THE EXPANSION OF THE "RIGHT TO DIE": PHYSICIAN-ASSISTED SUICIDE, CONCEPTS OF STATE AUTONOMY & THE PROPER POLITICAL PROCESS FOR LEGALIZATION

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I. AN INTRODUCTION: PHYSICIAN-ASSISTED SUICIDE & THE "RIGHT TO DIE"

Physician-assisted suicide has been the subject of fierce debate over the past few decades, and there is no doubt that it is an extremely sensitive issue with compelling arguments from both its detractors and its supporters. Its opponents usually refer to the practice of physician-assisted suicide by either that name, simply "suicide," or euthanasia.[2] Advocates of physician-assisted suicide term the procedure as physician-assisted death, physician aid in dying, or "death with dignity."[3] This Note will use the term "physician-assisted suicide," as that seems to be the most neutral way to term the practice. In order to make sure that the connotations behind this term are expressed correctly and persuasively, it is important to begin with a discussion of various terms related to the broader concept of "the right to die," of which physician-assisted suicide is one subcategory.

The "right to die" has developed through case law (the progression of which will be addressed later), and its expression typically refers to a patient's right to refuse medical treatment or to have medical treatment withdrawn, even if either of those actions result in the patient's death.[4] This right is subject to heightened evidentiary standards that courts may impose on patients and/or their representatives.[5] The underlying rationale behind allowing patients or their representatives to make such irreversible decisions is that patient autonomy and the preservation of dignity are implicit in the concept of an individual's liberty rights.[6] Be that as it may, the concept of the "right to die," as opposed to the legal term, encompasses voluntary euthanasia, non-assisted suicide, and physician-assisted suicide.[7] It is important to note that physician-assisted suicide is simply a subset of this broader concept, and it is being developed through both courts and legislatures throughout the country.[8] Additionally, the major distinction between the general

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[2] Annette E. Clark, *Autonomy and Death*, 71 TUL. L. REV. 45, 100 (1996).
[3] 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, 65 (2009).
[4] *Physician-Assisted Suicide and the Right to Die with Assistance*, 105 HARV. L. REV. 2021, 2021 (1992).
[5] *See generally* Cruzan v. Missouri, 497 U.S. 261 (1990).
[6] Jennifer Porter, *Who Lives? Who Dies? Who Decides?*, 14 GEO. J. L. & PUB. POL'Y 599, 600 (2016).
[7] Lara 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, 444 (2002).
[8] *Id.*

"right to die" as it is understood in the United States and physician-assisted suicide as it is understood generally is that the "right to die" is mostly passive, while physician-assisted suicide requires the physician to take an active role in helping the patient achieve the goal of his or her death.[9]

"Euthanasia" is defined as "the act or practice of killing or permitting the death of hopelessly sick or injured individuals (as persons or domestic animals) in a relatively painless way for reasons of mercy."[10] As with the "right to die," physician-assisted suicide is simply part of this definition, although many incorrectly consider "euthanasia" and "physician-assisted suicide" synonymous.[11] However, using the terms interchangeably is a misnomer and ignores the various procedural safeguards in place for the latter.

Relatedly, "assisted suicide" is defined as "suicide committed by someone with assistance from another person."[12] Without the prefatory term "physician," this could include all persons rendering suicidal aid to another, ranging from a physician to a friend to a complete stranger being paid for a "mercy killing."[13] By contrast, "physician-assisted suicide" is defined as "suicide by a patient facilitated by means (as a drug prescription) or by information (as an indication of a lethal dosage) provided by a physician aware of the patient's intent."[14]

This demonstrates the importance of utilizing the correct terminology when referring to this practice and placing it in the public sphere for discourse and debate, which is, as this Note will demonstrate, where these arguments properly belong.

