

2020

Medical Aid in Dying by Telehealth

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Konstantin Tretyakov, *Medical Aid in Dying by Telehealth*, 30 Health Matrix 325 (2020)

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MEDICAL AID IN DYING BY TELEHEALTH

Konstantin Tretyakov[†]

ABSTRACT

Medical aid in dying is a form of medical treatment recognized in several states and the District of Columbia and available to adult residents of those states who are competent and suffer from a terminal disease. Timely access to it is critical for qualifying patients. The article explores the possibility of facilitating access to medical aid in dying via telehealth—a method of providing health care remotely by means of electronic communication. Specifically, I analyze the feasibility of medical aid in dying by telehealth from clinical and legal perspectives. I also examine a relevant normative issue of the nature of in-person medical examination and its relation to a valid doctor-patient relationship. I conclude that while clinically medical aid in dying can be provided to some qualifying patients, existing legal restrictions make it problematic. I argue that to improve access to medical aid in dying, we need to rethink what “in-person medical examination” means in the digital age.

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INTRODUCTION

Imagine that a patient and his¹ physician, who has already been following the patient and monitoring his condition for several months, each open a new smartphone application installed on their phones. The app allows them to hear and see each other using their devices' microphones and high-resolution cameras. When outfitted with various medical attachments, the app also allows the patient to take his vital signs and send that information directly to the physician. Both the physician and the patient log into the app using passwords known only to them; once secure connection is established and they are able to see and hear each other in real time, the patient makes an oral request for a certain medical treatment. The app's dictation software automatically uploads a transcript of the patient's request to his electronic-medical record (EMR). The doctor discusses the request with the patient and asks him to submit certain additional documents, such as a written request for the treatment, the patient's birth certificate, and proof of residency in the state where the doctor is licensed to practice medicine.

After the patient uploads all of the necessary documents via the app, his physician examines them and makes the patient's EMR accessible to his colleagues. This team of medical

1. In this essay, I use the pronoun "she" to refer to a doctor and the pronoun "he" to refer to her patient. This stylistic choice is for the purpose of clarity only.

professionals then determines whether the patient meets the eligibility criteria to receive the requested treatment. In order to do so, they consult the patient's EMR and data from the app. They ask him to take additional tests at a local provider's office. The results of those tests are then sent to the team for further analysis. Upon completing the remote-evaluation process, the team determines that the patient is eligible for the treatment. The doctor then writes a prescription and mails the prescribed medication to the patient.

The medication is a lethal dose of Secobarbital; the treatment the patient has requested from his physician is medical aid in dying (MAiD).²

MAiD, also known as physician-assisted death, death with dignity, or physician-assisted "suicide," is a medical treatment³ that is legally recognized and available to certain patients in several states and in the District of Columbia.⁴ The treatment consists of a physician prescribing to a qualifying patient a lethal

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2. See generally, *Frequently Asked Questions*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/faqs/> [<https://perma.cc/4VBC-8UFH>] (last visited Oct. 13, 2019) [hereinafter Death with Dignity FAQ].
 3. In this essay, I use the term "medical aid in dying" in the way it is used in some of the statutes legalizing the practice. See, e.g., COLO. REV. STAT. § 25-48-102 (West 2016). I do not use the unfortunate and factually inaccurate term "physician-assisted suicide." See *Morris v. Brandenburg*, 376 P.3d 836, 842–43 (N.M. 2016) ("[D]etailed expert testimony [submitted by proponents of legalization of MAiD] explain[s] that the medical and psychological professions do not consider a death from aid in dying to be a suicide."); *Id.* at 843 n.1 (explaining that "death from aid in dying is not the same as a suicide. Suicide is typically brought on by a 'psychiatric condition' such as depression and is characteristically an 'impulsive' and 'solitary act.' Accordingly, the family of a suicide victim will usually experience 'surprise, . . . shock and disbelief or anger, a whole set of emotional reactions . . . reflecting a lack of connection between the person who committed suicide' and those closest to that person. By contrast, aid in dying is characterized by a 'deliberative process,' which 'almost always involves the person discussing [aid in dying] with [his or her] family and friends.'") (ellipses in original).
 4. See H.B. 2739, 29th Leg. (Haw. 2018) (stating that as of early 2018, "five [other] states—Oregon, Washington, California, Vermont, and Colorado—and the District of Columbia have passed legislation to allow" MAiD); see also note 23, *infra*, discussing Montana's approach to MAiD.

dose of medication that the patient can then self-administer. Because MAiD can be provided legally only to patients suffering from a terminal disease, it is critical that they have timely access to it.⁵ Unfortunately, however, data suggest that a sizable proportion of patients who lawfully request MAiD are not granted access to the treatment because their condition declines shortly after requesting MAiD and they die “naturally,”⁶ or they are no longer capable to give informed consent to the treatment.⁷ There is also evidence that some population groups have not received MAiD at all.⁸

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5. Limited access to health care services is not, *per se*, a negative—in fact, some restrictions on who can access certain limited resources must be put in place to ensure a just rationing of those resources. *See generally*, I. Glenn Cohen, *Rationing Legal Services*, 5 J. LEGAL ANALYSIS 221 (2013) (comparing rationing principles applicable to the allocation of legal services and medical care). *But see* Carter v. Canada (Attorney General), 2015 SCC 5, 1 S.C.R. 343 (Can. 2015) (“A person . . . [who is terminally ill] has two options: she can take her own life prematurely, often by violent or dangerous means, or she can suffer until she dies from natural causes. The choice is cruel.”).
 6. *See, e.g.*, Elizabeth T. Loggers et al., *Implementing a Death with Dignity Program at a Comprehensive Cancer Center*, 368 NEW ENG. J. MED. 1417, 1417 (2013) (noting that “26.3% [of patients] initiated the process but either elected not to continue or died before completion.”).
 7. *Informed Consent: Code of Medical Ethics Opinion 2.1.1*, AM. MED. ASS’N, <https://www.ama-assn.org/delivering-care/ethics/informed-consent> [<https://perma.cc/P4HM-PXFN>] (last visited Dec. 20, 2019).
 8. Ronald A. Lindsay, *Oregon’s Experience: Evaluating the Record*, 9 AM. J. BIOETHICS 19, 22 (2009) (“The persons who have received assistance in Oregon are overwhelmingly White (in fact, not one African American has received assistance [in dying])”); OR. HEALTH AUTH’Y, OREGON DEATH WITH DIGNITY ACT 2017 DATA SUMMARY 7 (2018), available at https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATION_RESEARCH/DEATHWITHDIGNITYACT/Documents/year20.pdf [<https://perma.cc/WAF3-MC75>] [hereinafter OR. 2017 DATA SUMMARY] (noting that no patient who identified as black died from MAiD in 2017 in Oregon); *Accord* CAL. DEP’T PUB. HEALTH, CALIFORNIA END OF LIFE OPTION ACT 2017 DATA REPORT 6 (2018), available at <https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/2017EOLADataReport.pdf> [<https://perma.cc/F3XC-WL6M>].

There are a number of reasons why these patients' access to MAiD can be impeded. First and foremost, not all physicians in the states where MAiD is available actually participate in MAiD,⁹ which diminishes the pool of available providers and restricts access to MAiD. Second, MAiD is available only to the residents of the states where it is legal.¹⁰ Third, the statutory waiting period between requesting MAiD and receiving it can be further extended due to the actual waiting times to schedule appointments with available physicians and other medical professionals who evaluate the patient's eligibility for MAiD. Fourth, like with many other medical treatments, not all patients can bear the financial costs associated with MAiD.¹¹ Finally, potentially qualifying patients may be geographically located too far from the providers who participate in MAiD.

One way to mitigate some of these impediments could be to provide MAiD remotely by means of electronic communication: that is, by telehealth. As summarized by Ray Dorsey and Eric Topol, "[t]elehealth is the provision of health care remotely by means of a variety of telecommunication tools, including telephones, smartphones, and mobile wireless devices, with or without a video connection."¹² Though discussing death via tele-

9. See, e.g., Loggers et al., *supra* note 7, at 1419 ("Of 200 physicians surveyed [at Seattle Cancer Care Alliance], 81 responded (40.5%, a typical response rate for a general survey with no follow-up), with 29 physicians willing to act as a prescribing or consulting physician (35.8%), 21 willing to act as a consulting physician only (25.9%), and 31 unwilling to participate or undecided about participation (38.3%).").

10. Death with Dignity FAQ, *supra* note 3.

11. *Id.*

12. In this essay, I use the word "telemedicine" (or its synonym, "telehealth") to denote the delivery of health care remotely by means of electronic communication, including storing and transmitting patients' personal health information, remote monitoring, live consultation, and asynchronous information exchange. This definition comports with the way the terms "telemedicine" and "telehealth" are defined in the states where MAiD is now legal. One could argue that MAiD cannot fall under the term *telemedicine*, because MAiD is designed to alleviate the patient's suffering and not to heal the patient. In this essay, I stipulate that, since it has been recognized as a legitimate medical treatment option—and undertaken with physician intervention—in the states where it is legal, MAiD must fall within the ambit of medicine and medical treatment options in those states. See E. Ray

medical services may be controversial to some,¹³ as an emergent and effective method for delivering care,¹⁴ its use for that purpose may soon increase.

In early 2019, the legislature of Hawaii recognized telemedicine's potential to improve access to MAiD.¹⁵ And why couldn't it? Telehealth has proved to be efficient in increasing access to other medical treatments, such as critical infant care.¹⁶ With telemedicine, patients who seek MAiD can more easily find and connect with the doctors who provide it.¹⁷ Furthermore, telemedicine can shorten waiting times between patient appointments,¹⁸ which can be critical on both a statutory and practical level. Finally, because telemedicine providers can quickly assemble a team of medical professionals to evaluate the patient seeking MAiD, unlike medical professional who might be

Dorsey & Eric J. Topol, *State of Telehealth*, 375 *NEW ENG. J. MED.* 154, 154 (2016); *HAW. REV. STAT. ANN.* § 346–59.1 (2017) (providing definitions for telemedicine and telehealth); *See generally* Gonzales v. Oregon, 126 S.Ct. 904, 925 (2006) (holding that it is up to each state to decide whether MAiD is a recognized option of medical treatment).

13. Julia Jacobs, *Doctor on Video Screen Told a Man He Was Near Death, Leaving Relatives Aghast*, *N.Y. TIMES* (Mar. 9, 2019), <https://www.nytimes.com/2019/03/09/science/telemedicine-ethical-issues.html> [<https://perma.cc/G9WQ-BM6Q>].
14. Dorsey & Topol, *supra* note 13.
15. Donna Clark, *Medical Aid in Dying in the 50th State*, *ONCOLOGY NURSING NEWS* (Apr. 5, 2019), <https://www.oncnursingnews.com/contributor/donna-clark/2019/04/medical-aid-in-dying-in-the-50th-state> [<https://perma.cc/3SK7-93KW>].
16. Jeremy M. Kahn, *The Use and Misuse of ICU Telemedicine*, 305 *JAMA* 2227 (2011) (discussing telemedicine aimed at “expanding the reach and availability of intensivist clinicians” for neonatal intensive-care units).
17. Jeremy M. Kahn, *Virtual Visits—Confronting the Challenges of Telemedicine*, 372 *NEW ENG. J. MED.* 1684, 1684 (2015) (“For patients, telemedicine can reduce travel expenses and the opportunity costs associated with obtaining care, such as missed hours or days of work.”).
18. *How Telehealth Can Reduce Healthcare Wait and Travel Times*, *INTOUCH HEALTH*, <https://intouchhealth.com/how-telehealth-can-reduce-healthcare-wait-and-travel-times/> [<https://perma.cc/VWP6-TSY3>] (last visited Dec. 20, 2019).

confined to a brick and mortar office, it further improves access to and the quality of treatment.¹⁹

While there is sizable literature on the separate topics of MAiD and telemedicine, the discussion at their intersection is significantly sparser,²⁰ and this essay aims to narrow that gap. The discussion on this topic is important not only because of its obvious practical implications for patients and doctors who request and provide MAiD, but also because it provides an opportunity to reevaluate certain conventions about the doctor-patient relationship in the era of telehealth.

In this essay, I advance Hawaii's initiative and analyze whether or not it is *clinically feasible* to accomplish via telehealth the other stages of the MAiD protocol—requesting the treatment, evaluating the patient, and prescribing him with a lethal dose of medication. I also examine the current *legal frameworks* for both MAiD and telemedicine to see whether or not they allow for the digitalization of MAiD. Lastly, I discuss several *normative implications* of “tele-MAiD” and its impact on the burgeoning MAiD field.

The argument unfolds as follows. First, I synthesize the protocol for MAiD adopted in those states where the treatment is legal. Roughly speaking, it consists of four main stages: (1) request for MAiD; (2) evaluation of a potentially qualifying patient; (3) dispensation of a lethal medication to the qualifying patient; and (4) ingestion of that substance.

