End-of-Life Liability Issues

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Introduction: About 3,800 years ago, the Code of Hammurabi decreed that physicians who harm their patients shall have their hands cut off.[1] And ever since then, the physician-patient relationship has spawned potential civil, criminal, and administrative liability. This discourse addresses liability issues that physicians may confront when caring for the terminally ill.

Physicians and the law: To protect the public health, each state has a compelling interest in regulating medical practice, which each state generally does by statutes.[2] To implement those statutes, states look to courts that hear medical malpractice claims, courts that hear criminal complaints, and agencies that oversee physician licensing and discipline.

Most often, physicians learn the law as defendants in malpractice claims. In an adversary system that they view as antithetical to seeking truth, physicians have seen negligence awards and their own liability premiums soar. They have seen colleagues investigated, charged, convicted, and punished under criminal statutes. And physicians have seen the agencies that license them resort to remedies ranging from reprimand to revocation—and put unprecedented numbers of colleagues out of business.

Physicians risk civil, criminal, and administrative liability when caring for the terminally ill. But reasoning deductively in a scientific world, a doctor doesn't "think like a lawyer." Few physicians know the elements of negligence or informed consent; and that leads to inappropriate defensive medicine. Few know the criminal law, and fewer can fathom the administrative law that governs the physician-discipline process.

The physician-discipline process: Court dockets readily confirm the staggering numbers of malpractice claims and still-rare, but increasing numbers of criminal complaints against physicians.[3] But states still report a failure to protect the public from "medical negligence, incompetence, or illegal and unethical practices."[4] So in the past decade, legislatures have vested administrative agencies with ever-increasing authority to investigate, prosecute, and adjudicate physician-misconduct claims. These agencies act under a system that frustrates even skilled attorneys—that body of jurisprudence known as administrative law.

Just about anyone can complain to licensing and discipline agencies; and, it seems, just about anyone does. Most complaints come from patients, patients' relatives, hospitals, other health professionals, insurance companies, court clerks, state or federal agencies, and the Federation of State Medical Boards. In some states, almost every malpractice claim breeds a misconduct complaint. And agencies investigate every complaint.

Each state has enacted a laundry list of conduct that can lead to professional discipline.[5] Conduct involving negligence, gross negligence, incompetence, gross incompetence, unprofessional conduct, and moral unfitness seem unspecific and vague. Yet agencies routinely enforce these unspecific, vague standards—because courts believe that physicians should know what the public interest requires.

Agencies may issue a reprimand, which declares conduct improper without limiting the physician's right to practice. Censure harshly condemns the conduct, but still does not limit the right to practice. Agencies may impose substantial monetary fines. Usually, agencies impose sanctions only after a formal hearing. But if they discover an imminent danger to the public health, agencies may summarily suspend a physician's right to practice.

Agencies may restrict a physician's ability to prescribe controlled substances or to perform surgery. They may mandate supervised practice. They may impose probation, which for a prescribed time, subjects the physician to monitoring. They may suspend a license, which for a prescribed time, prevents the physician from practicing. And agencies may revoke a license, thus "forever placing the offender beyond the pale."[6] Restoring a revoked license requires petition and review that take years to complete—and frequently fail. But even if a physician escapes a misconduct complaint unscathed, defending misconduct complaints that result in a hearing can cost the accused physician between $80,000 and $100,000.[7]

The same agency may fulfill three conflicting roles. In a quasi-legislative role, agencies promulgate rules and regulations that implement physician-discipline statutes. In a quasi-executive role, agencies investigate and prosecute alleged violations of physician-discipline statutes. Finally, in a quasi-judicial role, agencies hold hearings to determine whether physicians have violated physician-discipline statutes, and then impose sanctions.

The United States Supreme Court has found that an agency's acting as prosecutor, judge, and jury does not violate the constitution.[8] Indeed, wrote the High Court, "Without a showing to the contrary, state administrators 'are assumed to be men of conscience and intellectual discipline, capable of judging a particular controversy fairly on the basis of its own circumstances.' "[9] But in the physician-discipline process, the Supreme Court's words disregard administrative law's realities.

