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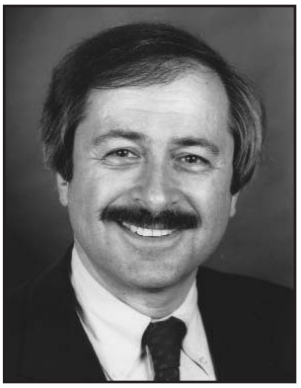
A Message from the Section Chair



As the holiday season approaches, your Section is busy planning an exciting schedule of events for "Health Law Day" at the NYSBA's 121st Annual Meeting. The programs will be timely and thought provoking. Please mark you calendar for Wednesday, *January 28, 1998*. That date may appear to be a bit distant; however, I promise that it will be here sooner than you think.

Committee meetings during the Annual Meeting are scheduled for Wednesday, January 28, 1998, at 9:15 AM. Please plan to attend as the committees will be planning their activities for the next 12 months. Our first program is entitled "**Promoting Accountability in Managed Care: The Response by the Courts, Policy Makers and the Providers."** It will begin at 10:00 AM and will be presented by our Committee on Ethics in the Delivery of Health Care. Topics will include legal, policy and programmatic answers to questions involving the balancing of cost and quality. Speakers include Dr. Mark R. Chassin, former Commissioner of the New York State Department of Health; James R. Tallon, Jr., President of the United Hospital Fund of New York; Lori Dutcher, Vice President for Legal and Regulatory Affairs at Kaiser Permanente, Northeast Division, Columbia University School of Law Professor William Sage; and others.

A Section luncheon will take place from 12:30 PM - 2:00 PM, during which we will have the benefit of some informal remarks by **Hank Greenberg, General Counsel to the Department of Health**. Questions and answers will follow.

Since controversy is no stranger to those of us who practice health law, lunch will be followed at 2:00 PM by **"The Legal Implications of the Medicinal Use of Marijuana,"** sponsored by the Committee on Public Health. Speakers include Assembly Member Richard N. Gottfried, Chair, Assembly Health Committee; Dr. Robert B. Milman, Acting Chair of the Department of Public Health at New York Hospital; Paul A. Clyne, Assistant District Attorney, Albany County; and Jeffrey Bluestein, Ph.D., a bioethicist at Albert Einstein College of Medicine. All Section members are, of course, invited to attend.

This will be a great Annual Meeting! We are looking forward to a full schedule of events, together with lots of time for networking.

Leadership Changes

I am pleased to announce the appointment of **Jeffrey S. Gold** and **L. Susan Slavin** as Co-Chairs of the Consumer/Patients Rights Committee. These individuals bring a wealth of advocacy experience from both the private and public sectors. Ms. Slavin is well known for her work on behalf of health care consumers and has addressed the most recent Health Women 2000 conference at the request of the Surgeon General's Office. Mr. Gold, who is not related to your Section Chair, is Chief of the Health Care Bureau of the Attorney General's Office.

INSIDE THIS ISSUE

Due to the initial success of that Bureau's activities, its structure has become a model for attorneys general in a number of other jurisdictions.

We will miss **Dave Daniels'** contributions as Chair of the **Committee on Legislation**. Dave has given the Section visibility with both the Senate and the Assembly and has helped to make us a credible force with those bodies of government. Unfortunately, the commitments of an ever-expending practice have prompted his resignation. I am pleased that **Philip Rosenberg**, an energetic and active member of the Section who is currently Vice Chair of the Legal Education Committee and a member of the Committee on Legislation, has agreed to assume the **Chair**. Phil will be assisted by a new **Vice Chair, Patrick Taylor.** Currently General Counsel at Albany Medical Center, Pat is no stranger to legislation having served as Chief of Staff to the Assembly's Education Committee and as an Assistant Counsel to Governor Cuomo.

Future Plans

As this message is being written we are looking forward to the next CLE offering, "An Introduction to Health Care Financing and Reimbursement," scheduled for New York City, Uniondale, Buffalo and Albany. Also, on January 29, 1998, the Section will co-sponsor "The Dilemma of Patient Privilege in Guardianship Proceedings." This program, presented by the Committee on Issues Affecting Persons With Disabilities, will take place during the Annual Meeting. We are also planning a number of additional seminars and events for the winter and spring. Stay tuned for further details. Other future activities will be developed by the Section's committees during their forthcoming meetings.

In Conclusion

Finally, I would note that this is your Section. Please participate in its committees, CLE programs and the Annual Meeting. I encourage you to join a committee, as our Section does its work through the committee structure. If you would like to be added, please contact the appropriate chair. Also, if you have any questions or suggestions as to how the Section can do a better job, please contact me or any member of the Executive Committee. Thanks!

Barry A. Gold

From the Editors

Last term the United States Supreme Court handed down several decisions related to health law. For example, the Supreme Court, in *Kansas v. Hendricks*, 117 S. Ct. 2072 (1997), addressed issues of mental illness in upholding Kansas' Sexually Violent Predator Act. The first article by Professor Michael Perlin assesses the Court's handling of the Kansas statute. The Court's most renowned health law decisions were undoubtedly the physician-assisted suicide cases—*Washington v. Glucksberg*, 117 S. Ct. 2258 (1997), and *Vacco v. Quill*, 117 S. Ct. 2293 (1997). The second article, by Dale Moore, analyzes the Court's opinions in these cases. The third article, by Kathleen A. Carlsson, questions whether the best judgment standard for physicians, long espoused by the New York Court of Appeals, can continue in the face of changes in the financing of health care. Finally, we introduce "'Net Worth," a column by Margaret Murray in which she gives helpful advice on doing health law research over the Internet.

We look forward to editing the *Health Law Journal* this year. If you would like to submit an article for publication in an upcoming issue please contact either Professor Barbara Atwell or Professor Audrey Rogers as follows:

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Thank you.

Barbara L. Atwell and Audrey Rogers
Editors

"Mixed-Up Confusion"*: *Kansas v. Hendricks*, Sexually Violent Predator Laws, and Empty Promises

by Prof. Michael L. Perlin

Prior to the 1970s, most states had enacted statutes providing for the commitment of sexual offenders. These laws often provided for indefinite (potentially stretching to lifetime) institutionalization for those who were classified as "repetitive and compulsive" sex offenders,[1] and were commonly seen as an appropriate use of the police power. These laws were also premised on a therapeutic basis: they assumed that mental health professionals could make accurate predictions about an offender's future behavior, and that some number of offenders might be treatable.[2] By 1970, there were sex offender laws in 60 percent of all American jurisdictions.[3]

However, by the time that the Supreme Court's "civil rights revolution" reached mental disability law,[4] psychiatrists and lawyers were both beginning to challenge the assumption that sex offenders were both mentally ill and treatable, and influential professional organizations advocated the repeal of such statutes "because of the dubious theoretical and empirical relationship between a specific mental disability and sexually violent tendencies."[5] After the Supreme Court ruled that sex offenders could not be committed to a treatment facility until they were found guilty—at a hearing with full procedural protections—of having committed the antecedent criminal acts,[6] sex offender statutes fell into disfavor, and many states began to repeal these laws.[7]

This trend was sharply reversed, however, in 1990, when the state of Washington—responding to a particularly heinous murder[8]—"revamp[ed] and resurrect[ed] its sex offender involuntary commitment system."[9] Other states followed quickly (many in the wake of New Jersey's enactment of the so-called "Megan's Law"),[10] and by 1997, at least 17 states had enacted some sort of a "modern" sex offender statute.[11]

All of these statutes are based on a legislative desire to protect the public from a group of offenders that is widely (and universally) despised: criminals who sexually abuse and molest young children.[12] They differ in content, but share certain elements. In each case, the state must prove—by a quantum of either "beyond a reasonable doubt" or "clear and convincing evidence"—(1) a history of violent acts, (2) a current mental disorder or abnormality, (3) the likelihood of future sexually harmful acts, and (4) a nexus between all of the first three elements.[13] In most of these statutes, commitment is indefinite, and release is allowed when it is shown that the offender is no longer dangerous by reason of a mental disorder.[14]

Kansas enacted its Sexually Violent Predator Act (SVPA) in 1994 as a means of seeking the institutionalization of that "small but extremely dangerous group of sexually violent predators . . . who do not have a mental disease or defect that renders them appropriate for involuntary treatment pursuant to the [general involuntary civil commitment statute.]"[15] It established a separate commitment process for "the long-term care and treatment of the sexually violent predator," statutorily defined as:

> [A]ny person who has been convicted of or charged with a sexually violent offense and who suffers from a mental abnormality or personality disorder which makes the person likely to engage in the predatory acts of sexual violence.[16]

"Mental abnormality" was defined as a "congenital or acquired condition affecting the emotional or volitional capacity which predisposes the person to commit sexually violent offenses in a degree constituting such person a menace to the health and safety of others."[17] The Act initially pertained to the following sorts of offenders: (1) a presently confined person who had been convicted of a "sexually violent offense" and was scheduled for release from prison, (2) a person who had been "charged with a sexually violent offense" but had been found incompetent to stand trial, (3) a person who had been found "not guilty by reason of insanity of a sexually violent offense," and (4) a person found "not guilty" of a sexually violent offense because of a mental disease or defect.[18]

Leroy Hendricks had been convicted of taking "indecent liberties" with two teenage boys, and was subsequently sentenced to a term of 5-20 years in state prison.[19] Shortly before his scheduled release from prison, the state invoked the SVPA, seeking to have him civilly committed as a sexually violent predator.[20] At the subsequent jury trial, Hendricks testified as to his past history of sexual offenses and to his self-described inability to refrain from committing such offenses (stating he "can't control the urge").[21] Expert witnesses testified that Hendricks' diagnosis was "personality trait disturbance, passive-aggressive personality, and pedophilia," and that pedophilia qualified as a "mental abnormality" under the SVPA.[22] The state's expert testified that Hendricks was likely to commit sexual offenses against children in the future if he were not committed; Hendricks' expert testified that it was not possible to predict with any degree of accuracy the future dangerousness of a sex offender.[23]

