

January 2017

A Deliberate Departure: Making Physician-Assisted Suicide Comfortable for Vulnerable Patients

Browne Lewis
Cleveland-Marshall College

Follow this and additional works at: <https://scholarworks.uark.edu/alr>



Part of the [Health Law and Policy Commons](#), and the [Medical Jurisprudence Commons](#)

Recommended Citation

Browne Lewis, *A Deliberate Departure: Making Physician-Assisted Suicide Comfortable for Vulnerable Patients*, 70 Ark. L. Rev. 1 (2017).

Available at: <https://scholarworks.uark.edu/alr/vol70/iss1/1>

This Article is brought to you for free and open access by ScholarWorks@UARK. It has been accepted for inclusion in Arkansas Law Review by an authorized editor of ScholarWorks@UARK. For more information, please contact scholar@uark.edu.

A Deliberate Departure: Making Physician-Assisted Suicide Comfortable for Vulnerable Patients

Browne Lewis

I. INTRODUCTION

On an episode of Marvel's *Jessica Jones*, Kilgrave uses his mind control powers to get Jack Denton to give him both of his kidneys.¹ After he loses his kidneys, Denton goes on dialysis and has a stroke.² Therefore, when private investigator Jessica Jones tracks down Denton, she discovers that he is wheelchair-bound and unable to speak.³ Denton goes to great lengths to write a note asking Jones to kill him.⁴ This fictionalized story may be the reality for some people. Everyone wants to live a happy life and to have a good death. Some people have the privilege of dying suddenly or of passing away peacefully while they are asleep. Unfortunately, for many people the process of dying can be a painful ordeal.⁵ Due to advances in medicine, even people who are terminally-ill can now remain on earth

· Leon M. & Gloria Plevin Professor of Law, Cleveland-Marshall College of Law; B.A., Grambling State University; M.P.P., Humphrey Institute; J.D., University of Minnesota School of Law; L.L.M., University of Houston Law Center. I would like to thank Dean Lee Fisher and the Cleveland-Marshall Fund for providing financial support for this article. I would like to thank my assistant Diane Adams and my research assistants Nicole Rode and Monica Garcia for their hard work on this project. Finally, I would like to thank the United States-United Kingdom's Fulbright Scholar Program for giving me the opportunity to spend a semester at King's College in London, so that I could finish my research.

1. *Jessica Jones: AKA Crush Syndrome*, at 40:46-41:23 (Netflix 2015).

2. *Id.* at 29:40.

3. *Id.* at 29:53-30:00.

4. *Id.* at 31:57.

5. See HOSPICE FOUND. OF AM., A CAREGIVER'S GUIDE TO THE DYING PROCESS 11-18 (2011), https://hospicefoundation.org/hfa/media/Files/Hospice_TheDyingProcess_Docutech-READERSPREADS.pdf [<https://perma.cc/JB6B-ZD9T>].

longer.⁶ For some, longevity can be a blessing, for others it can be a curse.⁷ The majority of terminally-ill patients who choose physician-assisted suicide do so because their illnesses (1) prevent them from engaging in activities that they enjoy, (2) cause them to lose their independence, and (3) take away their dignity.⁸ Those patients are comforted by knowing that they control the time and place of their deaths.⁹ Presently, the gift of a deliberate departure is only available to residents of five American states.¹⁰ Five of those states are predominantly white and upper-middle class.¹¹ Consequently, patients who may be vulnerable because of age, disability, race or socio-economic status may be left at the mercy of a heartless grim reaper.¹² Patients in those populations are denied the opportunity to receive assistance to end their pain and suffering because most of them live in states where physician-assisted suicide is illegal and they do not have the financial resources to relocate to a state

6. Elizabeth Andreoli, *Consent to Medical Treatment: The Right to Have Peace of Mind*, 35 ARK. LAW. 24, 24 (2000).

7. *Increased Life Expectancy, a Curse or a Blessing*, LET'S SHARE OUR KNOWLEDGE (Oct. 5, 2013), <https://pennyd1708.wordpress.com/2013/10/05/increased-life-expectancy-a-curse-or-a-blessing/> [<https://perma.cc/DQR8-43Y5>].

8. OR. PUB. HEALTH DIV., OR. HEALTH AUTH., OREGON DEATH WITH DIGNITY ACT: 2015 DATA SUMMARY 4 (2016), <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf> [<https://perma.cc/7HPG-SYBX>].

9. Katherine A. Chamberlain, *Looking for a "Good Death": The Elderly Terminally Ill's Right to Die by Physician-Assisted Suicide*, 17 ELDER L.J. 61, 75 (2009); Ruth C. Stern & J. Herbie Difonzo, *Stopping for Death: Re-Framing Our Perspective on the End of Life*, 20 U. FLA. J.L. & PUB. POL'Y 387, 400 (2009).

10. See CAL. HEALTH & SAFETY CODE § 443.2 (West 2016); MONT. CODE ANN. § 50-9-101 (West 2015); OR. REV. STAT. ANN. § 127.800 (West 2016); VT. STAT. ANN. tit. 18, § 5281 (West 2013); WASH. REV. CODE ANN. § 70.245.901 (West 2009).

11. See *Quick Facts: Vermont*, U.S. CENSUS BUREAU (2015), <https://www.census.gov/quickfacts/table/RHI125215/50,53,41,30,00> [<https://perma.cc/E2GD-TF54>] (showing that Montana, Oregon, Washington, and Vermont have populations that are over eighty percent white and median household incomes of at least \$47,000); see also *Map: Median Household Income in the United States*, U.S. CENSUS BUREAU (2015), https://www.census.gov/library/visualizations/2016/comm/cb16-158_median_hh_income_map.html [<https://perma.cc/QQ2D-52CE>] (showing that California and Washington have median household incomes above that of the national average of \$55,775, and Vermont is at the median household income).

12. *Rural Health Disparities*, RURAL HEALTH INFO. HUB (Oct. 31, 2014), <https://www.ruralhealthinfo.org/topics/rural-health-disparities> [<https://perma.cc/7AKP-ZQW9>].

where the procedure has been legalized.¹³ Persons opposed to the legalization of physician-assisted suicide have argued that the availability of the practice puts vulnerable patients at risk.¹⁴ Those persons raise some valid concerns. Nonetheless, the answer is not to deprive terminally-ill, vulnerable patients the freedoms given to other terminally-ill patients. In fact, these vulnerable patients probably need physician-assisted suicide more than their more advantaged counterparts. For example, because of inequities in the health care system, low-income patients and patients of color are forced to endure poor pain management.¹⁵ In addition, patients in those populations are more likely to be diagnosed at later stages of the disease.¹⁶ Thus, they are more likely to be classified as terminal.¹⁷ Safeguards should be put in place to protect vulnerable patients who want the opportunity to die with dignity.

This Article is divided into four parts. Part I discusses the history and the evolution of the “right to die movement” in the United States. The current legal landscape in the United States is examined in Part II. In Part III, I analyze some of the relevant ethical concerns caused by the availability of physician-assisted suicide. My analysis primarily focuses on the Oregon statute¹⁸ because it is the oldest physician-assisted suicide law in the United States and it has served as a model for laws in the United States and abroad.¹⁹ For example, Lord Falconer’s Bill, which

13. Ryan T. Anderson, *Always Care, Never Kill: How Physician-Assisted Suicide Endangers the Weak, Corrupts Medicine, Compromises the Family, and Violates Human Dignity and Equality*, HERITAGE FOUND. (Mar. 24, 2015), <http://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak> [https://perma.cc/9FJF-VF8J].

14. Margaret K. Dore, “Death with Dignity”: A Recipe for Elder Abuse and Homicide (*Albeit Not by Name*), 11 MARQ. ELDER’S ADVISOR 387, 397-400 (2010).

15. René Bowser, *Racial Bias in Medical Treatment*, 105 DICK. L. REV. 365, 368 (2001).

16. Eric L. Krakauer, Christopher Crenner & Ken Fox, *Barriers to Optimum End-of-Life Care for Minority Patients*, 50 J. AM. GERIATRICS SOC’Y 182, 182 (2002).

17. See Maia Davis, *Minorities Undertreated for Pain, Illness*, BALT. SUN (May 26, 2002), http://articles.baltimoresun.com/2002-05-26/news/0205260003_1_palliative-care-pain-medication-health-care [https://perma.cc/6FYK-CJUG].

18. OR. REV. STAT. ANN. §§ 127.800-.897 (West 2016).

19. See *Doctor-Assisted Dying: Final Certainty*, ECONOMIST (June 27, 2015), <http://www.economist.com/news/briefing/21656122-campaigns-let-doctors-help-suffering-and-terminally-ill-die-are-gathering-momentum> [https://perma.cc/DJQ6-GMUR].

was defeated by the British Parliament, was modelled after Oregon's Death with Dignity Act.²⁰ Most of the misgivings about the legalization of physician-assisted suicide stem from the belief that persons who may be vulnerable because of their race, ethnicity, age, disability and economic status will be adversely impacted.²¹ Relying on the "vulnerable patient" argument, opponents were able to prevent the passage of the British law.²² In addition, this sentiment was expressed by members of the New York Task Force on Life and the Law when they issued a report in 1994 unanimously recommending that New York laws prohibiting assisted suicide and euthanasia not be modified.²³ The history of the "right to die" movement in the United States is a long and varied one.²⁴

20. See Lewis M. Cohen, *Unified Debate*, SLATE (Aug. 11, 2014, 11:49 PM), http://www.slate.com/articles/health_and_science/medical_examiner/2014/08/assisted_suicide_debate_in_united_kingdom_house_of_lords_on_death_with_dignity.html [https://perma.cc/X4ZK-QXDM]. In September of 2015, 118 MPs voted in favor of the bill and 330 MPs voted against it. See James Gallagher & Philippa Roxby, *Assisted Dying Bill: MPs Reject 'Right to Die' Law*, BBC (Sept. 11, 2015), <http://www.bbc.com/news/health-34208624> [https://perma.cc/N6N2-D7Z2].

21. See, e.g., Rowena Mason, *Assisted Dying Bill Overwhelmingly Rejected by MPs*, GUARDIAN (Sept. 12, 2015), <https://www.theguardian.com/society/2015/sep/11/mps-begin-debate-assisted-dying-bill> [https://perma.cc/E3TD-W2C9].

22. See Gallagher & Roxby, *supra* note 20.

23. N.Y. STATE TASK FORCE ON LIFE & THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 1 (1995), <http://rci.rutgers.edu/~tripmcc/phil/taskforceonlifeandthelaw-whendeathissought-executivesummary.pdf> [https://perma.cc/Y7NW-EPKJ]. The Task Force concluded:

The risks would extend to all individuals who are ill. They would be most severe for those whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, or membership in a stigmatized social group. The risks of legalizing assisted suicide and euthanasia for these individuals, in a health care system and society that cannot effectively protect against the impact of inadequate resources and ingrained social disadvantage, are likely to be extraordinary.

Id.

24. See, e.g., Sarah Childress, *The Evolution of America's Right-to-Die Movement*, PBS (Nov. 13, 2012), <http://www.pbs.org/wgbh/frontline/article/the-evolution-of-americas-right-to-die-movement/> [https://perma.cc/VCM7-CMGM].

II. THE HISTORY AND EVOLUTION OF THE RIGHT TO DIE MOVEMENT

The physician-assisted suicide battle has been and continues to be fought in the legal court and in the court of public opinion. After the United States Supreme Court held that a person does not have a fundamental right to determine the time and manner of his or her death,²⁵ the proponents of physician-assisted suicide used the media to take the fight to the people.²⁶ Persons on both sides of the debate have spent a lot of time and resources lobbying law makers.²⁷ They have also expended a great deal of money waging media campaigns to garner public support for their respective positions.²⁸ Both sides have used terminology in an attempt to control the manner in which the public perceives the process that permits a licensed physician to write a prescription for a lethal dose of medication so a terminally-ill patient can end his or her life.²⁹

Opponents of the procedure often refer to it as physician-assisted suicide with emphasis on the word “suicide.”³⁰ They hope to conjure up the image of physicians helping patients to

25. See generally *Washington v. Glucksberg*, 521 U.S. 702 (1997) (holding that Washington State’s ban on physician-assisted suicide does not violate the Fourteenth Amendment, as there is no fundamental right to die).

26. See, e.g., Valerie Richardson, *Assisted Suicide Movement Gaining Traction Across the U.S.*, WASH. TIMES (Jan. 21, 2015), <http://www.washingtontimes.com/news/2015/jan/21/assisted-suicide-movement-gaining-traction-in-acro/> [https://perma.cc/W2D7-N3X3].

27. See Ovetta Wiggins, *Agonizing over the Right to Die*, WASH. POST (Feb. 20, 2016), https://www.washingtonpost.com/local/md-politics/agonizing-over-the-right-to-die/2016/02/20/a5dfaf5c-d5a7-11e5-be55-2cc3c1e4b76b_story.html?utm_term=.d9476e19aa65 [https://perma.cc/DKV5-UM6X].

28. See Deepashri Varadharajan, *Brittany Maynard’s Death with Dignity Campaign Puts US Laws Back in Focus*, ALJAZEERA AM. (Oct. 12, 2014, 2:00 PM), <http://america.aljazeera.com/articles/2014/10/12/brittany-maynardsdeathwithdignitycampaignputsuslawsbackinfocus.html> [https://perma.cc/VF7K-UMRN].

29. Eliyahu Federman, *Physician-Assisted Suicide Debate: Are We Using the Right Language?*, FORBES (Oct. 27, 2014, 3:43 PM), <https://www.forbes.com/sites/realspin/2014/10/27/physician-assisted-suicide-debate-are-we-using-the-right-language/#2faa536170e5> [https://perma.cc/R53Y-4Q4W]. . .

30. See Ryan T. Anderson, *Hurting the Seriously Ill Rather than Helping*, WASH. TIMES (Oct. 19, 2016), <http://www.washingtontimes.com/news/2016/oct/19/physician-assisted-suicide-hurts-the-seriously-ill/> [https://perma.cc/5RYZ-UBXZ].

commit suicide.³¹ The word “suicide” has a negative connotation for many people.³² Historically, committing suicide was a criminal offense.³³ The punishment was the denial of a proper burial for the deceased and the inability of the decedent’s family to inherit his or her property.³⁴ Currently, persons who commit suicide may be denied the right to be buried in consecrated ground.³⁵ The majority of states no longer classify suicide or attempted suicide as a crime,³⁶ however, some American jurisdictions³⁷ and some countries impose criminal liability on a person who aids or abets a suicide.³⁸ Suicide clauses are included in some life insurance policies.³⁹

31. *See id.*

32. Lydia Saad, *U.S. Support for Euthanasia Hinges on How It’s Described*, GALLUP (May 29, 2013), <http://www.gallup.com/poll/162815/support-euthanasia-hinges-described.aspx> [<https://perma.cc/DJ6C-4T3P>].

33. H. Tristram Engelhardt, Jr. & Michele Malloy, *Suicide and Assisting Suicide: A Critique of Legal Sanctions*, 36 SW. L.J. 1003, 1018 (1982).

34. Rebecca C. Morgan et al., *The Issue of Personal Choice: The Competent Incurable Patient and the Right to Commit Suicide*, 57 MO. L. REV. 1, 7-8 (1992) (“In England, it was common for a suicide’s body to be buried in the road, generally at the crossroads, with either a stake through the body or a stone placed over the face.”).

35. *See, e.g., Guide to Jewish Funeral Practice*, UNITED SYNAGOGUE CONSERVATIVE JUDAISM, <http://www.uscj.org/JewishLivingandLearning/Lifecycle/JewishFuneralPractice/GuidetoJewishFuneralPractice.aspx> [<https://perma.cc/AM8S-86LU>].

36. Engelhardt & Malloy, *supra* note 33, at 1018-19.

37. CAL. PENAL CODE § 401 (West 2016) (“Every person who deliberately aids, or advises, or encourages another to commit suicide, is guilty of a felony.”); MICH. COMP. LAWS ANN. § 750.329a (West 2016) (“A person who knows that an individual intends to kill himself or herself and does any of the following with the intent to assist the individual in killing himself or herself is guilty of criminal assistance to the killing of an individual, a felony punishable by imprisonment for not more than 5 years or a fine of not more than \$10,000.00, or both: (a) Provides the means by which the individual attempts to kill himself or herself or kills himself or herself. (b) Participates in an act by which the individual attempts to kill himself or herself or kills himself or herself.”); S.D. CODIFIED LAWS § 22-16-37 (2016) (“Any person who intentionally in any manner advises, encourages, abets, or assists another person in taking or in attempting to take his or her own life is guilty of a Class 6 felony.”).