At least one court described a physician-discipline agency as "a tribunal predisposed to conviction."[10] Another described the physician-discipline process as: "a schizophrenic fact of justice [that] threaten[s] complete objectivity."[11] Indeed, yet another observed that "[T]he board was forced to become creative in order to effectively vent its moral outrage. It did so with all the subtlety of the proverbial eight-hundred-pound gorilla that it has become."[12] But relying on the Supreme Court's faith in administrative law and in those who enforce it, courts almost always uphold adverse physician-discipline determinations.[13]

In malpractice cases, plaintiffs must establish by a preponderance of the evidence that the physician's violating a relevant standard of care proximately caused the patient's harm. In criminal cases, the government must prove its case beyond a reasonable doubt. In civil and in criminal cases, physicians retain a panoply of due-process protections. But in the physician-discipline process, evidentiary standards and due-process protection evaporate.

In a very few states, evidence admitted at disciplinary hearings must conform to that state's well-detailed evidentiary rules for civil actions.[14] But in most states, the "probative and relevant evidence" admitted at physician-discipline hearings often includes hearsay.[15]
In a very few states, physician misconduct must be established by "clear and convincing evidence" that is "highly probable or reasonably certain."[16] But in most states, physician misconduct must be established by a "preponderance of the evidence" that is "the stronger evidence, however slight the edge may be."[17] Actually, in most states, physician misconduct will be established by "substantial evidence" that is "*less* than a "preponderance."[18] Indeed, this "substantial evidence" standard—that in most states can strip physicians of their right to practice—requires only "evidence beyond a scintilla."[19]

While physician-discipline statutes require experts to establish that a physician violated a relevant standard, they do not require even suggesting that the patient suffer any harm. And those statutes view physicians' rights to discovering the nature and extent of testimony against them *before* the hearing as being severely curtailed or non-existent.

Agencies typically offer an internal appeal of their final determinations. But physicians find scant solace in having an agency preside over an appeal of its own decision. Yet physicians must exhaust all administrative remedies before seeking judicial review.

Courts exercise only limited judicial review of agency determinations—and generally defer to the agency's' presumed expertise in health-related matters.[20] In essence, judicial review "distills to whether the [agency's] findings have a rational basis and are factually supported.[21] Courts thus uphold determinations that *some* evidence in the record supports.[22] And again, this standard requires only "evidence beyond a scintilla."[23]

Thus physicians who escape liability in court may face an agency that stacks the odds against them—in a climate that favors yet more physician oversight and accountability. Plaintiffs who do not succeed in court may use the same allegations in a physician-discipline complaint—and put the physician, who did succeed in court, out of business. Thus the reality—and more often the fear—of incurring civil, criminal, and administrative liability has molded physicians' conduct when they care for the terminally ill.[24]

Sources of end-of-life liability: Under the common-law right to preserve one's bodily integrity, competent adults, defined as those with decision-making capability, may refuse medical treatment.[25] The seminal case, *In re Quinlan*, was the first state-court decision to allow physicians to withdraw a respirator from a patient who was in a persistent vegetative state.[26] In a ruling that jolted the medical and legal communities, the Quinlan Court held that in end-of-life decisions, patients' judgments must prevail over physicians' judgments.[27] Since Quinlan was decided in 1976, courts and legislatures have struggled to fix medical management's legal boundaries in the context of end-of-life care.

In fixing those boundaries, courts have uniformly held that no legal distinction exists between withholding or withdrawing life-sustaining medical treatment.[28] And where physicians have withdrawn life-sustaining treatment, no successful civil suit or criminal

prosecution against them has yet been reported.[29] Yet when physicians override a patient's wish to withdraw life-sustaining treatment, they cite their fear of such civil suit or criminal prosecution. Those fears increase when patients lose the capacity to make such decisions.