The jury unanimously found beyond a reasonable doubt that Hendricks was a sexually violent predator. Following this, the trial judge determined, as a matter of state law, that pedophilia was a "mental abnormality" under state law, and Hendricks was subsequently committed.[24]

The Kansas Supreme Court reversed the order of commitment, agreeing with Hendricks that the SVPA violated the due process clause, and finding that, in order to commit a person

involuntarily in a civil proceeding, a state is required by "substantive" due process to prove by clear and convincing evidence that the person is both (1) mentally ill, and (2) a danger to himself or to others.[25] It then determined that the Act's definition of "mental abnormality" did not satisfy what it perceived to be this Court's "mental illness" requirement in the civil commitment context, and as a result, held that Hendricks' substantive due process rights were violated.[26]

The Supreme Court, per Justice Thomas, reversed, and reinstated the order of commitment, in an opinion that, in the words of Bob Dylan, reflects nothing less than "mixed-up confusion." First, the majority found that the statute's use of the phrase "mental abnormality" satisfied substantive due process guarantees, citing *Foucha v. Louisiana*[27] for the proposition that the liberty interest in freedom from physical restraint is "not absolute,"[28] and looking to *Addington v. Texas*[29] for support of the proposition that "[i]t thus cannot be said that the involuntary civil confinement of a limited subclass of dangerous persons is contrary to our understanding of ordered liberty."[30]

Commitment ordinarily requires proof of dangerousness and "some additional factor" such as "mental abnormality" or "mental illness," thus limiting involuntary civil confinement to those who "suffer from a volitional impairment rendering them dangerous beyond their control."[31] The Kansas statute thus was like other statutes that the Court had upheld:

> It requires a finding of future dangerousness, and then links that finding to the existence of a "mental abnormality" or "personality disorder" that makes it difficult, if not impossible, for the person to control his dangerous behavior. [citation omitted.] The precommitment requirement of a "mental abnormality" or "personality disorder" is consistent with the requirements of these other statutes that we have upheld in that it narrows the class of persons eligible for confinement to those who are unable to control their dangerousness.[32]

The Court rejected Hendricks' argument that *Addington* and *Foucha* required proof of a *mental illness*, and that his "mental abnormality" was not such an illness (but was rather a term coined by the Kansas legislature). Stated the Court:

> Contrary to Hendricks' assertion, the term "mental illness" is devoid of any talismanic significance. Not only do "psychiatrists disagree widely and frequently on what constitutes mental illness," . . . but the Court itself has used a variety of expressions to describe the mental condition of those properly subject to civil confinement.[33]

Pedophilia, the Court reasoned, was classified by "the psychiatric profession" as a "serious mental disorder"; this disorder—marked by a lack of volitional control, coupled with predictions of future dangerousness—"adequately distinguishes Hendricks from other dangerous persons who are perhaps more properly dealt with exclusively through criminal proceedings."[34] "Hendricks' diagnosis as a pedophile, which qualifies as a 'mental abnormality' under the Act, thus plainly suffice[d] for due process purposes."[35]

The Court also rejected Hendricks' arguments that the SVPA established *criminal* proceedings, and thus violated both the double jeopardy and *ex post facto* provisions of the Constitution. Turning first to Hendricks' double jeopardy arguments, it found that the Act implicated neither "of the two primary objectives of criminal punishment: retribution or deterrence,"[36] reasoning—as to retribution—that the Act "does not affix culpability for prior criminal conduct" (noting further that a criminal conviction is not a prerequisite for commitment under the Act) and that no finding of criminal intent is required as a precedent to a commitment order ("an important element in distinguishing criminal from civil statutes").[37] It also found that, as persons subject to the SVPA suffered from a mental condition that prevented them from "exercising adequate control over their behavior," the Act could not be seen as functioning as a deterrent.[38] Although the SVPA does involve an "affirmative restraint," that, in and of itself, does not mean that the Act imposes punishment: "If detention for the purpose of protecting the community from harm *necessarily* constituted punishment, then all involuntary civil commitments would have to be considered punishment. But we have never so held."[39]

The Court rejected Hendricks' other arguments as to the Act's punitive nature as well. Although the Act allows for potentially indefinite commitment, that possibility is constitutionally trumped by the fact that duration is "linked" to the purposes of the commitment ("to hold the person until his mental abnormality no longer causes him to be a threat to others"); moreover, there is a built in year-long limit to a single commitment (after which time, the court must again determine if the individual still satisfies the commitment standard).[40]

Hendricks argued further that the use of procedural protections that are traditionally found in criminal trials transformed the proceedings into criminal ones. The majority rejected this argument as well. Kansas's provision of these protections, the Court found, simply demonstrated the "great care" that the state had taken to confine only a "narrow class of particularly dangerous individuals . . . after meeting the strictest procedural standards," and this decision did not thus transform a civil commitment proceeding into a criminal one.[41]

Finally on this point, Hendricks claimed that the Act was punitive because it did not offer any legitimate "treatment." Here, the majority noted that "incapacitation" may be a legitimate end of the civil law, and added that it had never held that "the Constitution prevents a State from civilly detaining those for whom no treatment is available, but who nevertheless pose a danger to others."[42] It would be of "little value," the opinion continued, "to require treatment as a precondition for civil confinement of the dangerously insane when no acceptable treatment existed. To conclude otherwise would obligate a State to release certain confined individuals who were both mentally ill

and dangerous simply because they could not be successfully treated for their afflictions."[43]

Noting that states had "wide latitude" in developing treatment regimens, and that a state could serve its purpose "by committing [sexually dangerous persons] to an institution expressly designed to provide psychiatric care and treatment," the Court concluded that Kansas had thus "doubtless satisfied its obligation to provide available treatment."[44] Beyond this, while it conceded that the specific treatment program offered Hendricks "may have seemed somewhat meager," the Court placed great weight on a statement made at oral argument by Kansas's counsel that, by that time, Hendricks was receiving over 30 hours of treatment per week.[45]

On this point, it thus concluded:

> Where the State has "disavowed any punitive intent"; limited confinement to a small segment of particularly dangerous individuals; provided strict procedural safeguards; directed that confined persons be segregated from the general prison population and afforded the same status as others who have been civilly committed; recommended treatment if such is possible; and permitted immediate release upon a showing that the individual is no longer dangerous or mentally impaired, we cannot say that it acted with punitive intent. We therefore hold that the Act does not establish criminal proceedings and that involuntary confinement pursuant to the Act is not punitive.[46]

The Court thus concluded that the double jeopardy clause was not violated.[47] Similarly, because it had determined that the Act did not impose punishment, it ruled that its application did not present ex post facto concerns.[48]

Justice Kennedy concurred in the judgment to express "caution against dangers inherent when a civil confinement law is used in conjunction with the criminal process, whether or not the law is given retroactive application."[49] Although he found from the record before the court that the Kansas statute passed constitutional muster, he expressed this concern: "If, however, civil confinement were to become a mechanism for retribution or general deterrence, or if it were shown that mental abnormality is too imprecise a category to offer a solid basis for concluding that civil detention is justified, our precedents would not suffice to validate it."[50]

Justice Breyer dissented in an opinion joined in full by Justices Souter and Stevens and in part by Justice Ginsburg. Although the dissenters agreed that the SVPA's definition of "mental abnormality" satisfied substantive due process, they concluded that the failure to provide Hendricks with adequate treatment gave the Act a punitive cast, and, as a result, violated the ex post facto clause of the Constitution.

The dissent began with what it characterized as "the area of agreement" with the majority.[51] Looking to *Foucha* and *Addington* as the sources of the rule that civil commitment of a person who was mentally ill and dangerous did not necessarily violate the due process clause (assuming the commitment took place "pursuant to proper procedures and evidentiary standards"), Justice Breyer set out three reasons why he believed Kansas "acted within the limits that the Due Process Clause substantively sets."[52]

First, although he conceded that there was controversy within the psychiatric profession as to whether a disorder such as pedophilia was a mental *illness* (referring, on this point to amicus briefs filed by the American Psychiatric Association, arguing that it was not, and by the Menninger Clinic, arguing that it was), he concluded that there was no question that it could be denominated a mental *disorder.* Although the fact that there was an intraprofessional dispute might help "inform the law by setting the bounds of what is reasonable, . . . it cannot here decide just how States must write their laws within those bounds."[53]

Second, Justice Breyer found that Hendricks' abnormality—that included "a specific, serious, and highly unusual inability to control his actions"—was "akin to insanity for purposes of confinement," a sort of "irresistible impulse."[54] Third, this mental abnormality made Hendricks dangerous, and, as Hendricks appeared to fall outside the limits of Kansas' general civil commitment statute (that allowed for commitment only of those who lacked capacity to make informed treatment decisions),[55] it was permissible for Kansas to create separate legislation upon which to base confinement of a mentally disordered, dangerous person such as Hendricks.[56]

Justice Breyer did not see *Hendricks* as a case that required the court to determine whether the due process clause *always* required treatment (if, for example, it forbade civil confinement of an untreatable, mentally ill, dangerous person), since Kansas argued that pedophilia was a *treatable* disorder, and at least two amicus groups made similar (uncontradicted) assertions.[57] The question to be asked, then, was this: Does the due process clause require a state to provide treatment that it concedes is available to a person whom it concedes is treatable?[58]

Justice Breyer then turned his attention to the ex post facto clause argument.[59] He found the post-commitment institutionalization under the Act to bear "obvious" resemblances to criminal punishment.[60] First, testimony of a state official revealed that "confinement takes place in the psychiatric wing of a prison hospital where those whom the Act confines and ordinary prisoners are treated alike."[61] Second, he found that incapacitation—one of the basic objectives of the Act—was also an important purpose of punishment.[62] Third, the Act only imposes its sanctions on an individual who "has previously committed a criminal offense."[63] And finally, the procedural guarantees and standards of the Act are those "traditionally associated with the criminal law."[64]