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19. That said, telemedicine is not a panacea against all problems that restrict access to MAiD, such as high medication costs. See Taimie Bryant, *Aid in Dying: The Availability of Ideal Medications for Use in “Right to Die” Jurisdictions in the United States*, 34 QUINNIPIAC L. REV. 705, 711–12 (2016) (“[T]he price for a lethal dose of liquid sodium pentobarbital is \$15,000–\$25,000. The price for a lethal dose of secobarbital, another barbiturate, has risen to \$3,000–\$5,000.”) (footnotes omitted).
20. For a notable exception, see Catharine J. Schiller, *Medical Assistance in Dying in Canada: Focus on Rural Communities*, 13 J. NURSE PRAC. 628, 631 (2017) (mentioning that “the [Canadian] legislation does not state that [assessments of eligibility for MAiD and the prescribing process associated with MAiD] must be performed in person. The decision of the federal government not to include such a restriction meant that the possibility of using telemedicine for this purpose remained open, an option that was particularly important for rural and remote communities.”).

Second, I explore the current state of telemedicine and argue that for certain patients, from a clinical perspective, the first three stages of the MAiD protocol can be completed remotely using electronic means of communication: telehealth.

Third, I examine whether or not completing those stages via telehealth involves heightened risks of legal liability for participating providers. I consider the patients' privacy, federal and state regulation of medical devices, electronic prescriptions for controlled substances, and state regulation of medical practice.

Fourth, I argue that the largest-legal obstacles to the digitalization of MAiD concern the requirement that the doctor conduct an "in-person" examination of the patient before prescribing to him a controlled substance, such as Secobarbital. This requirement stems from the traditional normative view of the doctor-patient relationship, which I argue needs to be revised to accommodate the evolving nature of that relationship in the advent of telehealth.

I. MEDICAL AID IN DYING PROTOCOLS IN THE UNITED STATES

As of January 2019, MAiD is legally available in the District of Columbia and seven states—California, Colorado, Hawaii, Oregon, Vermont, Washington,²¹ and Montana.²² In all of those jurisdictions, providers who participate in MAiD follow the protocol detailed in respective statutes, as well as the protocol supplemented by individual state's regulations.²³ This Section I

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21. H.B. 2739, 29th Leg. (Haw. 2018) (stating that as of early 2018, "five [other] states—Oregon, Washington, California, Vermont, and Colorado—and the District of Columbia have passed legislation to allow" MAiD).
 22. Strictly speaking, MAiD has not been legalized in Montana. Instead, the Montana Supreme Court has recognized the statutory defense of consent against criminal charges of homicide brought against physicians who participated in MAiD that resulted in the patient's death. *See Baxter v. State*, 224 P.3d 1211, 1215 (Mont. 2009) ("The consent statute would shield physicians from homicide liability if, with the patients' consent, the physicians provide aid in dying to terminally ill, mentally competent adult patients."). For ease of reference, however, I refer to Montana as a state in which MAiD is "legal."
 23. Montana physicians who offer MAiD to their patients appear to follow the protocol adopted in other states. *See Morris v. Brandenburg*, 376 P.3d 836, 855 (N.M. 2016) (explaining that a

focuses primarily on the statutory requirements from which legal liability for practicing MAiD via telemedicine may arise.

The components of MAiD are largely the same in participating states. It is available only to the residents of that state who: (1) are eighteen or older; (2) are capable of making medical decisions; (3) seek MAiD voluntarily; and, (4) have an irreversible, incurable disease that is likely to result in death in six months or less within reasonable medical judgment (i.e. a terminal disease).²⁴ MAiD providers—an extensive team of attending physicians, consulting (or second) physicians, mental health specialist (psychologist, psychiatrist, or social worker), and pharmacists—all must be licensed to practice medicine in that state.²⁵

The process of obtaining MAiD starts with the patient's request. For example, in California, the patient must make two oral requests, separated by a fifteen to twenty-day waiting period,

physician who practices MAiD in Montana relies on the standard of care set forth in the Oregon Death with Dignity Act); *See* Loggers et al., *supra* note 7, at 1418 tbl. 1 (providing local guidelines supplementing state requirements).

24. CAL. HEALTH & SAFETY CODE § 443.1(q) (West 2018); COLO. REV. STAT. § 25-48-103 (2018); D.C. CODE § 7-661.01(16) (2017); HAW. REV. STAT. § 327L-1 (2019); OR. REV. STAT. § 127.800 (12) (2017); VT. STAT. ANN. tit. 18, § 5281(10) (2015); WASH. REV. CODE § 70.245.010(13) (2009).
25. Loggers et al., *supra* note 7, at 1419 (noting that, in practice, such teams may include other specialists, for example patient advocates). It also appears that in the vast majority of cases, mental-health specialists do not participate in MAiD consultations. OR. 2017 DATA SUMMARY, *supra* note 9, at 7 (“A total of 92 physicians wrote 218 prescriptions [for MAiD] during 2017. [5] patients were referred for psychological or psychiatric evaluation.”); WASH. ST. DEP’T HEALTH, 2017 DEATH WITH DIGNITY ACT REPORT 9 (2018), available at <https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2017.pdf> [<https://perma.cc/4PRM-FNEF>] [hereinafter *WASH. 2017 REPORT*] (noting that 2% of patients who died from MAiD in 2017 were referred to psychological or psychiatric evaluation); CTR. FOR HEALTH AND ENVTL. DATA, COLO. DEP’T OF PUB. HEALTH AND ENV’T, COLORADO END-OF-LIFE OPTIONS ACT, YEAR ONE 2017 DATA SUMMARY 4 (2018) (providing that out of sixty patients participating in MAiD in 2017, one has obtained mental health provider’s confirmation).

as well as one written request.²⁶ The written request must be made in the presence of two witnesses who certify that the patient is mentally capable, is acting voluntarily, and is not being coerced to sign the request.²⁷ In addition, at least fifteen or twenty days must pass between the first oral request and the dispensation of the medication to the patient,²⁸ and at least forty-eight hours must pass between the written request and the dispensation of medication.²⁹ In California, the statute explicitly provides that the request must be made “solely and directly by the individual diagnosed with the terminal disease and shall not be made on behalf of the patient.”³⁰ Statutes in other states, while not expressly forbidding the patient’s proxy to make a request on the patient’s behalf, effectively impose the same restriction.³¹ The patient can withdraw request for MAiD at any time.³²

The patient first files his request with an attending physician.³³ Only one state, Vermont, requires that verbal requests be made in the physical presence of an attending physician; other states do not so specify.³⁴ The patient’s attending

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26. CAL. HEALTH & SAFETY CODE § 443.3(a) (West 2018); HAW. REV. STAT. ANN. § 327L-2 (2019) (requiring a waiting period of twenty days); *See, e.g.*, VT. STAT. ANN. tit. 18, §§ 5283(a)(1)–(4) (West 2015).
 27. CAL. HEALTH & SAFETY CODE §§ 443.3(b)(2), (3) (West 2018).
 28. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 443.3(a) (West 2018).
 29. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 443.5(a)(12) (West 2018).
 30. CAL. HEALTH & SAFETY CODE § 443.2(c) (West 2018).
 31. WASH. REV. CODE § 70.245.090 (2009) (“To receive a prescription for [MAiD medication], a qualified patient shall have made an oral request and a written request.”); COLO. REV. STAT. § 25-48-103(1) (2018) (“An adult resident of Colorado may make a request . . . to receive a prescription for [MAiD] medication . . .”).
 32. CAL. HEALTH & SAFETY CODE § 443.3(a) (West 2018).
 33. CAL. HEALTH & SAFETY CODE § 443.3(b) (West 2018).
 34. *Compare* VT. STAT. ANN. tit. 18, §§ 5283(a)(1), (2) (West 2015) (“The patient ma[kes] an oral request to the physician in the physician’s physical presence for medication to be self-administered for the purpose of hastening the patient’s death. No fewer than 15 days after the first oral request, the patient made a second oral request to the physician in the physician’s physical presence . . .”), *with* COLO. REV. STAT. § 25-48-104(1) (2018) (“In order to receive a prescription for medical aid-in-dying medication

physician is “a physician who has primary responsibility for the care of a terminally ill individual and the treatment of the individual’s terminal illness.”³⁵ This suggests that the attending physician and her patient may be in an existing doctor-patient relationship when the patient requests MAiD, although there is no express requirement that this must be the case.³⁶

Upon receiving the patient’s request, the attending physician must first confirm that the patient meets MAiD eligibility requirements. The attending physician then informs the patient about: (1) his diagnosis and prognosis; (2) the risks associated with taking MAiD medications; (3) the results of taking that medication; and, (4) alternative end-of-life care options, such as palliative care, hospice care, and pain control.³⁷ The attending physician must inform the patient that he has the right to revoke his MAiD request at any time and that he may elect not to take the medication after receiving it.³⁸ Other states require even more. For example, Vermont’s statute provides that the attending physician must base her medical evaluation of the patient on an “in-person” examination.³⁹

pursuant to this article, an individual who satisfies the requirements [provided in the statute] must make two oral requests, separated by at least fifteen days, and a valid written request to his or her attending physician.”).

35. COLO. REV. STAT. § 25-48-102(2) (2018).
36. It bears noting that several statutes define “patient” as a person “under the care of a physician.” *E.g.* WASH. REV. CODE § 70.245.010(9) (2009); D.C. CODE § 7-661.01(13) (2017). Implicitly, this indicates that a patient seeking MAiD must have an established relationship with a doctor; looking deeper, however, these statutes do not specify that the relationship must exist between the patient and the attending physician before the request for MAiD is made. Indeed, some health care providers have interpreted the relevant provision to be silent on whether the doctor-patient relationship must predate the request for MAiD; they have supplemented their MAiD protocols so that they explicitly include that requirement. Loggers et al., *supra* note 7, at 1418 (noting that Seattle Cancer Care Alliance in the state of Washington does not accept new patients solely for the purpose of providing them with MAiD).
37. WASH. REV. CODE § 70.245.040 (2009); COLO. REV. STAT. § 25-48-106 (2018).
38. CAL. HEALTH & SAFETY CODE § 443.5(a)(6) (West 2018).
39. VT. STAT. ANN. tit., 18, § 5283(a)(5)(A) (West 2015).

Additionally, the attending physician must also refer the patient to a consulting physician who is tasked with examining the patient and his medical record in order to (1) confirm the patient's diagnosis and prognosis, and (2) confirm that the patient is capable of and, in fact is, making an informed, voluntary decision to get the MAiD medication.⁴⁰ If the attending physician believes that the patient lacks the capacity necessary to make an informed decision about MAiD, she must refer the patient to a mental health specialist who can confirm that the patient's judgment is not impaired by a psychological or psychiatric disorder or depression.⁴¹

If, after following these steps, the patient is found to meet the statutory MAiD eligibility requirements, then the attending physician must inform him about the logistics of the procedure (including, but not limited, to the importance of notifying the patient's family, not taking the medication in a public place, and not taking the medication alone), and must ensure, once again, that the patient's choice is free and informed.⁴² Following that, the physician writes a prescription for a lethal dose of medication (usually secobarbital, pentobarbital, or morphine sulfate⁴³) and can either dispense the medication to the patient directly, or, with the patient's consent, send the prescription to a pharmacist who can then dispense the medication to the physician, the patient, or the patient's designee.⁴⁴ At all stages of MAiD, the involved medical professionals must carefully notate the aforementioned steps in the patient's medical record.⁴⁵ The attending physician must also notify the proper state governmental agencies overseeing MAiD after writing a prescription for the medication.⁴⁶

40. WASH. REV. CODE § 70.245.040(1)(d) (2009); CAL. HEALTH & SAFETY CODE § 443.5(a)(3) (West 2018).

41. *See, e.g.*, D.C. CODE § 7-661.04(a) (2017); OR. REV. STAT. § 127.825 (2017).

42. *See, e.g.*, COLO. REV. STAT. § 25-48-106(h)-(i) (2018); CAL. HEALTH & SAFETY CODE § 443.5(a)(5) (West 2018).

43. *See, e.g.*, 21 C.F.R. §§ 1308.12(b), (e) (2018).

44. VT. STAT. ANN. tit., 18, § 5283(a)(13) (2015); COLO. REV. STAT. § 25-48-106(k)-(l) (2018).

45. *See, e.g.*, WASH. REV. CODE § 70.245.120 (2009); D.C. CODE § 7-661.06(a)(3)(E) (2017).

46. *See e.g.*, CAL. HEALTH & SAFETY CODE § 443.5(a)(11) (West 2018); VT. STAT. ANN. tit., 18, § 5293 (2015).

II. PROVIDING MEDICAL AID IN DYING BY TELEMEDICINE IS CLINICALLY FEASIBLE

This Part II briefly describes the current state of telemedicine and argues that it is clinically feasible, both for some patients seeking MAiD and medical professionals providing it, to follow the MAiD protocol through telehealth.