Quinlan spawned statutes that permit competent adults to make medical decisions after they become incompetent to make those decisions. Living wills permit competent adults to formally instruct others when to refrain from using life-support measures to prolong their lives during their own catastrophic illness.[30] Advance directives permit competent adults to formally designate others to make health-care decisions when their makers become incompetent. Unlike most powers of attorney, advance directives remain in effect during their maker's incompetency.[31] The Federal Patient Self-Determination Act now requires hospitals to inform patients of their right to refuse medical treatment and of their right to create and use advance directives.[32]

Do-not-resuscitate [DNR] statutes permit physicians and patients to direct that cardiopulmonary resuscitation [CPR] be withheld.[33] Surrogate decision-making statutes permit courts to allow particular people to make health care decisions for those who have become incapacitated and have executed neither a living will nor an advance directive.[34] Only a few states reject this principle of substituted judgment: New York in all situations;[35] Missouri, if artificial nutrition is involved; [36] Michigan, if the patient is neither terminally ill nor permanently unconscious; [37] and Maine in name, although not in fact.[38]

The Supreme Court has yet to address whether surrogates may refuse treatment on behalf of those who have never been competent to make a decision. But court involvement in end-of-life care of the incompetent has increased. Professor George Annas has observed "an increasing trend to ask the courts whether life-sustaining treatment should be withheld from patients who are unable to make this decision themselves. Judges are asked to decide this question, not because they have any special expertise, but because only they can provide the physicians with civil and criminal immunity for their actions."[39]

Other experts opine that Professor Annas overstates courts' involvement in end-of-life care. But they concede that "provider perception of a legal system that continually lurks in the shadows is both real and powerful." [40] Indeed, Timothy Quill, MD, of *Vacco v. Quill*,[41] wrote that end-of-life decisions are "influenced more by considerations of risk management than by those of patient care." [42] A study of physicians familiar with end-of-life issues reports that "[f]ear of legal liability often interferes with the physician's ability to make the best choice for the patient."[43] Another study reports that physicians caring for the terminally ill often bow to family demands because they fear adverse legal outcomes.[44]

Despite the paucity of experience to support such consternation, physicians' concerns about being sued for malpractice in end-of-life situations have worsened.[45] A 1995 study confirmed that: "Physicians may be apprehensive about being sued by a family member who wants a different level of care provided than specified in the patient's directive."[46] When patients become incapable of expressing their medical preferences, physician anxiety about family members becoming plaintiffs intensifies.[47]

The stereotypical situation takes place when the long-absent child arrives from some distant place at the last minute, uninvited and unexpected. The child then disrupts the caring scene with unreasonable demands for previously-neglected futile medical assaults.[48] Legal suspicion thus clouds the relationship between physicians and families. Indeed, one appellate court found that disregarding a family's wishes to withdraw life support from a patient in a persistent vegetative state would subject her physicians to civil liability.[49]

Some studies report that only 15-20% of people prepare a written directive.[50] Others report that only 6% ever do.[51] Difficulties with end-of-life decisions may thus reflect physician uncertainty about patient wishes. Physicians who try to fulfill their patients' wishes may not be sure of what those wishes are. Indeed, studies consistently have shown that while physicians believe that they know their patients' treatment preferences, they often do not.[52] And that may flow from the many terms in end-of-life statutes that are ambiguous.

Statutory provisions often apply to the terminally ill, yet rarely define "terminally ill." An Illinois statute describes "an incurable and irreversible condition [where] death is imminent and the application of death delaying procedures serves only to prolong the dying process."[53] But the statute does not define "imminent." Nor does it give guidance for determining when a life-sustaining treatment is delaying death rather than prolonging life.