These criteria—standing alone—would not be enough to transform a civil commitment into punishment, Justice Breyer conceded. But other factors were sufficient upon which to base a finding that the SVPA was a punitive statute. First, the dis-

senters looked at the time when the petition for further commitment was filed against Hendricks: "[W]hen a State believes that treatment does exist, and then couples that admission with a legislatively required delay of such treatment until a person is at the end of his jail term (so that further incapacitation is therefore necessary), such a legislative scheme begins to look punitive."[65] And they considered the teachings of *Allen v. Illinois*[66] that the availability of treatment was a "touchstone" in distinguishing whether a statute's purpose was civil or punitive.[67]

Considered through this lens, the SVPA, as applied to Hendricks, was a punitive statute, according to Justice Breyer. Treatment was *not* a significant objective of the act (being "incidental at best");[68] at the time of Hendricks' commitment, in fact, the state had neither funded any treatment programs nor entered into treatment contracts and provided "little, if any, qualified treatment staff."[69] The commitment program's own director, in fact, had stated that Hendricks was receiving "essentially no treatment."[70]

In addition, the fact that commitment proceedings under the SVPA did not begin until *after* offenders had served nearly their entire criminal sentence suggested that treatment was *not* a significant concern in the enactment of the law:

> An Act that simply seeks confinement, of course, would not need to begin civil commitment proceedings sooner. Such an Act would have to begin proceedings only when an offender's prison term ends, threatening his release from the confinement that imprisonment assures. But it is difficult to see why rational legislators who seek treatment would write the Act in this way—providing treatment years after the criminal act that indicated its necessity. . . . And it is particularly difficult to see why legislators who specifically wrote into the statute a finding that "prognosis for rehabilitating . . . in a prison setting is poor" would leave an offender in that setting for months or years before beginning treatment. This is to say, the timing provisions of the statute confirm the Kansas Supreme Court's view that treatment was not a particularly important legislative objective.[71]

Other factors compelled the same conclusion. As it applied to Hendricks, the Kansas law did not require consideration of using "less restrictive alternatives, such as postrelease supervision" instead of commitment; such "less restrictive alternative" language is found in almost all involuntary civil commitment statutes, and its absence here "can help to show that [the] legislature's 'purpose . . . was to punish.'"[72] Finally, a consideration of contemporary sex offender statutes from other jurisdictions revealed *no other* jurisdiction that contained all of the punitive aspects of the Kansas law (as to timing of invocation of the SVPA process and failure to consider less restrictive alternatives):

> Thus the practical experience of other States, as revealed by their statutes, confirms what the Kansas Supreme Court's finding, the timing of the civil commitment proceeding, and the failure to consider less restrictive alternatives, themselves suggest, namely, that for Ex Post Facto Clause purposes, the purpose of the Kansas Act (as applied to previously convicted offenders) has a punitive, rather than a purely civil, purpose.[73]

The dissenters rejected the state's arguments to the contrary, and restated what they saw as the scope of the state's commitment power under *Addington v. Texas*:

> [A] State is free to commit those who are dangerous and mentally ill in order to treat them. Nor does my decision preclude a State from deciding that a certain subset of people are mentally ill, dangerous, and untreatable, and that confinement of this subset is therefore necessary (again, assuming that all the procedural safeguards of *Addington* are in place). But when a State decides offenders can be treated and confines an offender to provide that treatment, but then refuses to provide it, the refusal to treat while a person is fully incapacitated begins to look punitive.[74]

Finally, the dissenters took issue with the majority's reading of the record below that had suggested that Hendricks was *untreatable*. A careful reading of both the Kansas Supreme Court's decision, however, revealed to the dissenters that Hendricks was *treatable*, but remained *untreated.*[75]

Because the SVPA imposed punishment on Hendricks, it thus violated the Ex Post Facto Clause, the dissenters concluded:

> The statutory provisions before us do amount to punishment primarily because, as I have said, the legislature did not tailor the statute to fit the nonpunitive civil aim of treatment, which it concedes exists in Hendricks' case. The Clause in these circumstances does not stand as an obstacle to achieving important protections for the public's safety; rather it provides an assurance that, where so significant a restriction of an individual's basic freedoms is at issue, a State cannot cut corners. Rather, the legislature must hew to the Constitution's liberty-protecting line. See THE FEDERALIST, No. 78, p. 466 (C. Rossiter ed. 1961) (A. Hamilton).[76]

Hendricks is a troubling opinion on many levels. First, it indicates that a majority (albeit, a bare one) of the Supreme Court is comfortable with a statutory scheme[77] that has the potential of transforming psychiatric treatment facilities into *de*

facto prisons and that uses mental health treatment as a form of social control,[78] thus making the statutory promise of treatment an empty one. Second, it suggests, for social control purposes, that the majority is comfortable with expansive legislative definitions of "mental disorder" that go far beyond what the drafters of the standard diagnostic nomenclature ever intended.[79] Third, it rejects the weight of contemporaneous research suggesting that treatment *is* available for "sexually violent predators" (such as Hendricks) that can significantly reduce the rate of recidivism.[80] Fourth, it strains to characterize a punitive statute—the *most* punitive of *any* of the new generation of SVPA laws as "civil," in a way that can only be characterized as "pretextual."[81] Fifth, it conflates and confuses legal and medical terminology[82] in a way that suggests that Justice Thomas is no more comfortable writing in this area of the law today than he was when he dissented five years ago in *Riggins v. Nevada*[83] or in *Foucha*.[84] Finally, it misses the point captured clearly and concisely by the Kansas Supreme Court:

> Mental illness is defined in K.S.A. 59-2902(h) as meaning any person who: "(1) [i]s suffering from a severe mental disorder to the extent that such person is in need of treatment; (2) lacks capacity to make an informed decision concerning treatment; and (3) is likely to cause harm to self or others." Here, neither the language of the Act nor the State's evidence supports a finding that "mental abnormality or personality disorder," as used in 59-29a02(a), is a "mental illness" as defined in 59-2902(h). Absent such a finding, the Act does not satisfy the constitutional standard set out in *Addington* and *Foucha*. Justice White, speaking for the majority of the United States Supreme Court in *Foucha*, clearly stated that to indefinitely confine as dangerous one who has a personality disorder or antisocial personality but is not mentally ill is constitutionally impermissible. 504 U.S. at 78. Similarly, to indefinitely confine as dangerous one who has a mental abnormality is constitutionally impermissible.[85]

The dissent is also not without problems. Although it does reveal the punitive nature of the Kansas statute (exposing the pretextual nature of the majority opinion, and leading to the appropriate conclusion that the ex post facto clause *should* apply to the case), its discussion of civil commitment law—especially its conflation of civil commitment law and insanity law[86]—is confusing and somewhat circular. Its failure to conclude that the Kansas statute violates substantive due process, however, is the opinion's most troubling aspect.[87]

Endnotes

1. *See, e.g.,* N.J. Stat. Ann. § 2A:164-3, repealed, L. 1978, N.J. Stat. Ann. § 2C:98-2.
2. Klotz, *Sex Offenders and the Law: New Directions*, in Law in a Therapeutic Key: Developments on Therapeutic Jurisprudence 131, 133 (D. Wexler & B. Winick eds.), citing Wettstein, *A Psychiatric Perspective on Washington's Sexually Violent Predators Statute*, 15 U. Puget Sound L. Rev. 597 (1992).
3. Klotz, *supra* note 2, at 133.
4. *See* 1 Michael L. Perlin, Mental Disability Law: Civil and Criminal § 1.03 (1989).
5. Klotz, *supra* note 2, at 133, citing Reardon, *Sexual Predators: Mental Illness of Abnormality? A Psychiatrist's Perspective*, 15 U. Puget Sound L. Rev. 849 (1992).
6. *Specht v. Patterson*, 386 U.S. 605, 608-609 (1967). *See also Humphrey v. Cady*, 405 U.S. 504, 512 (1972) (recommitment to facilities for sexual offenders required same bundle of procedural protections as those used in civil commitment hearings).
7. Klotz, *supra* note 2, at 133, citing, *inter alia*, Small, *The Legal Context of Mentally Disordered Sex Offender (MDSO) Treatment Programs*, 19 Crim. Just. & Behav. 127 (1992).
8. *See* Blacher, *Historical Perspective on the "Sex Psychopath" Statute: From the Revolutionary Era to the Present Federal Crime Bill,* 46 Mercer L. Rev. 889, 914-15 (1995).
9. Klotz, *supra* note 2, at 133.
10. N.J. Stat. Ann. § 2C7-1 to 7-11.
11. *Kansas v. Hendricks*, 117 S. Ct. 2072, 2095 (1997) (Breyer, J., dissenting).
12. *See e.g.,* Klotz, *Sex Offenders and the Law: New Directions*, in Mental Health and Law: Research Policy and Services 257 (B. Sales & S. Shah eds. 1996).
13. Janus, *The Use of Social Science and Medicine in Sex Offender Commitment*, 23 N. Eng. J. on Crim. & Civ. Confinement 347, 348-49 (1997) (citing statutes).
14. *Id.* at 349 (citing statutes).
15. *Hendricks,* 117 S. Ct. at 2077, citing Kan. Stat. Ann. § 59-29a01 (preamble).
16. Kan. Stat. Ann. § 59-29a02(a).
17. Kan. Stat. Ann. § 59-29a02(b).
18. Kan. Stat. Ann. § 59-29a03(a).

    In the case of an offender who was scheduled to be released from prison, the custodial agency was required to notify the local prosecutor 60 days before that person's anticipated release. *Id.* § 59-29a03. The prosecutor was then obligated, within 45 days, to decide whether to file a petition in state court seeking the person's involuntary commitment. *Id.* § 59-29a04. If such a petition were filed, the court was to determine whether "probable cause" existed to support a finding that the person was a "sexually violent predator" and thus eligible for civil commitment. Upon such a determination, transfer of the individual to a secure facility for professional evaluation would occur. *Id.* § 59-29a05. After that evaluation, a trial would be held to determine beyond a reasonable doubt whether the individual was a sexually violent predator. If that determination were made, the person would then be transferred to the custody of the Secretary of Social and Rehabilitation Services (the "Secretary") for "control, care and treatment until such time as the person's mental abnormality or personality disorder has so changed that the person is safe to be at large." *Id.* § 59-29a07(a).