A. Current Legal Status of Physician-Assisted Suicide

Physician-assisted suicide is legal in a few foreign countries, and it is lawful in even fewer American states.[15] The most liberal of such laws are in Belgium, a country that allows children to request

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[9] *See generally* Washington v. Glucksberg, 521 U.S. 702 (1997).
[10] "euthanasia." Merriam-Webster Online Dictionary. 2017. https://www.merriam-webster.com/dictionary/euthanasia (last visited February 2, 2017).
[11] *See generally* John Deigh, Physician-Assisted Suicide and Voluntary Euthanasia: Some Relevant Differences, 88 J. CRIM. L. & CRIMINOLOGY 1155 (1998).
[12] "assisted suicide." Merriam-Webster Online Dictionary. 2017. https://www.merriam-webster.com/dictionary/assisted%20suicide (last visited February 2, 2017).
[13] Need cite and explain "mercy killing" if it is in quotes.
[14] "physician-assisted suicide." Merriam-Webster Online Dictionary. 2017. https://www.merriam-webster.com/dictionary/physician-assisted%2Bsuicide (last visited Febuary 2, 2017).
[15] Christina Sandefur, *Safeguarding the Right to Try*, 49 ARIZ. ST. L.J. 513, 515-16 (2017).

physician-assisted suicide as long as they are competently able to understand the consequences of the request.[16] By contrast, the statutory rights that have been created in the various jurisdictions within the United States where physician-assisted suicide is legal are incredibly strict and contain a number of procedural safeguards. Physician-assisted suicide is currently a statutory right in Oregon, Washington, Vermont, California, Colorado, and the District of Columbia.[17] It is legal at common law only in the state of Montana.[18] Before assessing these safeguards as indicating the best approach to obtaining and implementing physician-assisted suicide within the states, a brief historical overview is necessary to place the progression of the law in this area in its proper context.

B. Supreme Court Jurisprudence & The "Right to Die"

The first case ever to be heard by the United States Supreme Court regarding the issues related to "right to die" was *Cruzan v. Director, Missouri Department of Health*.[19] The plaintiff, Nancy Cruzan, was a woman who, as a result of a car crash, was left in a persistent vegetative state.[20] Surgeons placed a feeding tube in her arm for long-term support, and her parents objected to the feeding tube once it became apparent that Nancy would not regain her mental faculties.[21] When her parents asked the hospital to remove the feeding tube, the hospital stated that it could not do so without a court order, which the parents subsequently sought.[22] The trial court initially approved the court order based on evidence that Nancy had told a friend earlier that year that she:

> expressed thoughts at age twenty-five in somewhat serious conversation with a housemate friend that if sick or injured she would not wish to continue her life unless she could live at least halfway normally suggests that given her present condition she would not wish to continue on with her nutrition and hydration.[23]

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[16] *See* Charlotte McDonald-Gibson, *Belgium Extends Euthanasia Law to Kids*, TIME (Feb. 13, 2014), http://time.com/7565/belgium-euthanasia-law-children-assisted-suicide.
[17] *See supra* note 15.
[18] *Id.*
[19] Cruzan v. Missouri, 497 U.S. 261, 277 (1990).
[20] *Id.* at 266.
[21] *Id.*
[22] *Id.* at 267.
[23] *Id.* at 268.

The State of Missouri, as well as Nancy's guardian ad litem, immediately appealed the decision.[24] The Missouri Supreme Court reversed, ruling that in the absence of a legitimate living will or clear and convincing evidence, a person may not refuse treatment for another, even a family member.[25]

Nancy's parents then petitioned the Supreme Court of the United States for a writ of certiorari, and the Court agreed to hear the case.[26] The Supreme Court of the United States held that the State of Missouri's "clear and convincing" evidence standard did not violate the Due Process Clause of the Fourteenth Amendment.[27] Writing for the majority, Chief Justice Rehnquist recognized a competent individual's right to refuse life-saving medical treatment.[28] However, the Court ruled that it was not a violation of the Fourteenth Amendment for a third party seeking to refuse life-saving medical treatment for an incompetent individual to bear a higher burden of proof.[29] The Court stated, "An incompetent person is not able to make an informed and voluntary choice to exercise a hypothetical right to refuse treatment or any other right."[30]

