 42 reported assisted deaths”¹⁰² in Oregon.

capable of making an informed decision, the attending physician or consulting physician shall refer the individual to a licensed mental health professional for a determination of whether the individual is mentally capable and making an informed decision.”); cf. HAW. REV. STAT. ANN. § 327L-6 (2018) (requiring attending providers in Hawaii to refer the patient for counseling notwithstanding the presence of a mental disorder).

96. Weithorn, *supra* note 25, at 666 (citation omitted); see also Toomey, *supra* note 90, at 11 (“A diagnosis of dementia does not make someone incompetent; people can remain broadly competent for years after a clinical diagnosis, which may occur at different points in the development of the disease in different patients.”); Appelbaum, *supra* note 9, at 1835 (“[A] diagnosis of dementia or a psychotic disorder may be presumed incorrectly to indicate incompetence.”).

97. Catherine S. Shaffer et al., *A Conceptual Framework for Thinking About Physician-Assisted Death for Persons With a Mental Disorder*, 22 PSYCH., PUB. POL’Y & L. 141, 147 (2016).

98. See *Baxter v. Montana*, 224 P.3d 1211, 1222 (Mont. 2009).

99. See Orentlicher et al., *supra* note 72, at 260 (noting that the Montana Supreme Court recognized PAD as legitimate “without issuing any guidelines, other than the requirement that patients be mentally capacitated adults who are terminally ill and able to self-administer the medication”).

100. Wendy E. Hiscox, *Physician-Assisted Suicide in Oregon: The ‘Death with Dignity’ Data*, 8 MED. L. INT’L 197, 209–10 (2007).

101. See *id.*

102. *Id.*

Professor Lois A. Weithorn makes the astute observation that, “[w]hile further delineation of . . . competence standards would be helpful,” perhaps “the drafters may have chosen instead to allow health care practitioners to rely on scientific literature, clinical training, and guidance from their disciplines and institutions when conducting competence evaluations.”¹⁰³ This is likely true. Indeed, there are issues that come with including certain competency tools and criteria in state statutes; after all, science evolves, and statutes are difficult to amend. But even with that in mind, and as Professor Weithorn candidly concedes, it is “unlikely that the average health care practitioner is aware of the available evidence-based decision-making capacity assessment strategies and tools.”¹⁰⁴ Indeed, Professor Weithorn goes on to cite sources that suggest clinicians are likely to be unfamiliar with the “debates, challenges, and pitfalls relevant to the conduct of such evaluations” and that even “mental health professionals, as a group, may be unprepared to perform these evaluations.”¹⁰⁵

To make matters even more complicated, there is currently no concrete consensus within the scientific community as to how to conduct proper competency assessments.¹⁰⁶ Beyond that, physicians, philosophers, and legislators presumably differ in the weights they would ascribe to certain traits (e.g., ability to form a narrative, ability to reason, ability to function, etc.) in making these determinations. In fact, there is no reason to assume that all doctors or all legislators are ideologically homogeneous based on their professions. For instance, some scholars argue adamantly

103. Weithorn, *supra* note 25, at 683.

104. *Id.* at 691.

105. *Id.*

106. See Appelbaum, *supra* note 9, at 1838. Compare Bourgeois et al., *supra* note 76 (describing the local adoption of the California End of Life Option Act by UCSFMC, which requires a mental health assessment of all patients requesting end-of-life services), with Linda Ganzini, *Psychiatric Evaluations for Individuals Requesting Assisted Death in Washington and Oregon Should Not Be Mandatory*, 36 GEN. HOSP. PSYCHIATRY 10, 10 (2014) (“[I]n the case of legalized PAD in Washington and Oregon, requiring a psychiatric consultation in every case is burdensome, unnecessary and possibly unworkable.”), and HAW. REV. STAT. ANN. § 327L-6 (2018) (Hawaii requires a counseling referral in all cases). Although it remains true that there is no clear consensus, in practice, and as evidenced by most of the articles herein cited, many scholars, programs and pedagogies incorporate some form of the four criteria listed above. See Paul S. Appelbaum & Thomas Grisso, *The MacArthur Treatment Competence Study I: Mental Illness and Competence to Consent to Treatment*, 19 LAW & HUM. BEHAV. 105, 109 fig. 1 (1995) (laying out the four criteria as the ability to communicate a choice, the ability to understand relevant information, the ability to appreciate the situation and its likely consequences, and the ability to manipulate information rationally).

that “through clear, informed, and persistent advanced directives, people should be allowed to direct their future death in the event of severe dementia”;¹⁰⁷ others have argued for specialized decision-making modules for those with decisional impairments.¹⁰⁸ The unmistakable upshot from this array of views is that the “guidance” Professor Weithorn—and presumably the drafters of these statutes—envisioned for physicians is still evolving, changing, and growing.¹⁰⁹ In Justice O’Connor’s words, the states, through “democratic process[es],” are still pushing ever forward in their attempts at achieving that “proper balance.”¹¹⁰

And therein lies the problem. If each patient represents a unique case, then each patient should require a separate and individual competency assessment. But if physicians are less-than-confident in their abilities to perform a competency assessment, and if some physicians, albeit unconsciously, let their personal views on the matter inform their ultimate decisions, then those patients who come to such decisions are entering a rather fraught framework.

Patient autonomy deserves to be respected, but so too do the various interests of the states in which these debates are playing out. The problem accurately framed thus becomes how to help foster that balance in the presence of many competing factors.

III. SOLUTION

A. BACKGROUND

In a noble effort to ensure that physicians have the guidance they need, Compassion & Choices—a nonprofit organization that works to improve care and expand choice at the end of patients’ lives—convened the Physician Aid-in-Dying Clinical Criteria Committee (the “PAD Committee”) in July of 2012.¹¹¹ The PAD Committee’s stated purpose was to “create clinical criteria for physicians who are willing to provide [aid in dying] to patients who

107. Paul T. Menzel, *Advance Directives, Dementia, and Eligibility for Physician-Assisted Death*, 58 N.Y.L. SCH. L. REV. 321, 323 (2014).