38. Sonya Donnelly & Sophia Purcell, *The Evolution of the Law of Assisted Suicide in the United Kingdom and the Possible Implications for Ireland*, 15 MEDICO-LEGAL J. IR. 82, 82-83 (2009). The Suicide Act of 1961 made it a crime to encourage or assist a suicide or suicide attempt in England and Wales. *Id.* at 82. Northern Ireland has a similar law. *Id.* The Criminal Law (Suicide) Act of 1993 “was enacted to decriminalize suicide.” *Id.* The law expressly bans the practice of physician-assisted suicide. *Id.* at 83.

39. Kelly S. Noble, *Accidental Death or Was It?: The Question of Suicide in Life Insurance and Accidental Death Insurance*, 39 THE BRIEF 50, 50-53 (2010). The Oregon statute specifically states that choosing physician-assisted suicide does not impact a

Proponents of the practice argue that it should be called physician-aided dying.⁴⁰ Their objective is to get the public to see the physician as a comforter who is helping the patient to die with dignity.⁴¹ They contend that suicide is not involved because the patient is already dying; the physician's action merely hastens the dying process so the patient can avoid unnecessary suffering.⁴² In this Article, I use physician-assisted suicide because it is the term that has typically been used to refer to the practice.

The main opponents of the legalization of physician-assisted suicide are religious organizations like the Roman Catholic Church and physician groups like the American Medical Association (AMA).⁴³ The Disability Rights Education & Defense Fund and other advocates for persons with disabilities also oppose the legalization of physician-assisted suicide.⁴⁴ According to Catholic Doctrine, suicide is a mortal sin, so the Church strongly opposes any attempt to legalize the practice.⁴⁵ In fact, Pope Francis denounced the "right to die" movement, stating that it is a "false sense of compassion" to deem euthanasia as an act of dignity because it is a sin against God and creation.⁴⁶ The Church of England actively opposed the assisted suicide bill introduced in Parliament.⁴⁷ Prior to the

person's ability to get insurance or to receive insurance benefits. OR. REV. STAT. ANN. § 127.875 (West 2016).

40. Kathryn L. Tucker, *When Dying Takes Too Long: Activism for Social Change to Protect and Expand Choice at the End of Life*, 33 WHITTIER L. REV. 109, 156 (2011).

41. *Id.* at 149-51, 157.

42. *Id.* at 155.

43. K.K. DuVivier, *Fast-Food Government and Physician-Assisted Death: The Role of Direct Democracy in Federalism*, 86 OR. L. REV. 895, 927-28, 934-35 (2007).

44. Anna Gorman, *Disability Advocates Fight Assisted Suicide Measures*, KAISER HEALTH NEWS (June 29, 2015), <http://khn.org/news/disability-advocates-fight-assisted-suicide-measures/> [<https://perma.cc/4GGK-ZP7L>].

45. Richard E. Coleson, *Contemporary Religious Viewpoints*, 35 DUQ. L. REV. 43, 45-48 (1996).

46. *Pope Says Assisted Suicide Is a "Sin Against God"*, CBS NEWS (Nov. 14, 2014, 11:33 AM), <http://www.cbsnews.com/news/pope-says-assisted-suicide-is-a-sin-against-god/> [<https://perma.cc/F9HL-AQPK>].

47. *Assisted Suicide*, CHURCH ENG., <https://www.churchofengland.org/our-views/medical-ethics-health-social-care-policy/assisted-suicide.aspx> [<https://perma.cc/F7M2-J8YD>] (declaring that the Church of England cannot support the Assisted Dying Bill).

vote on the bill, the Church updated its website to state the following: “The value of individuals’ lives, protection of the vulnerable and respect for the integrity of the doctor-patient relationship are central to the Church of England’s concerns about any proposal to change the law.”⁴⁸ The AMA issued an opinion stating its opposition to physician-assisted suicide.⁴⁹ The AMA explained its position by stating, “Physician-assisted suicide is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks.”⁵⁰

The two non-profit organizations going around the country advocating for the legalization of physician-assisted suicide are Compassion and Choices and the Death with Dignity National Center.⁵¹ According to its website, Compassion and Choices “helps people plan for and achieve a good death.”⁵² The Death with Dignity National Center claims that its mission is “to promote Death with Dignity laws based on the model Oregon Death with Dignity Act, both to provide an option for dying individuals and to stimulate nationwide improvements in end-of-life care.”⁵³

Even in the states where physician-assisted suicide is permitted, the availability of the procedure is limited.⁵⁴ American legislatures are often influenced by public opinion when making laws that impact personal decision-making. For instance, the victory that gays and lesbians won to have same-

48. *Id.*

49. *The American Medical Association Code of Medical Ethics’ Opinions on Physician Participation on Abortion, Assisted Reproduction, and Physician-Assisted Suicide*, 15 *AMA J. ETHICS* 206, 206-07 (2013).

50. *Id.*

51. Tom Strode, *D.C. Gives Initial OK to Assisted Suicide*, *BAPTIST PRESS* (Nov. 2, 2016), <http://www.bpnews.net/47822/dc-gives-initial-ok-to-assisted-suicide> [<https://perma.cc/J9VL-DELE>].

52. *National Program Updates: Better Care. Greater Choice.*, *COMPASSION & CHOICES MAG.*, at 15 (2013), https://www.compassionandchoices.org/wp-content/uploads/2016/07/Fall_2013_Dean_Edell.pdf [<https://perma.cc/3U5R-PHGA>].

53. *About Us*, *DEATH WITH DIGNITY*, <https://www.deathwithdignity.org/about/> [<https://perma.cc/VA2A-WV45>].

54. Steven Reinberg, *Doctor-Assisted Deaths Didn’t Soar After Legalization*, *U.S. NEWS* (July 5, 2016, 4:00 PM), <http://health.usnews.com/health-care/articles/2016-07-05/doctor-assisted-deaths-didnt-soar-after-legalization> [<https://perma.cc/8C56-UG2F>].

sex marriages legally recognized in all fifty states⁵⁵ might not have occurred had the American people not changed their stance on the issue.⁵⁶ Likewise, the reluctance on the part of the courts and legislatures to conclude that persons have a fundamental right to assisted suicide⁵⁷ may stem from the fact that assisted suicide has not been widely embraced by the American people.⁵⁸ However, the tide may be turning.⁵⁹ The Catholic Church, a key opponent of physician-assisted suicide, appears to be losing its ability to influence the way personal issues like abortion and same-sex marriages are viewed.⁶⁰ When the public sees these issues as personal choices instead of moral concerns, opinions are more likely to shift towards respecting the rights of people to make their own decisions with regard to these matters.⁶¹

In 2004, the Hemlock Society, one of the main proponents of physician-assisted suicide, merged with an organization

55. See *Obergefell v. Hodges*, 135 S. Ct. 2584 (2015) (declaring that same-sex marriage is a fundamental right and requiring states to recognize validly performed out-of-state same-sex marriages).

56. *Changing Attitudes on Gay Marriage*, PEW RES. CTR. (May 12, 2016), <http://www.pewforum.org/2016/05/12/changing-attitudes-on-gay-marriage/> [<https://perma.cc/83QT-LX5G>].

57. *Washington v. Glucksberg*, 521 U.S. 702, 705-06 (1997); Yale Kamisar, *Forward: Can Glucksberg Survive Lawrence? Another Look at the End of Life and Personal Autonomy*, 106 MICH. L. REV. 1453, 1453-55 (2008) (highlighting cases where courts declined to find a right to physician-assisted suicide).

58. Andrew Walther, *Poll Shows Americans Oppose Assisted Suicide as Bills Legalizing Assisted Suicide Fail*, LIFENEWS (Apr. 17, 2015, 11:07 AM), <http://www.lifenews.com/2015/04/17/poll-shows-americans-oppose-assisted-suicide-as-bills-legalizing-assisted-suicide-fail/> [<https://perma.cc/TT35-6S6C>]. Nevertheless, a different poll showed that public support for physician-assisted suicide has increased. Andrew Dugan, *In U.S., Support Up for Doctor-Assisted Suicide*, GALLUP (May 27, 2015), <http://www.gallup.com/poll/183425/support-doctor-assisted-suicide.aspx> [<https://perma.cc/UU6B-653W>].

59. Frank Newport, *Americans Continue to Shift Left on Key Moral Issues*, GALLUP (May 26, 2015), <http://www.gallup.com/poll/183413/americans-continue-shift-left-key-moral-issues.aspx> [<https://perma.cc/3M32-CAR7>]. According to a Gallup poll, in 2001, forty-nine percent of Americans found assisted suicide to be morally acceptable. *Id.* That percentage increased to fifty-six percent in 2015. *Id.*

60. *Insight into the Conscience of the Complex Catholic: Liberals, Moderates and Conservative Catholics All See Pope Francis as Aligned with Their Politics, Majority See Catholic Church as Out of Touch and Far to the Right*, SHRIVER MEDIA, <http://www.shrivermedia.com/snapshot/> [<https://perma.cc/RPR9-XJKY>].

61. DENNIS P. HOLLINGER, *CHOOSING THE GOOD: CHRISTIAN ETHICS IN A COMPLEX WORLD* 117 (2005).

called Compassion in Dying.⁶² After the merger, the name of the organization was changed to Compassion and Choices.⁶³ The original members of that non-profit organization emphasized the right to die.⁶⁴ In fact, Derek Humphry, a British journalist and founder of the Hemlock Society, wrote a book detailing how he helped his first wife, who was suffering from bone cancer, to end her life.⁶⁵ The current members have attempted to change the tone of the conversation by stressing that their mission is for patients to have the choice to decide how and when they die.⁶⁶

In addition, media coverage of the topic may have impacted the manner in which members of the public feel about the “right to die” movement. In the beginning, the face of the movement was Dr. Jacob “Jack” Kevorkian, a self-proclaimed euthanasia activist who invented a “suicide machine.”⁶⁷ After several arrests for assisting in suicides, Kevorkian was convicted of second degree murder for administering a lethal dose of drugs to a patient suffering from Lou Gehrig’s disease.⁶⁸ During Kevorkian’s trial, the media reported that he had been nicknamed “Doctor Death” and speculated that he was a little too aggressive when it came to assisting in suicides.⁶⁹ Consequently, persons who opposed physician-assisted suicide

62. GUENTER LEVY, ASSISTED DEATH IN EUROPE AND AMERICA: FOUR REGIMES AND THEIR LESSONS 5 (2011).

63. *Id.*

64. See DEREK HUMPHRY, FINAL EXIT: THE PRACTICALITIES OF SELF-DELIVERANCE AND ASSISTED SUICIDE FOR THE DYING 52 (3d ed. 2010).

65. *Id.*; DEREK HUMPHRY, JEAN’S WAY: A LOVE STORY 1-2, 50 (1978); Lawrence K. Altman, *How-To Book on Suicide Is Atop Best-Seller List*, N.Y. TIMES, Aug. 9, 1991, at A10.

66. *Our Mission*, COMPASSION & CHOICES, <https://www.compassionandchoices.org/who-we-are/> [<https://perma.cc/P838-GWDL>].

67. Annette E. Clark, *Autonomy and Death*, 71 TUL. L. REV. 45, 93-94 (1996).

68. William H. Colby, *Society’s Challenge: Finding a Better Way to Die*, 82 WIS. LAW. (2009), <http://www.wisbar.org/newspublications/wisconsinlawyer/pages/article.aspx?Volume=82&Issue=4&ArticleID=1828> [<https://perma.cc/BRY7-4UGK>]; Lora L. Manzione, *Is There a Right to Die?: A Comparative Study of Three Societies (Australia, Netherlands, United States)*, 30 GA. J. INT’L & COMP. L. 443, 463 n.104 (2002).

69. See Pam Belluck, *He Faces 10-25 Years in Dying Man’s Death: Kevorkian Found Guilty of Murdering a Dying Man*, N.Y. TIMES, Mar. 27, 1999, at A1; Manzione, *supra* note 68, at 463.

were able to convince members of the public that the legalization of the procedure would lead to doctors coercing patients, especially the elderly and disabled, to end their lives.⁷⁰ Kevorkian died on June 3, 2011, so any damage his actions may have done to the “right to die” movement has faded.⁷¹

Persons advocating for the legalization of physician-assisted suicide now have a new “poster person” in the form of Brittany Maynard.⁷² When she was newly married, twenty-nine year old Maynard was diagnosed with aggressive cancer.⁷³ After a few unsuccessful treatments, Maynard’s doctors told her that her brain tumor was inoperable and that she had only six months to live.⁷⁴ Maynard and her family decided that physician-assisted suicide was the best option for her.⁷⁵ Since Maynard lived in California, a state that had not legalized physician-assisted suicide, she and her family relocated to Oregon where she could legally end her life.⁷⁶ Maynard received support from Compassion and Choices.⁷⁷ Prior to her death, Maynard gave numerous interviews arguing that every terminally ill patient should have the right to choose when and how they die.⁷⁸ Maynard’s experience was instrumental in getting California to legalize physician-assisted suicide and in

70. See WESLEY J. SMITH, *FORCED EXIT: EUTHANASIA, ASSISTED SUICIDE, AND THE NEW DUTY TO DIE* xix-xxiii (Encounter Books 2006) (1997).

71. Jack Kevorkian, *Convicted in Assisted Suicides, Dies at 83*, NBC NEWS (June 3, 2011, 4:42 PM), http://www.nbcnews.com/id/43265235/ns/us_news-life/t/jack-kevorkian-convicted-assisted-suicides-dies/#.WLPVO_nytPY [<https://perma.cc/WK4F-SC6K>].

72. See David Bryant, *The Need for Legalization and Regulation of Aid-in-Dying and End-of-Life Procedures in the United States*, 18 QUINNIPAC HEALTH L. 287, 288 (2015).

73. Brittany Maynard, *My Right to Death with Dignity at 29*, CNN (Nov. 2, 2014, 10:44 PM), <http://www.cnn.com/2014/10/07/opinion/maynard-assisted-suicide-cancer-dignity/> [<https://perma.cc/VX6S-TDSZ>].

74. *Id.*

75. *Id.*

76. *Id.*

77. BRITTANY MAYNARD FUND: AN INITIATIVE OF COMPASSION & CHOICES, <http://thebrittanyfund.org/> [<https://perma.cc/LPE5-2FQD>].

78. See Maynard, *supra* note 73; see also Lindsey Bever, *How Brittany Maynard May Change the Right-to-Die Debate*, WASH. POST (Nov. 3, 2014), https://www.washingtonpost.com/news/morning-mix/wp/2014/11/03/how-brittany-maynard-may-change-the-right-to-die-debate-after-death/?utm_term=.c83af2b328c0 [<https://perma.cc/3PM3-2RGS>].

placing the “right to die” issue on legislative agendas throughout the United States.⁷⁹

III. THE LEGAL LANDSCAPE

The majority of states in the United States have not taken steps to legalize physician-assisted suicide.⁸⁰ The process is probably illegal in those jurisdictions because of the existence of blanket manslaughter statutes.⁸¹ Five states have explicitly criminalized the process by statute.⁸² Terminally ill patients in

79. Rachel Aviv, *The Death Treatment: When Should People with a Non-Terminal Illness Be Helped to Die?*, NEW YORKER (June 22, 2015), <http://www.newyorker.com/magazine/2015/06/22/the-death-treatment> [<https://perma.cc/Q5GA-6LQK>]; Sharon Bernstein, *California Assembly Passes Right-to-Die Bill Inspired by Brittany Maynard*, HUFFINGTON POST (Sept. 9, 2015, 8:43 PM), http://www.huffingtonpost.com/entry/right-to-die-brittany-maynard_us_55f0cfe2e4b093be51bda5aa [<https://perma.cc/L4L2-ZHJ2>].

80. Bryant, *supra* note 72, at 295; *In re Extradition of Exoo*, 522 F. Supp. 2d 766, 779-80 (S.D. W.Va. 2007).

81. See *State-by-State Guide to Physician-Assisted Suicide*, PROCON, <http://euthanasia.procon.org/view.resource.php?resourceID=000132> [<https://perma.cc/B3UZ-SX8U>].