For physicians, advance directives are limited by their own ambiguity. Although "meaningful quality of life," "acceptable quality of life," and "extraordinary means" appear, the terms are never defined.[54] Indeed, one study reports that of 688 advance directive documents, only 5% contained specific treatment instructions and that 87% were ambiguous.[55]

Do-not-resuscitate statutes have not completely resolved physicians' liability anxieties. CPR's dismal success rate makes it difficult for plaintiffs to prove that a physician's failure to administer CPR proximately causes any legally compensable injury.[56] Still, many physicians believe that administering even unsuccessful CPR is preferable to facing a malpractice suit's or a misconduct complaint's potentially damaging outcome.

Media attention may fuel physicians' fears of unwelcome litigation. For example, in 1997, the United States Supreme Court decided *Washington v. Glucksberg* and *Vacco v. Quill*.[57] In *Glucksberg* and in *Quill* respectively, the Court held that the neither the Due Process Clause nor the Equal Protection Clause confer a constitutional right to assisted suicide.[58] These cases did not involve criminal actions, and nothing in their holdings suggests that states will prosecute more physicians. Yet NBC's Today Show reported that the Supreme Court's decisions in *Washington v. Glucksberg* and *Vacco v. Quill* "could make murder charges against doctors more common." [59]

Although the risk of criminal prosecution in end-of-life care is extremely small, it looms large for physicians who make treatment decisions for the terminally ill.[60] Fear of prosecution, conviction, and punishment may skew treatment of the most vulnerable patients toward overtreatment or undertreatment.[61] Indeed, 40% of physicians act contrary to their consciences by overtreating dying patients—because to do otherwise would risk

liability.[62] The very legal and regulatory environments intended to protect patients may therefore inadvertently cause many terminally-ill patients to be treated inappropriately."[63] And the terminally ill are most often treated inappropriately when they have severe, persistent pain.

The first comprehensive study of end-of-life care in the United States, which analyzes data from 1997 through 2002, suggests that pain management for dying patients is inadequate. Indeed, reports the study, nearly half of the 1.6 million Americans living in nursing homes experience persistent, severe pain that is treated deficiently.[64] Another study reports that 80% of those afflicted with end-stage cancers experience persistent, severe pain.[65] And terminally-ill AIDS patients report similar statistics.[66] Although physicians can relieve that pain in 90% of those patients, they rarely do.[67] Throughout the United States, 60 to 70% of patients who experience persistent, severe pain are treated deficiently.[68]

The mainstay for treating persistent, severe pain remains the opium-derived controlled substances that include morphine.[69] But medical training in treating pain remains wanting.[70] And drugs that treat severe pain have become the major focus in the war on their abuse.[71] Recent studies report that patients who experience severe pain can tolerate enormous doses of morphine without experiencing the respiratory depression that can prove fatal.[72] But 30 years in the private practice of Otolaryngology/ Head & Neck Surgery have convinced the author otherwise. Indeed, no standard has emerged for managing persistent, severe pain, and pain-management protocols remain plagued by major disagreements. Although most states have enacted pain-management statutes, even members of physician-discipline boards lack a clear understanding of legally and medically-acceptable pain management.[73] Plaintiffs' and prosecuting attorneys fare no better. Thus while undertreating pain has reached epidemic proportions in the United States, physicians blame that on the confusing regulatory oversight invited by the law. [74]

Without clear pain-management guidelines, agencies often interpret the law in any way they see fit.[75] A physician who spent five years and $140,000 fighting the California Medical Board's charges of over-prescribing summarized physicians' fears. "A doctor, if he really wants to cover himself, is going to underprescribe. There's no law against underprescribing other than the law of compassion." "Doctors hear about these [investigations] happening, and compassion goes out the window.[76] Courts, however, do not always agree.