108. See Wright, *supra* note 92, at 161.

109. See Bourgeois et al., *supra* note 76, at 450 (concluding that the guidelines the drafters themselves came up with “will likely be re-examined over time depending on collective *ongoing* clinical experience”) (emphasis added).

110. *Washington v. Glucksberg*, 521 U.S. 702, 737 (1997) (O’Connor, J., concurring).

111. See Orentlicher et al., *supra* note 72, at 260.

request it.”¹¹² Such a committee is not unique. For instance, the initial passage of Oregon’s Act “catalyzed the Center for Ethics in Health Care, Oregon Health & Science University, to convene the Task Force to Improve the Care of Terminally-Ill Oregonians.”¹¹³ But as noted in Part II, *supra*, the existence of clinical criteria, even useful criteria, does not imply the necessary broad physician knowledge, acceptance, or familiarity with said criteria. This Note recommends that states’ Death with Dignity laws statutorily create committees, not unlike the one convened by Compassion & Choices, and furnish them with the power to promulgate and update clinical guidelines for their respective state’s physicians concerning the appropriate clinical criteria necessary for competency decisions.

Many academics and practitioners have applauded the existence of clinical guidelines, recognizing their utility to patients, providers, and professionals.¹¹⁴ Potential benefits to providers include aiding doctors who are “uncertain about how to proceed, overturn[ing] the beliefs of doctors accustomed to outdated practices, improv[ing] the consistency of care, and provid[ing] authoritative recommendations that reassure practitioners about the appropriateness of their treatment policies.”¹¹⁵

Clinical guidelines likewise enhance patient benefits.¹¹⁶ Indeed, the “principal benefit of guidelines is to improve the quality of care received by patients,”¹¹⁷ but guidelines can also improve the consistency of care,¹¹⁸ empower patients to make more informed choices,¹¹⁹ and even influence public policy.¹²⁰

112. *Id.*

113. THE TASK FORCE TO IMPROVE THE CARE OF TERMINALLY-ILL OREGONIANS, THE OREGON DEATH WITH DIGNITY ACT: A GUIDEBOOK FOR HEALTH CARE PROFESSIONALS 4 (2007).

114. See Steven H. Woolf et al., *Potential Benefits, Limitations, and Harms of Clinical Guidelines*, 318 BRITISH MED. J. 527, 528 (1999).

115. *Id.*

116. *See id.*

117. *See id.* at 527.

118. *See id.* (noting that “[p]atients with identical clinical problems receive different care depending on their clinician, hospital, or location,” a problem especially pronounced in PAD discussions where differing ideologies might lead to the aforementioned issue of “doctor shopping,” discussed *supra* note 100).

119. *See* Woolf et al., *supra* note 114.

120. *See id.* (“Guidelines call attention to underrecognised health problems, clinical services, and preventive interventions and to neglected patient populations and high risk groups. Services that were not previously offered to patients may be made available as a response to newly released guidelines. Clinical guidelines developed with attention to the public good can promote distributive justice, advocating better delivery of services to those

As an initial matter, it is important to discuss why this Note does not endorse the view that statutes themselves should include the relevant clinical criteria or competency assessment instruments. The answer is that any science, especially a science concerning a discipline bereft of much data, is constantly changing (as briefly discussed in Part II, *supra*). For instance, UCSFMC's guidelines do not "at present . . . support PAD requests for those with a history of suicidal behavior or psychotic illness."¹²¹ It is, of course, possible that a "future, modified iteration of the protocol could perhaps allow for the PAD option for those with a distant history of suicidal behavior or fully compensated psychotic illness."¹²² One might vigorously defend or critique such a "possibility." But that is not the point. Rather, the point is that, in this author's view, medical committees are better forums for updating and responding to new scientific developments than are the floors of legislative halls. Indeed, statutory amendment processes are difficult enough on their own, and adding an additional layer of uncertainty seems tantamount to trapping the statutes in the scientific landscape of the years in which they were enacted.

Thus, a more appealing avenue might be to have the statutes create medical committees and furnish those committees with the authority to promulgate competency guidelines (and, potentially, other kinds of guidelines as well)¹²³ for physicians in their states. Although no Death with Dignity statute currently has anything like the above as a part of its legislative schema, such a proposal is not novel in the realm of medical-legal statutes or proposals (or statutes in general, for that matter). Take Oregon's newly enacted statutes regarding psilocybin regulation, for instance.¹²⁴ Oregon

in need. In a cash limited healthcare system, guidelines that improve the efficiency of health care free up resources needed for other (more equitably distributed) healthcare services.").

121. Bourgeois et al., *supra* note 76, at 450.

122. *Id.*

123. For instance, another key issue is whether a patient is actually terminal within the meaning of the statute (i.e., not likely to survive beyond another six months). See, e.g., Steinbock, *supra* note 64, at 237 ("[W]hile doctors can predict death when it will occur within days, the prediction of death within six months is much less reliable. This being the case, how useful is the Oregon requirement as a guideline?"); cf. Koocher, *supra* note 43, at 4 ("An important challenge to making use of [medical assistance in dying] involves the 6-month prognosis requirement typically included in most statutes.").