82. ARK. CODE ANN. § 5-10-106(b) (2016) (“(b) It is unlawful for any physician or health care provider to commit the offense of physician-assisted suicide by: (1) Prescribing any drug, compound, or substance to a patient with the express purpose of assisting the patient to intentionally end the patient’s life; or (2) Assisting in any medical procedure for the express purpose of assisting a patient to intentionally end the patient’s life.”); GA. CODE ANN. § 16-5-5(b) (West 2016) (“(b) Any person with actual knowledge that a person intends to commit suicide who knowingly and willfully assists such person in the commission of such person’s suicide shall be guilty of a felony and, upon conviction thereof, shall be punished by imprisonment for not less than one nor more than ten years.”); IDAHO CODE ANN. § 18-4017(1) (West 2016) (“(1) A person is guilty of a felony if such person, with the purpose of assisting another person to commit or to attempt to commit suicide, knowingly and intentionally either: (a) Provides the physical means by which another person commits or attempts to commit suicide; or (b) Participates in a physical act by which another person commits or attempts to commit suicide.”); N.D. CENT. CODE ANN. § 12.1-16-04 (West 2016) (“(1) Any person who intentionally or knowingly aids, abets, facilitates, solicits, or incites another person to commit suicide, or who provides to, delivers to, procures for, or prescribes for another person any drug or instrument with knowledge that the other person intends to attempt to commit suicide with the drug or instrument is guilty of a class C felony; (2) Any person who, through deception, coercion, or duress, willfully causes the death of another person by suicide is guilty of a class AA felony.”); 11 R.I. GEN. LAWS ANN. § 11-60-3 (West 2016) (“An individual or licensed health care practitioner who with the purpose of assisting another person to commit suicide knowingly: (1) Provides the physical means by which another person commits or attempts to commit suicide; or (2) Participates in a physical act by which another person commits or attempts to commit suicide is guilty of a felony and upon conviction may be punished by

Hawaii live in a state of limbo because, even though physician-assisted suicide has not been legalized in that state, there is not a criminal prohibition against the process.⁸³ Currently, only six American states and the District of Columbia permit physicians to prescribe lethal doses of medication for terminally-ill patients who want to end their lives.⁸⁴ Physician-assisted suicide was legalized in Colorado, Oregon, and Washington by public initiatives.⁸⁵ Legislatures in Vermont and California enacted statutes making physician-assisted suicide legal for residents of those states.⁸⁶ A Montana court made lethal doses of medication available to terminally-ill patients in that state by preventing the conviction of doctors who write the prescriptions.⁸⁷ Thus, physician-assisted suicide is judicially recognized as a valid statutory defense to homicide in Montana.⁸⁸ The Washington, D.C., City Council passed a measure to legalize physician-assisted suicide in the nation's capital by a margin of eleven to two.⁸⁹

imprisonment for up to ten (10) years, by a fine of up to ten thousand dollars (\$10,000) or both.”).

83. In Hawaii, a person commits manslaughter if he or she intentionally causes another person to commit suicide. HAW. REV. STAT. ANN. § 707-702 (West 2016). This appears to deal with situations where a person is forced to commit suicide. It seems to require more aggressive action than just assisting with a suicide.

84. See Bryant, *supra* note 72, at 297-300.

85. Thomas M. Carpenter, *In Whose Court Is the Ball?: The Scope of the People's Power of Direct Legislation*, 28 ARK. LAW. 35, 36 (1994) (explaining the difference between a referendum and an initiative: initiatives allow citizens to propose their own laws and have the same force and effect as any act of the legislature).

86. See Bryant, *supra* note 72, at 297-300.

87. *Baxter v. State*, 224 P.3d 1211, 1222 (Mont. 2009).

88. *Id.*

89. Lauren Markoe, *Washington, D.C., Approves "Death with Dignity Act,"* RELIGION NEWS SER. (Nov. 1, 2016), <http://religionnews.com/2016/11/01/washington-dc-approves-death-with-dignity-act/> [https://perma.cc/7VLQ-ETKQ].

A. Public Initiatives (Oregon, Washington, and Colorado)

1. *The Oregon Death with Dignity Act*

Oregon was the first state to have physician-assisted suicide legalized through a public initiative.⁹⁰ It took years of congressional and judicial battles for Oregon's Death with Dignity Act (DWDA) to be implemented.⁹¹ The proponents of physician-assisted suicide learned from the Washington experience.⁹² For example, unlike Initiative 119 that was defeated in Washington,⁹³ Oregon's initiative, Measure 16, expressly prohibited euthanasia by lethal injection.⁹⁴ On November 8, 1994, Oregon voters approved Measure 16 as Oregon's DWDA.⁹⁵

A month after the approval of Measure 16, several doctors and patients brought a class action lawsuit asking the court to invalidate the resulting statute.⁹⁶ The plaintiffs claimed that the Oregon statute violated both the First and Fourteenth Amendments of the United States Constitution and the provisions of several federal statutes, including the Americans with Disabilities Act (ADA).⁹⁷ In response, United States District Court Judge Michael Hogan issued an injunction temporarily preventing the implementation of the law.⁹⁸ A few months later, Judge Hogan made the injunction permanent.⁹⁹ The United States Ninth Circuit Court of Appeals reversed Judge Hogan's ruling in 1997.¹⁰⁰

90. See *Oregon Death with Dignity Act: A History*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/oregon-death-with-dignity-act-history/> [<https://perma.cc/A4JP-J3DJ>].

91. *Id.*

92. *Id.*

93. *Id.*

94. *Id.*

95. *Oregon Death with Dignity Act: A History*, *supra* note 90.

96. *Id.*

97. *Id.*

98. *Lee v. Oregon*, 869 F. Supp. 1491, 1491 (D. Or. 1994).

99. *Lee v. Oregon*, 891 F. Supp. 1439, 1439 (D. Or. 1995).

100. *Lee v. Oregon*, 107 F.3d 1382, 1383 (9th Cir. 1997).

Even though both the court and the people had spoken, the Oregon Legislature was not supportive of the DWDA.¹⁰¹ As a result, the Legislature attempted to abolish the law by asking the voters to approve Measure 51, a referendum¹⁰² that would have repealed the 1994 Act. The voters showed their support for the statute a second time by rejecting Measure 51.¹⁰³ The opponents of physician-assisted suicide were not deterred. They turned to Congress for help. Senator Orin Hatch (R-Utah) and Representative Henry Hyde (R-Illinois) asked the United States Drug Enforcement Administration (DEA) to investigate and punish doctors who wrote prescriptions so that their patients could take federally controlled drugs to end their lives.¹⁰⁴

On June 5, 1998, United States Attorney General Janet Reno stated that the federal government would not prosecute physicians who issued prescriptions in compliance with Oregon's DWDA.¹⁰⁵ Nonetheless, newly appointed Attorney General John Ashcroft reversed the government's position on this issue and announced that he planned to restrict the use of controlled substances for physician-assisted suicide.¹⁰⁶ The United Supreme Court ruled that Ashcroft did not have the authority to take his proposed action because the Federal Controlled Substances Act (FCA) did not empower the Attorney General to prohibit doctors from prescribing regulated drugs for use in physician-assisted suicide.¹⁰⁷ This federal victory was somewhat overshadowed by the fact that on April 30, 1997, President William Clinton signed the Federal Assisted Suicide

101. ARTHUR EUGENE CHIN ET AL., OREGON'S DEATH WITH DIGNITY ACT: THE FIRST YEAR'S EXPERIENCE I (1999).

102. *Referendum*, BLACK'S LAW DICTIONARY (10th ed. 2014) ("The process of referring a state legislative act, a state constitutional amendment, or an important public issue to the people for final approval by popular vote.")

103. Raphael Cohen-Almagor & Monica C. Hartman, *The Oregon Death with Dignity Act: Review and Proposals for Improvement*, 27 J. LEGIS. 269, 274-275 (2001).

104. *Id.*

105. S. REP. NO. 105-372, at 7-8 (1998).

106. Statement from Attorney Gen. Reno on Oregon's Death with Dignity Act (June 5, 1998), <https://www.justice.gov/archive/opa/pr/1998/June/259ag.htm.html> [https://perma.cc/YVL9-X3PE].

107. *Gonzales v. Oregon*, 546 U.S. 243, 253-54 (2005).

Funding Restriction Act of 1997.¹⁰⁸ According to the Act, “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.”¹⁰⁹

2. *The Washington Death with Dignity Act*

In 1990, in an attempt to have physician-assisted suicide legalized in the State of Washington, a group of residents put Initiative 119 on the ballot.¹¹⁰ Washington State voters rejected Initiative 119 in 1991.¹¹¹ After the defeat of Initiative 119, physicians were not willing to help their patients commit suicide because they feared being prosecuted.¹¹² At that time, according to Washington law, a person who was found guilty of promoting a suicide attempt could be sentenced to up to five years imprisonment and fined up to \$10,000.¹¹³ A person was guilty of promoting a suicide attempt if he or she knowingly caused or helped another person to attempt suicide.¹¹⁴ The jurisdiction also had a Natural Death Act (NDA) that exempted doctors who withheld or withdrew life-sustaining treatment in compliance with their patients’ requests from being prosecuted for assisting a suicide.¹¹⁵ In 1992, the legislature amended the NDA to make it clear that doctors who prescribed lethal doses of medication to terminally-ill patients were not protected by the provisions of the Act.¹¹⁶

In 1994, two doctors, three terminally-ill patients, and a nonprofit organization filed an action challenging the constitutionality of the Washington statutes that criminalized

108. *Id.* at 243.

109. Assisted Suicide Funding Restriction Act of 1997, 42 U.S.C. §§ 14401-08 (2012).

110. 42 U.S.C. § 14402(a) (2012).

111. Melvin I. Urofsky, *Leaving the Door Ajar: The Supreme Court and Assisted Suicide*, 32 U. RICH. L. REV. 313, 338 (1998).

112. *Id.* at 340.

113. *Id.* at 346.

114. WASH. REV. CODE ANN. § 9A.36.060(2) (West 2016); WASH. REV. CODE ANN. § 9A.20.021(C) (West 2016).

115. WASH. REV. CODE ANN. § 70.122.070(1) (West 2016).

116. WASH. REV. CODE ANN. § 70.122.100 (West 2016).

physician-assisted suicide.¹¹⁷ The plaintiffs argued that the right to choose physician-assisted suicide was a liberty interest protected by the Due Process Clause of the Fourteenth Amendment.¹¹⁸ Therefore, they maintained that the laws depriving terminally ill patients of that right were unconstitutional.¹¹⁹ The United States Supreme Court (Supreme Court) held that the right to assistance in committing suicide is not a fundamental liberty interest.¹²⁰ Consequently, the Supreme Court refused to evaluate the validity of the laws applying a strict scrutiny standard.¹²¹

The Washington statutes survived a rational basis analysis because the Supreme Court concluded that Washington's ban was rationally related to legitimate government interests including the state's interest in (1) preserving human life; (2) protecting the integrity and ethics of the medical profession; and (3) protecting vulnerable groups like the impoverished, elderly, and disabled from "abuse, neglect, and mistakes."¹²² The Supreme Court eliminated another possible constitutional argument for proponents of physician-assisted suicide by ruling that New York's ban on assisting suicide did not violate the Equal Protection Clause of the Fourteenth Amendment.¹²³ After their appeals to the courts and the state legislature were unsuccessful, proponents of physician-assisted suicide took the issue back to the people. On November 4, 2008, Washington residents voted to pass Ballot Initiative 1-1000, the Washington

117. *Washington v. Glucksberg*, 521 U.S. 702, 707-08 (1997).

118. *Id.* at 708.

119. *Id.* at 707-08.

120. *Id.* at 728.

121. *Id.*

122. *Glucksberg*, 521 U.S. at 728-31.

123. *Vacco v. Quill*, 521 U.S. 793, 797 (1997). The plaintiffs argued that terminally-ill patients on life-support were advantaged over terminally-ill patients who were not on life-support because they could legally end their lives by having their doctors withdraw treatment. *Id.* at 798. On the other hand, terminally-ill patients who were not on life-support did not have the legal right to end their lives. *Id.* The Supreme Court rejected that argument stating that "[t]he distinction comports with fundamental legal principles of causation and intent. First, when a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication." *Id.* at 801.

Death with Dignity Act.¹²⁴ The law took effect in 2009.¹²⁵ The public continues to pressure state legislatures to address the issue of physician-assisted suicide. Legislatures have responded. In 2015, twenty-five state legislatures considered bills that would have legalized the practice.¹²⁶ Nonetheless, only two state legislatures—California and Vermont—reacted by passing statutes legalizing physician-assisted suicide.¹²⁷ The debate surrounding the issue continues to be active. On May 10, 2016, the Medical Aid in Dying Act, a bill intended to legalize physician-assisted suicide, was introduced in the New York State Assembly.¹²⁸

3. *The Colorado End of Life Options Act*

In 2016, the battle over physician-assisted suicide came to Colorado. On one side, Compassion & Choices, a national nonprofit organization based in Colorado, spent millions of dollars to galvanize public efforts to pass Proposition 106, a ballot initiative.¹²⁹ Proposition 106 was designed to “allow terminally ill patients to take life-ending, doctor-prescribed sleeping medication.”¹³⁰ The measure was modeled after Oregon’s statute.¹³¹ Opponents of physician-assisted suicide, including the Archdiocese of Denver, contributed millions of

124. Arthur Svenson, *Death with Dignity’s Emerging Conceit: Could Vacco v. Quill Be Losing Its Appeal?*, 31 U. LA VERNE L. REV. 45, 45 (2009).

125. *Id.*

126. Malak Monir, *Half the States Look at Right-to-Die Legislation*, USA TODAY (Apr. 16, 2015, 1:02 PM), <http://www.usatoday.com/story/news/politics/2015/04/15/death-with-dignity-laws-25-states/25735597/> [<https://perma.cc/Z9MW-K26C>].

127. See *Death with Dignity Acts*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/learn/death-with-dignity-acts/> [<https://perma.cc/SV9Z-WAQE>].

128. See *Bill A10095 Summary*, N.Y. STATE ASSEMBLY, http://assembly.state.ny.us/leg/?default_fld=&leg_video=&bn=A10059&term=2015&Summary=Y&Actions=Y&Floor%26nbspVotes=Y&Memo=Y&Text=Y [<https://perma.cc/CU7Q-VJIG>].

129. Jennifer Brown, *Colorado Passes Medical Aid in Dying, Joining Five Other States*, DENVER POST (Nov. 9, 2016), <http://www.denverpost.com/2016/09/23/proposition106-medical-aid-in-dying/> [<https://perma.cc/ES83-FGU7>].

130. *Id.*

131. *Id.*

dollars to defeat the initiative. Nonetheless, supporters of the measure played on the emotions of voters by running television commercials featuring Brittany Maynard.¹³² As a result, Colorado voters in November 2016, overwhelmingly voted to pass the ballot initiative, with nearly sixty-five percent of voters in favor of physician-assisted death for terminally ill patients.¹³³ Under the new Colorado law, two physicians “would have to agree [that] the person is mentally competent and has fewer than six months to live, and person choosing to die would have to self-administer” the medication.¹³⁴

B. Legislative Intervention (Vermont and California)

1. *The Vermont Patient Choice and Control at the End of Life Choices Act*

On May 20, 2013, Governor Peter Shumlin made Vermont the first state in the United States to legalize physician-assisted suicide using the legislative process when he signed the Patient Choice and Control at the End of Life Choices Act.¹³⁵ At the signing, Governor Shumlin stated, “All [the bill] does is give those who are facing terminal illness, are facing excruciating pain, a choice in a very carefully regulated way.”¹³⁶ The Act was effective immediately.¹³⁷ The Vermont law is similar to the

132. *Id.*

133. Gaby Galvin, *Colorado Overwhelmingly Passes Aid-in-Dying Law*, U.S. NEWS & WORLD REP. (Nov. 9, 2016), <https://www.usnews.com/news/politics/articles/2016-11-09/colorado-joins-5-states-to-allow-physician-aided-death-for-terminally-ill> [<https://perma.cc/HD8C-TBJV>].

134. *Id.*

135. See Kathryn L. Tucker, *Issues in Vermont Law, Vermont’s Patient Choice at End of Life Act: A Historic “Next Generation” Law Governing Aid in Dying*, 38 VT. L. REV. 687, 687-88 (2014); Jason McLure, *Vermont Passes Law Allowing Doctor-Assisted Suicide*, REUTERS (May 20, 2013, 3:14 PM), <http://www.reuters.com/article/us-usa-vermont-assisted-suicide-idUSBRE94J0QC20130520> [<https://perma.cc/ES83-FGU7>].

136. Wilson Ring, *Vermont Legalizes Assisted Suicide*, BENNINGTON BANNER (May 20, 2013, 8:38 PM), <http://www.benningtonbanner.com/stories/vermont-legalizes-assisted-suicide,355760> [<https://perma.cc/6UFN-9VQL>].