    In the case of an indigent person, the state was required to provide, at public expense, the assistance of counsel and an examination by mental health care professionals. *Id.* § 59-29a06. The individual also received the right to present and cross-examine witnesses, and the opportunity to review documentary evidence presented by the state. *Id.* § 59-29a07. Once an individual was confined, the Act required that "the involuntary detention or commitment . . . shall conform to constitutional requirements for care and treatment." *Id.* § 59-29a09.

    Confined persons were afforded three different avenues of review: First, the committing court was obligated to conduct an annual review to determine whether continued detention was warranted. *Id.* § 59-29a08. Second, the Secretary was permitted, at any time, to decide that the confined individual's condition had so changed that release was appropriate,

and could then authorize the person to petition for release. *Id.* § 59-29a10. Finally, even without the Secretary's permission, the confined person could at any time file a release petition. *Id.* § 59-29a11. If the court found that the state could no longer satisfy its burden under the initial commitment standard, the individual would be freed from confinement.

See Hendricks, 117 S. Ct. at 2077-78.

19. *In re Care and Treatment of Hendricks*, 912 P.2d 129, 130 (Kan. 1996), *reversed*, 117 S. Ct. 2072 (1997). Hendricks had been arrested and convicted at least five prior times on other charges stemming from sexual offenses committed against children or teenagers. *See Hendricks*, 117 S. Ct. at 2078.
20. *Id.*
21. *Id.*
22. *Id.* at 2079 n.2.
23. *Id.*
34. *Id.* at 2079.
25. *Hendricks*, 912 P.2d at 137.
26 *Id.* at 138.
27. 504 U.S. 71, 80 (1992); *see generally* 3 PERLIN, *supra* note 4, § 15.25A (1996 Supp.).
28. *Hendricks*, 117 S. Ct. at 2079.
29. 441 U.S. 418, 426 (1979); *see generally* 1 PERLIN, *supra* note 4, §§ 3.37-3.39.
30. *Hendricks*, 117 S. Ct. at 2080.
31. *Id.*
32. *Id.*
33. *Id.* citing, in part, to *Ake v. Oklahoma*, 470 U.S. 68, 81 (1985); *see generally* 2 PERLIN, *supra* note 4, § 8.32; 3 PERLIN, *supra* note 4, § 17.17. Added the court:

> *See, e.g., Addington*, 441 U.S. at 425-26 (using the terms "emotionally disturbed" and "mentally ill"); *Jackson [v. Indiana]*, 406 U.S. [715], 732, 737 [(1972)] (using the terms "incompetency" and "insanity"); *cf. Foucha*, 504 U.S. at 88 (O'Connor, J., concurring in part and concurring in judgment) (acknowledging State's authority to commit a person when there is "some medical justification for doing so").

Id. at 2080-81.

34. *Id.* at 2081.
35. *Id.*

Interestingly, in a footnote, the majority noted:

> We recognize, of course, that psychiatric professionals are not in complete harmony in casting pedophilia, or paraphilias in general, as "mental illnesses." Compare Brief for American Psychiatric Association as Amicus Curiae 26 with Brief for Menninger Foundation et al. as Amici Curiae 22-25. These disagreements, however, do not tie the State's hands in setting the bounds of its civil commitment laws. In fact, it is precisely where such disagreement exists that legislatures have been afforded the widest latitude in drafting such statutes. *Cf. Jones v. United States,* 463 U.S. 354, 365, n. 13 (1983) (parallel citations omitted). As we have explained regarding congressional enactments, when a legislature "undertakes to act in areas fraught with medical and scientific uncertainties, legislative options must be especially broad and courts should be cautious not to rewrite legislation." *Id*. at 370 (internal quotation marks and citation omitted).

Id. at 2081 n.3.

36. *Id.* at 2082.
37. *Id.*
38. *Id.*
39. *Id.* at 2083 (emphasis in original).
40. *Id.*
41. *Id.*
42. *Id.* at 2084. Added the Court: "A State could hardly be seen as furthering a 'punitive' purpose by involuntarily confining persons afflicted with an untreatable, highly contagious disease." *Id.*
43. *Id.*
44. *Id.* at 2085 n.4, citing, in part, *Allen v. Illinois*, 478 U.S. 364, 373 (1986); *see generally* 1 PERLIN, *supra* note 4, § 3.27
45. *Hendricks*, 117 S. Ct. at 2085.
46. *Id.*
47. *Id.* at 2085-86.
48. *Id.* at 2086.
49. *Id.* at 2087 (Kennedy, J., concurring).
50. *Id.*
51. *Id.* at 2088 (Breyer, J., dissenting). Justice Ginsburg did not join in this portion of the dissent.
52. *Id.*
53. *Id.*
54. *Id.* at 2089.
55. *See* KAN. STAT. ANN. § 59-2902(h).
56. *Hendricks*, 117 S. Ct. at 2089 (Breyer, J., dissenting), and *see id.:*

> Because (1) many mental health professionals consider pedophilia a serious mental disorder; and (2) Hendricks suffers from a classic case of irresistible impulse, namely he is so afflicted with pedophilia that he cannot "control the urge" to molest children; and (3) his pedophilia presents a serious danger to those children; I believe that Kansas can classify Hendricks as "mentally ill" and "dangerous" as this Court used those terms in *Foucha.*

57. *Id.* at 2090.
58. *Id.*
59. Justice Ginsburg joined in the remainder of the dissent.
60. *Hendricks*, 117 S. Ct. at 2090 (Breyer, J., dissenting).
61. *Id.*
62. *Id.* at 2090-91.
63. *Id.* at 2091.
64. *Id.*
65. *Id.* at 2091-92.
66. 478 U.S. 364, 367-73 (1986).
67. *Hendricks*, 117 S. Ct. at 2092.
68. *Id.*, quoting *Hendricks,* 912 P.2d at 136.
69. *Id.* at 2093, citing *Hendricks*, 912 P.2d at 131, 136.
70. *Id.,* quoting *Hendricks,* 912 P.2d at 131, 136.
71. *Id.* at 2094 (citation omitted).
72. *Id.* at 2094-95, quoting, in part, *Bell v. Wolfish*, 441 U.S. 520, 539 n.20 (1979).
73. *Id.* at 2095. Iowa also delayed civil commitment until the end of the offender's prison term and failed to require consideration of less restrictive alternatives. However, that law—*see* IOWA CODE ANN. § 709C.12—applies only prospectively, thus avoiding constitutional problems under the Ex Post Facto clause. *Id.*
74. *Id.* at 2096.
75. *Id.* The basis for the majority's conclusion that Hendricks was receiving treatment came from two sources, according to the dissenters: a statement made by counsel for Kansas at oral argument, and a trial judge's

statement in the record of a habeas proceeding in Hendricks' case that took place a year after his commitment. Neither, the dissenters concluded, served as appropriate justification for the conclusion that Hendricks was receiving treatment at the time he filed suit. *Id.* at 2096-97.

76. *Id.* at 2098.

77. As the Kansas law is the *most* punitive of any of the SVPA laws, *see id.* at 2095-96 (Breyer, J., dissenting), it is certainly reasonable to assume that any *less* punitive such law will also pass constitutional muster. *See* Janus, *Preventing Sexual Violence: Setting Principled Constitutional Boundaries on Sex Offender Commitments*, 72 IND. L.J. 157, 158 (1996) ("As the Court decides the sex offender cases, it will likely draw a bright line on the constitutional map of civil commitment") (article published prior to the decision in *Hendricks*).

78. *See* 3 PERLIN, *supra* note 4, § 15.25A, text accompanying note 479.36 (1996 Supp.), discussing Justice Thomas's dissent in *Foucha v. Louisiana*, 504 U.S. 71 (1992), in this context; *see also*, MICHAEL L. PERLIN, LAW AND MENTAL DISABILITY § 4.38 (1994).

79. *See* Brief of *amicus* American Psychiatric Association, *Kansas v. Hendricks*, No. 95-1649 (available from LEXIS, GENFED, BRIEFS library):

> When a State invokes this power, the reality of the confinement must support the claim that it is in the individual's interest. If "mental illness" were freely subject to legislative definition (through new terms like "mental abnormality" or otherwise), or if anyone "crazy" or "sick" enough to engage in repeated serious offenses could be civilly confined for that reason, the limits on deprivations of liberty to protect the public safety would quickly disappear. When an assertion of a parens patriae interest is not well grounded, the State either is acting to punish the individual, and thus has to meet the requirements for a valid criminal sanction, or is acting to serve others' interests by preventive detention, and thus has to meet the stringent standards for such action—neither of which Kansas can do.

80. *See, e.g.,* Marques, et al., *Effects of Cognitive-Behavioral Treatment on Sex Offender Recidivism*, 21 CRIM. JUST. & BEHAV. 28, 28-52 (1994); Marshall & Pithers, *A Reconsideration of Treatment Outcome with Sex Offenders*, 21 CRIM. JUST. & BEHAV. 10, 10-27 (1994); Becker & Hunter, *Evaluation of Treatment Outcome for Adult Perpetrators of Child Sexual Abuse,* 19 CRIM. JUST. & BEHAV. 74 (1992).

On the ways that social science is used in sex offender cases in general, *see* Janus, *supra* note 13. There is no current empirical evidence to suggest that sex offenders have different recidivism rates than do nonsex offenders. Simon, *The Myth of Sex Offender Specialization: An Empirical Analysis*, 23 N. ENG. J. ON CRIM. & CIV. CONFINEMENT 387 (1997).

81. *See* 1 PERLIN, *supra* note 4, § 1.05B (1996 Supp.).

82. *See, e.g., Hendricks*, 117 S. Ct. 2080, discussed *supra* text accompanying note 33, and *id.,* note 33.

83. 504 U.S. 127 (1992); *see* 2 PERLIN, *supra* note 4, § 5.65A (1996 Supp.); PERLIN, *supra* note 78, § 2.18; *see generally*, Perlin & Dorfman, *Sanism, Social Science, and the Development of Mental Disability Law Jurisprudence*, 11 BEHAV. SCI. & L. 47 (1993) (Perlin & Dorfman, *Sanism*); Perlin & Dorfman, *Is It More Than "Dodging Lions and Wastin' Time"? Adequacy of Counsel, Questions of Competence, and the Judicial Process in Individual Right to Refuse Treatment Cases*, 2 PSYCHOLOGY, PUB. POL'Y & L.114 (1996); Perlin, *Decoding Right to Refuse Treatment Law*, 16 INT'L J. L. & PSYCHIATRY 151 (1993).