124. See OR. REV. STAT. ANN. §§ 475A.225–30 (West 2020).

residents voted in 2020 to pass Measure 109,¹²⁵ allowing anyone access to psilocybin for therapeutic use. The hope was that Measure 109 would open the door for more research into “psilocybin’s therapeutic benefits in treating anxiety, depression, and PTSD.”¹²⁶ Recognizing that there were still swaths of unknown data about the drug, however, the same ballot measure established the Oregon Psilocybin Advisory Board (OPAB), which “makes recommendation[s] to [The] O[regon] H[ealth] A[uthority] on available scientific studies and research on the safety and efficacy of psilocybin in treating mental health conditions,” and “makes recommendations on the requirements, specifications and guidelines for providing psilocybin services in Oregon.”¹²⁷

The law dictates that the governor of Oregon will appoint fourteen to sixteen members to the OPAB,¹²⁸ and mandates inclusion of a “psychologist . . . who has professional experience engaging in the diagnosis of treatment of mental, emotional, or behavioral condition[s],”¹²⁹ a “physician,”¹³⁰ and an “expert in the field of public health who has a background in academia.”¹³¹ Beyond those requirements, the law gives the governor discretion in choosing between an array of other qualified individuals listed throughout the text of the statute.¹³²

Or consider New York state’s emergency medical services council.¹³³ The law stipulates a council of thirty-two members that includes “representatives of voluntary ambulance services, advanced life support first response services, ambulance services operating for profit, municipal ambulance services, hospitals, a statewide organization representing volunteer fire services, municipal tax districts providing ambulance services, physicians,

125. See Julia Naftulin, *Oregon Has Become the First State to Legalize ‘Magic’ Mushrooms for Therapeutic Use. Here’s What that Means.*, INSIDER (Nov. 4, 2020), <https://www.businessinsider.com/oregon-first-ever-state-to-legalize-psilocybin-for-therapeutic-use-2020-11> [<https://perma.cc/JG37-JYCC>].

126. *Id.*

127. *Oregon Psilocybin Services—Oregon Psilocybin Advisory Board*, OR. HEALTH AUTH., <https://www.oregon.gov/oha/ph/preventionwellness/pages/psilocybin-advisory-board-meetings.aspx> [<https://perma.cc/3C8Y-DDBC>].

128. See OR. REV. STAT. ANN. § 475A.225(1)(a)(A) (West 2020).

129. See *id.* § 475.A225(1)(b)(B).

130. See *id.* § 475.A225(1)(b)(C).

131. See *id.* § 475.A225(1)(b)(E).

132. See, e.g., *id.* § 475A.225(b)(A)(iv) (for instance, an individual who represents “the Addictions and Mental Health Planning and Advisory Council.”).

133. See N.Y. PUB. HEALTH § 3002 (McKinney 2023).

and nurses.”¹³⁴ Even more to the point, the law furnishes the council with the “power . . . to enact, and from time to time, amend and repeal, rules and regulations establishing minimum standards for ambulance services . . . the provision of prehospital emergency medical care . . . the development of a statewide emergency medical services system” and other enumerated areas of concern.¹³⁵ Further, the law creates a state emergency medical advisory committee, which “shall develop and recommend to the state council statewide minimum standards for: (a) medical control; (b) treatment, transportation and triage protocols, including protocols for invasive procedures and infection control; and (c) the use of regulated medical devices and drugs by emergency medical services personnel.”¹³⁶

The statute’s statement of purpose says that the council was created “to develop minimum training standards for certified first responders, emergency medical technicians and advanced emergency medical technicians and minimum equipment and communication standards for advanced life support first response services and ambulance services.”¹³⁷ Presumably, as is the case with physicians and psychologists treating terminally ill patients, first responders and emergency medical technicians have knowledge based in part on guidance from their own disciplines. The existence of such council-creating legislation suggests that the state felt a more uniform approach could improve the quality of care and make more robust guidance widely available.

Indeed, the bill’s own legislative history bolsters that assumption. The Medical Society of the State of New York wrote in support of this bill to the office of the governor; it “fe[lt the emergency medical service council would] significantly improve the quality of the emergency services available to the people of this State.”¹³⁸ The Hospital Association of New York State felt similarly. Writing to the governor’s office, they stated “it is apparent that emergency medical service is one of the weakest links in the delivery of health care in the nation” and that the

134. *Id.* § 3002(1).

135. *See, e.g.*, § 3002(2) (authorizing the state council to enact rules and regulations that establish minimum standards for emergency medical care, subject to the commissioner’s approval).

136. *Id.* § 3002-a(2).

137. *Id.* § 3000.

138. Letter from Gerard L. Conway to the Hon. Michael Whiteman, Couns. to Gov. Wilson (May 31, 1974) (on file with author).

“enactment of these bills will help to ensure a more *coordinate* and effective system of emergency health care.”¹³⁹ And the New York State Highway Users Conference, although concerned in part with a possible loss of federal funds, wrote that the council “can upgrade emergency medical services which are vital to a long term commitment to reducing traffic deaths.”¹⁴⁰

Finally, although this does not purport to even come close to an exhaustive list, consider Arkansas’ Acute Stroke Act.¹⁴¹ Recognizing that the “death rate from stroke” in Arkansas is “the highest in the nation,”¹⁴² the state’s General Assembly created the “Acute Stroke Task Force”¹⁴³ imbued with the power to “[m]ake recommendations to the State Board of Health,”¹⁴⁴ “[p]ursue both public and private funding,”¹⁴⁵ and, most pertinent, “[d]evelop standards and policy recommendations.”¹⁴⁶

In sum, although this Note’s proposal might be novel as it pertains to PAD legislation, it is anything but new with regard to various state statutes. Indeed, given the prominence of these types of arrangements in other medical-legal spheres, the proposal at hand can benefit significantly from the structure of existing statutes.

B. A “COMPETENCY COMMITTEE” STATUTE

OPAB’s structure, appointment mechanisms, and purpose could all inform how a theoretical medical competence committee might look.

For one, OPAB is established by statute within the state’s health authority.¹⁴⁷ Already, a difference emerges. As Death with Dignity notes, “there is no state program for participation in the existing aid-in-dying laws and people do not apply to state health departments. It is up to eligible patients and licensed physicians

139. Letter from James H. Fitzpatrick, Dir. of Gov. Relations, to Hon. Michael Whiteman, Couns. to Gov. Wilson (May 23, 1974) (emphasis added) (on file with author).