137. Terri Hallenbeck, *Vermont Adjusts to New Way of Dying*, USA TODAY (July 14, 2013), <http://www.usatoday.com/story/news/nation/2013/07/14/vermont-adjusts-to-new-way-of-dying/2514847/> [<https://perma.cc/N2XQ-LH4W>].

Oregon and Washington statutes.¹³⁸ It permits doctors to prescribe lethal doses of medication to terminally-ill patients who want to end their lives.¹³⁹ The Vermont law contains the same safeguards as the Oregon statute including the requirement that the patient states three times that he or she wants to end his or her life.¹⁴⁰ In addition, the patient must obtain a concurring opinion from a second doctor confirming that the patient has less than six months to live and a determination that the patient is mentally competent.¹⁴¹ Nonetheless, after July 1, 2016, the Vermont law was set to transform into a model that requires less governmental monitoring and reporting by a physician.¹⁴² In April 2015, the Vermont Legislature acted to make the provisions permanent with the passage of S.108.¹⁴³

2. California End of Life Option Act

Brittany Maynard relocated to Oregon so she could obtain a prescription for a lethal dose of medication to end her life.¹⁴⁴ After Brittany's death, her husband, Dan Diaz, and her mother, Debbie Ziegler, joined the fight to make physician-assisted suicide legal in California.¹⁴⁵ Christy O'Donnell is a former Los

138. Terri Hallenbeck, *Vermont Adjusts to New Way of Dying*, USA TODAY (July 14, 2013), <https://www.usatoday.com/story/news/nation/2013/07/14/vermont-adjusts-to-new-way-of-dying/2514847/> [<https://perma.cc/N2XQ-LH4W>].

139. Paris Achen, *Permanent Version of Vt. Assisted Suicide Bill Signed*, USA TODAY (May 20, 2015, 6:30 PM), <http://www.usatoday.com/story/news/nation/2015/05/20/permanent-version-of-vt-assisted-suicide-bill-signed/27675289/> [<https://perma.cc/8W76-GMQC>].

140. VT. STAT. ANN. tit. 18, §§ 5283(a)(1)-(4) (West 2016).

141. VT. STAT. ANN. tit. 18, § 5283(a)(7) (West 2016).

142. Kathryn L. Tucker, *Vermont's Patient Choice at End of Life Act: A Historic "Next Generation" Law Governing Aid in Dying*, 38 VT. L. REV. 687, 687-688 (2014).

143. *Oregon Death with Dignity Act: A History*, *supra* note 90.

144. Catherine E. Shoichet, *Brittany Maynard, Advocate for "Death with Dignity," Dies*, CNN (Nov. 3, 2014, 8:43 PM), <http://www.cnn.com/2014/11/02/health/oregon-brittany-maynard/> [<https://perma.cc/86BE-X7WQ>].

145. Gary Peterson, *Brittany Maynard's Husband, Back in East Bay, Honors Message of His Late Wife in Right-to-Die Movement*, MERCURY NEWS (Aug. 12, 2016, 4:05 AM), <http://www.mercurynews.com/2015/06/01/brittany-maynards-husband-back-in-east-bay-honors-message-of-his-late-wife-in-right-to-die-movement/> [<https://perma.cc/Q4QT-8J3Z>].

Angeles police officer, a lawyer and a single mother.¹⁴⁶ When doctors diagnosed Christy with stage IV lung adenocarcinoma, they told her that it had spread to her brain.¹⁴⁷ As a result, doctors predicted that Christy only had about six months to live.¹⁴⁸ Instead of following in Brittany's footsteps and moving to Oregon, Christy decided to join the fight to legalize physician-assisted suicide in California.¹⁴⁹ Christy explained her decision by stating, "I think it's a terrible injustice that I don't have the choice to die in the manner I want to and instead that I'm forced to very likely die in protracted pain and I might even die alone."¹⁵⁰ Christy lived long enough to see her dream come true; however, she may not live long enough to take advantage of the new law because she will probably be dead by the time it takes effect.¹⁵¹

On October 5, 2015, Governor Jerry Brown signed into law the End of Life Option Act.¹⁵² The statute allows a terminally ill

146. Nicole Weisensee Egan, *Terminally Ill Single Mom Christy O'Donnell: I'm a Conservative Christian and I Support Death with Dignity*, PEOPLE (June 30, 2015, 4:05 PM), <http://people.com/celebrity/terminally-ill-single-mom-christy-odonnell-opens-up-to-katie-couric-wednesday/> [<https://perma.cc/VCE4-3F5X>].

147. *Id.*

148. Nicole Weisensee Egan, *Terminally Ill California Mom: Why Can't I Die on My Own Terms*, PEOPLE (Mar. 5, 2015, 5:15 PM), <http://people.com/celebrity/christy-odonnell-terminally-ill-california-mom-i-want-to-die-on-my-own-terms/> [<https://perma.cc/BZ2U-3NCA>].

149. Egan, *supra* note 146.

150. Sarah Zagorski, *Terminally Ill Mother Says She's "Inspired" by Brittany Maynard, Wants to Kill Herself Too*, LIFENEWS (Mar. 6, 2015, 5:57 PM), <http://www.lifenews.com/2015/03/06/terminally-ill-mother-says-shes-inspired-by-brittany-maynard-wants-to-kill-herself-too/> [<https://perma.cc/S5CL-YZKH>].

151. Niraj Chokshi, *Californians Gained the Right to Die, But the Terminally Ill Who Wanted It Have to Wait*, WASH. POST (Oct. 19, 2015), https://www.washingtonpost.com/national/californians-gained-the-right-to-die-but-the-terminally-ill-who-wanted-it-have-to-wait/2015/10/19/1556eab2-7360-11e5-8d93-0af317ed58c9_story.html?utm_term=.628bc6261c7f [<https://perma.cc/EQ9K-5Q4A>]. Christy joined a class action lawsuit asking the Court to find that the statute criminalizing assisted suicide did not apply to physicians who provided lethal medication. *See Donorovich-O'Donnell v. Harris*, 194 Cal. Rptr. 3d 579, 582 (Cal. Ct. App. 2015). The plaintiffs wanted to be able to get the medicine before the new physician-assisted suicide law took effect. *Id.* The judge sympathized with the plight of the plaintiffs, but she ruled against them. *Id.*

152. Letter from Governor Edmund G. Brown Jr. to Members of the Cal. State Assemb. (Oct. 5, 2015), https://www.gov.ca.gov/docs/ABX2_15_Signing_Message.pdf [<https://perma.cc/CEQ7-TEYY>]. In a letter to the members of the California State Assembly, Governor Brown wrote:

patient with the capacity to make medical decisions to request a prescription for a lethal medication, exempts a prescribing physician from criminal liability, and includes rigorous procedures and safeguards to protect against abuse.¹⁵³ Passage of the law in California is important because of the number of people who live in the state.¹⁵⁴ Therefore, physician-assisted suicide is now available to almost three times as many people.¹⁵⁵ California is also the most racially and economically diverse state to permit terminally-ill patients to request physician-assisted suicide.¹⁵⁶ Therefore, it can serve as a good testing ground for critics claiming that the availability of physician-assisted suicide endangers vulnerable patients.

ABx2 15 is not an ordinary bill because it deals with life and death. The crux of the matter is whether the State of California should continue to make it a crime for a dying person to end his life, no matter how great his pain or suffering I do not know what I would do if I were dying in prolonged and excruciating pain. I am certain, however, that it would be a comfort to be able to consider the options afforded by this bill. And I wouldn't deny that right to others.

Id.

153. CAL. HEALTH & SAFETY CODE §§ 443.2-.14 (West 2016); Mollie Reilly, *Right to Die Becomes Law in California*, HUFFINGTON POST (Oct. 6, 2015), http://www.huffingtonpost.com/entry/right-to-die-california_us_560c6037e4b076812700b6d8 [https://perma.cc/FS5Z-DFJD].

154. According to the United States Census Bureau, California's 2015 population was estimated at 39.1 million—approximately twelve percent of the entire U.S. population. *Quick Facts: California, U.S.* CENSUS BUREAU, <https://www.census.gov/quickfacts/table/PST045215/06,00> [https://perma.cc/8HA6-XEUE].

155. At the time California enacted the physician-assisted suicide statute, its population (39.1 million) was over three times larger than the combined population (12.8 million) of the four states with existing doctor-assisted suicide legislation (Montana, Oregon, Vermont, and Washington). See *Quick Facts: California, Montana, Oregon, Vermont, Washington, U.S.* CENSUS BUREAU, <https://www.census.gov/quickfacts/table/PST045215/53,41,30,50,06,00> [https://perma.cc/4CQV-YR9W]. With the addition of California, the total number of Americans with access to physician-assisted suicide rose to 51.9 million, or sixteen percent of the general population. See *id.*

156. When compared to the other four states, California has the lowest percentage of “White Alone” individuals, with respect to the entire population, and has the highest percentage of both “Black or African American Alone” and “Asian Alone.” See *id.* The Census Bureau also reported that despite having the highest median household income of the five states, California also has one of the highest poverty rates in the country. See *id.*

C. Judicial Interpretation

It is the role of legislatures to decide whether or not to enact statutes legalizing physician-assisted suicide.¹⁵⁷ Nonetheless, in states where the legislatures have failed to act, courts may analyze the legal issues pertaining to physician-assisted suicide on a case-by-case basis.¹⁵⁸ In Montana and New Mexico, the courts were tasked with determining whether or not doctors should be allowed to help terminally-ill patients to end their lives.¹⁵⁹

1. *Montana (Baxter v. State)*

In deciding the *Baxter* case, the Montana Supreme Court held that physician-assisted suicide is not against the State's public policy.¹⁶⁰ After he retired, doctors diagnosed Robert Baxter with lymphocytic leukemia.¹⁶¹ Baxter underwent multiple rounds of chemotherapy, but his physicians predicted that he would not survive the cancer.¹⁶² As a result of his cancer and the chemotherapy treatments, Baxter was in constant pain.¹⁶³ After his doctor told Baxter that he would get progressively worse, he asked his physician to give him a prescription for a lethal dose of medication so that he could end his life.¹⁶⁴ Baxter's request was declined because doctors faced prosecution under the State's homicide statutes.¹⁶⁵

Baxter and four physicians filed an action asking the court to find the application of homicide statutes to cases involving assisted suicide by physicians was unconstitutional.¹⁶⁶

157. See Charles H. Baron, *Pleading for Physician-Assisted Suicide in the Courts*, 19 W. NEW ENG. L. REV. 371, 399 (1997) (suggesting that an avenue for adoption of physician-assisted suicide is through individual state legislatures).

158. *Id.* at 400-02.

159. *Baxter v. State*, 224 P.3d 1211, 1214 (Mont. 2009); *Morris v. Bradenburg*, 376 P.3d 836, 838 (N.M. 2016).

160. *Baxter*, 224 P.3d at 1222.

161. *Id.* at 1214.

162. *Id.*

163. *Id.*

164. *Id.*

165. *Baxter*, 224 P.3d at 1214.

166. *Id.*

Compassion & Choices, a nonprofit organization, was also a plaintiff.¹⁶⁷ Baxter won the case because the District Court opined that a person's right to die with dignity is protected by the privacy and dignity clauses of the Montana Constitution.¹⁶⁸ In order to exercise that right, a patient can request assistance from a physician.¹⁶⁹ In order to safeguard a patient's right to physician-assisted suicide, the Court ordered the State to stop prosecuting physicians who write prescriptions for lethal doses of medication so their terminally-ill patients can end their lives.¹⁷⁰

The State appealed the decision to the Montana Supreme Court.¹⁷¹ That Court concluded that it did not have to consider the constitutional arguments in order to decide the case because the physicians had not violated the homicide statutes.¹⁷² Relying upon a consent theory, the Court ruled that doctors who assist in patient suicides can avoid prosecution for homicide by asserting a consent defense.¹⁷³ In addition, the Court concluded that the actions of a physician who assists in a suicide do not rise to the level of homicide.¹⁷⁴ Under the provisions of the relevant statute, a person does not commit homicide unless he or she "purposely or knowingly" causes the death of another person.¹⁷⁵ The only role the physician plays in the process is writing the prescription for the lethal dose of medication.¹⁷⁶ Because a physician does not force his or her patient to take the prescribed medication he or she does not directly cause the patient's death.¹⁷⁷ Suicide is not a crime in Montana; therefore, by providing the lethal dose of medication, a physician is not assisting in the commission of a crime.¹⁷⁸

167. *Id.*; *Our Mission*, *supra* note 67.

168. *Baxter*, 224 P.3d at 1214.

169. *Id.*

170. *Id.*

171. *Id.* at 1212-13.

172. *Id.* at 1215.

173. *Baxter*, 224 P.3d at 1222.

174. *Id.*

175. *Id.* at 1215 (citing MONT. CODE ANN. § 45-5-102 (2009)).

176. *See id.* at 1217.

177. *Id.*

178. *Baxter*, 224 P.3d at 1217.

The Montana Supreme Court also opined that the physicians would be protected by the provisions of the Terminally Ill Act.¹⁷⁹ That Act provides immunity from criminal and civil liability to physicians who comply with their patients' requests to withhold or withdraw life-sustaining treatment.¹⁸⁰ The Court reasoned that, by giving immunity to physicians, the legislature indicated that it was in the best interest of the public to allow patients to refuse medical treatment even if that refusal leads to death.¹⁸¹ Moreover, the Court concluded that nothing in the Act signified that doctors could not go a step further and supply patients with the means to end their lives.¹⁸² The Court noted that when a physician withdraws medical treatment, he or she is directly involved in the dying process.¹⁸³ On the other hand, a physician who provides the patient with the lethal dose of medication is only indirectly responsible for the patient's death.¹⁸⁴ Consequently, the Court determined that if direct physician assistance is not against public policy, a physician should not be penalized for indirectly participating in the process.¹⁸⁵

In essence, the *Baxter* decision permits physicians in Montana to provide assisted-suicide to their terminally-ill patients. Nonetheless, it is not exactly accurate to say that the *Baxter* decision legalized physician-assisted suicide in the state. The ruling in the case does not prevent the legislature from explicitly criminalizing the process.¹⁸⁶ Therefore, terminally-ill patients in Montana are not on the same footing with terminally-ill patients who live in states that have laws specifically making physician-assisted suicide legal.

179. *Id.* at 1219.

180. *Id.* (citing MONT. CODE ANN § 50-9-204 (2009)).

181. *Id.* at 1217.

182. *Id.* at 1218.

183. *Baxter*, 224 P.3d at 1218.

184. *Id.*

185. *Id.*

186. Evelyn Keyes, *Two Conceptions of Judicial Integrity: Traditional and Perfectionist Approaches to Issues of Morality and Social Justice*, 22 NOTRE DAME J.L. ETHICS & PUB. POL'Y 233, 249-50 (2008).

2. *New Mexico* (Morris v. Brandenburg)

In New Mexico, intentionally helping someone to end his or her life is a fourth degree felony.¹⁸⁷ Dr. Katherine Morris, a surgical oncologist, Dr. Aroop Mangalik, a physician, and Aja Riggs, a patient who had been diagnosed with uterine cancer, filed a lawsuit asking the court to issue an order stating that physicians who provided mentally competent, terminally-ill patients with prescriptions for lethal doses of medication cannot be prosecuted under the felony statute.¹⁸⁸ The plaintiffs argued that applying the statute to physician-assisted suicide cases would offend the provisions of the New Mexico Constitution, including Article II, Section 4's guarantee of inherent rights and Article II, Section 18's Due Process Clause.¹⁸⁹

After a trial on the merits, the New Mexico District Court held that Section 30-2-4 prohibits assisted suicides.¹⁹⁰ Nonetheless, the District Court stated that the statute's application to situations involving physician-assisted suicide would violate the inherent-rights guarantee and substantive due process protections provided by Article II, Section 4 and Article II, Section 18 of the New Mexico Constitution.¹⁹¹ Because the District Court determined that mentally competent, terminally-ill patients have a fundamental right to physician-assisted suicide it conducted a strict scrutiny analysis.¹⁹² Based upon that analysis, the District Court concluded that the State had failed to prove that criminalizing physician-assisted suicide would further a compelling interest.¹⁹³ In support of her decision, District Court Judge Nan G. Nash stated, "This court cannot envision a right more fundamental, more private or more integral to the liberty, safety and happiness of a New Mexican than the right of a

187. N.M. STAT. ANN. § 30-2-4 (West 2016).

188. *Morris v. Brandenburg*, 356 P.3d 564, 567-68 (N.M. Ct. App. 2015).