84. *See* 3 PERLIN, *supra* note 4, § 15.25A (1996 Supp.); *see generally*, Perlin & Dorfman, *Sanism*, *supra* note 83.

85. *Hendricks,* 912 P.2d at 138.

86. *See supra* text accompanying note 54.

87. *See generally* Janus, *supra* note 77, at 213:

> A system that compromises our traditional constitutional values cannot last. Sex offender commitment laws confuse too many important values. Obscuring the critical role that mental disorder plays in defining the state's police powers, these laws embrace a dangerous jurisprudence of prevention. We must find other, more truthful and more principled ways to prevent sexual violence.

This article is adapted from 1 MICHAEL L. PERLIN, MENTAL DISABILITY LAW: CIVIL AND CRIMINAL (1989), § 2.16A (1997 Supp.) (in print).

*Bob Dylan, *Mixed-Up Confusion* (1962).

The Supreme Court Speaks on Physician-Assisted Suicide

by Dale L. Moore*

On June 26, 1997, the United States Supreme Court issued its opinions in *Washington v. Glucksberg*[1] and *Vacco v. Quill*,[2] the cases in which Washington's and New York's statutes criminalizing assisting suicide were challenged on constitutional grounds. The Court's decision to reject those challenges was unanimous; the rationales on which the justices relied, however, were diverse. In this article, I will briefly review the backgrounds of these two cases before turning to the Court's opinions. After discussing the reasoning and implications of Chief Justice Rehnquist's opinions for the five-justice majority, I will explore the possibilities left open by the various views reflected in all of the opinions.

I. Background

Much has been written about the events and analyses that preceded these two cases,[3] and I will not restate that history here. Suffice it to say that in the midst of the public and professional debate that had been intensified because of publicity surrounding Dr. Kevorkian's activities, plaintiffs in Washington and New York sought federal court judgments declaring unconstitutional those states' statutes criminalizing assisting suicide. The plaintiffs included terminally ill patients as well as physicians who stated that they would be willing to provide assistance with suicide in certain cases but for the statutory prohibitions. In the Washington case, these plaintiffs were joined by a nonprofit organization called Compassion in Dying, which provides counseling to those considering physician-assisted suicide. The plaintiffs were successful in the courts of appeals, in the Ninth Circuit with a favorable *en banc* opinion; in the Second Circuit with a panel opinion. Although the courts of appeals relied on different constitutional provisions in their decisions, they both found the state statutes unconstitutional as applied to competent, terminally ill adults capable of self-administering medication to hasten their deaths. The attorneys general of Washington and New York sought Supreme Court review, which was granted.

II. The Supreme Court Majority

Writing for himself and Justices O'Connor, Scalia, Kennedy, and Thomas, Chief Justice Rehnquist disagreed with the analyses of the courts of appeals. The Ninth Circuit, which had relied on a substantive due-process analysis, had noted that the plaintiffs' equal-protection argument was "not insubstantial."[4] The Second Circuit, which had relied on an equal protection analysis, had rejected the substantive due-process argument. The Supreme Court rejected both.

A. The Due-Process Analysis

The Chief Justice identified the question for the Court as "whether the 'liberty' specially protected by the Due Process Clause includes a right to commit suicide which itself includes a right to assistance in doing so."[5] Having already stated that one of the "primary features" of the Court's due-process analysis is that "the Due Process Clause specially protects those fundamental rights and liberties which are, objectively, 'deeply rooted in this Nation's history and tradition,'"[6] and having already reviewed sufficient historical information to conclude that the Court was "confronted with a consistent and almost universal tradition that has long rejected the asserted right,"[7] Chief Justice Rehnquist was well on his way to justifying the majority's reversal of the Ninth Circuit decision. He devoted much of the remainder of the opinion to two matters: first, explaining why the respondents' reliance on *Planned Parenthood v. Casey*[8] and *Cruzan v. Director, Missouri Dep't of Health*[9] was misplaced, and second, outlining the state interests to which a prohibition on assisting suicide is rationally related.

The majority explained that reliance on *Cruzan* was inapt essentially for two reasons. First, the Court's assumption in *Cruzan*, which is that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment, was "entirely consistent with this Nation's history and constitutional traditions."[10] In contrast, the decision to commit suicide, while concededly intensely personal, has no such history of legal recognition and protection. Second, the majority refused to read *Cruzan* as "'recogniz[ing] a liberty interest in hastening one's own death.'"[11] Indeed, the Court demonstrated again that its acknowledgment of a Fourteenth Amendment liberty interest in *Cruzan* was more limited: "We have also assumed, and strongly suggested, that the Due Process Clause protects the traditional right to refuse unwanted lifesaving medical treatment."[12] The majority also rejected the Ninth Circuit's analogy to *Casey,* stating:

> That many of the rights and liberties protected by the Due Process Clause sound in personal autonomy does not warrant the sweeping conclusion that any and all important, intimate, and personal decisions are so protected, and *Casey* did not suggest otherwise.[13]

Finally, the majority examined the several state interests implicated by the Washington prohibition on assisting suicide. These include preservation of life, prevention of suicide, protecting the integrity of the medical profession, and protecting vulnerable groups from abuse, neglect, mistakes, coercion, prejudice, and indifference. In addition, concern about starting down the slippery slope toward voluntary and involuntary euthanasia could make a state wish to draw the line where Washington has.

B. The Equal-Protection Analysis

The essence of the Second Circuit's ruling in *Vacco v. Quill*[14] was as follows:

> The New York statutes criminalizing assisted suicide violate the Equal Protection Clause because, to the extent that they prohibit a physician from prescribing medications to be self-administered by a mentally competent, terminally ill person in the final stages of his terminal illness, they are not rationally related to any legitimate state interest.[15]

In rejecting this analysis, the Chief Justice made three basic points. First, he noted that New York's statutes permitting refusal of treatment yet banning assisting suicide do not draw any distinctions among similarly situated persons. "*Everyone*, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; *no one* is permitted to assist a suicide."[16] Second, he disagreed with the Second Circuit's conclusion that "ending or refusing life-saving medical treatment 'is nothing more nor less than assisted suicide'."[17] That conclusion, of course, was at the heart of the Second Circuit's finding of an equal-protection problem. The Chief Justice, however, found the distinction between refusing treatment and consuming a lethal dose of medication quite valid for a number of reasons, including: the differing mechanisms of death (the underlying illness versus an overdose) and the intent of the physician (to respect a patient's wishes to be free of unwanted treatment versus the intent that a patient be "'made dead'.")[18] Accordingly, the Court concluded that New York's distinguishing between refusing lifesaving treatment and assisting a suicide is not only not arbitrary and irrational but rather is well-supported by logic and contemporary practice and therefore entirely consistent with the Constitution.[19]

III. The Other Opinions

Justices Souter and Stevens concurred in the Court's judgments only, writing lengthy opinions to explain their reservations about the Court's analyses. Justices Ginsburg and Breyer also concurred in the judgments only. Both of them also joined Justice O'Connor's opinion; Justice Breyer did so "except insofar as [Justice O'Connor's opinion] join[ed] the majority."[20] Justice Breyer wrote separately as well. Finally, Justice O'Connor, who joined the majority opinion also wrote separately to express views that in Justice Breyer's opinion "have greater legal significance than the Court's opinion suggests."[21] A reading of these opinions demonstrates that the "unanimity" of the Court's decision is illusory.

A. Justice Souter

The principal Souter opinion dealt with the due process issues raised in *Washington v. Glucksberg*.[22] After providing a lengthy review of the scope and nature of substantive due-process analysis, Justice Souter turned to a discussion of the state's interests, which he characterized as "sufficiently serious to defeat the claim that the [state's law] is arbitrary or purposeless."[23] In fact, he found one of those interests dispositive: the "recognized state interest in the protection of nonresponsible individuals and those who do not stand in relation either to death or to their physicians as do the patients whom respondents describe."[24] Earlier in his opinion, Justice Souter had discussed the state's argument that any attempt to confine a right of physician assistance to the population of patients identified by the courts of appeals' opinions would fail;[25] here, he seemed persuaded by at least a piece of that argument:

> The case for the slippery slope is fairly made out here, not because recognizing one due process right would leave a court with no principled basis to avoid recognizing another, but because there is a plausible case that the right claimed would not be readily containable by reference to facts about the mind that are matters of difficult judgment, or by gatekeepers who are subject to temptation, noble or not.[26]

Justice Souter also noted the superior ability of legislatures to obtain and assess the disputed facts about physician-assisted suicide, including whether regulatory measures adequate to protect the vulnerable parties described above are indeed feasible. Accordingly, although he concluded that the Court should "stay its hand" for the time being, he did not foreclose future judicial consideration: "While I do not decide for all time that respondents' claim should not be recognized, I acknowledge the legislative institutional competence as the better one to deal with that claim at this time."[27]

B. Justice Stevens

Justice Stevens opened his opinion with the observation that there is "room for further debate about the limits that the Constitution places on the power of the States to punish the practice [of physician-assisted suicide]."[28] He first discussed the analogy to the death penalty, the constitutionality of which acknowledges that a state need not treat all human life as of equal value, at least in terms of having an equal right to preservation. According to Justice Stevens, this meant that states that have authorized the death penalty (Washington and New York are among them):

> must acknowledge that there are situations in which an interest in hastening death is legitimate. Indeed, not only is that interest sometimes legitimate, I am also convinced that there are times when it is entitled to constitutional protection.[29]

Justice Stevens then turned to the analogy to the *Cruzan* decision, agreeing with the majority that it did not control the resolution of these cases. He pointed out, however, that *Cruzan* stands for the proposition that those who are "already on the threshold of death"[30] have a protected liberty interest that may be superior to the state interest in preservation of life. He labeled that liberty interest as stronger than the common-law

right to refuse treatment, calling it "an interest in deciding how, rather than whether, a critical threshold shall be crossed."[31]