140. Letter from A.J. Marvin, Chairman, to Hon. Michael Whiteman, Couns. to Gov. Wilson (May 30, 1974) (on file with author).

141. See ARK. CODE ANN. §§ 20-9-1001–05 (West 2005).

142. *Id.* § 20-9-1002(6).

143. *Id.* § 20-9-1003.

144. *Id.* § 20-9-1004(1).

145. *Id.* § 20-9-1004(2).

146. *Id.* § 20-9-1004(3).

147. See OR. REV. STAT. ANN. § 475A.225(1)(a)(West 2020).

to implement the act on an individual, case-by-case basis.”¹⁴⁸ There is good reason to keep making these determinations on a case-by-case basis rather than subject them to some state-authorized adjudicatory process; indeed, some scholars already note the “burden [a mandatory psychiatric referral would have] on a terminally ill patient,”¹⁴⁹ and the same logic would likely apply to a belabored, enduring adjudicatory hearing (especially when a condition for eligibility is six months to live). But that issue does not arise where the clinical criteria on which physicians base their case-by-case assessments are promulgated by a committee housed in the state’s health department. In other words, having clinical criteria intertwined with the state’s health department would generally not add additional procedural labors to patients; would not change the fact that assessments are conducted on a case-by-case basis; and would not add a requirement that state physicians participate in a statutory scheme.

There are two separate statutory sections relevant for our purposes in OPAB’s scheme: one that sets out OPAB’s members and their respective appointment processes, compensation, meetings, and other relevant rules,¹⁵⁰ and one that defines the parameters of its duties.¹⁵¹ As previously mentioned, the governor of Oregon appoints fourteen to sixteen members to OPAB, and membership must include a psychologist, a physician, and an expert in the field, among others.¹⁵²

A competency medical board might consist of relevant specialists in the field. Although the aforementioned PAD Committee was tasked with creating a set of guidelines for physicians in all aspects of the PAD context, its membership is still illuminating: such members included a University of California Davis School of Medicine Endowed Chair of Bioethics, the Director of the Health Law Institute at the Hamline University School of Law, a Geriatric Care Manager, a former executive manager of the Oregon Hospice Association, and a clinical professor of psychiatry, among others.¹⁵³ Indeed, the variety of professions and expertise

148. FAQ, *supra* note 7.

149. Bourgeois et al., *supra* note 76, at 445.

150. See OR. REV. STAT. ANN. § 475A.225 (West 2020).

151. See *id.* § 475A.230.

152. See *id.* § 475A.225.

153. See Orentlicher et al., *supra* note 72, (Supp. 2016, at n.a) [hereinafter “Orentlicher Supp. Material”].

present on the panel is itself a testament to the complexity of the problem.

The appointment process can take a variety of forms. Various issues with such a process are discussed below, *infra*, but for purposes of this section, the governor might appoint various members to serve limited terms. OPAB contemplates its members serving four-year terms, but at the pleasure of the governor.¹⁵⁴ OPAB likewise contemplates that a majority of the voting members constitutes a quorum, and that official action by OPAB requires the approval of a “majority of the voting members of the board.”¹⁵⁵

The statutory provision of OPAB that lays out its duties and responsibilities is perhaps most illuminating.¹⁵⁶ For instance, the law provides that OPAB shall “[m]ake recommendations . . . on available medical, psychological, and scientific studies, research, and other information relating to the safety and efficacy of psilocybin”¹⁵⁷ and further that it shall “[m]ake recommendations to the authority on the requirements, specifications and guidelines for providing psilocybin services.”¹⁵⁸

This Note envisions something similar for a proposed PAD statute. For instance, the law might contemplate that a competency board utilizes all available medical, psychological, and scientific studies relating to issues of competency, patient death, and competency evaluations, among other issues, and subsequently makes recommendations to the state health authority concerning competency guidelines that state physicians might then utilize. These guidelines might describe—among other important inclusions—relevant criteria, thresholds, and procedures.

There are myriad statutory tools that could help ensure the committees maintain independence while also securing legislative involvement. One method might be a mandatory reporting section that requires the committee to transmit its findings to the

154. See OR. REV. STAT. ANN. § 475A.225(2)(a) (West 2020).

155. See *id.* § 475A.225(3)–(4). Of course, a competency board need not adopt every nuance from OPAB. It is not unrealistic to contemplate certain votes or quorums requiring supermajorities based on the delicate nature of the subject matter involved. This Note, however, does not purport to sketch out with specificity the exact mechanics of a competency board; rather, this Note attempts to make the point that certain mechanics and technicalities might differ based on the subject matter of the committee in question.

156. See *id.* § 475A.230.

157. *Id.* § 475A.230(2).

158. *Id.* § 475A.230(3).

legislature at a predetermined rate, so that the committee retains democratic accountability.¹⁵⁹ Another solution might be to put the actual promulgation power into the hands of the state boards of health.¹⁶⁰ And yet another approach might be for the laws creating committees to mirror agency rulemaking provided for in the Administrative Procedure Act (APA) and require committees to solicit comments from the public and other interested parties.¹⁶¹ Such a system might include a further (and APA-analogous) requirement that the committees digest and respond to any comments they receive on proposed rulemakings.¹⁶²

This Note does not purport to set out a definitive version of a competency committee, nor does it provide an exhaustive list of elements. The foregoing proposals, however, attempt to highlight some of the ways in which the envisioned committees might serve to bolster medical knowledge, engage with the political process, and involve as many voices as possible.