In *Estate of Henry James v. Hillhaven Corp.*, a nurse refused to follow a physician's morphine prescription for a terminally-ill man. Although settled for an undisclosed amount, the jury award pain and suffering—and punitive—damages of $15 million.[77] *Gaddis v. United States* involved the failure to diagnosis a laryngeal cancer—that caused severe pain.[78] In addition to wrongful death damages, the court awarded pain and suffering damages of $125,000.[79] *Bergman v. Chin* involved a terminally-ill patient with lung cancer whose pain was inadequately managed.[80]Although a damage cap statute mandated reduction to $250,000, the jury awarded pain and suffering damages of $1.5 million.[81]

In criminal cases, physicians who act as no more than "drug-pushers" are appropriately tried, convicted, and punished.[82] But a Utah physician who prescribed morphine to five of his terminally-ill patients was found guilty of manslaughter and negligent homicide.[83] Prosecutorial misconduct—in failing to provide the exculpatory expert opinion that the prosecutor had heard—caused the conviction to be overturned. But the physician faces a new trial. In such criminal cases, physician liability flows from the "double-effect doctrine." Under the "double-effect doctrine," controlled substances may be used to relieve pain and anxiety in the terminally-ill, even if doing so foreseeably hastens the patient's death.[84] In some cases, relieving extreme pain, agitation, delirium, or breathing difficulty requires physicians to sedate the dying patient into unconsciousness. In this subset of "double-effect" called "terminal sedation," the patient, sedated into coma, often dies within days.[85]

The "double-effect doctrine" has long been controversial in moral philosophy, in medical ethics, and in law.[86] But it has been incorporated into the Code of Ethics of the American Medical Association [AMA].[87] The AMA's purporting to speak for an entire profession, however, should raise concerns. First, the steadily-declining AMA membership roster claims only a third of America's physicians.[88] Second, the AMA's president appoints the entire Council on Ethical and Judicial Affairs, which authors the AMA's Code of Ethics.[89] Thus, not one author of the AMA's Code of Ethics has ever been elected. Third, in asserting ethical positions, that unelected Council often ignores ethical positions that America's physicians support.[90] But that should not surprise anyone, because when it issues ethical guidelines, that unelected Council never even polls those physicians.[91] Still, the Attorney General, Congress and the Supreme Court accord AMA ethical positions pivotal deference. Thus the Attorney General, Congress and the Supreme Court have embraced as legitimate practice the doctrine of "double-effect." [92]

Under the "double-effect doctrine," the morality or legality of physicians' conduct turns on intent. Did the physician prescribe with intent to hasten death? Or did that physician prescribe with intent to relieve pain, agitation, delirium, or breathing difficulty—with death foreseeably following?[93] Deciding intent mires physicians in ethical and legal quandaries.

From an idealized ethical perspective, intentions are clear and distinct. But in real end-of-life situations, physicians' intentions become complex, ambiguous, and contradictory.[94] In treating the terminally-ill, physicians rarely act with only one intent. Instead, they act with several intents—that may include a real possibility of hastening their patients' death.[95] Where physicians may incur civil, criminal, or administrative penalties based on their intent, their ethical and legal quandaries turn on just who may rightfully determine that intent.

Under basic jurisprudence, intent may be inferred from conduct. But under the "double-effect doctrine," what physicians *say* becomes more important than what they actually *do*. To avoid civil, criminal, or administrative penalties for their prescribing practices, physicians must assert their own intent. And in asserting that intent, they must never admit that they have honored a patient's or a family's request for a patient's death. Instead, they must assert that they have prescribed only to relieve pain and suffering—which in the just-described realities of end-of-life care, mires physicians in doctrinal hypocrisy. And by

embracing the "double-effect doctrine," the AMA, the Attorney General, Congress and the Supreme Court have ensured that the hypocrisy will endure. They have also ensured that when physicians prescribe for the terminally ill, their intent may be determined by those who can make no credible claim to medical expertise. And that flows from the AMA's acquiescence to determination of physicians' prescribing intent by federal law enforcement agents—because of its unyielding opposition to physician-assisted suicide.