189. *Id.* at 568.

190. *Id.* at 568, 570.

191. Findings & Conclusions at ¶NN, *Morris v. Brandenburg*, 356 P.3d 564 (*No. D-202-CV-201202909*).

192. *Id.* at ¶KK.

193. *Id.* at ¶LL.

competent, terminally ill patient to choose aid in dying.”¹⁹⁴ As a result, the District Court issued an order permanently enjoining the State from prosecuting any physician who provides physician-assisted suicide to mentally competent, terminally-ill patients.¹⁹⁵

The State filed an appeal with the Court of Appeals of New Mexico.¹⁹⁶ On Appeal, the attorneys representing the State argued that a person does not have a fundamental right to receive assistance from a third-party in order to end his or her life.¹⁹⁷ They also claimed that the District Court’s ruling violates the doctrine of separation of powers because it legalized conduct that the legislature had designated as criminal.¹⁹⁸ The Court of Appeals ruled in favor of the State.¹⁹⁹ Writing for the majority, Judge Timothy L. Garcia reversed the District Court’s ruling that the right to physician-assisted suicide is a fundamental liberty interest under the New Mexico Constitution.²⁰⁰ One concern expressed by the Court of Appeals was that the right would only belong to a small segment of the state’s population, mentally competent patients suffering from terminal illnesses.²⁰¹ The Court of Appeals reasoned that fundamental constitutional rights that protect life, liberty and happiness should be enjoyed by all people.²⁰² The plaintiffs appealed the case to the New Mexico Supreme Court.²⁰³ That Court heard oral arguments on the matter,²⁰⁴ and on June 30,

194. *Id.* at ¶JHH; Erik Eckholm, *New Mexico Judge Affirms Right to ‘Aid in Dying’*, N.Y. TIMES (Jan. 13, 2014), https://www.nytimes.com/2014/01/14/us/new-mexico-judge-affirms-right-to-aid-in-dying.html?_r=0 [<https://perma.cc/BH9L-PKEW>].

195. *Morris v. Brandenburg*, 356 P.3d 564, 570 (N.M. Ct. App. 2015); Findings & Conclusions, *supra* note 186, at ¶OO.

196. *Brandenburg*, 356 P.3d at 570.

197. *Id.*

198. *Id.*

199. *Id.* at 580.

200. *Id.* at 567, 585.

201. *Brandenburg*, 356 P.3d at 575, 583.

202. *Id.* at 583.

203. *Morris v. Brandenburg*, 376 P.3d 836, 836 (N.M. 2016).

204. Russell Contreras, *Justices Grill Attorneys in New Mexico Assisted Suicide Case*, WASH. TIMES (Oct. 26, 2015), <http://www.washingtontimes.com/news/2015/oct/26/new-mexico-supreme-court-hears-assisted-suicide-ca/> [<https://perma.cc/F2SQ-6HAD>].

2016, reversed the Court of Appeals, declining “to hold that there is an absolute and fundamental [New Mexico] constitutional right to a physician’s aid in dying.”²⁰⁵

D. City Council Vote (Washington D.C.)

Prior to the Washington, D.C., City Council’s vote on a bill legalizing physician-assisted suicide, council member Mary Cheh stated, “It allows someone who is on death’s doorstep the option to choose a peaceful death.”²⁰⁶ In response, her fellow council member voted to enact the legislation.²⁰⁷ The bill made physician-assisted suicide legal in the District and empowered physicians to prescribe lethal medication to terminally-ill patients.²⁰⁸ However, Congress has the power to block legislation enacted by the D.C. City Council.²⁰⁹ Relying on the federal Home Rule Act, members of the House Committee on Oversight and Government Reform decided to send a resolution disapproving the passage of D.C.’s Death with Dignity Act.²¹⁰ The resolution was not voted on by the full House and a similar Senate resolution never made it out of committee.²¹¹ Consequently, on February 18, 2017, Washington, D.C., joined the ranks of places in the United States where terminally-ill patients can receive physician-assisted suicide.²¹²

205. *Brandenburg*, 376 P.3d at 839.

206. Markoe, *supra* note 89.

207. *Id.*

208. *Id.*

209. *How a Bill Becomes a Law*, COUNCIL D.C., <http://dccouncil.us/pages/how-a-bill-becomes-a-law> [<https://perma.cc/Q3KU-2CV5>].

210. *DC Homerule*, COUNCIL D.C., <http://dccouncil.us/pages/dc-home-rule> [<https://perma.cc/TBP6-FCFH>]; Lacey Johnson, *U.S. Representatives Vote Against D.C. Assisted Suicide Law*, REUTERS (Feb. 13, 2017), <http://www.reuters.com/article/us-washingtondc-euthanasia-idUSKBN15T09B> [<https://perma.cc/MV6K-K2NH>].

211. Evan Wilt, *Congress Misses Chance to Stop Assisted Suicide in D.C.*, WORLD (Feb. 21, 2017), https://world.wng.org/2017/02/congress_misses_chance_to_stop_assisted_suicide_in_dc [<https://perma.cc/PY6Y-CRSR>].

212. Bradford Richardson, *D.C. Physician-Assisted Suicide Law Goes Into Effect*, WASH. TIMES (Feb. 18, 2017), <http://www.washingtontimes.com/news/2017/feb/18/dc-physician-assisted-suicide-law-goes-effect/> [<https://perma.cc/GN8C-DBXB>].

E. The Process

In order to understand the ethical concerns that will be discussed later, it is necessary to comprehend the manner in which the physician-assisted suicide process works. The Oregon, Washington, Vermont and California statutes contain similar provisions, so the information in this section is applicable to all of those states.²¹³ The statutes permit a capable, terminally-ill adult resident to request a prescription for a lethal dose of medication from a willing physician.²¹⁴ If the physician is not willing to write the prescription, he or she must refer the patient to another physician.²¹⁵ Once the patient receives the medication, he or she can take it if and when he or she wishes.²¹⁶ The statutes forbid lethal injection, so the patient must be able to ingest the medication without assistance.²¹⁷ In order to be eligible to receive the prescription for the medication, the patient must satisfy the requirements listed in the statutes and adhere to the procedures mandated by the statutes.²¹⁸

The statute only applies to cases involving adult patients, so the person must be over the age of eighteen.²¹⁹ In addition, the person must be capable of making health-care decisions and of communicating those decisions to the appropriate health care provider.²²⁰ In order to be deemed to have that capacity, the

213. CAL. HEALTH & SAFETY CODE § 443.2(a) (West 2016).

214. See, e.g., OR. REV. STAT. ANN. § 127.805 (West 2016); WASH. REV. CODE ANN § 70.245.190(1)(d) (West 2016).

215. OR. REV. STAT. ANN. § 127.855 (West 2016); VT. STAT. ANN. tit. 18, § 5285(a) (West 2016); WASH. REV. CODE ANN. § 70.245.190(1)(d).

216. FAQs, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/faqs/> [<https://perma.cc/Q4GZ-EY59>].

217. OR. REV. STAT. ANN. § 127.880 (West 2016); VT. STAT. ANN. tit. 18, § 5292 (West 2016); WASH. REV. CODE ANN. § 70.245.80(1) (West 2016).

218. OR. REV. STAT. ANN. § 127.885 (West 2016); VT. STAT. ANN. tit. 18, §§ 5283(a)(1)-(15) (West 2016); WASH. REV. CODE ANN. § 70.245.020(1) (West 2016).

219. OR. REV. STAT. ANN. § 127.800 (West 2016); VT. STAT. ANN. tit. 18, § 5281(a)(8) (West 2016); WASH. REV. CODE ANN. § 70.245.010(1) (West 2016).

220. OR. REV. STAT. ANN. § 127.800 (“‘Capable’ means that in the opinion of a court or in the opinion of the patient’s attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient’s manner of communicating if those persons are available.”); VT. STAT. ANN. tit. 18, § 5281(2) (“‘Capable’ means that a patient has the ability to make and communicate health care decisions to a physician, including communication through persons familiar

person must be of sound mind.²²¹ That standard is relatively low because the decision can be made by the person's primary-care physician without the benefit of any kind of psychiatric or psychological evaluation.²²² In fact, prior to requesting the prescription, the person does not have to undergo any type of counseling.²²³ However, if the physician suspects that the person is suffering from a psychiatric or psychological disorder or depression that impairs his or her judgment, the physician must refer that person to counseling.²²⁴ The patient will not be eligible to receive a prescription for the lethal dose of medication unless the person conducting the counseling concludes that the patient does not have a psychiatric or psychological condition or depression that is impairing his or her judgment.²²⁵ A person does not have to be mentally competent to withdraw his or her request for the prescription for the lethal dose of medication.²²⁶

In order to request a prescription for the lethal dose of medication, the patient must be a resident of the state.²²⁷ The

with the patient's manner of communicating if those persons are available."); WASH. REV. CODE ANN. § 70.245.010(3) ("Competent" means that, in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist, or psychologist, a patient has the ability to make and communicate an informed decision to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.');

221. OR. REV. STAT. ANN. § 127.897 (West 2016); WASH. REV. CODE ANN. § 70.245.010.

222. David L. Sloss, *The Right to Choose How to Die: A Constitutional Analysis of State Laws Prohibiting Physician-Assisted Suicide*, 48 STAN. L. REV. 937, 965 (1996).

223. *Id.*

224. OR. REV. STAT. ANN. § 127.825 (West 2016); OR. REV. STAT. ANN. § 127.800 ("Counseling" means one or more consultations as necessary between a state licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is capable and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment."); VT. STAT. ANN. tit. 18, § 5283(a)(8) (West 2016); WASH. REV. CODE ANN. § 70.245.060 (West 2016); WASH. REV. CODE ANN. § 70.245.010(5) ("Counseling" means one or more consultations as necessary between a state licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is competent and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.');

225. OR. REV. STAT. ANN. § 127.825.

226. OR. REV. STAT. ANN. § 127.845 (West 2016); VT. STAT. ANN. tit. 18, § 5283(a)(10); WASH. REV. CODE ANN. § 70.245.100 (West 2016).

227. OR. REV. STAT. ANN. § 127.860 (West 2016); VT. STAT. ANN. tit. 18, § 5283(a)(5)(E); WASH. REV. CODE ANN. § 70.245.040(1)(b) (West 2016).

patient must establish a connection to the state to be recognized as a resident. At the time the patient requests the medication, he or she must provide proof of residency.²²⁸ The following are acceptable forms of proof: (1) a state driver's license; (2) a state voter's registration card; (3) a deed or lease showing ownership or rental of real estate in the state; or (4) a recent state income tax return.²²⁹ Moreover, the patient must have been diagnosed with an "incurable and irreversible" disease.²³⁰ The patient's physician must predict that the patient will die within six months of the diagnosis in order for the patient to satisfy the terminal illness requirement.²³¹

Patients who are eligible to request the prescription for the lethal dose of medication are required to follow the procedure set forth in the statutes.²³² Traditionally, when the law permits a person to make a legally-sanctioned, life-altering decision, the legislation includes an execution process that must be strictly followed. For example, in order for a person's will to be validly executed, it must be signed, witnessed and/or acknowledged.²³³ The Oregon and Washington statutes require the patient seeking the life-ending medication to follow a set protocol; the mandated process is actually similar to the will execution process.²³⁴

After the patient meets the initial statutory capacity mandates, the patient's decision to apply for the lethal dose of medication must be informed, and his or her request must conform to the statutory guidelines.²³⁵ In order for a patient's decision to be considered informed, his or her physician must

228. OR. REV. STAT. ANN. § 127.860; WASH. REV. CODE ANN. § 70.245.130 (West 2016).

229. OR. REV. STAT. ANN. § 127.860; WASH. REV. CODE ANN. §§ 70.245.130(1)-(3).

230. OR. REV. STAT. ANN. § 127.815 (West 2016); VT. STAT. ANN. tit. 18, § 5283(a)(5)(A); WASH. REV. CODE ANN. § 70.245.010(13) (West 2016).

231. OR. REV. STAT. ANN. § 127.800 (West 2016); VT. STAT. ANN. tit. 18, § 5281(a)(10) (West 2016); WASH. REV. CODE ANN. § 70.245.040(1)(a).

232. OR. REV. STAT. ANN. § 127.805 (West 2016); WASH. REV. CODE ANN. § 70.245.020 (West 2016).

233. OR. REV. STAT. ANN. § 112.235 (West 2016).

234. OR. REV. STAT. ANN. § 112.235; OR. REV. STAT. ANN. § 127.810 (West 2016); WASH. REV. CODE ANN. § 70.245.030 (West 2016).

235. OR. REV. STAT. ANN. § 127.860 (West 2016); VT. STAT. ANN. tit. 18, § 5283(a)(5)(E); WASH. REV. CODE ANN. § 70.245.070 (West 2016).

give the patient the following information: (1) the medical diagnosis and prognosis; (2) the potential risks and probable results of taking the medication; and (3) the other available choices, including comfort care, hospice care and pain control.²³⁶ This informed consent is similar to the consent a physician is required to give a patient prior to performing surgery or another medical procedure on that patient.²³⁷ The goal is to make sure that the patient has all of the necessary information before he or she decides to request the lethal dose of medication.²³⁸

The written request for the medication must contain the patient's signature.²³⁹ As an added precaution, in the patient's presence, at least two people must attest that "to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request."²⁴⁰ The pool of persons who can serve as witnesses is limited in order to protect the patient's interests.²⁴¹ For example, one of the witnesses must be disinterested.²⁴² Another precautionary measure included in the statutes is to prohibit the doctor caring for the patient from acting as a witness to the request.²⁴³ However, if the requesting patient is a resident of a long-term care facility, the facility must choose one of the witnesses.²⁴⁴ Once the patient makes the request, another physician must examine the patient's medical

236. OR. REV. STAT. ANN. § 127.860; VT. STAT. ANN. tit. 18, § 5283(a)(5)(E); WASH. REV. CODE ANN. §§ 70.245.040 (1)(c)(i)-(v).

237. OR. REV. STAT. ANN. § 127.800 (West 2016); OR. REV. STAT. ANN. § 677.097 (West 2016).

238. John B. Mitchell, *My Father, John Locke, and Assisted Suicide: The Real Constitutional Right*, 3 IND. HEALTH L. REV. 45, 74 (2006).

239. OR. REV. STAT. ANN. § 127.810; WASH. REV. CODE ANN. § 70.245.030 (West 2016).

240. OR. REV. STAT. ANN. § 127.860; VT. STAT. ANN. tit. 18, § 5283(a)(5)(E); WASH. REV. CODE ANN. § 70.245.030(1).

241. Browne Lewis, *A Graceful Exit: Redefining Terminal to Expand the Availability of Physician-Facilitated Suicide*, 91 OR. L. REV. 457, 470 (2012).

242. OR. REV. STAT. ANN. § 127.860; VT. STAT. ANN. tit. 18, § 5283(a)(5)(E); WASH. REV. CODE ANN. §§ 70.245.030(2)(a)-(c).

243. OR. REV. STAT. ANN. § 127.860; VT. STAT. ANN. tit. 18, § 5283(a)(5)(E); WASH. REV. CODE ANN. § 70.245.030(3).

244. OR. REV. STAT. ANN. § 127.860; VT. STAT. ANN. tit. 18, § 5283(a)(5)(E); WASH. REV. CODE ANN. § 70.245.030(4).

records and confirm the diagnosis.²⁴⁵ Even with all of these safeguards in place, critics argue that the availability of physician-assisted suicide puts vulnerable patients at risk for neglect and/or abuse.²⁴⁶

IV. ETHICAL ISSUES

The Oregon statute turns twenty in 2017.²⁴⁷ During that time, many dying patients have ended their lives using lethal doses of medication prescribed by their doctors.²⁴⁸ Most physician-assisted suicide bills proposed in the United States and abroad have been modelled after the Oregon statute.²⁴⁹ The Oregon statute has not undergone any major revisions since its enactment.²⁵⁰ Thus, most of the ethical concerns that have been raised have gone unresolved. Most persons who are critical of the current physician-assisted suicide legal regimen that exists in the United States argue that it does not contain enough protections to shield terminally-ill patients who are vulnerable because of factors other than their illnesses—including age, disability, mental illness, race and economic status—from abuse.²⁵¹ Some proponents of physician-assisted suicide have written these concerns off as speculative because they have not been presented with evidence of wide-spread abuse of patients

245. OR. REV. STAT. ANN. § 127.860; VT. STAT. ANN. tit. 18, § 5283(a)(5)(E); WASH. REV. CODE ANN. § 70.245.050(3).

246. *Sampson v. State*, 31 P.3d 88, 97 (Alaska 2001); Eric Johnson, *Assisted Suicide, Liberal Individualism and Visceral Jurisprudence: A Reply to Professor Chemerinsky*, 20 ALASKA L. REV. 321, 333-34 (2003).