C. BENEFITS

Such a system would have many benefits. As previously noted, guidelines help patients and physicians. They also help the field more generally.¹⁶³ In other words, medical researchers can

159. Congress, for example, often requires administrative agencies to transmit reports, studies, and other information on a specified timeline. See WILLIAM T. EGAR, CONG. RSCH. SERV., R46357, CONGRESSIONALLY MANDATED REPORTS: OVERVIEW AND CONSIDERATIONS FOR CONGRESS (2020). Reasons for such mandated reports vary, but often they “help legislators monitor . . . activity, ensure compliance with legislative intent, focus . . . attention on matters of importance to [the legislature], and assess the effectiveness of existing programs and policies.” *Id.* at 2. Indeed, these policy purposes have transcended legislative halls. For instance, a pending bill would make these congressionally mandated reports accessible to the public on a government-maintained website. See Access to Congressionally Mandated Reports Act, H.R. 2485, 117th Cong. (2021). Although this Note does not purport to draw with precision the contours of any reporting requirement, the point is that *some* reporting requirement would seem to increase democratic transparency and accountability.

160. Arkansas’ Acute Task Force statute, for example, provides that “[t]he State Board of Health *after consultation with* the Acute Stroke Care Task Force . . . may promulgate rules to further the intent of this subchapter.” ARK. CODE § 20-9-1005 (2005) (emphasis added).

161. See Administrative Procedure Act, 5 U.S.C. § 553(c) (1946) (“After notice required by this section, the agency shall give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments with or without opportunity for oral presentation.”).

162. See *id.* (“After consideration of the relevant matter presented, the agency shall incorporate in the rules adopted a concise general statement of their basis and purpose.”).

163. See, e.g., Woolf, *supra* note 114, at 527–28.

“benefit from the spotlight that evidence based guidelines shine on gaps in the evidence.”¹⁶⁴ Relatedly, methods of guideline development can focus attention on “key research questions,”¹⁶⁵ highlight gaps in the known literature,¹⁶⁶ and identify flaws in existing studies.¹⁶⁷ Especially in a setting that requires either a majority or unanimous approval for the promulgation of guidelines, the rigor and debate attending such meetings of the board would likely be robust, productive, and constructive.

Another important benefit that might spring from such a system is an abundance of helpful data. For instance, it will be much easier to say with some authority how clinical criteria are working when there is a more uniform set of guidelines for doctors to work from. For example, if physicians were concluding that patients in Oregon were competent to request PAD at a much higher level than patients in California, and if California and Oregon both had standardized—but differing—sets of competency guidelines, it would be much easier to look to the guidelines and say with some sense of certainty whether one set of guidelines is more deferential than the other. Now, in a system with competing guidelines, it is much harder to make these types of claims. It is true that certain hospitals likely have certain competency guidelines applicable to their own physicians. But the larger scale of state-wide practices, when compared against the small scale of local hospital systems, suggests that more objective points of comparison would prove beneficial in aiding transparency and furthering research.

Finally, uniformity is something that states should strive for. Dr. Hiscox has noted, and this Note has discussed, *supra*, various concerns related to patients “doctor shopping,” a phenomenon wherein the patient searches for a doctor who will give them the competency determination they seek.¹⁶⁸ A series of uniform guidelines would make it less likely that a patient could “shop around” for a doctor more willing to provide a positive competency assessment; doctors would be more likely to stick to their state guidelines, and more uniformity would ensue.

164. *Id.* at 528.

165. *Id.*

166. *See id.*

167. *See id.*

168. *See Hiscox, supra* note 100, at 209–10.

D. PROBLEMS

1. *Capture*

Regulatory “capture”—the domination of government agencies by professionals from the industries they regulate¹⁶⁹—might pose a problem to these theoretical medical committees. Part II raised the issue that certain end-of-life advocacy groups are particularly prominent in directing requesting patients to what some scholars might call “willing” doctors. Could a similar problem exist through committee membership? For instance, the PAD Committee was convened by Compassion & Choices, which describes itself as “the leader of the [end-of-life] choice movement for more than 30 years through support, education, and advocacy.”¹⁷⁰ Further, the committee itself included Compassion & Choice’s Medical Director.¹⁷¹ Might it be problematic for an advocacy group to convene and then take part in such a committee?

Two responses come to mind. First, if the Governor of the State, elected duly by the people of the State, makes appointments, committee members might be considered to have democratic backing. In other words, perhaps the question of whether or not advocacy group committee membership is per se problematic is best left to the democratic process, as Justice O’Connor suggested in her *Glucksberg* concurrence with regard to competency assessments.¹⁷² It might therefore follow that a Governor who continues to appoint board members with a history of advocacy, and who continues to win reelection, is responding to the broader democratic process.

Of course, a downside to exclusive reliance on gubernatorial appointments is the possibility of a rapid change in orientation

169. See Will Kenton, *What is Regulatory Capture?*, INVESTOPEDIA (Mar. 1, 2021), <https://www.investopedia.com/terms/r/regulatory-capture.asp> [perma.cc/5656-4B4G] (“Regulatory capture is an economic theory that says regulatory agencies may come to be dominated by the industries or interests they are charged with regulating. The result is that an agency, charged with acting in the public interest, instead acts in ways that benefit incumbent firms in the industry it is supposed to be regulating.”). In this case, capture would entail (possibly) competency committees becoming dominated by pro-PAD physicians.

170. Orentlicher Supp. Material, *supra* note 153, at 1.

171. See *id.*

172. See *Washington v. Glucksberg*, 521 U.S. 702, 736 (1997) (O’Connor, J., concurring) (“There is no reason to think the democratic process will not strike the proper balance between the interests of terminally ill, mentally competent individuals who would seek to end their suffering and the State’s interests in protecting those who might seek to end life mistakenly or under pressure.”).

when a new governor comes into office (e.g., when the prior governor was pro-PAD, and the new governor is hostile toward the practice). Such whiplash to the system could disrupt reliance interests, create conflicting definitions, and indeed doom the very purposes for which the committee was envisioned in the first instance. Thus, it becomes important to consider various other ways to construct the committee that might mitigate the damage capture entails. For one, it might be beneficial for the statute to prescribe appointment power to a rotating list of relevant stakeholders, including, among others, state health care authorities, hospitals, universities, and interest groups. The turnover might alleviate the risk of any one group dominating the committee over long stretches of time. Or the committee might require a unanimous (or close to unanimous) vote in order to promulgate certain guidelines, which would help to ensure that no one interest dominates by virtue of overrepresentation.