The AMA's Code of Ethics could cause criminal liability for prescribing practices: Under its 1994 Death with Dignity Act, only Oregon provides detailed, closely-monitored conditions under which physicians may hasten death of the terminally ill.[96] But condemning assisted suicide as "fundamentally incompatible with the physician's role as healer," the AMA has championed almost every attempt to subvert that duly enacted Oregon law.[97] The Ninth Circuit vacated a three-year long injunction that stayed the Act's implementation.[98] But Congressional conservatives reacted immediately to subvert Oregon's Act—by trying to rewrite the Controlled Substances Act that addresses drug abuse in the United States.[99]

Under two separate, now-defunct statutes, an amended Controlled Substances Act would, in essence, transmute the "double-effect doctrine" into federal law. The amended Act would proclaim using controlled substances to relieve pain—even if death follows—legitimate medical practice.[100] But using controlled substances to assist suicide would not be legitimate medical practice and would therefore violate the Act.[101] Using controlled substances to assist suicide—even under Oregon law—would therefore subject physicians' federal controlled-substances registration to revocation. And it would subject physicians to criminal prosecution—and a 20-year mandatory prison term.[102]

At first, the AMA feared involvement by Drug Enforcement Administration [DEA] agents as "unacceptable federal intrusion over matters of state law regarding the practice of medicine." [103] But in supporting an almost identical proposal, the AMA apparently rethought its concerns.[104] To vindicate the "double-effect doctrine," the AMA exalted the proposed Pain Relief Promotion Act for "reducing physicians' exposure to criminal investigation and prosecution for legitimate medical practices."[105] But before it stalled indefinitely in the Senate, the Pain Relief Promotion Act passed in the House of Representatives by a 271-156 majority.[106] Many attribute that majority vote in the House to the AMA's support.

But the AMA's reasoning raises medical and constitutional concerns.[107] First, the Act would impose a national solution on issues that historically have been handled by the states. Second, DEA agents would intrude into the physician-patient relationship.[108] Third, the Attorney General would act as though Oregon's Death with Dignity Act, a duly enacted state law, does not exist.[109] Fourth, where even physicians strongly disagree, and where no prescribing standard has emerged, DEA agents—instead of physicians—would determine appropriate prescribing practices.[110] And fifth, when physicians prescribe controlled substances, DEA agents would interpret physicians' intent.[111] Under AMA reasoning, those most-empowered by federal law to determine appropriate prescribing practices and physician intent would be those least qualified to do so.

But AMA reasoning did not die with the Pain Relief Promotion Act. Instead, it was resurrected by Attorney General John Ashcroft. Thus in November 2001, in what has become known as the "Ashcroft directive," the Attorney General decided to define "legitimate medical purpose." With no credible claim to medical expertise, Mr. Ashcroft wrote that using controlled substances to aggressively manage pain is a "legitimate medical purpose." [112] But under the "Ashcroft directive," using controlled substances to assist suicide is "inconsistent with the public interest" and is not a "legitimate medical purpose."[113] Repeatedly citing the "double-effect doctrine" and its incorporation into the AMA's Code of Ethics, the "Ashcroft directive" effectively annulled the Death with Dignity Act and Oregon's four-year experience in applying it. And under the "Ashcroft directive," physicians who comply with that duly enacted Oregon law risk having their prescribing privileges suspended or revoked—and a 20-year prison sentence.[114]

The Honorable Robert E. Jones, a federal district court judge appointed by the first President Bush, at first restrained the "Ashcroft directive" temporarily. In his April 17, 2002, decision, Judge Jones restrained the "Ashcroft directive" permanently.[115] In a decision that sharply criticized Attorney General Ashcroft, Judge Jones wrote that in deciding that prescribing controlled substances to assist suicide had no "legitimate medical purpose," Mr. Ashcroft had overstepped his authority. Indeed, wrote Judge Jones: " ... the Ashcroft directive is not entitled to deference under any standard and is invalid." [116]

Judge Jones admonished: "To allow an attorney general—an appointed executive whose tenure depends entirely on whatever administration occupies the White House—to determine the legitimacy of a particular medical practice without a specific congressional grant of such authority would be unprecedented and extraordinary."[117]

Undaunted and still asserting the AMA's Code of Ethics, the Attorney General took his case to the Ninth Circuit Court of Appeals.[118] As of this writing, that appeal has not been decided.