247. *Death with Dignity Act*, OR. HEALTH AUTH., <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/index.aspx> [https://perma.cc/8PUC-DTUG].

248. See OR. PUB. HEALTH DIV., *supra* note 8. Since the law was passed in 1997, a total of 1,545 people have had DWDA prescriptions written and 991 patients have died from ingesting medications prescribed under the Act. *Id.* at 2.

249. Thaddeus Mason Pope, *Oregon Shows That Assisted Suicide Can Work Sensibly and Fairly*, N.Y. TIMES (Oct. 7, 2014, 12:39 PM), <http://www.nytimes.com/roomfordebate/2014/10/06/expanding-the-right-to-die/oregon-shows-that-assisted-suicide-can-work-sensibly-and-fairly> [https://perma.cc/G96J-DDF9].

250. OR. REV. STAT. ANN. § 127.897 (West 2016).

251. Johnson, *supra* note 246, at 333-34.

included in these so called “vulnerable” groups.²⁵² However, with the exception of California, the states where the process is legal are some of the least diverse areas in the country.²⁵³

I will discuss two classes of possible ethical problems. First, I will examine the trepidations that pertain to vulnerable persons who are included in the pool of patients who are eligible to choose physician-assisted suicide. Then, I will explore the plight of vulnerable persons who are unable to qualify for physician-assisted suicide because legislators have purposefully excluded them from the provisions of the statutes. In the final section of the Article, I will propose steps that can be taken to ensure that both classes of patients are able to avail themselves of the process.

A. Included but Not Protected

The patients discussed in this Section have the opportunity to be eligible for physician-assisted suicide. However, because of the vulnerabilities of those patients, it may not be in their best interests to seek the procedure under the current legal regime. Instead of permitting those patients to die with dignity, the availability of physician-assisted suicide may leave them at risk to become victims of abuse and undue influence. The safeguards included in the statutes may not be enough to protect those patients from people who deem them to be disposable.

1. *The Elderly and the Physically Disabled*

We live in a society that values youth and independence. Thus, older people and disabled people may be considered to be contemptible because they lack those attributes. In recognition of that fact, there are federal laws that are designed to protect the elderly and the disabled from being the victims of

252. Eric T. Sanders, *Kevin Sampson v. State of Alaska*, 15 ISSUES L. & MED. 199, 201 (1999).

253. The white population in the respective states are as follows: California (73.2%), Montana (89.4%), Oregon (87.9), Washington (80.7%) and Vermont (95%). *Quick Facts: California, Montana, Oregon, Vermont, Washington*, *supra* note 149.

discrimination.²⁵⁴ The majority of states also have statutes in place to prevent older persons and persons with disabilities from being abused.²⁵⁵ This adult protection system is similar to the legal scheme that is used to protect children.²⁵⁶ Nonetheless, the law cannot change hearts and beliefs. Thus, the legalization of physician-assisted suicide may not be beneficial for the elderly and disabled patients. For example, elderly and disabled people, who may be perceived by society, family members and health care providers as a burden, may be coerced or manipulated into requesting physician-assisted suicide.²⁵⁷

One of the strongest critics of physician-assisted suicide is Wesley J. Smith, a bioethicist and a best-selling author.²⁵⁸ Smith claims that elderly and disabled people are frequently made to feel like they have a duty to die to avoid being a burden to society and their families.²⁵⁹ Smith's opinion is shared by numerous scholars, including Dr. Nancy J. Osgood who testified before Congress to argue that federal funds should not be used

254. Age Discrimination Act of 1967, 29 U.S.C. § 623 (2012); Americans with Disabilities Act, 42 U.S.C. § 12112 (2012).

255. See generally Nina A. Kohn, *Outliving Civil Rights*, 86 WASH. U. L. REV. 1053 (2009) ("Elder protection systems significantly burden the constitutional rights of older adults—including the right to informational privacy, the right to engage in consensual sexual relations, and the right to enjoy equal protection of the law.").

256. Vulnerable Adults Protection Act, MINN. STAT. ANN. § 626.557(1) (West 2016). The Act states that:

The legislature declares that the public policy of this state is to protect adults who, because of physical or mental disability or dependency on institutional services, are particularly vulnerable to maltreatment; to assist in providing safe environments for vulnerable adults; and to provide safe institutional or residential services, community-based services, or living environments for vulnerable adults who have been maltreated. In addition, it is the policy of this state to require the reporting of suspected maltreatment of vulnerable adults, to provide for the voluntary reporting of maltreatment of vulnerable adults, to require the investigation of the reports, and to provide protective and counseling services in appropriate cases.

Id.

257. Donald H. J. Hermann, *The Question Remains: Are There Terminally Ill Patients Who Have a Constitutional Right to Physician Assistance in Hastening the Dying Process*, 1 DEPAUL J. HEALTH CARE L. 445, 463 (1997).

258. Wesley J. Smith, NAT'L REV., <http://www.nationalreview.com/author/wesley-j-smith> [<https://perma.cc/A65B-XESY>].

259. SMITH, *supra* note 70, at 15, 248.

to cover the costs of physician-assisted suicide.²⁶⁰ Osgood supported her opposition to the legalization of the practice by stating the following:

Older people, living in a suicide-permissive society characterized by ageism, may come to see themselves as a burden on their families or on society and feel it is incumbent on them to take their own lives False The right to die then becomes not a right at all but rather an obligation In a society that devalues old age and old people, in which older adults are seen as “expendable” and as an economic burden on younger members, older people may come to feel it is their social duty to kill themselves.²⁶¹

The normal aging process can be a difficult journey for some people. As a person ages, he or she suffers mental and physical decline.²⁶² Once a person hits middle age, there is more to reflect upon than to look forward to. For some persons, that fact can be depressing, especially if they have outlived most of their friends and family members.²⁶³ Eventually, even an older person who is in relatively good health may become dependent on other people. When an elderly person is diagnosed with a terminal illness, he or she has to reach out to family members for support. In some cases, an adult child may be forced to take on the role of caregiver. Parents are used to taking care of their children; many become uncomfortable when the roles are reversed. The adult child may be perfectly content to care for the elderly patient during his or her last days. Nonetheless, the terminally-ill elderly patient may choose the procedure to avoid

260. *Assisted Suicide: Legal, Medical, Ethical and Social Issues: Hearing Before the Subcomm. on Health & Env't of the Comm. on Commerce*, 105th Cong. 71-76 (1997) (statement of Nancy J. Osgood, Professor of Gerontology and Sociology, Virginia Commonwealth University, Medical College of Virginia).

261. Nancy J. Osgood, *Assisted Suicide and Older People—A Deadly Combination: Ethical Problems in Permitting Assisted Suicide*, 10 *ISSUES L. & MED.* 415, 418 (1995).

262. *Id.* at 421-22.

263. Anissa Rogers, *Factors Associated with Depression and Low Life Satisfaction in the Low-Income, Frail Elderly*, 31 *J. GERONTOLOGICAL SOC. WORK* 167, 168 (1999); Sukhpreit Sohi, *Depression: Risk Factors and Treatment Options*, 35 *WYO. LAW.* 52, 52 (2012).

being an emotional, physical and/or financial burden on that child.²⁶⁴

Terminally-ill elderly persons who do not have any family may be especially susceptible to the suggestion that they end their lives.²⁶⁵ Therefore, the patient's request for the lethal dose of medication may not really be voluntary. This is a concern because, once the patient becomes eligible to receive the prescription for the lethal dose of medication, nothing in the statutes requires the physician to determine exactly why the patient wants to end his or her life.²⁶⁶

Critics of physician-assisted suicide are also concerned that the elderly and disabled may be forced to end their lives using the lethal doses of medication.²⁶⁷ That apprehension may stem from the fact that the statutes do not contain mechanisms for reporting abuse or require monitoring of the use of the medication.²⁶⁸ Further, after he or she writes the prescription, the physician's role in the process is limited. The physician can, but is not required to witness the patient taking the medication.²⁶⁹ As a consequence, the patient usually dies at home surrounded by family members who may benefit from his or her death²⁷⁰ and/or members of an organization like

264. Steven H. Aden, *You Can Go Your Own Way: Exploring the Relationship Between Personal and Political Autonomy in Gonzales v. Oregon*, 15 TEMP. POL. & CIV. RTS. L. REV. 323, 334 (2006).

265. Rebecca L. Volpe & Deborah Steinman, *Peeking Inside the Black Box: One Institution's Experience Developing Policy for Unrepresented Patients*, 36 HAMLIN L. REV. 265, 266-67 (2013) (discussing the increasing number of seniors who are alone or unrepresented).

266. According to the annual reports from the Oregon Public Health Division, the three main reasons most patients gave for selecting physician-assisted suicide were: (1) loss of autonomy, (2) inability to participate in activities that make life enjoyable, and (3) loss of dignity. OR. PUB. HEALTH DIV., *supra* note 8, at 4.

267. The statutes make this type of action a crime. *See, e.g.*, OR. REV. STAT. ANN. § 127.890 (West 2016).

268. According to the Oregon Public Health Division's 2014 Report, only 125 of the 218 patients who got prescriptions ingested the medication. OR. PUB. HEALTH DIV., *supra* note 8, at 3.

269. According to the Oregon Public Health Division's 2015 Report, the doctors who prescribed the medication were present for the deaths of 14 patients (10.8%). *Id.* at 4. That number represented a decline from previous years where physicians were present for 15.7% of the deaths. *Id.*

270. The statute requires the physician to recommend that the patient notify his or her next of kin of his or her decision to request the medication. OR. REV. STAT. ANN. §

Compassion and Choices that may use the death for political reasons.²⁷¹ The opportunity to “doctor shop” also exposes elderly and disabled patients to abuse.²⁷² The case of Kate Cheney is a good example of what can go wrong when a patient is encouraged to keep searching until he or she finds a physician who is willing to certify him or her as eligible to receive a prescription for the lethal dose of medication.²⁷³

While she was living with her daughter, Erika, eighty-five-year-old Kate Cheney was diagnosed with terminal stomach cancer.²⁷⁴ Kate allegedly told Erika that she was thinking about getting a prescription for a lethal dose of medication so she could end her life.²⁷⁵ As a result, Erika and Kate went to the doctor who was treating Kate.²⁷⁶ That doctor referred Kate to a psychiatrist who concluded that Kate was not capable of requesting the medication because she was cognitively impaired.²⁷⁷ At that time, Kate was having difficulty remembering recent events and people.²⁷⁸ The psychiatrist also expressed his concern that Kate was being pressured by Erika to ask for the prescription.²⁷⁹

127.835 (West 2016). The patient may take the physician’s statement as a command instead of a suggestion.

271. Nicole Weisensee, *New Brittany Maynard Video Released on One-Year Anniversary of Launch of Her Campaign*, PEOPLE (Oct. 6, 2016, 6:02 PM), <http://people.com/human-interest/new-brittany-maynard-video-released/> [https://perma.cc/G97C-CG3Q]. Compassion and Choices used Brittany Maynard’s death to gain public support for and to lobby for physician-assisted suicide. *Id.* Barbara Coombs Lee, the president of the organization, was quoted as saying, “Brittany came on the scene and set in motion a chain of events that passed an aid-in-dying bill through the California legislature less than one year after her death. We had been trying to do that since 1991.” *Id.*

272. CHIN ET AL., *supra* note 101, at 7. The statute does not limit the number of doctors that the patient can see. *Id.* Therefore, the patient can keep visiting doctors until the patient finds one who is willing to deem the patient capable of receiving a prescription for the lethal dose of medication. At least five of the fifteen deaths reported in the first year of the Oregon statute’s operation were of patients who had first been turned down by at least one physician. *Id.*

273. Herbert Hendin & Kathleen Foley, *Physician-Assisted Suicide in Oregon: A Medical Perspective*, 24 ISSUES L. & MED. 121, 131-32 (2008).

274. *Id.* at 131.

275. *Id.*

276. *Id.*

277. *Id.* at 131-32.

278. Hendin & Foley, *supra* note 273, at 132.

279. *Id.*

Erika sought a second opinion from a psychologist who acknowledged that Kate was having short-term memory problems and being pressured by Erika.²⁸⁰ Nonetheless, the psychologist determined that Kate was competent to request the medication.²⁸¹ Once Kate received the prescription for the lethal dose of medication, Erika put her in a nursing home for a week.²⁸² While she was in the nursing home, Kate repeatedly asked Erika to let her return home.²⁸³ Erika eventually complied with Kate's wishes.²⁸⁴ After Kate left the nursing home and returned to Erika's house, she ingested the lethal dose of medication and died.²⁸⁵

It is unclear why Erika was so persistent in her quest for her mother to take the lethal medication. Erika may have been motivated by compassion because she did not want to see her mother suffer. She may have been inspired by greed if she would benefit financially from Kate's death. Erika may have just been suffering from caregiver's fatigue.²⁸⁶ Regardless of Erika's motive, it appears that Kate did not choose to end her life; Erika made the choice for her.²⁸⁷ In light of her age and medical condition, Kate may not have had the energy to fight for her right to decide whether or not to end her life. This scenario indicates why the elderly and the disabled may be disadvantaged by the legalization of physician-assisted suicide.

The costs of end-of-life care are skyrocketing.²⁸⁸ Those costs will continue to increase as the baby boomers age.²⁸⁹ More

280. *Id.*

281. *Id.*

282. *Id.*

283. Hendin & Foley, *supra* note 273, at 132.

284. *Id.*

285. *Id.*

286. See Nathan E. Goldstein et al., *Factors Associated with Caregiver Burden Among Caregivers of Terminally Ill Patients with Cancer*, 20 J. PALLIATIVE CARE 38, 38-43 (2004); Stefan Staicovici, Comment, *Respite Care for All Family Caregivers: The Lifespan Respite Care Act*, 20 J. CONTEMP. HEALTH L. & POL'Y 243, 250-252 (2003); Jan F. Ybema et al., *Caregiver Burnout Among Intimate Partners of Patients with a Severe Illness: An Equity Perspective*, 9 PERS. RELATIONSHIPS 73, 73-87 (2002).

287. Hendin & Foley, *supra* note 273, at 132.

288. M. Cathleen Kavery, *Managed Care, Assisted Suicide, and Vulnerable Populations*, 73 NOTRE DAME L. REV. 1275, 1280 (1998).

and more elder patients are relying on Medicare or Medicaid to cover those costs.²⁹⁰ Therefore, the government has to find ways to reduce health-care costs. To that end, the Affordable Care Act included a provision that permitted Medicare to pay doctors and other health-care providers for consultations about end-of-life care.²⁹¹ In response, then Republican Vice-President nominee Sarah Palin accused the Obama administration and Democrats in Congress of creating “death panels” by eliminating sick senior citizens to reduce costs.²⁹² Public reaction to that statement caused the provision to be removed from the legislation.²⁹³ However, on October 30, 2015, as a part of its 2016 Medicare physician-fee schedule, the Centers for Medicare and Medicaid Services (CMS) approved payment for voluntary end-of-life counseling.²⁹⁴ Some persons are concerned that the physicians will focus their counseling on the cheapest option—physician-assisted suicide.²⁹⁵

There is the perception that the health care system devalues the lives of the elderly and the disabled.²⁹⁶ Consequently, opponents of the legalization of physician-assisted suicide

289. Kate Maher, *Reforming Medicare-Financed Graduate Medical Education*, 30 J. CONTEMP. HEALTH L. & POL'Y 337, 342-343 (2014).

290. According to the Oregon Public Health Division's 2015 Death with Dignity Act Report, the number of patients taking the lethal dose of medication that had only Medicare or Medicaid insurance was higher than in previous years (62.5% compared to 38.3%). OR. PUB. HEALTH DIV., *supra* note 8, at 4.

291. Jeanne Merkle Sorrell, *Ethics: The Patient Protection and Affordable Care Act: Ethical Perspectives in 21st Century Health Care*, 18 ONLINE J. ISSUES NURSING (2012), <http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/Columns/Ethics/Patient-Protection-and-Affordable-Care-Act-Ethical-Perspectives.html> [<https://perma.cc/PJ36-ESCL>].