Relatedly, it should be conceded that some general version of the problem of capture is likely unavoidable within these specialized committees. Physician participation is entirely voluntarily,¹⁷³ and it is likely true that a prerequisite for board participation should, at least normatively, involve some experience with assessing patients at an end-of-life stage. So, if only those who have experience with competency assessments during a patient's final stages of life would have the necessary qualifications to serve, it might follow that the board would be comprised primarily of pro-PAD advocates (assuming that those who oppose PAD would likely not participate in any PAD-related endeavors).

This concern might be addressed in a number of ways. First, there are myriad providers who deal with patients toward the ends of their lives, but do not deal with any PAD requests. For example, hospice and palliative care providers are often involved in at least some capacity with patients who have terminal illnesses. Indeed, some scholars have argued quite persuasively that these practitioners might be in a "better position to systematically screen for depression because they do not perform one time consultations but develop advocacy-based, positive, nonadversarial, longitudinal relationships with clients and their families from which to better

173. See OR. REV. STAT. 127.885(4) (2023) ("No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner.").

assess depression and other mental health and psychosocial issues.”¹⁷⁴ True, “federal law prohibits the use of Medicare or Medicaid funds for death with dignity mental health evaluation (about one third of death with dignity deaths) and hospice per diem rates are so scant that most cannot afford psychologists and psychiatrists on their staffs.”¹⁷⁵ But that being said, it seems no law would prohibit a former hospice worker from participating on a competency committee. And despite the foregoing, some hospitals have themselves noted the benefits of palliative consultation; for instance, Seattle Cancer Care Alliance now offers palliative care consultations as a matter of policy to all PAD participants.¹⁷⁶

It is also undoubtedly true that most physicians deal with competency assessments in non-PAD settings.¹⁷⁷ Indeed, competency evaluations at general hospitals most commonly include decisions like whether patients are competent to return home safely and care for themselves, whether patients are competent to refuse medical treatment, and whether patients are competent to give informed consent for proposed medical procedures.¹⁷⁸ Although some scholars have argued that the threshold for right-to-die competency evaluations should be higher than in other end-of-life scenarios, others disagree, asserting that “the . . . threshold for determining capacity to decide regarding medical aid in dying [should be the same] as is employed to determine capacity for other health care decisions related to survival near the end of life.”¹⁷⁹ Regardless of which approach is correct, including those physicians who deal with competency decisions at an end-of-life stage, but who do not deal with PAD requests, may indeed help to mitigate the damage that capture can pose.

174. Ganzini, *supra* note 106, at 11.

175. *Id.*

176. See Elizabeth Trice Loggers et al., *Implementing a Death with Dignity Program at a Comprehensive Cancer Center*, 368 NEW ENG. J. MED. 1417, 1423 (2013).

177. Cf. Michael G. Farnsworth, *Competency Evaluations in a General Hospital*, 31 PSYCHOSOMATICS 60, 65 (1990) (predicting that psychiatrists will more frequently encounter questions of competency “as the population ages and treatments become more complex”).

178. See *id.* at 61.

179. Weithorn, *supra* note 25, at 643; cf. Appelbaum, *supra* note 9, at 1836 (“In practice, the stringency of the test applied varies directly with the seriousness of the likely consequences of patients’ decisions.”).

Finally, it might also be true that those who oppose PAD would participate in competency committees in order to ensure their views remain a part of the scientific dialogue. The alternative, some anti-PAD scientists might imagine, would be a landscape entirely pro-PAD. Although a competency committee composed of advocates from both sides of the aisle might engender conflict, scientific conflict is often constructive,¹⁸⁰ and can work to further research goals similarly to how the American democratic process furthers policy goals.

2. Procedure

Some might argue that these changes would add hefty procedural burdens to an already laborious process. Given the fairly weak language of current state statutes, patients and family members do not have much authority under which to sue. Under this Note's proposal, that might change. Imagine a terminally ill patient's family who does not believe that the patient at issue is competent. Imagine further that, after a consult, an attending physician declares that the patient is indeed "competent" notwithstanding the family's objections. Under this proposal, a family might sue by pointing out discrepancies between the state's competency guidelines and the guidelines employed by the attending physician, if such discrepancies arise. Or, worse yet, the physician might employ the same clinical criteria on paper but make a determination at odds with (or in spite of) the criteria employed.

Although this is certainly a concern, its impact may be overstated. For one, the promulgations by the aforementioned medical committees should be viewed as guidelines rather than orders with binding effect.¹⁸¹ For example, the National Center for Complementary and Integrative Health has an online repository of clinical guidelines, and prefaces their introduction by noting that "[t]hese guidelines are not fixed protocols that must be followed, but are intended for health care professionals and

180. Amy R. Overton & Ann C. Lowry, *Conflict Management: Difficult Conversations with Difficult People*, in 26 *CLINICS IN COLON & RECTAL SURGERY* 259, 259 (2013) ("The proposed benefits of conflict include improved understanding of the task, team development, and quality of group decision making.").

181. This Note takes the view that, to the extent state legislatures even have the capacity to make these regulations binding on physicians, they should not, lest they risk a torrent of wrongful death or medical malpractice suits.

providers to consider.”¹⁸² The present issue in large part is not that doctors choose to disregard clinical guidelines; rather, it is that they are largely unaware¹⁸³ of (or overwhelmed by conflicting) guidelines. The purpose of such promulgations would be to make available to participating physicians a standardized set of clinical criteria with which to guide their assessments.