A. Current State of Telemedicine

As noted earlier, telehealth is the delivery of health care remotely by means of electronic communication. Initially, the use of telemedicine was limited to certain medical conditions (such as a stroke or trauma) for patients who were in hospitals or satellite clinics.⁴⁷ Now, however, the reach of telemedicine has expanded. Physicians are addressing an increasing number of conditions and, in turn, reaching an increasing number of patients by telehealth because it is a convenient and accessible health-care tool.⁴⁸

With respect to the number of patients and providers who use telehealth, its growth is largely attributable to the proliferation of the internet and the increased integration of smartphones into our lives.⁴⁹ It was clear in 2016 that “[w]ith increasingly available broadband and portable diagnostic technologies, telehealth is rapidly moving to the home.”⁵⁰ This tendency shows no signs of slowing down, as smartphones play a leading role in increasing access to telehealth.⁵¹ Indeed, by some estimates, “[b]y 2018 . . . 65 percent of interactions with healthcare facilities will occur with mobile devices. [Furthermore,] 80 percent of doctors already use smartphones and medical apps in their practice.”⁵² Smartphones feature new and rapidly evolving

47. Dorsey & Topol, *supra* note 13, at 154–155.

48. *Id.*

49. *Id.*

50. *Id.*

51. See, e.g., Mary E. Reed et al., *Real-Time Patient-Provider Video Telemedicine Integrated with Clinical Care*, 379 NEW ENG. J. MED. 1478, 1478 (2018) (indicating that of the 210,383 studied video visits “accessible through [i]nternet-connected, video-enabled mobile devices or computers” scheduled from 2015 through 2017, “[p]atients used smartphones for 74% of video visits, desktop computers for 20%, and tablets for 6% . . .”).

52. Quora, *What Are The Latest Trends In Telemedicine In 2018?*, FORBES (July 31, 2018, 3:38 PM), <https://www.forbes.com/sites/>

technology; accordingly, they enable doctors not only to see and hear their patients through microphones and high-resolution cameras, but also to measure the patients' heartbeat or even potentially perform ultrasound scanning.⁵³

Telehealth applications to various medical conditions also have increased. Importantly, telemedicine has become increasingly more accessible to patients with chronic conditions, such as chronic obstructive lung disease and heart disease, which can become terminal.⁵⁴ Telehealth has also proven to be an efficient and effective method of psychological counseling. For example, the American Psychiatric Association has found that “[t]elepsychiatry is equivalent to in-person care in diagnostic accuracy, treatment effectiveness, quality of care[,] and patient satisfaction. Patient privacy and confidentiality are equivalent to in-person care.”⁵⁵

quora/2018/07/31/what-are-the-latest-trends-in-telemedicine-in-2018 [https://perma.cc/B4D9-ADGP] (presenting the findings of the University of Texas School of Biomedical Informatics).

53. University of British Columbia, *Breakthrough Opens Door to Smartphone-Powered \$100 Ultrasound Machine*, SCIENCE DAILY (Sept. 11, 2018), <https://www.sciencedaily.com/releases/2018/09/180911110232.htm> [https://perma.cc/48BT-B2NG] (discussing the invention of a portable ultrasound scanner that can be powered by a smartphone).
54. AGENCY FOR HEALTHCARE RES. AND QUALITY, TELEHEALTH: MAPPING THE EVIDENCE FOR PATIENT OUTCOMES FROM SYSTEMATIC REVIEWS iv (2016), available at <https://effectivehealthcare.ahrq.gov/topics/telehealth/technical-brief> [https://perma.cc/GJ99-HUAK] (“The most consistent benefit has been reported when telehealth is used for communication and counseling or remote monitoring in chronic conditions such as cardiovascular and respiratory disease, with improvements in outcomes such as mortality, quality of life, and reductions in hospital admissions. Given sufficient evidence of effectiveness for these topics, the focus of future research should shift to implementation and practice-based research.”); *The Future of Healthcare: Telehealth. Here’s Why You Need to Consider Telemedicine in 2019*, CONTINUING EDUC. J., <https://aceaglobal.com/continuing-education-journal/medical-insights/the-future-of-healthcare-telehealth-heres-why-you-need-to-consider-telemedicine-in-2019/> [https://perma.cc/W3CN-UEFL] (last visited Feb. 11, 2020).
55. *What Is Telepsychiatry?*, AM. PSYCHIATRIC ASS’N (Jan. 2017), <https://www.psychiatry.org/patients-families/what-is-telepsychiatry> [https://perma.cc/G4U3-LMFA].

Finally, it is important to keep in mind that the migration of telehealth from hospitals to patients' homes is but one tendency in a broader trend of proliferation of information technology into health care.⁵⁶ Other tendencies include the digitalization of patients' medical records and secure cloud storage of patients' data.⁵⁷ These tendencies reinforce each other, making the presence of telemedicine more prominent in our lives and urging us to realize its potential more fully by creating new medical treatments that utilize telehealth. One such treatment is MAiD.

B. Requesting MAiD

Using analogies to currently marketed smartphone apps and technologies, we can readily imagine what MAiD by telehealth could look like. A patient seeking MAiD could file a request for the treatment on a smartphone application, provided that there is a secure Wi-Fi or cellular-data connection between the patient and the attending physician that allows them to identify each other.⁵⁸ Both the patient and the attending physician could use the smartphone's screen, virtual keyboard, camera, microphone, and voice recognition technology to file both verbal and written requests for MAiD. For example, a patient could dictate his request to seek MAiD to the smartphone, which could use its speech-dictation technology to transcribe the request⁵⁹ and use his

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56. *Health Information Technology Integration*, AGENCY FOR HEALTHCARE RES. & QUALITY, <https://www.ahrq.gov/ncepcr/tools/health-it/index.html> [<https://perma.cc/9M25-Q3Z7>] (last updated Aug. 2019).
57. Shourjya Sanyal, *5 Surprising Ways in Which Telemedicine Is Revolutionizing Healthcare*, FORBES (Oct. 31, 2018), <https://www.forbes.com/sites/shourjyasanyal/2018/10/31/5-surprising-ways-in-which-telemedicine-is-revolutionizing-healthcare> [<http://perma.cc/L8NQ-DSKG>].
58. Encrypted connection can be established, for example, between the patient's and the doctor's smartphones, and Tele-MAiD could be password-protected (the password can be given to the patient and the doctor via email by the doctor's medical institution); it could also use face-recognition technology or fingerprint scanning, available on smartphones, for additional security. Cf. Elizabeth O'Dowd, *Telehealth Video Consults Affect Health IT Infrastructure*, HIT INFRASTRUCTURE (Jan. 8, 2018), <https://hitinfrastructure.com/news/telehealth-video-consults-affect-health-it-infrastructure> [<https://perma.cc/S2CM-NERJ>].
59. See generally Bjorn Carey, *Smartphone Speech Recognition is Faster and More Accurate Than Typing*, STAN. ENGINEERING (Aug.

fingerprint to digitally “sign” it.⁶⁰ After that, the app could send the recording of the patient’s request to a server (for oral requests) and then fill in the written request form as required by statute using the transcription of the patient’s request,⁶¹ and send the form to the server from where the attending physician could download it. Additionally, the form could be made available to others, such as statutorily required witnesses,⁶² to certify the patient’s written request. Those individuals could either log in to the app using their credentials set up by the patient or the patient’s attending physician, or they could install and use the app on their smartphones.⁶³

Additionally, the app could be set up to remind the patient to file the second oral request with the attending physician or about the possibility to rescind the request at any time.⁶⁴ All data collected through the app could be encrypted and securely stored on a server hosted by the attending physician’s hospital or a third-party—this kind of record storage is standard in other areas of medical practice.⁶⁵ It is also worth noting that multiple

25, 2016), <https://engineering.stanford.edu/magazine/article/smartphone-speech-recognition-faster-and-more-accurate-typing> [<https://perma.cc/4ZXJ-PKJ8>].

60. *See generally* Robert Triggs, *How Fingerprint Scanners Work: Optical, Capacitive, and Ultrasonic Variants Explained*, ANDROID AUTHORITY (Mar. 28, 2019), <https://www.androidauthority.com/how-fingerprint-scanners-work-670934/> [<https://perma.cc/3UXF-2PMN>].
61. *See, e.g.*, OR. REV. STAT. § 127.897 (2017); CAL. HEALTH & SAFETY CODE § 443.11 (West 2018).
62. *See, e.g.*, OR. REV. STAT. § 127.805 (2018); CAL. HEALTH & SAFETY CODE § 443.2 (West 2018); D.C. CODE § 7-661.03 (2017); N.J. REV. STAT. § 26:16-4 (2019); HAW. REV. STAT. § 327L-2 (2019).
63. *See generally* Rachel Z. Arndt, *There’s an App for That: Clinicians are Using Apps to Improve Care*, MOD. HEALTHCARE (Dec. 9, 2017), <https://www.modernhealthcare.com/article/20171209/TRANSFORMATION03/171209903/there-s-an-app-for-that-clinicians-are-using-apps-to-improve-care> [<https://perma.cc/2NPP-Q53M>].
64. Seneca Perri-Moore et al., *Automated Alerts and Reminders Targeting Patients: A Review of the Literature*, 99 PATIENT EDUC. CONS. 953 (June 2016).
65. “Teladoc” is a patient portal and an app that connects patients and doctors in real time by video and phone calls. *See, e.g.*, *Teladoc Privacy Policy*, TELADOC, <http://teladochealth.com.s3-website-us>

applications already exist for interactions between doctors and patients;⁶⁶ perhaps their functionality could be extended to accommodate requests for MAiD.

C. Evaluating the Patient

State statutes effectively control how medical providers must evaluate a patient who requests MAiD.⁶⁷ The providers who make those determinations are the patient's attending physician, consulting physician, and mental health specialist.⁶⁸ The issue of using telemedicine in evaluating the patient turns on whether or not providers can make their determinations about the patient remotely using electronic communication.

Determining a patient's age and residency status could be easily verified via telehealth. For example, the patient could scan or upload a digital copy of his birth certificate or passport to the app to prove that he is an adult.⁶⁹ Likewise, to prove his residency, the patient could provide the attending physician with either: (1) a copy of his driver's license; (2) electronic copies of tax returns filed in the state where MAiD is sought; (3) a copy of documents establishing that the patient owns or leases real

east-1.amazonaws.com/en/privacy-policy/ [https://perma.cc/5A9M-Z7J9] (last visited Feb. 18, 2020).

66. Laura Landro, *Doctors Prescribe New Apps to Manage Medical Conditions*, WALL ST. J. (Nov. 9, 2016), <https://www.wsj.com/articles/doctors-prescribe-new-apps-to-manage-medical-conditions-1447094444> [https://perma.cc/6AS2-UEXH] (“Hospitals are developing new mobile apps to help patients manage serious medical conditions and feed information back to their doctors between visits, often in real time.”).
67. Patients must generally: (1) have a terminal illness; (2) be an adult competent to make medical decisions; (3) be a resident of the state where MAiD is sought; and (4) and make the decision to seek MAiD voluntarily. *See*, OR. REV. STAT. § 127.805 (2018); CAL. HEALTH & SAFETY CODE § 443.2 (West 2018); D.C. CODE § 7-661.03 (2017); N.J. REV. STAT. § 26:16-4 (2019); HAW. REV. STAT. § 327L-2 (2019).
68. *See, e.g.*, OR. REV. STAT. § 127.805 (2018); CAL. HEALTH & SAFETY CODE § 443.2 (West 2018); D.C. CODE § 7-661.03 (2017); N.J. REV. STAT. § 26:16-4 (2019); HAW. REV. STAT. § 327L-2 (2019).
69. *See Key Benefits of Mobile Scanning for Healthcare Teams*, SCANDIT (Aug. 8, 2018), <https://www.scandit.com/blog/key-benefits-of-mobile-scanning-for-healthcare-teams/> [https://perma.cc/JH7L-NKDG].

property in that state; or (4) the voter's registration documents.⁷⁰ In order to prevent identity fraud, the attending physician would download the documents and verify whether or not the information presented in those documents is accurate in the same way that she would if the documents were presented in hard copies.⁷¹

Determining the patient's competency and the voluntariness of his request involves consultations between the patient and the attending physician (or, with the physician's referral, between the patient and a mental-health specialist). During those consultations, the physician or the mental-health specialist determine whether or not the patient has the capacity to make an informed decision about MAiD.⁷² The attending physician must also determine whether the patient's request is voluntary—that is, whether or not the patient is being coerced into requesting MAiD.⁷³

Nothing inherent to MAiD—or the current use of telehealth—indicates that telehealth is ill-suited to such requirements. Although studies have not addressed the accuracy of assessing voluntariness to receive MAiD over telehealth, other studies indicate that the providers' ability to evaluate the voluntariness of the patient's request and the patient's competency over

70. For example, AirBnB, a peer-to-peer lodging network, requires its users to upload various forms of identification to AirBnB's server so that AirBnB may verify the user's identification and run background checks. *Airbnb ID Verification FAQ: How It Works for Hosts and Guests*, IGMS (Apr. 17, 2018), <https://www.igms.com/airbnb-id-verification/> [<https://perma.cc/FU9U-WKGS>].

71. *E.g.*, Jenny Gold, *Coming to a Doctor's Office Near You: Photo ID Check*, KAISER HEALTH NEWS (July 29, 2009), <https://khn.org/news/medical-id/> [<https://perma.cc/M528-84V4>] (explaining how doctors can fight identity theft); *See Fighting Identity Theft with the Red Flags Rule: A How-To Guide for Business*, FED. TRADE COMM'N, <https://www.ftc.gov/tips-advice/business-center/guidance/fighting-identity-theft-red-flags-rule-how-guide-business> [<https://perma.cc/68TT-5TBQ>] (last visited Feb. 18, 2020).

72. Andrew Collins & Brendan Leier, *Can Medical Assistance in Dying Harm Rural and Remote Palliative Care in Canada?*, 63 CAN. FAM. PHYSICIAN, 186, 189 (Mar. 2017).