Some final thoughts: End-of-life liability issues are driven by physicians' incurring civil, criminal, and administrative liability. And they are driven by physician's fears of that liability. Until coherent, agreed-upon standards for end-of-life care emerge, those fears will endure. Physicians who escape civil, criminal, or administrative actions with their reputations and, indeed, their freedom intact still incur substantial expenses for defending those actions. While professional liability policies pay the awards in malpractice cases, defending those cases causes those policies' premiums to escalate.[119] Only rarely do professional liability policies provide a defense against administrative actions. And they never provide a defense against criminal actions. Even when innocent, physicians face time away from their practice, their patients, and their income. And even when innocent, they face loss of professional and personal esteem, and sometimes media exposure.

Legal scholar Barry R. Furrow asserts that failure to properly manage pain is professional negligence.[120] And he suggests other liability theories that include failure to refer patients to pain management specialists, negligent or intentional infliction of emotional distress, and

failure to obtain informed consent. The Emergency Medical Treatment and Labor Act [EMTALA] was enacted to combat patient dumping, the refusal to treat patients who have no medical insurance.[121] Professor Furrow asserts that EMTALA may impose institutional liability on hospitals, as will corporate-negligence theory. Finally, Professor Furrow suggests suing nursing homes under the Omnibus Reconciliation Act and suing insurance companies under general agency theory.

Although laden with legal hurdles that remain untested, Professor Furrow's reasoning creates a "pincer's movement of liability" for physicians who care for the terminally ill. Afraid now of the civil, criminal, and administrative sanctions that they risk for overmedicating, physicians will become just as afraid of the sanctions that they will risk for undermedicating.

As it has for centuries, the law that governs end-of-life liability issues will continue to evolve. But one tenet will remain unchanged. Those who care for the terminally ill will, for time immemorial, risk civil, criminal, and administrative liability for their conduct.

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3. Ann Alpers, *Criminal Act or Palliative Care? Prosecutions Involving the Care of the Dying*, 26 J. L. Med. & Ethics 308 (1998).

4. Physician Discipline: Can State Boards Protect the Public?: Hearing Before the Subcommittee on Regulation, Business Opportunities, and Energy of the Committee on Small Business, 101st Cong., 2d Sess. (1990) at 2; See also U.S. Department of Health and Human Services, Medical Licensure and Discipline: An Overview (1986).

5. William J. Curran, Mark A. Hall, Mary Anne Bobinski, David Orentlicher, *Health Care Law & Ethics* 946 (5th Edition 1998).

6. American College of Legal Medicine, *Legal Medicine* 75 (5th Edition 2001), Chapter 7, Education and Licensure by S. Sandy Sanbar, (citing R.C. Derbyshire, *Offenders and Offenses*, 19 Hosp. Prac. 981 (1984)).

7. Personal communication with Anthony Z. Scher, Esq., private legal practitioner, Scarsdale, New York, December 27, 2001.

8. *Winthrow v. Larkin*, 421 U.S. 35, 95 S.Ct. 1456 (1975).

9. *Winthrow, ante,* 421 U.S. at 55, 95 S.Ct. at 1468.

10. *Application of Epstein*, 267 A.D. 27, 28, 44 N.Y.S.2d 921, 922 (3rd Dept. 1943).

11. *Lyness v. State Board of Medicine*, 529 Pa. 535, 546, 605 A.2d 1204, 1210 (Pa. 1992).

12. *Pons v. Ohio State Med. Bd.*, 66 Ohio St. 3d 619, 624. 614 N.E.2d 748, 753 (1993) (Pfeifer, J., dissenting).

13. American College of Legal Medicine, *Legal Medicine* 76 (5th Edition 2001), Chapter 7, Education and Licensure by S. Sandy Sanbar.