If there is a theme to be found in Justice Stevens's opinion, it is that the lines being drawn are not so clear as the majority would make them. That theme underlies the next section of his opinion, in which he observed that the state interests on which both Washington and the majority relied simply do not have the same power in all cases. Although he acknowledged that the potential harms about which the state may be concerned would support a general public policy against assisting suicide, they will not necessarily prevail over the interests of a particular patient. Accordingly, Justice Stevens would not "foreclose the possibility that an individual plaintiff seeking to hasten her death, or a doctor whose assistance was sought, could prevail in a more particularlized challenge."[32] Finally, in discussing the equal-protection analysis, he returned to his theme by noting the validity of the distinction between suicide and foregoing life-sustaining treatment but also stating: "I am not persuaded that in all cases there will in fact be a significant difference between the intent of the physicians, the patients or the families in the two situations."[33]

C. Justice Breyer

Although he concurred in the judgments, Justice Breyer distanced himself from the majority by identifying the interest at stake not as a "right to commit suicide with another's assistance," but rather a "right to die with dignity"—to control the manner of death and to avoid unnecessary and severe pain.[34] He concluded, however, that the statutes under discussion did not directly interfere with that interest. Were they to do so, for example, by preventing administration of palliative care or pain medication, a different case would be presented.[35]

D. Justice O'Connor

I have saved what is in my view the best for last. As she did in *Cruzan*, Justice O'Connor joined the majority opinion but wrote separately to highlight critical points. The somewhat personal tone of her observations makes them more powerful and compelling. She began:

> Death will be different for each of us. For 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. Some will seek medication to alleviate that pain and other symptoms.[36]

After making that observation, Justice O'Connor proceeded to identify the narrower issue that the respondents raised: "whether a mentally competent person who is experiencing great suffering has a constitutionally cognizable interest in controlling the circumstances of his or her imminent death."[37] She found no need to reach that question because everyone involved in these cases had agreed, as she put it, that in these states "a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death."[38] In making this dramatic statement, Justice O'Connor appeared to be challenging those states whose regulatory schemes may make physicians hesitant to provide the kind of relief she described to clean up their acts. The implication that resonates through her and Justice Breyer's opinions is that this sort of relief had better not be barred; if it is, a very different case would be presented. Justice O'Connor, the critical fifth vote for the majority opinion, emphasized again at the end of her opinion that there is "no dispute" that terminally ill patients in Washington and New York can obtain such relief even though it might hasten their deaths.[39]

IV. The Future

The debate surrounding these cases has already caused much greater attention to be focused on this country's poor track record in providing suffering, dying people with adequate pain medications and other comfort measures. In light of the emphases in Justice O'Connor's opinion as well as the recognition by professionals, politicians, and the public that pain and suffering that can be alleviated should be alleviated, improvements in this area will likely continue, and that is all to the good. One cannot lose sight of the possibility, however, that some truly intractable pain may not be controllable and that pain and suffering can be emotional as well as physical. Thus, although we appear to be headed in the right direction, there is still far to go.

A. Legislative Activity

Virtually all of the opinions from the Supreme Court invited, even encouraged, state legislatures to explore, debate, and research the many aspects of physician-assisted suicide. Numerous models exist for legislatures to consider, including one enacted in the Northern Territories of Australia (later repealed by the Australian Senate)[40] as well as one published in 1996 in the *Harvard Journal on Legislation*.[41] A model also has been developed in the state of Oregon, where another referendum on the initiative that voters approved in 1994 was on the ballot again in November 1997. Activity is certain to occur in other states as well.

B. In the Courts

On July 17, 1997, less than a month after the Supreme Court's physician-assisted suicide decisions were announced, the Florida Supreme Court handed down its ruling in *Krischer v. McIver*.[42] In that case Charles Hall, a terminally ill AIDS patient, and his physician challenged the Florida statute prohibiting assisting suicide in state court on both state and federal constitutional grounds. Dr. McIver, Mr. Hall's physician, testified that he would assist Mr. Hall in committing suicide. The trial judge enjoined the state attorney from enforcing the statute against Dr. McIver should he assist Mr. Hall in this fashion. The state attorney appealed, and the Florida Supreme Court reversed the trial court, upholding the constitutionality of the statute. In light of the Supreme Court decisions that pre-

ceded this one, the Florida court devoted the bulk of its discussion to the state constitutional question.

Further judicial action on these issues presumably could be taken on state constitutional grounds, in declaratory judgment proceedings, or perhaps in the context of criminal prosecutions. Given the fate of the efforts to convict Dr. Kevorkian, and in light of the views of prosecutors, discussed below, the latter alternative seems unlikely.

C. Prosecutors' Views

On the day after the Supreme Court opinions were issued, the *New York Times* published an account of interviews with district attorneys around the state.[43] The article noted that, the Timothy Quill case to the contrary notwithstanding, prosecutors in general said they had not tried a physician-assisted suicide case. The prosecutors opined that this is unlikely to change despite the Supreme Court's decision. Several reasons were given: a lack of evidence, in that such an act is "'shrouded and protected by the people closest to the person who allegedly wanted to die'";[44] that a "'jury will not find somebody guilty for something they believe in their hearts was a blessing, no matter what a legal statute says'";[45] and prosecutorial discretion.[46] Nonetheless, the state of the law is such that a physician who believes that assisting a patient with suicide is appropriate in a particular case must act at his or her peril.

V. Conclusion

The debate about access to physician-assisted suicide is not over. Its existence has had a positive, and, one would hope, lasting, effect in the increased attention to the quality of end-of-life care. For those who believe that a physician's assisting a patient with suicide is under some circumstances morally right and medically appropriate, however, the legal battle will continue.

Endnotes

1. 117 S. Ct. 2258 (1997).
2. 117 S. Ct. 2293 (1997).
3. *E.g.*, New York State Task Force on Life and the Law, When Death Is Sought (1994).
4. 117 S. Ct. 2262 n.7.
5. 117 S. Ct. 2267 (footnote omitted).
6. 117 S. Ct. 2268.
7. 117 S. Ct. 2269.
8. 505 U.S. 833 (1992).
9. 497 U.S. 261 (1990).
10. 117 S. Ct. 2270.
11. 117 S. Ct. 2270 (quoting *Compassion in Dying v. Washington*, 79 F.3d 790, 816 (9th Cir. 1996) (*en banc*)).
12. 117 S. Ct. 2267 (citing *Cruzan*).
13. 117 S. Ct. 2271 (citation omitted).
14. 117 S. Ct. 2293 (1997).
15. *Quill v. Vacco*, 80 F.3d 716, 731 (2d Cir. 1996).
16. 117 S. Ct. 2298 (emphasis in original).
17. 117 S. Ct. 2298 (quoting *Quill v. Vacco*, 80 F.3d at 729).
18. 117 S. Ct. 2299 (quoting Assisted Suicide in the United States, Hearings before the Subcommittee on the Constitution of the House Committee on the Judiciary, 104th Cong., 2d Sess. 367 (1996) (testimony of Dr. Leon R. Kass)).
19. 117 S. Ct. 2301-2302.
20. 117 S. Ct. 2310 (Breyer, J., concurring in the judgments).
21. 117 S. Ct. 2310 (Breyer, J., concurring in the judgments).
22. *See* 117 S. Ct. 2275-93 for this opinion.
23. 117 S. Ct. 2290 (Souter, J., concurring in the judgment in *Washington v. Glucksberg*).
24. 117 S. Ct. 2290 (Souter, J., concurring in the judgment in *Washington v. Glucksberg*).
25. 117 S. Ct. 2276 (Souter, J., concurring in the judgment in *Washington v. Glucksberg*).
26. 117 S. Ct. 2291 (Souter, J., concurring in the judgment in *Washington v. Glucksberg*).
27. 117 S. Ct. 2293 (Souter, J., concurring in the judgment in *Washington v. Glucksberg*). Justice Souter also concurred in the judgment in *Vacco v. Quill*, noting that the reasoning underlying his view that prohibiting assisted suicide is not arbitrary also supports the distinction between terminating life-sustaining treatment and assisting suicide. 117 S. Ct. 2302 (Souter, J., concurring in the judgment in *Vacco v. Quill*).
28. 117 S. Ct. 2304 (Stevens, J., concurring in the judgments).
29. 117 S. Ct. 2305 (Stevens, J., concurring in the judgments).
30. 117 S. Ct. 2307 (Stevens, J., concurring in the judgments).
31. 117 S. Ct. 2307 (Stevens, J., concurring in the judgments).
32. 117 S. Ct. 2309 (Stevens, J., concurring in the judgments).
33. 117 S. Ct. 2310 (Stevens, J., concurring in the judgments).
34. 117 S. Ct. 2311 (Breyer, J., concurring in the judgments).
35. 117 S. Ct. 2312 (Breyer, J., concurring in the judgments).
36. 117 S. Ct. 2303 (O Connor, J., concurring).
37. 117 S. Ct. 2303 (O Connor, J., concurring).
38. 117 S. Ct. 2303 (O Connor, J., concurring).
39. 117 S. Ct. 2303 (O Connor, J., concurring).
40. 117 S. Ct. 2267 n.16.
41. Charles H. Baron, Clyde Bergstresser, Dan W. Brock, Garrick F. Cole, Nancy S. Dorfman, Judith A. Johnson, Lowell E. Schnipper, James Vorenberg, Sidney H. Wanzer, *A Model Act to Authorize and Regulate Physician-Assisted Suicide*, 33 Harvard Journal on Legislation 1 (1996).
42. 697 So. 2d 97 (Fla. 1997).
43. Esther B. Fein, *Handling of Assisted-Suicide Cases Unlikely to Shift, Officials Say*, New York Times, June 27, 1997, A 19, col. 1 (hereinafter cited as Fein).
44. Fein, *supra* note 43, col. 3 (quoting Jeannine Pirro, Westchester County District Attorney).
45. Fein, *supra* note 43, col. 2 (quoting Frank Phillips, Orange County District Attorney).
46. Fein, *supra* note 43, col. 4 (citing William Fitzpatrick, Onondaga County District Attorney).