73. *Id.*

telehealth is materially similar to a face-to-face evaluation.⁷⁴ For doctors who routinely use telemedicine in their medical practice, there would be little to no change at all; they could use the camera and microphone of the smartphone to evaluate the patient's mental-health condition and any indicia of coercion.

Finally, one must consider whether it is possible to remotely diagnose the patient requesting MAiD with a terminal disease. According to the available data, most patients who qualify for MAiD and terminate their lives through it are at the terminal stage of cancer, amyotrophic lateral sclerosis (ALS), heart/circulatory disease, or chronic obstructive pulmonary disease (COPD).⁷⁵ The manufacturers of smartphone-telemedicine apps claim that their products can accurately diagnose at least some of those conditions using the technical features of mobile devices and artificial intelligence,⁷⁶ which allows for the potential to use telemedicine in diagnosing a patient requesting MAiD with terminal conditions. While there remains a need of enhanced evidence to substantiate these claims,⁷⁷ there

74. *Id.*

75. *See, e.g.,* OR. 2017 DATA SUMMARY, *supra* note 9, at 6 (providing that 76.9% of patients in Oregon who died ingesting MAiD medication suffered from cancer, 7% had ALS, 6,3% had a heart/circulatory disease); VT. DEP'T HEALTH, REPORT CONCERNING PATIENT CHOICE AT THE END OF LIFE 4 (2018), available at <https://legislature.vermont.gov/assets/Legislative-Reports/2018-Patient-Choice-Legislative-Report-12-14-17.pdf> [<https://perma.cc/32UN-NQA9>] (noting that between May 31, 2013, and June 30, 2017, eighty-three percent of patients who died from ingesting MAiD medication in Vermont had cancer and fourteen percent had ALS); WASH. 2017 REPORT, *supra* note 26, at 6 (noting that seventy-two percent of the patients in Washington who died in 2017 after ingesting MAiD medication had cancer, eight percent had a neurodegenerative disease (including ALS), nine percent suffered from a respiratory disease (including COPD), and eight percent had heart disease).

76. *See, e.g.,* Michael Goodman, *ResApp Brings Remote Diagnosis of Respiratory Disease Via Mobile App*, DIAGNOSTICS WORLD (Sept. 23, 2016), <http://www.diagnosticsworldnews.com/2016/09/23/resapp-brings-remote-diagnosis-of-respiratory-disease-via-mobile-app.aspx> [<https://perma.cc/5UJK-9T24>] (discussing a mobile application “developed to diagnose a wide range of conditions, including lower respiratory tract diseases such as . . . [chronic obstructive pulmonary disease].”).

77. Reed V. Tuckson et al, *Telehealth*, 377 NEW ENG. J. MED. 1585, 1586 (2017) (noting “an urgency for enhancing the evidence for

are at least three other factors that could weight in favor of the use of telemedicine in this area.

First, there is substantive data suggesting that telemedicine is an effective way of remotely monitoring patients with chronic conditions.⁷⁸ Accordingly, there are reasons to believe that monitoring the patients with chronic conditions such as ALS, heart disease, or COPD (which can ultimately lead to diagnosing them with a terminal stage of those diseases) is clinically feasible, especially if medical schools teach their students to use these new telemedicine tools.⁷⁹

Second, to enhance the quality of diagnostics, the patients requesting MAiD may take the necessary tests in local clinics and send the results to attending and consulting physicians.⁸⁰ Based on the information, the patient's medical record, and their personal observations of the patient, physicians can diagnose their

telehealth technology applications as clinicians and consumers expand their use in numerous areas," including management of chronic diseases); *See also* Stephen O. Agboola et al., *Digital Health and Patient's Safety*, 315 JAMA 1697, 1698 (2016) ("When care is delivered at distance, physicians and other clinicians may not detect subtle cues that they could detect in person.").

78. Annette M. Totten et al., *Telehealth: Mapping the Evidence for Patient Outcomes from Systematic Reviews*, 26 AGENCY FOR HEALTHCARE RES. AND QUALITY vi (June 2016).
79. *Cf.* Colette DeJong et al., *Incorporating a New Technology While Doing No Harm, Virtually*, 314 JAMA 2351, 2351 (2015) ("Physicians have long equated the physical examination with laying on of hands, but much evaluation can be done virtually—for example, by watching patients walk as a functional strength examination. Physicians can be trained to assess a patient through clinical mediators, such as a nurse who positions an electronic stethoscope to transmit heart sounds. Standardized patient encounters using telemedicine platforms could allow trainees to practice remote evaluation and manage difficult discussions, such as counseling an uninsured patient to seek emergency care for dyspnea despite the cost.").
80. *See, e.g.*, Heather Mack, *Doctor on Demand to add lab-testing services to their telemedicine platform*, MOBI HEALTH NEWS (May 3, 2017), <https://www.mobihealthnews.com/content/doctor-demand-add-lab-testing-services-their-telemedicine-platform> [<https://perma.cc/G7E8-QCUS>].

patients with a terminal disease.⁸¹ Conceivably, some of the qualifying patients' tests already are analyzed remotely.⁸²

Third, attending physicians who are in an already existing-physician-patient relationship will have the necessary context to easily address the patient's condition via remote diagnostics.⁸³ This is especially true for physicians who have had multiple opportunities to follow the patient before he requests MAiD. Indeed, studies have demonstrated that long term doctor-patient relationship can improve the accuracy of diagnostics.⁸⁴

In sum, from a clinical perspective, one could argue that the prospect of establishing the patient's compliance with both formal and clinical criteria for MAiD appear promising. This is especially true with respect to validating the formal requirements, the patient's capabilities, and voluntariness. As to remotely diagnosing terminal diseases, more data is required about the reliability of smartphones and their apps in that respect. However, there conceivably could be terminal conditions that the doctors could accurately diagnose through telemedicine, especially where the doctors have been following the patient's condition prior to the request for MAiD and where the doctors know how to use the diagnostic tools that telemedicine offers.

D. Providing Patients with Medication

The final aspect of MAiD is dispensing the medication. In many circumstances, a physician can dispense medication directly

81. *See id.*

82. For example, diagnosing a potentially qualifying patient with terminal cancer can involve taking X-ray images of the patient's body. Those images can be sent by internet to a radiologist located outside of the attending physician's hospital for interpretation (the practice known as teleradiology). *Teleradiology*, AM. C. RADIOLOGY, <https://www.acr.org/Advocacy-and-Economics/Legislative-Issues/Teleradiology> [<https://perma.cc/5XCZ-JCVM>] (last visited Oct. 13, 2019).

83. *See* AM. MED. ASS'N, AMA CODE OF MEDICAL ETHICS OPINIONS ON PATIENT-PHYSICIAN RELATIONSHIPS, available at <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/code-of-medical-ethics-chapter-1.pdf> [<https://perma.cc/BRR9-CS8S>] (last visited Sept. 27, 2019) (explaining that remote sensing and monitoring devices can "enhance the efficiency and quality of care" in already existing physician-patient relationships).

84. R. Kaba & P. Sooriakumaran, *The Evolution of the Doctor-Patient Relationship*, 5 INTL. J. SURGERY 57 (2007).

to her patient or the patient's representative during an office visit.⁸⁵ The attending physician can write an electronic prescription for medication, as long as the prescription verifiably has been issued by the attending physician on behalf of a qualified patient.⁸⁶ In the latter case, a pharmacist would dispense the medication.⁸⁷ After the prescription is written and sent to a pharmacist, the patient could either pick up the prescription "in person" or the drug could be delivered to the patient by mail.⁸⁸ All of these steps provide the qualifying patient with the MAiD medication, at which point the patient can decide whether or not to take it.

In conclusion, from a clinical standpoint, all relevant stages of MAiD protocol outlined in the statutes—patient requesting MAiD, patient's evaluation, and dispensation of MAiD drug to patient—can be completed by telemedicine for patients whose terminal conditions can be diagnosed remotely. Next, I consider whether medical professionals who decide to use telemedicine for MAiD incur higher risks of legal liability by doing so.

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85. See Matthew Grissinger, *Good Intentions, Uncertain Outcomes: Physician Dispensing in Offices and Clinics*, 40 PHARMACY & THERAPEUTICS 620 (2015).
86. *How Death with Dignity Laws Work*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/learn/access/> [<https://perma.cc/Q9WD-RCR5>] (last visited Feb. 19, 2020) (providing that electronic delivery of the prescription is acceptable in California, Colorado, Hawaii, Maine, New Jersey, and D.C.).
87. See, e.g., Arnold J. Rosoff, *On Being a Physician in the Electronic Age: Peering into the Mists at Point-&-Click Medicine*, 46 ST. LOUIS U. L. J. 111, 129 (2002) ("[T]he healthcare system in the United States is clearly moving toward establishing electronic links between physicians and pharmacists to facilitate ordering and dispensing prescription drugs more efficiently and safely.").
88. Laura Daily, *Should You Switch to a Mail-Order Pharmacy? Here are the Factors to Consider*, WASH. POST (Jan. 8, 2019), https://www.washingtonpost.com/lifestyle/home/should-you-switch-to-a-mail-order-pharmacy-here-are-the-factors-to-consider/2019/01/07/8b56f87a-0ede-11e9-8938-5898adc28fa2_story.html [<https://perma.cc/ES5M-N8JG>].

III. LEGAL ASPECTS OF PROVIDING MEDICAL AID IN DYING BY TELEHEALTH

An analysis of whether or not there are legal obstacles for a medical professional to follow the protocol for MAiD via telehealth is the necessary next step in this discussion. For purposes of this analysis and discussion, it is to be assumed that the medical professionals providing MAiD and the patient requesting it are both in the same state and that they are both using the app described in Part I. Let's call the app "Tele-MAiD." There exist four broad areas of healthcare law over which the issue of legality of telemedicine in MAiD, and Tele-MAiD span: (1) protection of the patients' privacy; (2) regulation of medical devices; (3) dispensation of controlled substances; and (4) regulation of the practice of medicine in general.⁸⁹

A. Privacy of Patients

Patient's privacy in the context of providing MAiD via telemedicine has two intertwined aspects: (1) confidentiality of the patient's medical records and (2) confidentiality of the patient's communication with medical professionals involved in the process.⁹⁰ Both aspects are regulated by federal and state law.

If the patient and his attending physician, consulting physician, and mental health specialist follow MAiD protocol when using Tele-MAiD, such use will necessarily create part of the patient's electronic medical record. For MAiD, the content of a patient's EMR is the same as the content of the medical records specified in the state statutes. That content must include: (1) all oral and written requests for MAiD; (2) the attending physician and consulting physician's diagnosis, prognosis, and verification that the patient is capable, acting voluntarily, and is making an

89. I focus here on the telehealth-specific aspects of MAiD, leaving aside the general liability issues (such as dispensing a wrong medication to the patient and facing medical malpractice liability claims). Such claims may arise in the context of providing MAiD both via telemedicine and by conventional means—as they do in all medical settings. For the same reason, I also assume that Tele-MAiD enables doctors to adequately evaluate a patient's eligibility for MAiD so that the higher risk of medical-malpractice claims against those medical professionals does not arise.

90. Andrey Ostashko, *HIPAA Requires Certain Measures for HER Confidentiality*, PROGNOCIS (Sept. 9, 2013), <https://prognocis.com/emr-confidentiality/> [<https://perma.cc/K6KY-DVC9>].

informed decision; (3) the mental health specialist's report and conclusions if a referral was made; (4) the attending physician's offer to the patient to withdraw request for MAiD; (5) the attending physician's certification that all statutory requirements have been met; and (6) the attending physician's notation about the steps taken for prescribing MAiD medication.⁹¹ If all stages of MAiD are completed via Tele-MAiD, then the patient's EMR also would consist of the patient's vital signs and other information about her condition obtained or transferred via smartphone, as well as all of the patient's communication with the MAiD team of medical professionals assigned to his case.⁹²

The content of the EMR created via Tele-MAiD falls under the definition of "health information" as provided in the federal law regulating patients' privacy—the Health Insurance Portability and Accountability Act (HIPAA).⁹³ HIPAA defines health information as

any information, whether oral or recorded in any form or medium, that is created or received by a health care provider . . . and relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.⁹⁴

HIPAA requires the Secretary of Health and Human Services to issue national standards of protection of patients' health information, including requirements for the security of that

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91. OR. REV. STAT. § 127.855 (2017); WASH. REV. CODE § 70.245.120 (2009); VT. STAT. ANN. tit. 18, § 5283 (2015); CAL. HEALTH & SAFETY CODE § 443.8 (West 2016); COLO. REV. STAT. § 25-48-111 (2018); D.C. CODE § 7-661.06 (2017). For example, in Vermont, the attending physician must also certify that the patient was either enrolled in hospice care or was informed about hospice care. VT. STAT. ANN. tit. 18, § 113 (2015). Relatedly, the District of Columbia statute specifically requires the attending physician to document the patient's residency. D.C. LAW, § 21-182 (2016).
92. *What is an Electronic Health Record?*, HEALTH IT, <https://www.healthit.gov/faq/what-electronic-health-record-ehr> [<https://perma.cc/AN74-6ZDN>] (last visited Oct. 13, 2019).
93. *See* Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996).
94. 42 U.S.C. § 1320d(4) (2018).

information stored in electronic format.⁹⁵ Those standards are codified in the Privacy Rule and the Security Rule.⁹⁶ The rules require covered entities and their business associates to: (1) adopt and implement privacy policies; (2) train their personnel to comply with those policies; (3) secure patients' records containing personally identifiable health information; (4) ensure the confidentiality, integrity, and availability of the patient's health information created, received, stored, or transmitted by covered entities and business associates; and (5) protect that information against being hacked and disclosed to third parties without authorization.⁹⁷

Conceivably, creating the EMR for a patient requesting TeleMAiD will not impose on covered entities a higher burden to protect the patient's protected information than what providers already bear under the familiar requirements of federal law. Nor will it require significant additional investments in the already-existing infrastructure of maintaining the patient's medical records electronically. Generally speaking, it appears that much (if not all) of the content of MAiD patient's medical record described in the state statutes may already exist in electronic form, especially in large hospitals where MAiD has been made available to qualifying patients.⁹⁸ Additionally, many healthcare providers already use various apps to receive, store, and transmit personal health information of their patients, and adding TeleMAiD to that pool of resources and data will not change how the standards of privacy and security should be and are

95. 42 U.S.C. § 1320d-1 (2018).