292. Bruce Japsen, *With Palin's 'Death Panels' Debunked, Congress Pushes End-of-Life Planning*, FORBES (July 5, 2015, 9:00 AM), <https://www.forbes.com/sites/brucejapsen/2015/07/05/with-palin-death-panels-debunked-congress-pushes-end-of-life-planning/#5290189852a1> [<https://perma.cc/7FDQ-ATWJ>].

293. *Id.*

294. Robert Lowes, *Medicare Approves Payment for End-of-Life Counseling*, MEDSCAPE (Oct. 30, 2015), <http://www.medscape.com/viewarticle/853541> [<https://perma.cc/92JY-B62L>].

295. Marilyn Golden, *The Danger of Assisted Suicide Laws*, CNN (Oct. 14, 2014, 4:04 PM), <http://www.cnn.com/2014/10/13/opinion/golden-assisted-suicide/> [<https://perma.cc/5KH8-TGNQ>].

296. Marshall B. Kapp, *Old Folks on the Slippery Slope: Elderly Patients and Physician-Assisted Suicide*, 35 DUQ. L. REV. 443, 451-52 (1996).

contend that, in order to reduce health care costs, physicians and insurance companies may aggressively encourage elderly and disabled patients to request prescriptions for the lethal dose of medication.²⁹⁷ For instance, one of the main reasons given by patients who have elected physician-assisted suicide is the loss of autonomy.²⁹⁸ Proponents of physician-assisted suicide argue that persons in those situations should be given the opportunity to end their lives.²⁹⁹ Unfortunately, many disabled people do not have much autonomy.³⁰⁰ Thus, physicians might use the “loss of autonomy” argument to encourage a disabled person to end his or her life.

A person with a physical disability already faces significant challenges.³⁰¹ As a result, a physician may reason that, for that person, a diagnosis of a terminal illness is more devastating than for an able-bodied patient. Even a well-intended physician may be more paternalistic when dealing with elderly and disabled patients.³⁰² Therefore, the physician may feel more of a duty to help those patients end their suffering. Moreover, if the disability requires long-term treatment, the insurance company may be willing to cover the cost of physician-assisted suicide in order to reduce costs.

The legislatures attempted to address these concerns. For instance, the statutes expressly state that a patient’s eligibility for physician-assisted suicide cannot be based solely on his or

297. See Andrew L. Batavia, *Disability and Physician-Assisted Suicide*, 336 NEW ENG. J. MED. 1671, 1671-73 (1997); Anthony J. Dangelantonio, *Physician-Assisted Suicide: The Legal and Practical Contours*, 4 RISK-ISSUES HEALTH & SAFETY 55, 60-61 (1993); Susan M. Wolf, *Physician-Assisted Suicide in the Context of Managed Care*, 35 DUQ. L. REV. 455, 466 (1996).

298. E. Dahl & N. Levy, *The Case for Physician Assisted Suicide: How Can It Possibly Be Proven?*, 32 J. MED. ETHICS 335, 335 (2006).

299. Tania Salem, *Physician-Assisted Suicide: Promoting Autonomy or Medicalizing Suicide?*, 29 HASTINGS CTR. REP. 30, 31 (1999).

300. Kapp, *supra* note 296, at 448-50.

301. *Common Barriers to Participation Experienced by People with Disabilities*, CTR. DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/ncbddd/disabilityandhealth/disability-barriers.html> [<https://perma.cc/FU6X-4E5K>].

302. S. Elizabeth Malloy, *Beyond Misguided Paternalism: Resuscitating the Right to Refuse Medical Treatment*, 33 WAKE FOREST L. REV. 1035, 1069-1076 (1998).

her age or disability.³⁰³ Hence, those characteristics alone should not lead a physician to presume that the patient would want a prescription for the lethal dose of medication. This clarification is designed to reduce the possibility that elderly and disabled patients will be sacrificed to save medical costs.³⁰⁴ Nonetheless, there is nothing that prevents physicians from ignoring this language in the statutes.

Another protection included in the statutes is the requirement that witnesses attest to the fact that the patient was not forced to make the written request for the medication.³⁰⁵ This precaution does not address coercion that can occur before the terminally-ill patient gets in front of the witnesses. In addition, since the statutory monitoring is limited after the patient receives the prescription,³⁰⁶ it does not prevent a patient from being forced to fill the prescription and/or to ingest the medication.

2. *The Mentally Ill*

The elderly and the disabled may not be the only vulnerable patients at risk. Persons dealing with psychological disorders may also be easily exploited. Mentally ill patients present a unique problem. On the one hand, there are laws in place to ensure that the mentally ill have the same rights and protections as persons who have not been diagnosed with a mental illness.³⁰⁷ Therefore, a mentally ill person who has been diagnosed with a terminal illness should have the right to choose physician-assisted suicide like any other terminally-ill patient. However, since persons suffering from mental illnesses are vulnerable, there are laws in place to protect them from harm and exploitation.³⁰⁸ As a result, the physician-assisted suicide

303. OR. REV. STAT. ANN. § 127.805 (West 2016).

304. Lewis, *supra* note 241, at 472-73.

305. OR. REV. STAT. ANN. § 127.810 (West 2016).

306. Lewis, *supra* note 241, at 468.

307. *See, e.g.*, 42 U.S.C. § 12101 (2012).

308. *See, e.g.*, *Public Policy: Current Federal Elder Justice Laws*, NAT'L CTR. ELDER ABUSE, <https://ncea.acl.gov/whatwedo/policy/federal.html> [<https://perma.cc/D5LB-V4S6>].

statutes should contain special protections for mentally ill patients who have been diagnosed with a terminal illness.

Currently, the statutes do not require that a patient receive counseling prior to requesting the prescription unless the treating physician feels that the “patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment.”³⁰⁹ Physicians frequently do not refer their patients for counseling prior to prescribing the lethal dose of medication.³¹⁰ Thus, any safeguards in the statutes designed to protect the mentally ill are illusory. When opposing the physician-assisted suicide, Smith stated, “when society accepts the fundamental premise that killing is an acceptable answer to human suffering, those with serious psychiatric conditions become easy targets.”³¹¹

Legislatures have attempted to protect mentally ill patients by including several safeguards in the statutes. The physician has the option of sending the patient to counseling if he or she believes that the person is suffering from a mental illness or depression that impairs his or her judgment.³¹² Given the time pressures faced by physicians, a physician may not be able to spend enough time with a patient to accurately assess the patient’s state of mind.³¹³ Hence, some mentally ill patients may be falling through the cracks. Furthermore, the patient is given the opportunity to rescind the request for the medication at any time.³¹⁴ As a further protection, the statutes mandate a waiting period between the request for the medication and the writing of

309. OR. REV. STAT. ANN. § 127.825 (West 2016).

310. According to the Oregon Public Health Division’s 2014 Death with Dignity Act Report, only three of the 105 patients who ingested the medication in 2014 were referred for formal psychiatric or psychological evaluation. OR. PUB. HEALTH DIV., *supra* note 8, at 2.

311. Wesley J. Smith, *Euthanasia’s Open Season on the Mentally Ill*, FIRST THINGS (June 26, 2015), <https://www.firstthings.com/web-exclusives/2015/06/euthanasias-open-season-on-the-mentally-ill> [<https://perma.cc/VB6R-673Y>] (discussing examples of cases where mentally-ill, physically healthy were permitted to end their lives using physician-assisted suicide).

312. OR. REV. STAT. ANN. § 127.815 (West 2016).

313. Sandra Camahan, *Does Concierge Medicine Promote Health Care Choice or Is It a Barrier to Access?*, 17 STAN. L. & POL’Y REV. 121, 128 (2006).

314. OR. REV. STAT. ANN. § 127.845 (West 2016).

the prescription to allow physicians to make sure that patients are capable of making an informed decision.³¹⁵ The doctor shopping loophole in the statutes may render this safeguard ineffective.³¹⁶ Furthermore, poverty may make some patients especially vulnerable to the whims of insurance companies.³¹⁷

3. *The Economically Disadvantaged*

Low-income people have to rely on state Medicaid programs for health insurance.³¹⁸ The Affordable Care Act gave states the opportunity to expand the availability of Medicaid in order to benefit more low-income people.³¹⁹ Consequently, since the number of economically-disadvantaged people relying on Medicaid will increase, states will eventually be forced to find ways to reduce costs.³²⁰ Opponents of physician-assisted suicide fear that Medicaid programs and private insurance companies may see the practice as a cost-saving measure.³²¹ As a consequence, terminally-ill patients with limited financial resources may be steered towards physician-assisted suicide.³²² The stories of two Oregon Medicaid patients may give these consternations some validity.

315. OR. REV. STAT. ANN. § 127.850 (West 2016).

316. *Why Assisted Suicide Must Not Be Legalized*, DISABILITY RTS. FOUND. & DEF. FUND, <https://dredf.org/public-policy/assisted-suicide/why-assisted-suicide-must-not-be-legalized/> [<https://perma.cc/DUK8-ZTKY>].

317. Ezekiel J. Emanuel & Margaret P. Battin, *What Are the Potential Cost Savings from Legalizing Physician-Assisted Suicide?*, 339 NEW ENGL. J. MED. 167, 167 (1998).

318. Frederick H. Cohen, *An Unfulfilled Promise of the Medicaid Act: Enforcing Medicaid Recipients' Right to Health Care*, 17 LOY. CONSUMER L. REV. 375, 376 (2005).

319. Rick Mayes, *An Analysis of the Political and Legal Debates Concerning Medicaid Expansion in Virginia*, 18 RICH. J.L. & PUB. INT. 23, 27 (2014).

320. The federal government will cover 100% of the medical costs for new recipients until 2017. Jean Sullivan & Rachel Gershaw, *State Fiscal Considerations and Research Opportunities Emerging from the Affordable Care Act's Medicaid Expansion*, 40 AM. J.L. & MED. 237, 238 (2014). Then, the federal contribution will be gradually reduced annually. *Id.* at 238. Thus, the responsibility for the additional Medicaid recipients will eventually shift to the states. *Id.* at 242.

321. Emanuel & Battin, *supra* note 317, at 167, 170.

322. Franklin G. Miller & Diane E. Meier, *Voluntary Death: A Comparison of Terminal Dehydration and Physician-Assisted Suicide*, 128 ANNALS INTERNAL MED. 559, 559 (1998).

Barbara Wagner was devastated when her doctor told her that her lung cancer was no longer in remission.³²³ As a treatment of last resort, Wagner's doctor prescribed Tarceva, a drug that might slow the growth of her tumors and give her an additional four to six months to live.³²⁴ Unfortunately, the drug cost \$4,000 per month.³²⁵ Because she could not afford to pay for the drug, Wagner turned to Medicaid for assistance.³²⁶ Wagner suffered another blow when she received a letter from Oregon's Medicaid program stating that it would not pay for the drug because it did not guarantee a five percent survival rate after five years.³²⁷ Wagner was not comforted by Medicaid's offer to pay fifty dollars to cover the cost of the drugs she would need to end her life.³²⁸ The pharmaceutical company gave Wagner the drug for free.³²⁹ Oregon's Medicaid program also would only agree to pay for prostate cancer patient Randy Stroup to obtain the lethal dose of medication he would need to commit suicide.³³⁰ After a public outcry, Stroup successfully appealed the denial of treatment.³³¹

4. *People of Color*

Patients of color are another population of people who may be treated as disposable. People of color, especially African Americans, are treated unfairly by health care providers.³³² That inequality may lead physicians to conclude that the lives of

323. Susan Donaldson James, *Death Drugs Cause Uproar in Oregon*, ABC NEWS (Aug. 6, 2008), <http://abcnews.go.com/Health/story?id=5517492> [<https://perma.cc/J63Y-XUUY>].

324. *Id.*

325. *Id.*

326. Wesley Smith, *'Right to Die' Can Become a 'Duty to Die'*, TELEGRAPH (Feb. 20, 2009, 8:01 PM), <http://www.telegraph.co.uk/comment/personal-view/4736927/Right-to-die-can-become-a-duty-to-die.html> [<https://perma.cc/792F-UGYW>].

327. James, *supra* note 323.

328. *Id.*

329. *Id.*

330. Smith, *supra* note 326.

331. *Id.*

332. See generally Kevin Outterson, *Tragedy and Remedy: Reparations for Disparities in Black Health*, 9 DEPAUL J. HEALTH CARE L. 735 (2005) (arguing that disparities in African American health was rooted in discrimination and survived to the present day).

people of color are not worth saving. Thus, physician-assisted suicide may become the number one treatment option for terminally-ill patients of color. Due to disparities in the United States health-care system, people of color tend to receive lower quality preventive care and poor pain management.³³³ For example, African Americans received medical treatment that is inferior to Whites for conditions that have been identified as the leading causes of death in America.³³⁴ As a result, patients of color are often placed in situations where they may end up terminally-ill. After patients of color are diagnosed with terminal illnesses, they often receive inadequate treatment and poor pain management.³³⁵ Consequently, physicians may be able to persuade those suffering patients to request a prescription for the lethal dose of medication.

It is not ethical to use resources to help these patients die when disparities in the system reduce their chances of living longer, healthy lives. Bioethicist Arthur Caplan contends that, instead of focusing on a patient's right to choose physician-assisted suicide, the health care profession should work to guarantee that every person is able to receive adequate health care and long-term care at the end of life.³³⁶ In American society, there may be a perception that the lives of persons of color are not valued.³³⁷ This is substantiated by the numerous

333. See generally Ruqaiijah Yearby, *Breaking the Cycle of 'Unequal Treatment' with Health Care Reform: Acknowledging and Addressing the Continuation of Racial Bias*, 44 CONN. L. REV. 1281 (2012) (discussing how racial bias in the health care system negatively impacts African Americans).

334. Bowser, *supra* note 15, at 367-70.

335. Dania Palanker, *Enslaved by Pain: How the United States Public Health System Adds to Disparities in Pain Treatment for African Americans*, 15 GEO. J. POVERTY L. & POL'Y 847, 851-852 (2008).

336. Arthur L. Caplan, Lois Snyder & Kathy Faber-Langendoen, *The Role of Guidelines in the Practice of Physician-Assisted Suicide*, 132 ANNALS INTERNAL MED. 476, 477-81 (2000).

337. Twila L. Perry, *The Transactional Adoption Controversy: An Analysis of Discourse and Subordination*, 21 N.Y.U. REV. L. & SOC. CHANGE 33, 61 (1994); Tony Lee, *Md. Gov. Martin O'Malley at MLK Rally: 'Lives of People of Color' Are "Often Valued Less" Than Whites'*, FOX NEWS (Aug. 28, 2013), <http://nation.foxnews.com/2013/08/28/md-gov-martin-o%E2%80%99malley-mlk-rally-lives-people-color-are-often-valued-less-whites> [https://perma.cc/LY9Y-YW6H]; Gregory D. Squires & Charis E. Kubrin, *Privileged Places: Race, Opportunity and Uneven*

reports of police shootings of unarmed men of color.³³⁸ Currently, the law has not been able to successfully ensure that physicians provide adequate medical care to people of color,³³⁹ and there is nothing in the statutes to prevent doctors from disproportionately encouraging people of color to end their lives once they are given a terminal diagnosis.³⁴⁰

B. Excluded Groups

Removing the loopholes from the statutes and providing better safeguards is not the end of the story. The current regime legalizing physician-assisted suicide excludes terminally-ill patients who may be vulnerable because of their age or the progression of their disease.³⁴¹ These patients may feel like they are disposable because they are treated as if they do not exist. That invisibility exposes those patients to pain and suffering that is considered unacceptable for other terminally-ill patients.

1. Minors

Unfortunately, persons under the age of eighteen suffer from terminal illnesses.³⁴² In some cases, parents may not be content to sit idly by and let their children suffer. Those parents may want the ability to hasten the deaths of their terminally-ill children with the use of lethal doses of prescription medication. They may simply want a physician to write a prescription for the

Development in Urban America, NAT'L HOUSING INST. (2016), <http://nhi.org/online/issues/147/privilegedplaces.html> [<https://perma.cc/8KBW-F78T>].

338. Mark A. Cunningham, *Civil Discourse and the Role of the Profession in Public Policy*, 63 LA. B.J. 186, 186 (2015).

339. Neil M. Gorsuch, *The Legalization of Assisted Suicide and the Law of Unintended Consequence: A Review of the Dutch and Oregon Experiments and Leading Utilitarian Arguments for Legal Change*, 2004 WIS. L. REV. 1347, 1384-85.

340. *Id.* at 1348, 1372, 1375, 1403.

341. *Oregon v. Ashcroft*, 368 F.3d 1118, 1121-22 (9th Cir. 2004).