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Is the Physicians Best Judgment Standard of *Toth* and *Rosenberg* Surviving Third Party Payers?

by Kathleen A. Carlsson*

The obligations of New York physicians to their patients have been clear since the 1898 Court of Appeals decision in *Pike v. Honsinger*.[1] The *Pike* court stated that physicians must possess the requisite skill and knowledge such as is possessed by the average member of the medical profession, must exercise ordinary and reasonable care, and their best judgment in the application of such professional knowledge and skill.

In 1968, the Court of Appeals elaborated upon and reaffirmed the best judgment requirement in *Toth v. Community Hospital at Glen Cove*.[2] In *Toth,* a pediatrician prescribed four liters of oxygen per minute for premature twins, but the nurses were alleged to have failed to follow his order, and instead administered six liters per minute.[3] There was evidence that six liters per minute was still the accepted community standard of practice in 1953, when the oxygen was administered.[4] However, there was also evidence of a recent research study that concluded that use of high levels of oxygen causes side effects including retrolental fibroplasia (RLF), resulting in blindness.[5] That is exactly what happened to these babies; they were blinded.[6]

In a malpractice action, the pediatrician defended on the theory that regardless of the proof as to whether the nurses actually administered four or six liters, he would not be guilty of lack of supervision because even if they gave six liters, that conformed to acceptable medical practice. The New York Court of Appeals rejected the physician's argument explaining that "evidence that a physician conformed to accepted community standards of practice usually insulates him from tort liability. . . . There is, however, a second principle involved in medical malpractice cases. Having its genesis in the reasonable man rule, this principle demands that a physician should use his best judgment and whatever superior knowledge, skill and intelligence he has."[7] The court continued:

> The necessary implication of this latter principle is that evidence that the defendant followed customary practice is not the sole test of professional malpractice. If a physician fails to employ his expertise or best judgment, and that omission causes injury, he should not automatically be freed from liability because in fact he adhered to acceptable practice. There is no policy reason why a physician, who knows or believes there are unnecessary dangers in the community practice, should not be required to take whatever precautionary measures he deems appropriate. For example, a physician believes that a course of treatment is highly dangerous. Using his expertise and exercising his best judgment, he decides that certain steps can safely be taken to minimize the risks. However, through carelessness, he omits to take the necessary safeguards. As a result, injury occurs. We see no justification for the position that, as a matter of law, because other reputable physicians did not think the precautions necessary and did not view the treatment actually given as improper, there may be no tort liability. It is not unreasonable to impose upon a physician, who believes that added precautions are necessary, the obligation that he act diligently in taking the necessary safety measures. This conclusion is nothing more than an application of the rule that a physician should at all times use his own best judgment and care.[8]

The court went on to state in a footnote:

> Although the problem is not present here, it must be acknowledged that as sound as the requirement may be that a physician use his best judgment and care as well as exercise whatever superior knowledge, skill and intelligence he has, this principle not only supplements, but on occasion may conflict with the rule that general medical practice is the usual measure of tort liability for medical practitioners. Thus, in the illustration given above, the additional measures may ultimately prove harmful. If those measures were not accepted by other physicians in general, the physician might find himself held responsible for failing to follow the community standard. Fairness and the avoidance of any principle of strict liability would seem to require that the physician not be held liable for exercising his best judgment at least in the case where the procedures used by the physician had some reputable support in the profession.[9]

The issue of best judgment then arose in prison cases where the cost of care is borne by a third party government. In *Pisacano v. State*,[10] a 1959 case from the Appellate Division, Fourth Department, a prison physician failed to prescribe cortisone even though he considered it the best treatment. The court held that the physician was obligated to use his best judg-

ment to determine what was best for his patient, and had no right to consider what that cost would be for the jail. "Sound medical judgment results from a fair and uninfluenced analysis and determination, based only on physical condition and needs and potential benefits, not on extraneous factors and certainly not on the inflexibility of a budget."[11] In *Bowers v. The County of Essex*,[12] a jail inmate was taken by the sheriff to be examined by a physician, Herbert Savel, M.D., who diagnosed a hernia and is alleged to have failed to order surgery unless the sheriff, who had custody of the inmate, would authorize the surgery. The court held that when "a physician agrees to treat a patient, he obligates himself to use his best judgment. . . . That his services are rendered . . . at the request of someone other than the patient does not affect the physician s liability."[13] The court stated that Dr. Savel "had the responsibility to prescribe and order the required medical treatment; if the Sheriff then refused to produce the plaintiff for the operation, the doctor would have been relieved of further responsibility."[14] The court denied a motion to dismiss, stating, "The negligence or malpractice alleged against Dr. Savel is that he failed to take the responsibility for actually prescribing or ordering the medical treatment."[15]

In *Rho v. Ambach*,[16] a deputy chief medical examiner for the City of New York, charged with physician incompetence, asserted an "accepted medical practice" defense, which the court rejected:

> Finally, petitioner argues that because the hearing committee concluded that his actions, while short of meeting the national standards for a board-certified forensic pathologist, were in conformity with the practices of the New York City Medical Examiner's office, they cannot be viewed as negligent since they meet the standard of practice in the locality. But the "locality rule" does not insulate from guilt doctors who, like petitioner, a board-certified forensic pathologist, possess superior knowledge and skills that exceed local standards, and provided the wherewithal (e.g., equipment, personnel, funding) to use these attributes is available (*Riley v. Wieman*, 137 AD2d 309, 315).[17]

The best judgment rule does not apply only to human patients. In *Restrepo v. State,*[18] a 1989 case, the court of claims determined that a race track veterinarian must consider and weigh only treatment options for a horse that are in the horse's best interests as a patient, and the veterinarian has no right to make his treatment decision based on other concerns such as whether the public will be inconvenienced by the race starting late.

In 1992, the New York Court of Appeals again applied the best judgment standard in *Rosenberg v. Equitable Life Assurance Society*.[19] When Sidney Rosenberg sought insurance from defendant Equitable Life, he was 51 years of age, a diabetic, and had an eight-year history of heart disease, including a heart attack at age 44. Because of this history, defendant required an independent evaluation of Rosenberg's condition. It referred him to Dr. Arora, a physician of its choosing, for a stress (exercise) electrocardiogram (EKG). Sylvia Rosenberg, his widow and administratrix, sought damages from defendant for her husband's wrongful death from cardiac failure, resulting, as the jury found, from the stress EKG it had ordered. The jury awarded her a substantial verdict.[20] Dr. Arora was not a party to this action. The *Rosenberg* court reversed the judgment against the defendant and dismissed the complaint. It said that the insurance company s order for the stress test resulted in no liability to the company since the insurance company had no authority over the physician who makes the decision whether to conduct the test they requested or as they requested it. "[D]efendant's independent contractor was a medical professional under no duty to perform the examination in a manner contrary to his legal and professional responsibilities."[21] The court said that the insurance company could not reasonably anticipate that Dr. Arora would follow its orders and perform the exam against his best judgment. "[N]o medical doctor can be *required* to render services which, in the doctor's professional judgment, are dangerous or contraindicated."[22]

However, there are some indications that this rule is now being disregarded by some physicians. A California study of Medicare patients reported July 11, 1997, in *JAMA* has found that Medicare patients in conventional fee-for-service health plans are twice as likely to have eye surgery for cataracts as those in a large Western health maintenance organization (HMO). The study made no conclusions as to whether the fee-for-service patients were being offered surgery too often or whether the HMO patients were prevented from having it. The findings suggest, however, that a huge number of patients are not being offered "best judgment" by their physicians. These physicians arguably have chosen financial gain over their patients' well being. Undoubtedly there must have always been some physicians who could not be trusted but until now the courts have condemned it. There was also a recent article in *Newsday*[23] that stated that a Catholic-sponsored HMO, *Fidelis Care of New York*, recently took over another HMO and that *Fidelis* does not offer family planning within its network; instead it makes referrals to another HMO for such care. The article did not explain the mechanism, but one might question whether it is possible that a physician who accepts payment from *Fidelis* can offer his "best judgment" to his patient if he is following the order of *Fidelis* to refuse to answer the family planning questions that his patients are seeking.

In at least one case, it appears that the New York court was backing away from enforcing the best judgment rule.[24] In December of 1986 Robert Carlen, M.D., a jail physician, sought an injunction from the Supreme Court, Suffolk County to direct his employer, the county health commissioner, to refrain from interfering with his best judgment in the care of inmates. He alleged in his petition that he had been directed to favor prescribing certain drugs from a list of in-stock drugs, rather than the ones he believed to be best, that he was ordered to perform examinations out of his area of practice for which he was not qualified, that he was ordered to refrain from writ-

ing the substance of disagreements as to diagnosis and treatment in the patient charts, that he was directed not to order weight control diets for obese patients, and that he was ordered not to inform an AIDS-related complex patient of his diagnosis. This physician was not able to prove any bad outcomes but he could and did allege that these treatment plans were against his best judgment and that he was threatened to change his orders or be fired. The lower court dismissed Dr. Carlen s petition on the ground that he failed to exhaust his administrative remedies. The Appellate Division affirmed the dismissal on exhaustion grounds. The Appellate Division then went on to say:

> [3] Over and above this flaw in the proceeding, we are of the view that the petition fails to state a cause of action. *The respondents clearly had the authority to direct the manner in which the petitioner performed his duties*. The petition and the papers submitted by the petitioner in response to the respondents' motion to dismiss fail to demonstrate that the respondents exceeded their authority in any way and is therefore insufficient as a matter of law (*see, McGraw v. Shapiro,* 56 A.D.2d 624, 391 N.Y.S.2d 681) (emphasis added).[25]

This physician was then charged by the defendant with insubordination and incompetence. The defendant appointed a hearing officer who held a hearing and found Dr. Carlen guilty of all charges, and then the defendant dismissed Dr. Carlen. In the ensuing article 78 proceeding[26] the Appellate Division dismissed his petition, but added that regarding Dr. Carlen s challenge to the respondent's authority to direct the manner in which he provided treatment to county patients:

> [W]e note that we previously determined, as a matter of law, that the respondent had the authority to direct the manner in which the petitioner performed his duties, and that the petitioner's arguments set forth in the instant proceeding virtually mirror those propounded and rejected earlier (*see, Carlen v. Harris,* 140 A.D.2d 288, 527 N.Y.S.2d 538).[27]

The Court of Appeals declined to review.