Further, it should be noted that there are some cases that might warrant an additional layer of scrutiny. For example, if the above scenario involving family members actually did play out, it might not be necessarily problematic; perhaps in cases where there are severe enough disagreements between family members to warrant a lawsuit, some added layer of protection is warranted.

Take, for instance, the famous case of Jahi McMath. After a tonsil removal surgery, the 13-year-old Jahi started coughing up blood; three hours later, her heart stopped.¹⁸⁴ Two days later, two hospital tests showed that Jahi was brain dead.¹⁸⁵ But Jahi’s mother, Latasha “Nailah” Winkfield, did not believe her daughter was dead.¹⁸⁶ Who was right? Scientific literature soon abounded; Jahi’s “MRI scan, performed 9 months after the ischemic insult, showed remarkable preservation of cortical and internal gross anatomy, with surprisingly little atrophy, despite cortical laminar necrosis, demyelination, and cystic encephalomalacia in the centrum semiovale, corpus callosum, and posterior pons and medulla.”¹⁸⁷ Indeed, “cerebral function . . . return[ed] intermittently.”¹⁸⁸ Despite the initial diagnosis of brain death, and despite Jahi’s doctors following “accept[able] medical

182. *Clinical Practice Guidelines*, NAT’L CTR. FOR COMPLEMENTARY & INTEGRATIVE HEALTH, <https://www.nccih.nih.gov/health/providers/clinicalpractice> [https://perma.cc/K7RW-M4DA].

183. *Cf.* Weithorn, *supra* note 25, at 691 (citing Andrea K. Shreve-Neiger et al., *Assessing the Need for Decision-Making Capacity Education in Hospitals and Long Term Care (LTC) Settings*, 34 *EDUC. GERONTOLOGY* 259, 365–67 (2008)) (noting that physicians revealed their decision-making assessment trainings had been sub-optimal).

184. *See* Samantha Schmidt, *Jahi McMath, the Calif. Girl in Life-Support Controversy, Is Now Dead*, *WASH. POST* (June 29, 2018), <https://www.washingtonpost.com/news/morning-mix/wp/2018/06/29/jahi-mcmath-the-calif-girl-declared-brain-dead-4-years-ago-is-taken-off-life-support/> [https://perma.cc/5NLE-4EV5].

185. *See id.*

186. *See* Wesley J. Smith, *Jahi McMath Was Not Brain Dead*, *NAT’L REV.* (May 3, 2021), <https://www.nationalreview.com/corner/jahi-mcmath-was-not-brain-dead/> [https://perma.cc/AG4A-58UD].

187. D. Alan Shewmon, *Truly Reconciling the Case of Jahi McMath*, 29 *NEUROCRIT. CARE* 165, 166 (2018).

188. *Id.* at 169.

standards,”¹⁸⁹ many scientists now believe that Jahi was never brain dead, but severely disabled.¹⁹⁰ Five years after her surgery, Jahi passed away due to complications from liver failure.¹⁹¹

But for Jahi’s mother’s persistence, there is a strong probability that Jahi’s doctors would have taken her off life support. Obviously, Jahi could not speak for herself; and family members, as in Jahi’s case, may have special insight into their family. In certain cases, familial opposition to a competency assessment so strong as to warrant a lawsuit might indeed warrant some added layers of procedural scrutiny. Indeed, a number of the state statutes which allow for PAD provide that consent and competency might be ascertained through persons familiar with the requesting patient, an implicit endorsement of the view that certain individuals have special insight into the patients at issue.¹⁹² Although this Note takes no position on how that scrutiny might be applied or enshrined, the point is that additional procedures are not necessarily problematic.

3. *Federalism*

This Note’s proposal also raises the normative question of why doctors in one state should follow their state guidelines. An initial problem this Note addressed was the issue of competing guidelines; why should a doctor in Oregon follow Oregon’s non-binding guidelines if she feels that California’s are better? Such a system could lead to a variety of differing guidelines; is not uniformity a goal of this proposal?

With respect to uniformity, federalism often means that the states will come to differing conclusions concerning what is and what is not appropriate to include in their guidelines. The same is true for the statutes themselves. Some states have PAD statutes,

189. *Id.*

190. *See id.* (presenting research affirming that Jahi’s case represents not a tragic instance of brain death but one of global ischemic penumbra (GIP), an illness whose symptoms mimic those of brain death).

191. *See* Debra Goldschmidt, *Jahi McMath, California Teen at Center of Brain-Death Controversy, Has Died*, CNN (June 29, 2018), <https://www.cnn.com/2018/06/29/health/jahi-mcmath-brain-dead-teen-death/index.html> [<https://perma.cc/Q2HQ-U39D>].

192. *See, e.g.*, ME. REV. STAT. ANN. tit. 22, § 2140(2)(C) (2019) (“[I]ncluding communication through persons familiar with the patient’s manner of communicating if those persons are available.”); N.J. STAT. ANN. § 26:16-3 (West 2019) (same); OR. REV. STAT. ANN. § 127.800(3) (West 2023) (same); VT. STAT. ANN. tit. 18, § 5281(2) (2023) (same); WASH. REV. CODE § 70.245.010(3) (2023) (same).

some do not, and the ones that do exist are not identical. As a democratic country, we accept these variations as reflective of federalism.¹⁹³

In fact, the states have various and often widely divergent guidelines for most medical issues.¹⁹⁴ In any event, providers are likely to follow their state's guidelines for two reasons: First, most doctors would likely hesitate to shirk guidelines in their home state for the reasons raised earlier regarding potential lawsuits by family members; in other words, no one wants to be sued. Second, and likely more importantly, the primary issue in this space is not that doctors are acting against their beliefs, but rather that their beliefs are bleeding out into their practice because of a lack of guidance. Whether or not a doctor chooses to follow state guidelines is always a personal choice not germane to any single specialty; the purpose is not to commandeer the process of making medical decisions, but instead to aid providers acting against a sparse and arid backdrop of guidance.