96. 45 C.F.R. §§ 160, 164 (2018). The Rules were most recently amended to reflect the changes introduced by another federal statute, the Health Information Technology for Economic and Clinical Health Act (the HITECH Act), which can be found in Title XIII, Division A, and in Title IV, Division B, of the American Recovery and Reinvestment Act, Pub. L. No. 111-5, 123 Stat. 115 (2009). Those changes were introduced to ensure that HIPAA standards of privacy and security were applicable not only to "covered entities"—health care providers, health plans, and health care clearinghouses—but also to their business associates (organizations or individuals to whom covered entities outsource their health care-related functions). *Id.*

97. *See generally* U.S. DEP'T HEALTH & HUM. SERV., HIPAA ADMINISTRATIVE SIMPLIFICATION REGULATION TEXT: 45 CFR PARTS 160, 162, AND 164 (2013).

98. HEALTH IT, *supra* note 93.

implemented.⁹⁹ This means that health care providers, as well as other covered entities and business associates, largely already comply with federal regulations regarding the privacy and security of the personal health information of patients who seek and obtain MAiD.¹⁰⁰

From the perspective of state law, the consequences of creating, transferring, and storing the EMRs of patients who seek (and potentially receive) MAiD appear to be two-fold as far as the exchange of the patients' data is concerned. First, if the servers—devices or programs that enable data exchanges—are located within the state where MAiD is provided and the patient's EMR does not leave the territory of the state, then there appears to be no additional privacy issues. This is so because the state laws that authorize MAiD do not prohibit creating EMRs of patients who receive or seek to receive MAiD.¹⁰¹ Similarly, medical providers operating in those states likewise do not face heightened privacy-protection requirements for MAiD patients compared to other patients, so the privacy of whose medical data they must maintain under applicable state laws remain unchanged. Furthermore, the existence of an app, like Tele-MAiD, that improves access to MAiD can also facilitate compliance with recording requirements. For example, requests for MAiD could be sent through Tele-MAiD as electronic files (with voice or text), which could be securely stored in the doctor's hospital or a third party's server.¹⁰² The same is true about

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99. Nathan Cortez, *The Mobile Health Revolution*, 47 U.C.D. L. REV. 1173, 1177 (2014) (“[M]obile health apps can link smartphones to hundreds of hospital monitors, allowing physicians to track patient vital signs remotely. Some apps allow physicians and patients to view CT scans, MRIs, PET scans, and other medical images remotely.”).
100. *See Numbers at a Glance*, HEALTH & HUM. SERV. (Aug. 31, 2019), <https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/data/numbers-glance/index.html> [<https://perma.cc/4CUY-9NFB>] (demonstrating that most HIPAA complaints are voluntarily resolved).
101. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 443.1(q) (West 2018); COLO. REV. STAT. § 25-48-103 (2018); D.C. CODE § 7-661.01(16) (2017); HAW. REV. STAT. § 327L-1 (2019); OR. REV. STAT. § 127.800 (12) (2017); VT. STAT. ANN. tit. 18, § 5281(10) (2015); WASH. REV. CODE § 70.245.010(13) (2009).
102. *See* Nate Lord, *Data Protection: Data In transit vs. Data At Rest*, DATAINSIDER: DIGITAL GUARDIAN'S BLOG (July 15, 2019),

communication between the patient and medical professionals on the MAiD team: all such communication would be recorded by Tele-MAiD's servers and, as such, form a part of the patient's EMR.¹⁰³

If data servers are located in another state where MAiD is not legal, the situation might be different. In that scenario, any data created in electronic communication between the patient and the doctor would “travel”¹⁰⁴ between the state where MAiD is legal to a server that may or may not be in a state where MAiD is prohibited, and then back to physician. In that scenario, the data constituting the patient's EMR would also be stored on a server outside of the state where MAiD is legal.

This *dépeçage* of data (and applicable state law) does not seem to expose the providers of MAiD to additional liability for violating privacy laws; after all, the state statutes authorizing MAiD do not specify that relevant medical records must be kept within those states.¹⁰⁵ One could argue that enabling MAiD—related communication between doctors and patients and storing the patients' EMRs might expose server providers to additional liability, conceivably on the grounds of either engaging in an unauthorized medical practice or being accomplices to “aiding and abetting suicide”¹⁰⁶ under the laws of a state where

<https://digitalguardian.com/blog/data-protection-data-in-transit-vs-data-at-rest> [https://perma.cc/N5J5-FDXS].

103. See Elena Muller, *The Role of Electronic Medical Records in Telehealth*, HEALTH RECOVERY SOLS., <https://www.healthrecoveryolutions.com/blog/the-role-of-electronic-medical-records-in-telehealth> [https://perma.cc/37WL-CG9V] (last visited Sept. 20, 2019).
104. I use “travel” to illustrate the process of the patient's app transmitting data from its location, Tele-MAiD's server processing the data in its location, and the server transmitting the data to the doctor's smartphone—wherever they each may be.
105. While MAiD statutes contain medical-record-documentation requirements, the statutes fail to specify where such documentation needs to be stored. See e.g. OR. REV. STAT. § 127.855 § 3.09 (2017); COLO. REV. STAT. § 25-48-111 (2016).
106. See Robert Rivas, *Survey of State Laws Against Assisting in a Suicide*, http://www.finalexitnetwork.org/Survey_of_State_Laws_Against_Assisting_in_a_Suicide_2019_update.pdf [https://perma.cc/E2CP-H7XF] (last visited Feb. 18, 2020).

their servers are located and where MAiD is a crime.¹⁰⁷ Both arguments, however, are unavailing. First, storing patients' data and enabling their communication with doctors is no more the practice of medicine than is building a hospital: while both activities make medical practice possible, neither constitutes diagnosing, treating, or prescribing a medical condition. Second, a state generally cannot prosecute conduct that occurs outside of its borders.¹⁰⁸ A limited exception to that general rule is the so-called "effects doctrine," pursuant to which "[a]cts done outside a jurisdiction, but intended to produce and producing detrimental effects within it, justify a state in punishing the cause of the harm."¹⁰⁹ Putting aside the issue of whether enabling MAiD in the state where it is legal from the server state constitutes a crime, such enabling produces no effects in the server state, and therefore cannot claim criminal jurisdiction over server providers on that ground. To avoid this problem altogether, it would be better for the server providers to keep their equipment enabling digital access to MAiD in the state where MAiD is legal, although this could be problematic to implement from a technical standpoint.

This demonstrates that access to Tele-MAiD for qualifying patients does not impose higher risks associated with the protection of the patients' privacy than those the covered entities already face. At the same time, transferring patients' data across state lines might catch the eye of particularly zealous state law enforcement authorities, although the risk of actual criminal prosecution on those grounds appears to be low.

B. Medical Devices

Tele-MAiD is very likely to be considered a medical device, because it is a "component, part, or accessory [of a smartphone on which it is installed], which is . . . intended for use in the diagnosis of disease or other conditions"¹¹⁰ Under the current

107. *Take Action in Your State*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/take-action/> [https://perma.cc/W5CT-4DG5] (last updated Oct. 11, 2019).

108. *In re Vasquez*, 705 N.E.2d 606, 610 (Mass. 1999) ("The general rule, accepted as 'axiomatic' by the courts in this country, is that a [s]tate may not prosecute an individual for a crime committed outside its boundaries.")

109. *Strassheim v. Daily*, 221 U.S. 280, 285 (1911).

110. 21 U.S.C. § 321(h) (2018) (referencing the intended capacity of a medical device to treat a disease, which does not apply to Tele-

regulatory framework, all medical devices (including apps) are divided into three classes based on their functionality intended by their manufacturers and developers. The classification is based on the degree of the risk that the intended functionality of a device entails: low (class one), moderate (class two), and high (class three).¹¹¹ This classification is significant for purposes of regulating the devices by the federal Food and Drug Administration (FDA). While medical devices from the first class receive very little oversight from the FDA, and devices from the second class require manufacturer’s premarket notification reviewed and generally accepted by the FDA,¹¹² medical devices from the third class, which “present[] a potential unreasonable risk of illness or injury,” require the FDA’s premarket approval.¹¹³ If the FDA grants its approval, then it typically does so only after the creator has endured long and costly clinical trials.¹¹⁴

At first blush, it may appear that Tele-MAiD belongs to the third class of medical devices; after all, it “presents a potentially unreasonable risk of illness and injury” because of the chance of remotely misdiagnosing the patient with a terminal disease. If that is true, then the developers of Tele-MAiD must obtain the FDA’s premarket approval before disseminating their product among doctors and patients.¹¹⁵

MAiD because that treatment is not directed to any particular disease or medical condition—it is rather a means for the patient to die with dignity).

111. Cortez, *supra* note 100, at 1201 (discussing the classification of medical devices and its application to apps); *See also* FOOD & DRUG ADMIN., MOBILE MEDICAL APPLICATIONS: GUIDANCE FOR INDUSTRY AND FOOD AND DRUG ADMINISTRATION STAFF 13 (2015), available at <https://research.unc.edu/files/2016/10/Mobile-Medical-Applications-FDA-Guidance-9-25-2013.pdf> [<https://perma.cc/D926-XRFS>] [hereinafter MOBILE MEDICAL APPS].
112. Cortez, *supra* note 100, at 1201–1202.
113. 21 U.S.C. § 360c(a)(1)(C)(II) (2018).
114. *See* JOSH MAKOWER ET AL., FDA IMPACT ON U.S. MEDICAL TECHNOLOGY INNOVATION: A SURVEY OF OVER 200 MEDICAL TECHNOLOGY COMPANIES (Nov. 2010), available at https://www.advamed.org/sites/default/files/resource/30_10_11_10_2010_Study_CAgenda_makowerreportfinal.pdf [<https://perma.cc/HX2V-5BYT>].
115. 21 U.S.C. § 360c(a)(1)(C)(II) (2018).

At the same time, it is important to keep in mind the FDA’s “functional” approach to regulating medical devices, including apps.¹¹⁶ In this respect, the determination of a class to which Tele-MAiD could belong requires parsing the functionality of that program. Those functions could include: (1) creating, storing, and transmitting the patient’s medical record, including requests for treatment and test results; (2) taking the patient’s vital signs; and (3) real-time consultations between the patient and the team of medical professionals evaluating his eligibility for MAiD.¹¹⁷ In light of this limited functionality of the app, it appears more appropriate to place it under the second class of medical devices.¹¹⁸ Those devices, as mentioned earlier, require a notice of intent to market them, filed with the FDA before they are offered to the public.

There are two other things to bear in mind about the FDA’s regulation of apps. First, as of 2019, the agency has not issued a final rule on this issue. Instead, it has published guidance, which “represents [the FDA’s] current thinking on the topic [and] does

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116. MOBILE MEDICAL APPS, *supra* note 112, at 4 (“Consistent with the FDA’s existing oversight approach that considers functionality rather than platform, the FDA intends to apply its regulatory oversight to only those mobile apps that are medical devices and whose functionality could pose a risk to a patient’s safety if the mobile app were to not function as intended.”).
117. It is important to underscore again that in proffering Tele-MAiD, I do not purport that it would, or even could, automatize the process of diagnosing patients with a terminal condition; it would simply aid physicians in that endeavor. *See* MAKOWER ET AL., *supra* note 115, at 27.
118. *See, Examples of Pre-Market Submissions that Include MMAs Cleared or Approved By FDA*, U.S. FOOD & DRUG ADMIN. (Sept. 26, 2019), <https://www.fda.gov/MedicalDevices/DigitalHealth/MobileMedicalApplications/ucm368784.htm> [<https://perma.cc/GP9G-CZXY>] (providing the list of mobile medical apps cleared or approved by FDA, where only two apps—both of which appear to be connected with an invasive glucose sensor system—have received premarket approval, with all other apps cleared by FDA through the notice-of-intent process); *See also* 21 U.S.C. § 360j(o) (2018) (excluding from the definition of “medical device” certain “decisions support software,” including the software intended “to serve as electronic patient records, including patient-provided information” and “for administrative support of a health care facility, including . . . appointment schedules . . .”).

not operate to bind FDA or the public.”¹¹⁹ The agency’s “wait and see” approach¹²⁰ arguably facilitates the dissemination of apps and is conducive to improving access of qualifying patients to MAiD through telemedicine.¹²¹ Second, as the FDA has explained, its rules implementing the standards for safety of medical devices apply to app developers, not app users.¹²² In this respect, it would be an odd result for doctors and patients to face adverse legal consequences for using the app.