14. See, e.g.:N.C. Gen. Stat. §90-14.6 (2002).

15. See, e.g.: NY Education Law § 6510[3][c]; *Doe v. Office of Prof'l Med. Conduct*, 81 N.Y.2d 1050 (N.Y. 1993); *Coderre v. De Buono*, 247 A.D.2d 793 (N.Y.A. D. 3rd Dept. 1998).

16. William J. Curran, et al, *ante*, *Health Care Law & Ethics* 950 (5th Edition 1998).

17. BLACK'S LAW DICTIONARY 1200 (7TH ED. 1999).

18. *Matter of 300 Gramatan Ave. Assocs. v. New York State Div. of Human Rights*, 45 N.Y.2d 176, 180, 379 N.E.2d 1183, 1186, 408 N.Y.S.2d 54, 56 (N.Y. 1978) (italics added).

19. BLACK'S LAW DICTIONARY 581 (7TH ED. 1999).

20. William J. Curran, et al, *Health Care Law & Ethics* 952 (5th Edition 1998).

21. See, e.g.: *Steckmeyer v. State Bd. For Prof'l Med. Conduct*, 295 A.D.2d 815 (N.Y.A.D. 3rd Dept. 2002).

22. William J. Curran, et al, *Health Care Law & Ethics* 952 (5th Edition 1998).

23. BLACK'S LAW DICTIONARY 581 (7TH ED. 1999).

24. T.E. Quill and R.V Brody, *You Promised Me I Wouldn't Die Like This!*, 155 Archives of Internal Med., 1250 (1995).

25. *Cruzan v. Director, Mo. Dept. of Health*, 497 U.S. 261 (1990).

26. *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976).

27. *Oregon v. Ashcroft*, No. 02-35587, *Brief of Amici Cruriae Margaret P. Battin, et al.(Bioethicists) in support of Plaintiffs-Appellees for Affirmance* (November 12, 2002) (citing *Quinlan,* 70 N.J. at 41) (C.A. 9th Cir).

28. See *Cruzan, ante*, 497 U.S. at 333.

29. David Orentlicher, *Trends in Health Care Decisionmaking: the Limits of Legislation,* 53 Md. L. Rev. 1255 (1994).

30. Bryan Garner, *A Dictionary of Modern Legal Usage* 535 (2nd ed. 1995).

31. *Id.*

32. Tom Mayo, *Patients' Rights*, Dallas Morning News, Dec. 15, 1991, at 4J.

33. Alan Meisel, *The Right to Die*, §§ 9.7-9.30 (2nd ed. 1995 & Supp. 1997).

34. *Id.,* § 1.7, ch. 14 (2nd ed. 1995 & Supp. 1997).

35. *In re Westchester County Medical Ctr. ex rel O'Connor*, 72 N.Y.2d 517 (N.Y. 1988).

36. *Cruzan,* 497 U.S. 261.

37. *Martin v. Martin*, 538 N.W.2d 399 (Mich. 1995).

38. *In re Swan*, 569 A.2d 1202 (Me. 1990); Meisel, *The Right to Die,* § 7.5, at 364-66.

39. Marshall B. Kapp, *Treating Medical Charts Near the End of Life: How Legal Anxieties Inhibit Good Patient Deaths*, 28 U. Tol. L. Rev. 521, 523 n14 (1997) (citing George J. Annas, *The Incompetent's Right to Die: The Case of Joseph Saikewicz*, 8 Hastings Ctr. Rep. 21(1978).

40. Kapp, 28 U. Tol. L. Rev. 521, 523 (n16) (citing Alan Meisel, *The "Right to Die": A Case Study in American Lawmaking*, 3 Eur. J. Health L. 49 (1996)).

41. *Vacco v. Quill*, 521 U.S. 793 (1997).

42. Kapp, 28 U. Tol. L. Rev. 521, 523 (n17) (citing Timothy E. Quill, *New York's Health Care Proxy Law*, 326 New Eng. J. Med. 495 (1992)).

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