In short, many of the aforementioned problems seem either overstated or inherent in a federalist system. This list is, of course, not exhaustive. But these and other problems tie into Justice O'Connor's premonition that the democratic processes of the states will continue to uncover better methods to respect the balance between patient autonomy and state interests. Different state statutes regarding these medical committees might inform what works, what does not, and what remains to be improved.

193. See, e.g., THE FEDERALIST NO. 45 (James Madison) ("The powers delegated by the proposed Constitution to the federal government are few and defined. Those which are to remain in the State governments are numerous and indefinite."); *Bond v. United States*, 564 U.S. 211, 222 (2011) ("By denying any one government complete jurisdiction over all the concerns of public life, federalism protects the liberty of the individual from arbitrary power. When government acts in excess of its lawful powers, that liberty is at stake."); *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting) ("It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.").

194. See, e.g., *State Policies*, GET AHEAD OF STROKE, <https://getaheadofstroke.org/state-policies/> [perma.cc/8AJ3-WE4N] ("Policies and regulations that guide stroke care vary widely by state."); Jenny Rough & Andy Markowitz, *List of Coronavirus-Related Restrictions in Every State*, AARP (Sept. 26, 2023), <https://www.aarp.org/politics-society/government-elections/info-2020/coronavirus-state-restrictions.html> [perma.cc/AJH9-X5T3] (compiling a list of differing state restrictions concerning the coronavirus); *Grading the States: An Analysis of Involuntary Psychiatric Treatment Laws*, TREATMENT ADVOCACY CENTER, <https://www.treatmentadvocacycenter.org/grading-the-states> [perma.cc/MG79-9DPU] (providing grades for differing state laws concerning involuntary psychiatric treatment laws).

CONCLUSION

States which currently allow PAD, and those planning on allowing the practice in the future, should incorporate competency committees into their PAD statutes. These committees can help provide guidance to physicians; improve the quality of competency data; and better balance the competing interests of patient autonomy and state police powers.

The right-to-die landscape is complicated and multifaceted. Justice O'Connor's statement that the states "are presently undertaking extensive and serious evaluation of physician-assisted suicide and other related issues"¹⁹⁵ remains accurate today. Embracing the fact that these "liberty interests [are] entrusted to the 'laboratory' of the states,"¹⁹⁶ legislatures should recognize current shortcomings in physician competency assessments and attempt to promulgate helpful guidelines to ensure uniformity and the best possible care for patients.

This Note takes no side in the contentious debate over the ethical implications of physician-assisted suicide. But given that certain states have legalized the practice, and given that there is a non-remote chance that other states will follow suit, it makes sense to provide as many resources to ensure that the practice is done in such a way that the autonomy of patients is preserved and the liberty interests of individuals, family members, and the various states are protected.

APPENDIX

TABLE 1: COMPARISON OF "COMPETENCY" DEFINITIONS IN STATE PAD STATUTES

State	Definition
California	"'Capacity to make medical decisions' means that, in the opinion of an individual's attending physician, consulting physician, psychiatrist, or psychologist, pursuant to Section 4609 of the Probate Code, the individual has the ability to understand the nature and consequences of a

195. *Washington v. Glucksberg*, 521 U.S. 702, 737 (1997) (O'Connor, J., concurring).

196. *Id.* (citation omitted).

	health care decision, the ability to understand its significant benefits, risks, and alternatives, and the ability to make and communicate an informed decision' to health care providers.” ¹⁹⁷
Colorado	“‘Mental capacity’ or ‘mentally capable’ means that in the opinion of an individual’s attending physician, consulting physician, psychiatrist or psychologist, the individual has the ability to make and communicate an informed decision to health-care providers.” ¹⁹⁸
District of Columbia	“‘Capable’ means that, in the opinion of a court or the patient’s attending physician, consulting physician, psychiatrist, or psychologist, a patient has the ability to make and communicate health care decisions to health care providers.” ¹⁹⁹
Hawaii	“‘Capable’ means that in the opinion of the patient’s attending provider or consulting provider, psychiatrist, psychologist, or clinical social worker, a patient has the ability to understand the patient’s choices for care, including risks and benefits, and make and communicate health care decisions to health care providers.” ²⁰⁰
Maine	“‘Competent’ means that, in the opinion of a court or in the opinion of the patient’s attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate an informed decision to health care providers, including communication through persons familiar with the patient’s manner of communicating if those persons are available.” ²⁰¹
New Jersey	“‘Capable’ means having the capacity to make health care decisions and to communicate them to a health care provider, including

197. CAL. HEALTH & SAFETY CODE § 443.1(e) (West 2022).

198. COLO. REV. STAT. § 25-48-102(10) (2023).

199. D.C. CODE § 7-661.01(2) (2017).

200. HAW. REV. STAT. ANN. § 327L-1 (2023).

201. ME. REV. STAT. ANN. tit. 22, § 2140(2)(C) (2019).

	communication through persons familiar with the patient's manner of communicating if those persons are available." ²⁰²
New Mexico	"'[C]apacity' means an individual's ability to understand and appreciate health care options available to that individual, including significant benefits and risks, and to make and communicate an informed health care decision." ²⁰³
Oregon	"'[Capable]' means that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available." ²⁰⁴
Vermont	"'[Capable]' means that a patient has the ability to make and communicate health care decisions to a physician, including communication through persons familiar with the patient's manner of communicating if those persons are available." ²⁰⁵
Washington	"'[Competent]' means that, in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist, or psychologist, a patient has the ability to make and communicate an informed decision to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available." ²⁰⁶

202. N.J. STAT. ANN. § 26:16-3 (West 2019).

203. N.M. Stat. Ann. § 24-7C-2(B) (2021).

204. OR. REV. STAT. ANN. § 127.800(3) (West 2023).

205. VT. STAT. ANN. tit. 18, § 5281(2) (2023).

206. WASH. REV. CODE § 70.245.010(3) (2023).