The FDA, however, is not the only agency that regulates apps used for medical purposes. Two other agencies—the Federal Trade Commission (FTC) and the Federal Communications Commission (FCC)—also exercise gatekeeping functions in regulating the app marketplace.¹²³ Under the Federal Trade Commission Act,¹²⁴ the developers of the app cannot make deceptive or misleading claims to consumers and that the app must not do “more harm than good.”¹²⁵ Should the issue of using

119. MOBILE MEDICAL APPS, *supra* note 112, at 4.

120. *Id.* (explaining that FDA chooses to administer guidance to inform consumers and manufacturers of which apps the agency plans to apply its authority over).

121. *But see* Cortez, *supra* note 100, at 1206 (“[N]otwithstanding this boilerplate, few people understand FDA guidance documents as being so impotent”).

122. U.S. FOOD & DRUG ADMIN., POLICY FOR DEVICE SOFTWARE FUNCTIONS AND MOBILE MEDICAL APPLICATIONS: GUIDANCE FOR INDUSTRY AND FOOD AND DRUG ADMINISTRATION STAFF (2017), available at <https://www.fda.gov/media/80958/download> [<https://perma.cc/LNH3-5ND5>].

123. In addition to the FTC and the FCC, several other federal agencies—the Department of Defense, the Department of Agriculture—exercise oversight also over telehealth—and potentially over medical apps. Their regulations, however, are specific to their areas of governance and I therefore omit them from this analysis. *See* OFF. OF THE NAT’L COORDINATOR FOR HEALTH INFO. TECH., FEDERAL TELEHEALTH COMPENDIUM 16–17 (Nov. 2016), available at https://www.healthit.gov/sites/default/files/federal_telehealth_compendium_final_122316.pdf [<https://perma.cc/8C2Z-KKU9>].

124. 15 U.S.C. §§ 41–58 (2018).

125. *Mobile Health Apps Interactive Tool*, FED. TRADE COMM’N, <https://www.ftc.gov/tips-advice/business-center/guidance/mobile-health-apps-interactive-tool> [<https://perma.cc/Z8L8-K2B7>] (last visited Feb. 18, 2020) [hereinafter *Mobile Health Apps*].

Tele-MAiD for MAiD ever appear on the FTC’s radar, that agency would likely focus on the patient’s privacy and the security of their identifiable-health information.¹²⁶

With respect to the first aspect of the FTC’s oversight, Tele-MAiD would not present a heightened risk to the security of the patient’s privacy compared to other mobile medical apps already on the market.¹²⁷ And Tele-MAiD’s functionality, which merely facilitates the communication between the patient and the doctors, would not be harmful in the statutory sense.¹²⁸ By the same token, as long as the app is not presented as a “self-diagnosing” tool, it is unlikely to mislead patients and doctors regarding its intended use and limited capabilities.

In contrast with the FDA and FTC, who focus primarily on concrete mobile health apps, the Federal Communications Commission’s regulatory authority appears to be more general.¹²⁹ The FCC regulates radio frequencies used by mobile network operators, which would be integral to the proper functioning of Tele-MAiD, that rely of broadband-internet service to connect patients and doctors. In this regard, the FCC’s stance toward regulating broadband-internet access can be of immense significance for any mobile health app—including the ones for MAiD. As of 2019, the FCC’s documents strongly suggest that the agency is very interested in maximizing the potential of broadband in health information technologies, including mobile health, electronic health records, and consulting patients.¹³⁰ At the same time, the agency is yet to issue concrete regulatory

126. Cortez, *supra* note 100, at 1211.

127. See Iryna Pototska, *HIPAA Requirements and Other Regulations Imposed on Medical Software*, YOLANTIS, <https://yalantis.com/blog/what-hipaa-requirements-apply-to-medical-app-development/> [<https://perma.cc/65P6-PKSN>] (last visited Oct. 10, 2019).

128. *Mobile Health Apps*, *supra* note 126.

129. *Connecting Americans to Health*, FED. COMM’NS COMM’N, <https://www.fcc.gov/about-fcc/fcc-initiatives/connecting-americans-health> [<https://perma.cc/VA44-ZXHB>] (last visited Oct. 10, 2019).

130. See generally FED. COMM’NS COMM’N, *CONNECTING AMERICA: THE NATIONAL BROADBAND PLAN 200–202* (2010) (describing the potential of applying broadband internet–based information technologies in health care, including electronic health records, remote patient monitoring, video consultations, etc.).

policies applicable to mobile apps.¹³¹ The agency’s enthusiasm, however, indicates low risks for developers, doctors, and patients who intend to use mobile health apps relying on broadband internet connection.

This analysis demonstrates that doctors do not face a higher risk of legal liability for using the MAiD app, which conceivably could fall under the category of Class two medical devices. Furthermore, the current general attitude of regulatory agencies creates a relatively friendly environment for mobile health app developers.

C. Dispensation of Controlled Substances

In the United States, the medications typically prescribed to qualifying patients for MAiD are secobarbital and pentobarbital.¹³² Both drugs are potent barbiturates used in anesthesia and have been designated as controlled substances by the federal government in all states where MAiD is now legal.¹³³ This designation is significant because controlled substances are

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131. *But see Connecting Americans to Health, supra* note 130 (highlighting the FCC’s August 2019 “Report and Order to strengthen its Rural Health Care Program by increasing transparency, predictability, and efficiency of program funding decisions” and support telehealth).
132. Bryant, *supra* note 20, at 715 (“Sodium pentobarbital and secobarbital are short-acting barbiturates ideally suited for aid-in-dying statutory purposes because it is feasible to consume as a single dose the quantity necessary to rapidly produce sleep, followed by a fatal effect that occurs easily and relatively quickly after ingestion.”) (footnote omitted). State reports also suggest that other MAiD drugs include phenobarbital, morphine sulfate, and a combination phenobarbital and chloral hydrate. WASH. 2017 REP., *supra* note 26; OR. 2017 DATA SUMMARY, *supra* note 9.
133. Both federal and state laws designate secobarbital and pentobarbital as Schedule II substances, meaning that while they have an approved medical use, they are also dangerous and have a high potential of abuse. *See* 21 C.F.R. § 1308.12(e) (2018); CAL. HEALTH & SAFETY CODE §§ 11055(e)(2), (4) (West 2018); COLO. REV. STAT. §§ 18-18-204(2)(d)(II), (IV) (2018); D.C. CODE § 48-902.06(4)(C),(D) (2013); HAW. REV. STAT. §§ 329-16(d)(3),(5) (2017); MONT. CODE § 50-32-224(4)(c), (e) (2019); OR. REV. STAT. § 475.005(6)(a) (2017); VT. STAT. ANN. tit. 18, §§ 4201(6), (29) (2015); WASH. REV. CODE § 69.50.101(e) (2017).

subject to stricter rules regarding their dispensation (including prescription and delivery) compared to other drugs.¹³⁴

Still, the state statutes legalizing MAiD specifically authorize attending physicians to prescribe MAiD medication to qualifying patients or to deliver that medication directly to them.¹³⁵ Furthermore, the Supreme Court has held that federal authorities cannot interfere with this process simply because they believe that MAiD is not a legitimate medical treatment option.¹³⁶ Tele-MAiD, however, presents the separate issue of whether an attending physician can dispense MAiD medication to the patient or his proxy if she has not examined that patient in the patient's "physical presence" or "in-person."¹³⁷ This issue—which concerns only in-state prescribing—is regulated by both federal and state law.

Under federal law, "[n]o controlled substance . . . may be delivered, distributed, or dispensed by means of the [i]nternet without a valid prescription"—that is, a prescription "issued for a legitimate medical purpose in the usual course of professional practice by a practitioner who has conducted at least [one] in-person medical evaluation of the patient."¹³⁸ "In-person evaluation," in turn, means "a medical evaluation that is conducted with the patient in the physical presence of the practitioner, without regard to whether portions of the evaluation are conducted by other health professionals."¹³⁹ So, in order for an attending physician to prescribe MAiD medication to the qualifying patient, she will need to have evaluated the patient "in person" at least once.

For patients who have not been examined "in person," the regulations provide for an option to be prescribed MAiD medication "by a practitioner engaged in the practice of

134. See Controlled Substances Act, Pub. L. No. 91-513, 84 Stat. 1292 (1970).

135. See, e.g., OR. REV. STAT. § 127.815(1) (2013); COLO. REV. STAT. § 25-48-106(1) (2018).

136. See *Gonzales v. Oregon*, 126 S. Ct. 904, 925 (2006).

137. I use the terms "physical presence" and "in person" throughout this essay to denote a situation in which the patient's body is in close proximity to the doctor and the doctor can directly observe the patient without using electronic communication.

138. 21 U.S.C. § 829(e)(1)–(2) (2018).

139. 21 C.F.R. § 1300.04(f) (2018).

telemedicine.”¹⁴⁰ That exception from the general “in-person” evaluation rule, however, is extremely narrow. To qualify for it, the practice of telemedicine¹⁴¹ must fall under one of the seven categories specified in the regulations, including telemedicine conducted while the patient is admitted into a hospital or a clinic, or while the patient is under the care of a physician registered to dispense Schedule II controlled substances, like phenobarbital and secobarbital.¹⁴² Theoretically, this gives qualifying terminal patients who are treated by physicians unwilling to participate in MAiD but registered to prescribe Schedule II controlled substances an opportunity to obtain MAiD medication from another physician who is willing to do so. This presents a challenging ethical and legal question of whether or not the unwilling physician could lodge a conscientious objection and unilaterally terminate her doctor-patient relationship with the qualifying patient based on his request for MAiD.¹⁴³ This, in turn, would likely terminate the willing physician’s eligibility to

140. 21 U.S.C. § 829(e)(3)(A) (2018).

141. 21 C.F.R. § 1300.04(i) (2018) (“[T]he practice of medicine in accordance with applicable [f]ederal and [s]tate laws by a practitioner (other than a pharmacist) who is at a location remote from the patient and is communicating with the patient, or health care professional who is treating the patient, using a telecommunications system.”).

142. 21 C.F.R. §§ 1300.04(i)(1)–(2) (2018) (listing several other categories, such as telemedicine encounters during a public health emergency or the Department of Veteran Affairs medical emergency, telemedicine practiced by an employee of Indian health services, or telemedicine practiced pursuant to a special registration); 21 C.F.R. §§ 1300.04(i)(3)–(7) (2018); See Nathaniel M. Lacktman, *Telemedicine Prescribing of Controlled Substances: The Dark Side of the New Congressional Bill*, HEALTH CARE L. TODAY (Apr. 29, 2018), <https://www.healthcarelawtoday.com/2018/04/29/telemedicine-prescribing-of-controlled-substances-the-dark-side-of-the-new-congressional-bill/> [https://perma.cc/324D-KF7Y] (describing an initiative in Congress “intended to ‘light a fire’ and require the [Drug Enforcement Administration] to promulgate interim final regulations [on special registration for telemedicine] no later than [ninety] days after the bill is enacted.”).

143. See John Y. Rhee et al., *A Medical Student Perspective on Physician-Assisted Suicide*, 152 CHEST J. 475 (2017).

prescribe her with the MAiD medication.¹⁴⁴ In practice, however, it appears more preferable for both qualifying patients and their attending physicians to conduct an “in-person” examination of the patient before the patient’s access to MAiD is inhibited. In Part IV, I discuss this restriction from a normative perspective, including whether it can find support in concerns similar to those expressed in the context of “pill mills” for opioid prescriptions.¹⁴⁵

In addition to federal rules, attending physicians who dispense controlled substances also are subject to state statutes and regulations. In some states, those regulations closely follow the federal approach. For example, in Hawaii, the statute provides that “[i]t shall be unlawful for any [physician] to administer, prescribe, or dispense any controlled substance without a bona fide physician-patient relationship.”¹⁴⁶ For that relationship to exist, “the treating physician or the physician’s designated member of the health care team, at a minimum shall . . . [p]ersonally perform a face-to-face history and physical examination of the patient”¹⁴⁷ A similar restriction exists in Vermont, where “a health care provider . . . may prescribe, dispense, or administer drugs . . . after having performed an appropriate examination of the patient “in person,” through telemedicine, or by the use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically.”¹⁴⁸ At the same time, the Vermont statute regulating MAiD provides that the attending physician must determine that the patient requesting MAiD “was suffering a terminal condition, based on the physician’s physical examination of the patient and review of the patient’s relevant

144. This situation could also present the question whether the first doctor (who enables the patient to get the MAiD medication from the doctor who provides MAiD through telemedicine) would be eligible for compensation under the federal health insurance programs such as Medicare.

145. See, e.g., Alene Kennedy-Hendricks et al., *Opioid Overdose Deaths and Florida’s Crackdown on Pill Mills*, 106 AM. J. PUB. HEALTH 291 (2016) (discussing “‘pill mills,’ a category that includes physicians, pain clinics, and other providers that dispense large quantities of prescription drugs, typically for cash only, outside the scope of standard medical practice.”).

146. HAW. REV. STAT. § 329-41(b) (2009).

147. HAW. REV. STAT. § 329-1 (2016).

148. VT. STAT. ANN. tit. 18 § 9361(b) (2017).

medical records.”¹⁴⁹ When faced with this apparent conflict between the two statutes, physicians in Vermont are likely to comply with the more restrictive rule of (arguably) a *lex specialis* statute applicable to MAiD.