Let us consider the significance of this decision for future medical treatments. Assume that another employed physician, whom we will call Dr. X, is directed by his administrative superior to issue medical orders that do not agree with his best judgment for the patient. What options does such an employed physician now have?

Dr. X is presented with a patient suffering from venereal warts. Podophyllin is a caustic material available for self-treatment. It is a standard medical treatment within accepted medical practice. However, Dr. X determines that since he is aware of another case in which a young patient was terribly burned with the podophyllin, his best judgment is to refer the patient to a surgeon to consider treating by electrocauterization, a standard treatment which would be under more precise control.

What does Dr. X do—order the podophyllin or the electrocauterization?

The first option is for Dr. X is to follow the court s direction in *Carlen* and obey the administrative superior. Prescribe for the patient what the superior directs—the podophyllin. Then he will not be fired. Assume that Dr. X wants very much to keep his job, disregards his judgment that electrocauterization is the best choice for his patient and orders the podophyllin justifying his decision with the fact that podophyllin is *a standard medical treatment* for venereal warts. Therefore any other physician who considered it a good treatment for the disease would be totally justified in ordering it. Why should Dr. X risk losing his job for such a minor distinction?

Dr. X orders podophyllin. The patient does not do well. He is seriously burned. Dr. X is then sued for malpractice. His defense is that he believed electrocauterization to be best but ordered podophyllin at the direction of his boss and that should constitute an adequate defense citing *Carlen v. Harris*. What does the court do? The court has the following options.

First, it can follow the *Carlen* decisions and hold Dr. X harmless because he is subordinate to his employer, not an independent practitioner. In *Carlen* the court said that the county (as employer) can tell the physician what to order since the physician is an employee subject to its control.[28] The respondents clearly had the authority to direct the manner in which the petitioner performed his duties.[29] Dr. X need not concern himself any longer with struggling to decide what he considers to be in each patient s best interest.

Second, the court could hold Dr. X responsible for violating his obligation to use his best judgment pursuant to *Pike, Toth* and *Rosenberg*.[30] When Dr. X is put into a situation by an employer where he cannot fulfill his obligations to both his patients and to his employer, rather than violate his fiduciary duty to his patient,[31] he should resign his position or accept that he could be dismissed for disobedience to his employer.

Finally, the court could modify and soften the best judgment rule to reflect that health care is expensive and that average care is good enough for patients who are receiving their care from insurance companies, governments and health maintenance organizations. The court might reserve the best judgment rule for private fee-for-service patients, recognizing that an HMO can provide cheaper care for more patients if it limits its drug formulary to a list of drugs obtained at higher discounts.

"Just following orders" could be a complete defense to malpractice if the administrative superior has directed Dr. X to order patient care that is within the bounds of *accepted medical practice*. The care may not be what Dr. X considers *best* for the patient, but it constitutes a medical procedure that reputable physicians use for such an illness.

Endnotes

1. 155 N.Y. 201, 49 N.E. 760 (1898).
2. 22 N.Y.2d 255, 239 N.E.2d 368, 292 N.Y.S.2d 440 (1968).
3. *Id.* at 259, 239 N.E.2d at 370, 292 N.Y.S.2d at 443-44.
4. *Id.* at 259-60, 239 N.E.2d at 370, 292 N.Y.S.2d at 447.
5. *Id.* at 258, 239 N.E.2d at 370, 292 N.Y.S.2d at 443.
6. *Id.* One infant lost all useful vision in her left eye, while the other baby developed RLF in both eyes and lost her sight completely.
7. *Id.* at 262, 239 N.E.2d at 373, 292 N.Y.S.2d at 447.
8. *Id.* at 263, 239 N.E.2d at 373, 292 N.Y.S.2d at 447-48.
9. *Id.* at 263 n.2, 239 N.E.2d at 373 n.2, 292 N.Y.S.2d at 448 n.2. *See also Burton v. Brookdale Hosp.,* 88 A.D.2d 221, 223, 452 N.Y.S.2d 875 (1st Dep't 1982) (court applied best judgment standard in a factually similar RLF case).
10. 8 A.D.2d 335, 188 N.Y.S.2d 35 (4th Dep't 1959).
11. *Id.* at 338-39, 188 N.Y.S.2d at 39.
12. 118 Misc. 2d 943, 461 N.Y.S.2d 959 (Sup. Ct. 1983).
13. *Id.* at 944, 461 N.Y.S.2d at 961.
14. *Id.*
15. *Id.*
16. 144 A.D.2d 774, 534 N.Y.S.2d 758 (3d Dep't 1988), *rev'd on other grounds,* 74 N.Y.2d 318, 546 N.Y.S.2d 1005 (1989).
17. *Id.* at 776, 534 N.Y.S.2d 760-61.
18. 146 Misc. 2d 349, 550 N.Y.S.2d 536 (Ct. Cl. 1989).
19. 79 N.Y.2d 663, 595 N.E.2d 840, 584 N.Y.S.2d 765 (1992),
20. *Id.* at 667, 595 N.E.2d at 842, 584 N.Y.S.2d at 767.
21. *Id.* at 670, 595 N.E.2d at 844, 584 N.Y.S.2d at 764.
22. *Id.* at 671, 595 N.E.2d at 845, 584 N.Y.S.2d at 770 (emphasis in original).
23. NEWSDAY, Thursday, September 11, 1997, page A5.
24. *Carlen v. Harris,* 140 A.D.2d 288, 527 N.Y.S.2d 538 (2d Dep't 1988).
25. *Id.* at 288, 527 N.Y.S.2d at 539. In fact, the case cited by the court, *McGraw v. Shapiro,* was initiated by an employee who was transferred to a different job location, and who was clearly obligated to follow the orders of her superior. It had nothing to do with the obligation of a physician to use his best judgment.
26. *Carlen v. Harris*, 200 A.D.2d 619, 608 N.Y.S.2d 851 (2d Dep't 1994).
27. *Id.*
28. *Carlen v. Harris,* 140 A.D.2d 288, 527 N.Y.S.2d 538 (2d Dep't 1988).
29. 527 N.Y.S.2d at 539.
30. *See* accompanying notes 1-9 and 19-22 *supra.*
31. *Aufrichtig v. Lowell*, 85 N.Y.2d 540, 546, 650 N.E.2d 401, 405, 626 N.Y.S.2d 743, 746 (1995) ("treating physician stands in relationship of confidence and trust to his patient. . . . In New York, the special relationship [is] akin to a fiduciary bond.")

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HEALTH LAW DAY

AT THE NYSBA ANNUAL MEETING

New York Marriott Marquis
(Wednesday, January 28, 1997)

8:00 AM—9:15 AM	Executive Committee Meeting.
9:15 AM—9:45 AM	Committee Meetings.
10:00 AM—12:30 PM	PROGRAM: "Promoting Accountability in Managed Care: The Response by the Courts, Policy Makers and the Providers."
12:30 PM—2:00 PM	SECTION LUNCH: Henry Greenberg, General Counsel, New York State Department of Health, Guest Speaker.

'Net Worth

by Margaret Moreland Murray*

The number of legal research sites on the Internet is increasing daily. This is as true in the area of health law as it is in other specialties. Additionally, the number of medical/consumer health sites is exploding. Since much of this is unknown territory, an initial reaction might be to stick with the known research tools. Would that be a mistake? It would mean ignoring a smorgasbord of information impossible to assemble anywhere else. It would also mean limiting oneself to a publishing timetable which might not satisfy current needs. For example, those interested in ongoing tobacco developments might hope that traditional sources would publish all relevant documents in a timely way—OR they might go to the *Tobacco Products Liability Project* of the Tobacco Control Resource Center, Inc. at **http://www.tobacco.neu.edu/** which contains an amazing selection of materials and is updated continually.

In this column I will introduce you to two meta-resources, sites which might not contain any original material but which have links to thousands of other resources. In future columns I will discuss some major university health law sites, government resources, discussion lists and resources in more defined areas, such as tobacco litigation or death and dying. If anyone has suggestions for future issues, send them to me at or in care of this publication.

Hieros Gamos: Guide to Health Law
http://www.hg.org/health.html

Hieros Gamos (HG) is a comprehensive guide to the entire field of law, and health law is one of the practice areas it includes. There are links to international and foreign materials, but most links are national. The news category included links to sources such as *New York Law Journal* health law articles and *Health Law News*, published by the Center for Health Law Studies at St. Louis University School of Law. You can make a direct connection to selected U.S. statutes, to the Code of Federal Regulations (which is searchable at this location), and to some state law. HG also has a link to a database, at Cornell, of U.S. Supreme Court case summaries that may be examined under the subheadings of Disease, Health and Medicare. At this time the database only covers the years 1990-1994, but I expect it will be expanded in the future. There are numerous links to government agency and program sites, and to organization and association sites—both legal and medical. However, a fair number of these were inactive. Finally, the list of online discussion groups contains instructions for subscribing to each list, as well as a description of the group's focus.

Findlaw: Health Law
http://www.findlaw.com/01topics/19health/index.html

This resource contains many of the same links that you will find in HG, but there are some differences. The first subcategory here is "Primary Materials," and you will find links to selected statutes and regulations. You will also see a link to Commission on Family & Medical Leave documents and the UK Mental Health Act. The subcategory on "Government Agencies" lists dozens of sites and also gives the user the capability to conduct a Boolean search of the federal government sites. The subcategory of "Publications" seems a bit more extensive that HG's, but the list of discussion groups seems comparable.

An interesting subcategory is "Outlines." This contains a law school outline for a medical malpractice class at the University of Minnesota Law School. Another unique subcategory is "Software." This contains links to companies—only two so far—that market software which might be useful to law firms practicing in this area. Finally, there are links to a number of WWW sites relevant to health law research.

***Margaret Moreland Murray is a lawyer/librarian for Research Services at Pace University School of Law.**

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