342. Browne Lewis, *The Ethics of Physician-Assisted Suicide—Disposable People: Physician-Facilitated and Vulnerable Populations*, Address at Gresham College (Jan. 25, 2016); see also *Mental Illness in Children: Know the Signs*, MAYO CLINIC, <http://www.mayoclinic.org/healthy-lifestyle/childrens-health/in-depth/mental-illness-in-children/art-20046577> [<https://perma.cc/KBQ7-ALDC>]; *Mental Health Facts: Children and Teens*, NAT'L ALLIANCE MENTAL ILLNESS, <https://www.nami.org/getattachment/Learn-More/Mental-Health-by-the-Numbers/childrenmhfacts.pdf> [<https://perma.cc/TMF6-G4S9>].

lethal medication, so they can have the opportunity to help their children to die with dignity. This decision may be influenced by the fact that the child is constantly in severe pain and/or the family is financially overburdened. The option of physician-assisted suicide is not available to parents in the United States because minor children are not covered in the five states that have legalized the practice.³⁴³

Nonetheless, the possibility that some parents will be able to end the lives of their terminally-ill children using physician-assisted suicide is not farfetched. In December 2013, the groundwork was laid for parents in Belgium to have the opportunity to choose physician-assisted suicide for their terminally-ill children.³⁴⁴ The Belgium Senate approved a statutory amendment that made euthanasia available to minors who have a “capacity of discernment.”³⁴⁵ In order for the amendment to apply, the minor must be in a “medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident.”³⁴⁶ In September 2016, a seventeen year-old Belgian became the first minor to utilize Belgium’s new law.³⁴⁷

Even in states where physician-assisted suicide is legal, the practice will probably not be expanded to include minors. The law presumes that persons under the age of eighteen are not

343. In order to be eligible to request the lethal medication, the patient must be an adult. OR. REV. STAT. ANN. § 127.805(1) (West 2016). An adult is defined as a person who is 18 years or older. OR. REV. STAT. ANN. § 127.800(1) (West 2016).

344. *Belgian Senate Votes to Extend Euthanasia to Children*, BBC (Dec. 13, 2013, 11:49 AM), <http://www.bbc.com/news/world-europe-25364745> [<https://perma.cc/B9X4-F8HL>]. Belgian Senator Jean-Jacques De Gucht stated that “[t]here is no age for suffering and, next to that, it’s very important that we have a legal framework for the doctors who are confronted with this demand today.” *Id.*

345. The Oregon and Washington statutes specifically prohibit active euthanasia. *See* OR. REV. STAT. ANN. § 127.888 (West 2016); WASH. REV. CODE ANN. § 70.245.180(1) (West 2016).

346. HERMAN NYS, *MEDICAL LAW IN BELGIUM* 125 (2010).

347. David Chazan, *Terminally Ill Child Becomes First Euthanized Minor in Belgium*, TELEGRAPH (Sept. 17, 2016, 4:06 PM), <http://www.telegraph.co.uk/news/2016/09/17/terminally-ill-child-becomes-first-euthanised-minor-in-belgium/> [<https://perma.cc/3MP8-ES5H>]. The teenager was reported to be “critically ill,” but no other information was provided. *Id.*

competent to make life-changing decisions.³⁴⁸ Therefore, minors are not legally permitted to perform numerous acts, including buying and selling property, executing wills and advanced directions, and signing legally binding contracts.³⁴⁹ The reluctance to permit minors to make medical decisions is based on the following two presumptions: (1) minors are not equipped to make sound medical decisions,³⁵⁰ and (2) parents act in the best interests of their children.³⁵¹

Because, in some states, minors are deemed incompetent to buy certain non-prescription drugs,³⁵² in order to prevent abuse,³⁵³ they should not be permitted to request a prescription for a lethal dose of medication. One concern is that minors may not understand the finality of death because they are immature and lack life experiences.³⁵⁴ Nonetheless, a terminally-ill minor may have a more intimate comprehension of death based upon his or her life experiences.³⁵⁵ In addition, minors may feel

348. Melinda T. Derish & Kathleen Vanden Heuvel, *Mature Minors Should Have the Right to Refuse Life-Sustaining Medical Treatment*, 28 J.L. MED. & ETHICS 109, 112-113 (2000).

349. See MD. CODE ANN. § 4-101 (West 2016); N.C. GEN. STAT. ANN. §§ 35A-1201(a)(1)-(6) (West 2016); Emily Buss, *The Parental Rights of Minors*, 48 BUFF. L. REV. 785, 786 (2000).

350. Anthony W. Austin, *Medical Decisions and Children: How Much Voice Should Children Have in Their Medical Care?*, 49 ARIZ. L. REV. 143, 152 (2007); Anne Compton-Brown, *Examining Patient Integrity and Autonomy: Is Assisted Death a Viable Option for Adolescents in the United States?*, 23 ANNALS HEALTH L. ADVANCE DIRECTIVE 86, 91-92 (2014).

351. Derish & Heuvel, *supra* note 348, at 112; B. Jessie Hill, *Medical Decision Making by and on Behalf of Adolescents: Reconsidering First Principles*, 15 J. HEALTH CARE L. & POL'Y 37, 38 (2012).

352. See, e.g., ALA. CODE § 20-2-190(e) (2016) (stating a person must be at least eighteen years old to take a drug containing pseudoephedrine); IND. CODE ANN. § 35-48-4-14.7(d)(1) (West 2016); N.C. GEN. STAT. ANN. § 90-113.56(c) (West 2016).

353. Pseudoephedrine is the key ingredient in methamphetamine, an illegal drug that is dangerous to make and easy to sell; it kills hundreds of thousands of minors a year in the United States. Patricia Stanley, *The Combat Methamphetamine Epidemic Act: New Protection or New Intrusion?*, 39 TEX. TECH L. REV. 379, 382 (2007); Susan Calcaterra & Ingrid A. Binswanger, *Psychostimulant-Related Deaths as Reported by a Large National Database*, 34 SUBSTANCE ABUSE 129, 129-131 (2013).

354. Sharon Cohen, *Because of Her Age, Many View Her as a Cause Celebre: Indiana Girl, 17, One of 35 Awaiting Execution*, L.A. TIMES (Jan. 18, 1987), http://articles.latimes.com/1987-01-18/news/mn-5522_1_paula-cooper [<https://perma.cc/LHS2-QENG>].

355. Kimberly Gordy, *Adding Life to the Adolescent's Years, Not Simply Years to the Adolescent's Life: The Integration of the Individualized Care Planning & Coordination*

pressured to die to relieve the suffering of their parents. Although the government is hesitant to interfere with parental control over their children, the government will step in if a parent is causing harm to or letting harm be caused to their minor children.³⁵⁶ For example, some courts have prevented parents from refusing medical treatments for their minor children because of religious reasons.³⁵⁷ Therefore, the law will not permit a parent to request a prescription for the lethal dose of medication on behalf of his or her terminally-ill minor child.

Because pain and suffering do not respect age, minors should be permitted to die with dignity. A minor who is suffering from a terminal illness is probably older than his or her chronological age.³⁵⁸ As a result, a terminally-ill minor should be given the opportunity to prove that he or she is mature enough to decide whether or not to request or assent to a parental request for a prescription to obtain the lethal dose of medication. Nevertheless, even persons who advocate for the legalization of physician-assisted suicide are uncomfortable with the thought of children being given the option of committing suicide.³⁵⁹ Before minors can be included in the group that can choose physician-assisted suicide, a lot of questions must be answered and numerous safeguards must be put in place. The main question is who gets to request the prescription—the parent(s) or the terminally-ill minor.³⁶⁰

2. Nonterminal Patients

The current physician-assisted suicide system does not meet the needs of two classes of patients. The first class includes patients suffering from diseases that destroy the physical body who are not deemed legally or medically terminal because their

Model and a Statutory Fallback Provision, 11 YALE J. HEALTH POL'Y L. & ETHICS 169, 179-80 (2011).

356. Ann Maclean Massie, *Withdrawal of Treatment for Minors in a Persistent Vegetative State: Parents Should Decide*, 35 ARIZ. L. REV. 173, 193-194 (1993).

357. Karen L. Diaz, *Refusal of Medical Treatment Based on Religious Beliefs: Jehovah's Witness Parents*, 16 J. CONTEMP. LEGAL ISSUES 85, 88-89 (2001).

358. Gordy, *supra* note 355, at 171-72.

359. *Id.* at 198-200; Derish & Heuvel, *supra* note 348, at 117-18.

360. Derish & Heuvel, *supra* note 348, at 118-19.

doctors expect them to survive longer than six months.³⁶¹ In those cases, the doctors rely on their medical judgments to conclude that the patients will die at some specified time in the future.³⁶² A patient in that category has a predicted expiration date, but that date is too far in the future for the patient to be labeled as terminal. For example, if a doctor states that the patient has seven months to live, that patient is not eligible for physician-assisted suicide.

The second class consists of patients suffering from progressive, irreversible brain disorders, like Alzheimer's disease, that gradually destroy their memories and their ability to learn, reason, and make decisions. Those patients are expected to physically survive their afflictions for an indeterminate period of time.³⁶³ Therefore, because they may live longer than six months, for purposes of requesting physician-assisted suicide, those patients are not recognized as being terminal.

The law needs to be expanded to serve the needs of patients in both of these groups. Some of the reasons articulated for legalizing physician-assisted suicide include the following: (1) permitting terminally-ill patients to die before they lose autonomy, (2) easing the pain and suffering of terminally-ill patients, and (3) reducing the costs of end-of-life care.³⁶⁴ Expanding the availability of physician-assisted suicide to non-terminal patients is consistent with those objectives.³⁶⁵ There are no easy fixes for the ethical issues discussed in this section. Nonetheless, legislatures should attempt to close the loopholes in the statutes and to add safeguards in order to allow vulnerable patients to die with dignity.

361. OR. REV. STAT. ANN. § 127.800 (West 2016) (“‘Terminal disease’ means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.”).

362. OR. REV. STAT. ANN. § 127.815 (West 2016).

363. Joan W. Dalbey Donahue, *Physician Assisted Suicide: A “Right” Reserved for Only the Competent?*, 19 VT. L. REV. 795, 825-26 (1995).

364. Lewis, *supra* note 241, at 484.

365. *Id.*

V. RECOMMENDATIONS

The statutes can be modified to alleviate some of the ethical concerns that have been raised by supporters and detractors of physician-assisted suicide. The recommendations in this section will benefit all patients who have been diagnosed with a terminal illness. Nonetheless, the suggestions are specifically necessary to protect patients who are in danger of being labelled as “vulnerable.”

A. Advanced Directives

Currently, the statutes do not permit a patient to request a prescription for the lethal dose of medication unless he or she is suffering from a terminal illness.³⁶⁶ One way to protect terminally-ill patients from being pressured to select physician-assisted suicide is to permit patients to choose the procedure as an option in an advanced directive before their conditions become terminal.³⁶⁷ When doctors discuss end-of-life options with their patients, they should include a discussion of physician-assisted suicide. At that time, the patient will probably be thinking clearer and better able to make a decision. After the patient starts treatment and the disease progresses, his or her judgment may be clouded by medication and pain. Additionally, a patient’s request for the prescription may be more voluntary if that request is made before the patient receives the terminal diagnosis. Once the physician tells the patient that his or her condition is terminal, the patient’s decision to make the request may be the result of fear and/or guilt. A patient may experience those emotions because he or she does not want to be a burden to family members.

366. *See, e.g.*, OR. REV. STAT. ANN. § 127.815.

367. OR. REV. STAT. ANN. § 127.897 (2016). This form could be modified to include language permitting patients to indicate their desire to request the lethal dose of medication once their conditions become terminal.

B. Mandatory Counseling

There should be a rebuttable presumption that a patient who receives a terminal diagnosis is going to experience severe emotional trauma. It should also be presumed that the level of distress a reasonable person would suffer under those circumstances would render him or her incapable of making a rational decision. The statutes should only permit these presumptions to be refuted by a reputable mental health professional. Thus, counseling should be mandatory for all patients who want to request the lethal dose of medication. The patient should have to undergo pre- and post-request counseling. During the pre-request counseling sessions, the patient should be evaluated to see if his or her judgment is too impaired to make a cogent decision about physician-assisted suicide. After a patient who is judged capable requests the prescription for the lethal dose of medication, he or she should be required to go through counseling to receive help in preparing for death. At that stage, if the patient consents, counseling could be made available to the patient's family members.

C. Independent Review Board

An independent review board consisting of persons from appropriate disciplines—including bioethics, counseling, law, medicine, nursing and social work—should be established to deal with reports of abuse. This board would create mechanisms for reporting suspected abuse. Persons who are mandatory reporters under the adult protection and the child protection systems would also be mandatory reporters under this system.³⁶⁸ Persons who are not mandatory reporters would be able to make anonymous reports via an established hotline. This board would also be tasked with providing the public with unbiased information about physician-assisted suicide to counteract the activities of opponents and proponents of the procedure that may

368. *See, e.g.*, ALASKA STAT. ANN. § 47.24.010 (West 2016) (listing persons required to report suspected abuse of vulnerable adults); N.Y. SOC. SERV. LAW § 413 (McKinney 2015) (listing persons and officials required to report cases of suspected child abuse or maltreatment).

have their own agendas. Finally, in order to lessen the amount of “doctor shopping” that occurs, this board would review cases where there are conflicting medical opinions about the patient’s competency.

D. Regulatory Agency

Under the current system, physician-assisted suicide is regulated by state public health departments.³⁶⁹ Because these organizations are responsible for a wide array of matters that impact the public’s health,³⁷⁰ physician-assisted suicide may not receive the attention that it deserves. With regard to physician-assisted suicide, the only things these agencies tend to do on a consistent basis are to collect the data and issue annual reports.³⁷¹ There needs to be more monitoring done after the patient receives the prescription. For example, the public health agencies have not done a good job keeping track of the patients and/or the medication.³⁷² Consider this scenario. Patient A receives and fulfills a prescription for a lethal dose of medication. Patient A dies without taking the medication. Patient A’s daughter finds the medication in A’s medicine cabinet. What does the daughter do with the unused medication? Can she sell it on the Internet to a terminally-ill patient in a state where physician-assisted suicide is not legal? Can she just pour it down the drain? The statutes require the unused medication to be responsibly disposed of, but no agency monitors the process to ensure compliance with that mandate.

369. Marilyn Golden & Tyler Zoanni, *Killing Us Softly: The Dangers of Legalizing Assisted Suicide*, 3 DISABILITY & HEALTH J. 16, 21 (defining “doctor shopping” as consecutively visiting doctors until one agrees to submit the patient to the desired treatment); *Public Health’s Role: The Oregon Health Authority’s Role in the Death with Dignity Act*, OR. HEALTH AUTH., <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ohdrole.aspx> [<https://perma.cc/C5HW-KQTH>].

370. *Public Health: Topics A to Z*, OR. HEALTH AUTH., <https://public.health.oregon.gov/Topics/Pages/Topics.aspx> [<https://perma.cc/QM8H-RFMJ>].

371. OR. REV. STAT. ANN. § 127.865 (West 2016).

372. Lewis, *supra* note 241, at 480-82. In its latest report, the Oregon Department of Public Health admitted that the ingestion status was unknown for forty-three patients who had requested the medication. OR. PUB. HEALTH DIV., *supra* note 8, at 3.

VI. CONCLUSION

Physician-assisted suicide is currently legal in six American states.³⁷³ In light of the recent shift in public opinion, that number is expected to grow. Proponents of the practice argue that it is necessary in order for terminally-ill patients to die with dignity. However, persons who oppose physician-assisted suicide claim that the procedure is nothing more than state-sanctioned murder. The present physician-assisted suicide regime may endanger vulnerable patients. The statutes do not contain enough safeguards to adequately protect terminally-ill patients who are susceptible to being abused because of factors like age, disability, mental illness, economic status and race. State legislatures must close the loopholes in the statutes and add precautions to protect the interests of terminally-ill vulnerable patients. Moreover, steps should be taken to give all terminally-ill patients the opportunity to choose to deliberately depart a body that no longer lets them live with dignity.

373. See Linda Ganzini, *Legalized Physician-Assisted Death in Oregon*, 16 QUT L. REV. 76 (2016); Jennifer Brown, *Colorado Passes Medical Aid in Dying, Joining Five Other States*, DENVER POST (Nov. 9, 2016, 11:40 AM), <http://www.denverpost.com/2016/11/08/colorado-aid-in-dying-proposition-106-election-results/> [<https://perma.cc/55LD-FYQH>].