In other states, local rules appear to be more open toward MAiD via telemedicine. At the same time, the state medical boards and similar institutions charged with enforcement of medical-care-quality standards may limit a physicians’ ability to prescribe MAiD medications to qualifying patients whom they have not examined in their “physical presence.” For example, in California, the relevant statute provides that “[n]o person or entity may prescribe, dispense, or furnish . . . dangerous drugs . . . on the [i]nternet for delivery to any person in [California], without *an appropriate prior examination* and medical indication.”¹⁵⁰ The language of this provision does not refer to an “in-person” examination. However, the Medical Board of California, which enforces these regulations, explained that “[i]n-person examinations not only enhance the opportunity to confirm if a patient needs the identified medication or to rule out other medical conditions, but ensures the patient is advised of alternative treatment options and is aware of potential side effects.”¹⁵¹ Notably, the Medical Board of California did not rule out the possibility that a doctor, who, for instance, would follow her patient via Tele-MAiD and record her observations and the patient’s diagnosis and prognosis in that manner, would necessarily violate the appropriate prior examination standard. An argument can also be made that under this scenario, the attending physician “is able to conduct a bona fide medical evaluation of the patient at the remote location, and is otherwise acting in the usual course of professional practice”¹⁵² in the same manner that other telehealth providers do.

149. VT. STAT. ANN. tit. 18 § 5283(a)(5)(A) (2015).

150. CAL. BUS. & PROF. CODE § 2242.1(a) (West 2016) (emphasis added).

151. Joan Jerzak, *Internet Prescribing—Information for Physicians*, MED. BD. OF CAL. (Feb. 2004), http://www.mbc.ca.gov/Licensees/Prescribing/Internet_Prescribing.aspx [<https://perma.cc/NS49-Q9W5>].

152. Implementation of the Ryan Haight Online Pharmacy Consumer Protection Act of 2008; Final Rule, 74 Fed. Reg. 15,603 (Apr. 6, 2009) (to be codified at 21 C.F.R. pts. 1300, 1301, and 1304).

In some states, medical boards appear to be more permissive. For example, in Washington, the state Medical Quality Assurance Commission in its “Appropriate Use of Telemedicine” guideline states that a “[t]elemedicine practitioner may provide any treatment deemed appropriate for the patient, including prescriptions, if the evaluation performed is adequate to justify the action taken.”¹⁵³ This standard, which emphasizes the existence of a valid, bona fide doctor-patient relationship, appears more sympathetic toward prescribing MAiD medications to qualifying patients followed and evaluated via telemedicine¹⁵⁴ than does California’s.

This analysis demonstrates that an attending physician who has not examined a patient “in person” can prescribe MAiD medication to that patient only under limited circumstances. Under federal law, the patient must either be treated by another physician authorized to dispense phenobarbital or secobarbital, or be admitted to a hospital or a clinic that has the same authorization.¹⁵⁵ In the alternative, the attending physician must have examined the patient in-person at least once before the patient requested MAiD. In any event, a prescription of seco- or pentobarbital to a qualifying patient without an in-person examination is likely to be a red flag for the Drug Enforcement Agency,¹⁵⁶ which can bring criminal charges against the physician and further impede the patient’s access to MAiD via telemedicine.¹⁵⁷ In addition, state medical boards can exercise

153. WASH. MED. QUALITY ASSURANCE COMM’N, APPROPRIATE USE OF TELEMEDICINE (GUIDELINE) 4 (2014), available at https://wmc.wa.gov/sites/default/files/public/documents/MD201403TelemedicineGuideline_approved10-3-14.pdf [<https://perma.cc/T52Q-5PJJ>].

154. *See Ancier v. Dep’t of Health*, 166 P.3d 829, 831 (Wa. App. Ct. 2007) (explaining that the practice of prescribing medications over the internet constituted unprofessional conduct where the interaction between the doctor and his patients was limited to reviewing the questionnaires filled out by the patients on the internet).

155. Dispensing and Purchasing Controlled Substances over the Internet, 66 Fed. Reg. 21181–21184 (2001).

156. *See U.S. v. Rosen*, 582 F.2d 1032, 1036 (5th Cir. 1978) (stating that the absence of a physical examination is an example of “condemned behavior”).

157. *See, e.g., Press Release: Doctor charged for prescribing narcotics to non-patients and ordered detained until trial*, U.S. DRUG ENFM’T

their discretion while enforcing rules of medical practice on physicians, and in some states, doctors are expressly prohibited from dispensing controlled substances to patients without an “in-person” examination.¹⁵⁸ That aspect of prescribing controlled substances to patients evaluated only telemedically is closely tied to another facet of the legality of MAiD via telehealth: the regulation of practice of medicine.

D. Regulation of Practice of Medicine

Medical professionals who provide MAiD via telehealth are subject to regulations of medical practice. Those regulations can be general (such as accepted standards of medical care) and specific (such as pertaining to the regulation of MAiD and telemedicine). Such regulations are enacted primarily at the state level because it is the states that exercise the general police power of protecting the well-being of their citizens, and one of the facets of that power is the authority to regulate the medical profession via state medical boards.¹⁵⁹ There are also norms relevant to the practice of medicine enacted at the federal level. Those federal norms fall into two large groups. First, they establish important rules about how the states and medical boards may or may not exercise their police power.¹⁶⁰ These “meta-level” rules provide for

ADMIN. (Mar. 20, 2019), <https://www.dea.gov/press-releases/2019/03/20/doctor-charged-prescribing-narcotics-non-patients-and-ordered-detained> [<http://perma.cc/ZT3P-5HA6>].

158. CTRS. FOR DISEASE CONTROL AND PREVENTION, PRESCRIPTION DRUG PHYSICAL EXAMINATION REQUIREMENTS (2015), available at <https://www.cdc.gov/phlp/docs/pdpe-requirements.pdf> [<https://perma.cc/72NC-5M69>].
159. Gabriel Scheffler, *Unlocking Access to Health Care: A Federalist Approach to Reforming Occupational Licensing*, 29 HEALTH MATRIX: J. L. MED. 293, 306 (2019).
160. *See, e.g.*, *Dent v. W. Va.*, 129 U.S. 114, 123 (1889) (“Due consideration, therefore, for the protection of society may well induce the state to exclude from practice those who have not such a license, or who are found upon examination not to be fully qualified.”); *Williamson v. Lee Optical of Okla. Inc.*, 75 S.Ct. 461, 487–88 (1955) (holding that state regulations of medical practice are subject to rational basis review if their constitutionality is challenged); *See N.C. St. Bd. of Dental Examiners v. F.T.C.*, 135 S. Ct. 1101, 1117 (2015) (holding that where state government exercises no supervisory power over board of dentistry’s regulatory activity, the board is not immune from antitrust proceedings).

checks on how the states can regulate medical practice by enacting their first-order regulations.¹⁶¹ Second, federal authorities enact rules that both fall under the enumerated power of the federal government and are relevant to the practice of medicine.¹⁶² These rules can be of immense importance. For example, 42 U.S.C. § 14401, which prohibits the use of federal funds in connection with MAiD, means that federal insurance programs like Medicare and Medicaid are unavailable to cover the expenses of the patients who obtain MAiD.¹⁶³

State regulations, however, impact the practice of medicine more deeply. Those regulations, as relevant to providing MAiD telemedically, cover three areas: (1) professional licensure; (2) regulation of telemedicine; and (3) the practice of MAiD. With respect to professional licensure, in all states where MAiD is available to qualifying patients, telehealth is not considered a separate form of medical practice; it is rather deemed “a legitimate means by which an individual may receive health care services from a health care provider without in-person contact with the health care provider.”¹⁶⁴ Accordingly, a physician who wishes to provide medical treatment—including MAiD—via telemedicine does not need to obtain a special license in addition to the general license that she already has.

A common issue at the intersection of licensing and telemedicine is the availability of interstate licensure for doctors who reside in one state and wish to provide medical care telemedically to patients in other states.¹⁶⁵ This issue, as important as it is, currently does not have much traction in the

161. N. C. St. Bd. of Dental Examiners v. F.T.C., 135 S.Ct. 1101, 1108–09 (2015).

162. 42 U.S.C. § 14401 (2018) (“Federal funds may not be used to pay for items and services [including assistance] the purpose of which is to cause [or assist in causing] the suicide, euthanasia, or mercy killing of any individual.”).

163. *See id.*

164. CAL. WELF. & INST. CODE § 14594(b) (West 2013); *Accord* COLO. REV. STAT. §§ 10-16-123(2)(h)(4)(e)(I)–(II) (2018); D.C. CODE § 31-3861(4) (2013); HAW. REV. STAT. § 453-2(b) (2017); MONT. CODE § 37-3-102(14) (2019); OR. REV. STAT. § 442.015(27) (2018); VT. STAT. ANN. tit. 8 § 4100k(h)(7) (2017); WASH. REV. CODE § 70.41.020(13) (2016).

165. *See generally, Legal Impediments to the Diffusion of Telemedicine*, 14 J. HEALTH CARE L. & POL’Y 1, 9–10 (2011).

MAiD context, because now doctors are allowed to provide MAiD only to patients who reside in the state where they are licensed.¹⁶⁶ For example, if a doctor residing and licensed in Colorado wishes to provide MAiD telemedically to the residents of California, then she must first get her Californian medical license and move to that state. Otherwise, the patient would be unable to get MAiD medication from his pharmacist in California under the prescription written by the doctor from another state, and California can initiate criminal proceedings against the doctor from Colorado for unauthorized practice of medicine.¹⁶⁷ There are efforts supported by a number of states to enter into an interstate-medical-licensure compact, which would allow physicians from one state to get a medical license in another state via an expedited procedure.¹⁶⁸ Unfortunately, as of January 2019, only three states where MAiD is legal (Colorado, Montana, and Washington) have entered this arrangement,¹⁶⁹ and despite that, the compact has had seemingly no impact on the practice of MAiD. In order for these compacts to make a difference, MAiD statutes in the states that allow this practice must change in order to create uniformity. If they do not change, or if more of those states do not join the compact, then the compact will have no impact on MAiD. The normative aspects of this issue are discussed in depth in Part IV.

The second area of state regulation of medical practice—delivery of medical care via telemedicine—has been the focus of state-medical boards for a number of years.¹⁷⁰ Despite the breadth of such works, my research has not uncovered a single statement from any board of medicine on the issue of providing MAiD through telehealth. Still, some relevant information can be gleaned from the boards' approaches to the issue's close cousin –

166. See COLO. REV. STAT. § 25-48-103(1) (2018).

167. *C.f.* Stacey Swatek Huie, *Facilitating Telemedicine: Reconciling National Access with State Licensing Laws*, 18 HASTINGS COMM. AND ENT. L. J. 1 377, 398 (1995).

168. Eric Wicklund, *Telemedicine Licensure Compact is Now Live in Half the Country*, MHEALTH INTELLIGENCE (Jan. 10, 2019), <https://mhealthintelligence.com/news/telemedicine-licensure-compact-is-now-live-in-half-the-country> [<https://perma.cc/U4XA-YF5R>].

169. COLO. REV. STAT. § 24-60-3602 (2018); MONT. CODE § 37-3-356 (2015); WASH. REV. CODE 18.71B (2017).

170. Wicklund, *supra* note 169.

prescribing controlled substances via internet. In this regard, medical boards appear to have taken the general approach that in-person medical examinations remain the golden standard of interaction with the patient to form a valid doctor-patient relationship.¹⁷¹ Accordingly, telemedicine is evaluated in terms of whether such a relationship was established. Considering our hypothetical Tele-MAiD app from before, its protocol appears to satisfy that criteria. This is especially true in light of federal regulations, according to which a doctor can prescribe a patient with a Schedule II controlled substance after at least one in-person examination.

Finally, one must consider whether the statutes legalizing MAiD impose any restrictions on delivering that medical treatment through telemedicine. As mentioned earlier, the most telehealth-averse state in this respect is Vermont, where the attending physician must perform at least one “in-person” medical examination of a patient requesting MAiD, and the patient, in turn, must request MAiD during a face-to-face encounter with the attending physician.¹⁷² While other states do not impose this requirement, their statutes *do* suggest that there should be an established physician-patient relationship between the individual requesting MAiD and the attending physician, which traditionally is understood to be created by a face-to-face encounter between the patient and the doctor.¹⁷³ Only Hawaii has expressly provided that the mental health specialist counseling to establish the patient’s (in)eligibility for MAiD can be provided through telehealth.¹⁷⁴

This Part analyzed whether a medical professional who wishes to provide MAiD services via telehealth might face additional legal obstacles in that endeavor. I outlined four areas where such hurdles could emerge: (1) privacy of the patients, (2) requirements to medical devices, (3) dispensation of medication without having examined the patient “in person,” and (4) standards of medical practice. The first two areas present no

171. *See e.g.* Jerzak, *supra* note 152.

172. *See* VT. STAT. ANN. tit. 18, § 5283 (2015)).

173. *See* Kiek Tates et al., *The Effect of Screen-to-Screen Versus Face-to-Face Consultation on Doctor-Patient Communication: An Experimental Study with Simulated Patients*, 19 J. MED. INTERNET RES. (2017).

174. HAW. REV. STAT. § 327L-1 (2019).

significant additional risks for medical professionals, as long as our hypothetical app, Tele-MAiD, properly protects the patients' data and entered the market after a premarket notification to the FDA; the app's developers do not make false or misleading claims; and, both doctors and patients correctly understand the app's functions. The biggest obstacles reside in the third area, the prescription of controlled substances, where the regulations operate under the age-old assumption of "in-person" medical evaluation being the hallmark of a valid doctor-patient relationship. The same assumption also animates the attitudes of some state medical boards toward telemedicine and presents a normative objection to the digitalization of MAiD. These obstacles are not insurmountable. In the next and final part, I probe the soundness of the normative claims underlying that assumption.

IV. TELE-MAiD AND DOCTOR-PATIENT RELATIONSHIP

Up to this point, my analysis of providing MAiD via telehealth has been descriptive: I outlined the MAiD protocol, the state of clinical practice, and law to determine whether it is feasible to improve access to MAiD by offering it via the app. Having answered that question in the affirmative, I now turn to a different inquiry: whether we *should* permit physicians and patients to access MAiD via telehealth.

Initially, MAiD might seem to be an unlikely candidate for delivery through telemedicine because of the impact it has on the patient's quality of life and because of the potential difficulty of creating a valid doctor-patient relationship, accurately evaluating a patient, and meticulously adhering to the standard of care. On closer look, however, that standard of care is reflected in the MAiD protocol prescribed by state law, and following it addresses some of the concerns typically raised about telehealth (such as informed consent, confidentiality, record-keeping, and mitigation of a possible harm to the patient).¹⁷⁵

The remaining normative objection to the digitalization of MAiD appears to concern the possibility of establishing a valid doctor-patient relationship by telehealth. In regulatory realms, this objection manifests itself as the requirement that the

175. See, e.g., B.M. Dickens & R.J. Cook, *Legal and Ethical Issues in Telemedicine and Robotics*, 94 INT'L. J. GYNECOLOGY & OBSTETRICS 73, 77 (2006).

attending physician must perform an “in-person” medical examination of the patient before prescribing him with a lethal dose of medication.¹⁷⁶ But is this a sound objection?¹⁷⁷ I conclude that the objection fails to keep pace with evolving technology and suggest that the “in-person”-examination requirement should be modified.

MAiD requires an “in-person” examination of the requesting patient by his attending physician. This requirement is either spelled out in the applicable state statutes or follows from the federal law on prescription of controlled substances.¹⁷⁸ The “in-person” examination traditionally is understood, for purposes of this requirement, as an examination performed by a doctor who is in close spatial proximity to the patient’s body. By contrast, the premise of telemedicine is that certain medical interactions do not require face-to-face contact.¹⁷⁹ Furthermore, telemedicine invites us to reevaluate the traditional approach to “in-person” examination in providing MAiD.

Rethinking this traditional approach bifurcates into two lines of inquiry: whether it makes sense to demand that an “in-person” examination must involve the patient’s body being in close proximity to the doctor; and whether the traditional approach is the only means of establishing a valid doctor-patient relationship for purposes of MAiD. Answering both of these questions in the

176. VT. STAT. ANN. tit. 18, § 5283(a)(5)(A) (2013); WASH. REV. CODE § 70.245.040(1(a)) (2009).

177. Pairing MAiD and telehealth also evokes several other normative issues related to the practice of MAiD, such as the soundness of the patient’s residency requirement and the appropriateness of spelling out the standard of care for MAiD in a statute. Because these issues are not directly relevant to the topic of this section, I leave their discussion for another essay.

178. For purposes of this section, I bracket out an exception from the federal law requirement, under which a doctor can prescribe a patient with a Schedule II substance if the doctor has not examined the patient in person and the patient is being treated by another practitioner or is admitted into a hospital or a clinic.

179. See *The Ultimate Telemedicine Guide | What Is Telemedicine?*, EVISIT (May 25, 2018), <https://evisit.com/resources/what-is-telemedicine/> [<https://perma.cc/VH78-KHS3>]; See also Shivan J. Mehta, *Telemedicine’s Potential Ethical Pitfalls*, AMA J. ETHICS (Dec. 2014), <https://journalofethics.ama-assn.org/article/telemedicines-potential-ethical-pitfalls/2014-12> [<https://perma.cc/D9F2-FSKF>].

negative would mean that the traditional approach is inapplicable in telemedicine and that MAiD should be extended to telehealth.

To answer the first question, consider a series of three short hypotheticals. First, a physician prepares to treat a patient who suffers from a highly contagious disease with an unknown infection mechanism. In order to protect the doctor from the disease, she and her patient are placed in the same room but are separated by a translucent wall of very thick glass. Both are positioned in close proximity to the wall; the distance between them is about two feet. The doctor and the patient can see and hear each other (there are sound amplifiers in both parts of the room) but they cannot smell or touch each other. The doctor examines the patient by asking him to perform certain actions—opening his mouth, coughing, flexing his limbs—and to use certain medical devices located on the patient’s side of the room (such as using a smartphone with an extension that turns it into a stethoscope). In this hypothetical, has the doctor performed an “in-person” examination of the patient?

Second, imagine the same hypothetical as above, except, in this case, the doctor and the patient are separated not by a wall of glass, but by a wall with a big digital screen with the digital images of the patient and the doctor. The screen is connected to high-resolution cameras that allow them to watch each other’s actions in real time. Furthermore, the doctor can zoom in and out on the image of the patient. Has the doctor performed an “in-person” examination of the patient?

Finally, consider the second hypothetical, except the doctor is sitting in front of a screen on his laptop, and the patient is one thousand miles away from the doctor. Everything else—the real-time response, the sound and audio fidelity, the zooming capabilities—has not changed. Has the doctor performed an “in-person” examination of the patient?

If you have answered the question in the first hypothetical in the affirmative, then I submit that you logically will answer the subsequent questions affirmatively as well. While there are distinctions between those scenarios, they are without a difference for purposes of determining whether an “in-person” examination took place. In the first and second hypotheticals, the doctor and the patient are in close spatial proximity to one another and interact with each other directly; however, they cannot touch each other. The fact that in these scenarios they are separated by different kinds of walls cannot justify the purported difference in

the nature of examination. In the second and third hypothetical, the only difference is the size of the screen and the distance between the doctor and the patient. If we posit that the doctor examined the patient in person in the second encounter, then those differences also are insignificant to determine the nature of their encounter in the third hypothetical.

I argue that the affirmative answer to the first hypothetical is the correct one. This is because the physical *presence* of the patient before the doctor—which is what the “in-person” standard demands—can manifest itself in various ways. While the spatial proximity between the doctor and the patient’s body certainly is one way to establish this connection, it is not the only one. From a scientific perspective, the patient’s image, voice, and health data shared with his doctor are undeniably physical. If that is the case, then the physical presence for the purpose of the “in-person” examination can be established by means of electronic communication.¹⁸⁰

Consistency and science, however, often give way to policy considerations when law is concerned.¹⁸¹ In this respect, the “in-person” examination requirement may not be met, as a matter of policy, when the physician and the patient use electronic communication. Such situations could emerge, for example, in the instance of the patient’s disease the diagnosis of which involves touching or smelling the patient by the doctor, which, as of today, are incapable of being performed electronically.¹⁸² For MAiD

180. This is not to say, of course, that electronic communication is sufficient to establish physical presence in *every* context. For example, in a boxing match, physical presence demands spatial proximity between the competing athletes because of the purpose of the tournament. The purposes of a doctor-patient relationship—building trust and providing medical care—can be served by electronic communication. See *50-state survey: Establishment of a patient-physician relationship via telemedicine*, AM. MED. ASS’N, <https://www.ama-assn.org/system/files/2018-10/ama-chart-telemedicine-patient-physician-relationship.pdf> [<https://perma.cc/W7WP-LLK8>] (last visited Sept. 20, 2019).

181. See, e.g., *Nix v. Hedden*, 13 S.Ct. 881, 882 (1893) (“Botanically speaking, tomatoes are the fruit of a vine, just as are cucumbers, squashes, beans, and peas. But in the common language of the people, whether sellers or consumers of provisions, all these are vegetables . . .”).

182. With respect to touching, however, one could imagine Tele-MAiD first directing the patient to put his smartphone on a certain part of his body, then causing the device to vibrate in a manner

provided via telemedicine, this means that the need for an “in-person” examination, as traditionally understood, remains for the terminal diseases that cannot be accurately diagnosed without the doctor touching and/or smelling her patient (or the patient’s body excretions). In these limited situations, “the quality of the remote physical examination is clearly inferior to the quality of an in-person examination.”¹⁸³ At the same time, as new broadband internet-based technologies develop, the traditional view of “in-person” examination faces the possibility of becoming more and more obsolete. This new approach is also consistent with efforts to expand the telemedicine exception for prescription of controlled substances under federal law.¹⁸⁴

The second line of inquiry outlined earlier asks whether a telemedicine encounter between the doctor and patient is sufficient to create a valid doctor-patient relationship.¹⁸⁵ The answer to this question may differ depending on the extent to

resembling the physician applying pressure to the patient’s body. It would then register contractions of the patient’s body in response to vibration and sends that data to the patient’s physician. *Ultrasonics—Medical Applications*, ENCYC. BRIT., <https://www.britannica.com/science/ultrasonics/Medical-applications> [<https://perma.cc/6M89-Y7YW>] (last visited Feb. 19, 2020).

183. Dorsey & Topol, *supra* note 13, at 156.

184. Nathaniel M. Lacketman & Thomas B. Ferrante, *Congress Proposes Change to Ryan Haight Act to Allow Telemedicine Prescribing of Controlled Substances*, HEALTH CARE L. TODAY (Mar. 5, 2018), <https://www.healthcarelawtoday.com/2018/03/05/congress-proposes-change-to-ryan-haight-act-to-allow-telemedicine-prescribing-of-controlled-substances> [<https://perma.cc/PH5R-LN9A>] (discussing initiatives in Congress to expand the telemedicine exceptions from controlled substances law and noting that the “exceptions are very narrow, highly technical, and simply outdated. The practice of telemedicine has evolved . . . , and the regulations fail to account for how legitimate telemedicine services are delivered today. For that reason, the exceptions do not easily align with direct-to-patient service models frequently sought by patients in areas such as telepsychiatry or substance use disorder treatment.”).

185. Of note, traditional in-person interactions between doctors and patients can often result in shallow and profit-driven relationships, too. Dorsey & Topol, *supra* note 13, at 156 (discussing how telemedicine can “create shallow patient-physician relationships that are based on transactions and undermine efforts to integrate care.”).

which the physician became involved with the health of her patient.¹⁸⁶ In the case of our hypothetical app, Tele-Maid, the physician actively follows the patient and communicates with him about his disease, maintains the patient's electronic medical record and shares it with her colleagues, diagnoses the patient with a terminal illness and discusses the alternatives to MAiD at length. The rigorous patient-evaluation process embedded in MAiD treatment ensures that a meaningful doctor-patient relationship exists and prevents the practice from devolving into a "drive-through" variety of medicine, which is characteristic of opioid "pill mills."¹⁸⁷ Furthermore, the depth and the scope of that interaction and communication might be higher than in a typical twenty-minute face-to-face encounter with a physician in a clinic. Therefore, it should be deemed sufficient to establish a valid, lasting doctor-patient relationship, with all rights and duties of provider and her patient that follow from it.¹⁸⁸ While the state boards of medicine, as described earlier, are understandably cautious about unscrupulous providers who fail to establish a meaningful doctor-patient relationship with their clients, this relationship is present when MAiD is provided telemedically.

CONCLUSION

Telemedicine has the potential to improve access to many medical treatments, including MAiD. I argue that a hypothetical app—called Tele-MAiD here—could make MAiD more accessible to qualifying patients and cost less to the health care system than current options. At the same time, it is critical to ensure that the quality of MAiD as a medical treatment is the same regardless of

186. See, e.g., John D. Blum, *Internet Medicine and the Evolving Legal Status of the Physician-Patient Relationship*, 24 J. LEGAL MED. 413, 414 (2003) (discussing various online activities of doctors and patients and whether those activities can establish the doctor-patient relationship).

187. Khary K. Rigg et al., *Prescription Drug Abuse & Diversion: Role of the Pain Clinic*, 40 J. DRUG ISSUES 681, 686–88 (2010).

188. Blum, *supra* note 187, at 437 ("While the physician-patient relationship is one that traditionally emerges from a face-to-face encounter, the courts do not require physical presence as a prerequisite for a legal relationship to be established between physician and patient").

whether it is provided telemedically or in the traditional way. In analyzing the clinical and legal aspects of providing MAiD via telemedicine and exploring some normative questions that that analysis evoked, I conclude that MAiD can be provided telemedically to patients with readily and accurately diagnosable-terminal illnesses. The largest legal obstacle to such implementation is the requirement that the attending physician conduct an “in-person” examination of the patient; this is so because telemedicine challenges the traditional understanding of an “in-person” examination. I suggest that that concept should be expanded to encompass examinations conducted in real time through modern means of electronic communication, such as Tele-MAiD. Such communication establishes a valid doctor-patient relationship between the patient seeking MAiD and his attending physician. Ultimately, these conclusions compel the finding that MAiD by telehealth is not only feasible, but also beneficial.