In her concurrence, Justice O'Connor wrote separately to address the issues that the Court did not decide; namely, that the Court was simply addressing a standard of proof as not in violation of the Constitution; and the Court was not deciding whether the Constitution required the several states to follow the directions of the patient's duly appointed surrogate.[31] She also noted that the Court also did not address the propriety of states developing other methods of safeguarding an incompetent individual's liberty interest in refusing medical treatment.[32] Justice O'Connor's concurrence focused on the majority's narrow holding.[33] The line that perhaps best expresses the implication of the Court's silence was this: "Today we decide only that one State's practice does not violate the Constitution; the more challenging task of crafting appropriate procedures for safeguarding incompetents' liberty interests is entrusted to the 'laboratory' of the States."[34] O'Connor observed that the issue was a delicate one.[35] As this was the first case that the Supreme Court heard regarding the "right to die," it is significant

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[24] *Id.*
[25] *Id.*
[26] *Id., cert. granted*, 492 U.S. 917 (1989).
[27] *Id.* at 286.
[28] *Id.* at 278.
[29] *Id.* at 280.
[30] *Id.*
[31] *Id.* at 289
[32] *Id.* at 290-92
[33] *Id.*
[34] *Id.* at 292.
[35] *Id.*

that the highest court in the federal judicial system was quick to defer to state interpretations of the "right to die," and indicates, from the beginning of the Court's jurisprudence, a willingness to leave such decisions up to the individual state.

Following *Cruzan*, the next major development in Supreme Court jurisprudence on the "right to die" specifically addressed the narrower, related issue of physician-assisted suicide in a pair of companion cases decided on the same day – *Washington v. Glucksberg*[36] and *Vacco v. Quill*.[37] In *Glucksberg*, the plaintiffs were physicians, terminally ill patients, and a non-profit organization called "Compassion in Dying."[38] They challenged Washington's ban against assisted suicide, claiming that it was a liberty interest protected by the Due Process Clause of the Fourteenth Amendment to the United States Constitution.[39] On writ of certiorari, the Supreme Court held that the Due Process Clause did not protect the right to assistance in committing suicide.[40] The Court reasoned that the State of Washington had an "unqualified interest in the preservation of human life" that was not to be weighed differently according to "the medical condition and the wishes of the person whose life is at stake."[41] The Court rejected such a "sliding-scale approach" and gave substantial deference to the "number of state interests" implicated by Washington's assisted suicide ban in reaching its holding.[42]

In *Vacco*, the plaintiffs were physicians, and they challenged a newly enacted prohibition in the state of New York against physician-assisted suicide, which criminalized the action.[43] The plaintiffs claimed the prohibition was a violation of the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution, because it treated patients with a terminal illness who are on life support differently than those who were not on life support.[44] Upon writ of certiorari, the Supreme Court held that states have a legitimate interest in outlawing assisted suicide, and that "liberty" does not include a right to physician-assisted suicide."[45] The Court again delineated a number of legitimate state interests that New York used to justify the ban, and further reasoned that Equal Protection was not violated because all individuals were subject to

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[36] Washington v. Glucksberg, 521 U.S. 702, 707-08 (1997).
[37] Vacco v. Quill, 521 U.S. 793, 797-98 (1997).
[38] *Washington*, 521 U.S. at 707-08.
[39] *Id.*
[40] *Id.* at 735.
[41] *Id.* at 729.
[42] *Id.*
[43] Vacco, 521 U.S. 793 at 797-98.
[44] *Id.* at 798.
[45] *Id.* at 807-09.

the statute and thus the prohibition did not treat individuals differently.[46] The Court said:

> On their faces, neither New York's ban on assisting suicide nor its statutes permitting patients to refuse medical treatment treat anyone differently from anyone else or draw any distinctions between persons. Everyone, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; no one is permitted to assist a suicide. Generally speaking, laws that apply evenhandedly to all "unquestionably comply" with the Equal Protection Clause.[47]

In addition to court cases, some states have addressed the issue of "right to die" through state statute. The first state to legalize physician-assisted suicide, Oregon, did so through a ballot measure, but a lengthy injunction delayed implementation of the law until 1997.[48] The Ninth Circuit Court of Appeals lifted the injunction and determined that several patients, doctors, and residential care facilities (all from the State of Oregon) lacked the "injury-in-fact" required for standing to bring a challenge to the law, and thus the federal court had no jurisdiction to decide any related constitutional issues.[49] The Supreme Court denied certiorari on the standing issue,[50] potentially because it had already expressed its opinions about the "right to die" and state autonomy in developing it. The United States Supreme Court was silent on the issue for several years.

The next Supreme Court case on this issue was brought in 2006. In *Gonzales v. Oregon*, after Oregon's Death with Dignity Act was passed, United States Attorney General John Ashcroft issued an Interpretive Rule that physician-assisted suicide was not a legitimate medical purpose and that any physician administering drugs to that effect violated the Controlled Substances Act.[51] Oregon, along with a physician, pharmacist, and several terminally ill patients from Oregon, challenged the rule.[52] The district court issued an injunction against the enforcement of the rule, which the Ninth Circuit Court of Appeals affirmed.[53] Upon granting the Attorney General's writ of certiorari, the United States Supreme Court affirmed.[54] The Court held that the Interpretive Rule was not entitled to deference under several prior deferential standards established by the Court, since in

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[46] *Id.* at 799-800.
[47] *Id.* at 800.
[48] Lee v. Oregon, 891 F.Supp. 1439, 1439 (D. Oregon 1995).
[49] *See* Lee v. Oregon, 107 F.3d 1382 (9th Cir. 1997).
[50] *Lee v. Harcleroad, cert. denied*, 522 U.S. 927 (1997).
[51] Gonzales v. Oregon, 546 U.S. 243, 254 (2006).
[52] *Id.* at 255.
[53] *Id.*
[54] *Id.* at 275.

order to be given deference, "the rule must be promulgated pursuant to authority Congress has delegated to the official."[55] The Court viewed his Interpretive Rule as an improper use of power, stating:

> The Attorney General has rulemaking power to fulfill his duties under the CSA. The specific respects in which he is authorized to make rules, however, instruct us that he is not authorized to make a rule declaring illegitimate a medical standard for care and treatment of patients that is specifically authorized under state law.[56] . . . The Government, in the end, maintains that the prescription requirement delegates to a single executive officer the power to effect a radical shift of authority from the States to the Federal Government to define general standards of medical practice in every locality. The text and structure of the CSA show that Congress did not have this far-reaching intent to alter the federal-state balance and the congressional role in maintaining it.[57]

Following that decision, the Supreme Court has been silent on the issue, and it seems well-settled that the Courts have, at least incidentally, adopted Justice O'Connor's approach in *Cruzan*, deferring to the states as to what falls within the constitutional bounds of the "right to die." What follows is a history of the various states that have legalized physician-assisted suicide within the United States.

II. PHYSICIAN-ASSISTED SUICIDE IN THE UNITED STATES

Discussions of the legalization of physician-assisted suicide through statute began to take place as early as 1906, when a woman named Anna Hill, whose mother had died a particularly painful death from cancer, inspired legislation in Ohio that contemplated legalizing "voluntary euthanasia" for competent adults who were fatally wounded, terminally ill, or suffering from extreme pain.[58] Ultimately, the bill was defeated.[59] In the following years, various

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[55] *Id.* at 258
[56] *Id.* at 258.
[57] *Id.* at 275.
[58] Thane Josef Messinger, *A Gentle and Easy Death: From Ancient Greece to Beyond Cruzan Toward A Reasoned Legal Response to the Societal Dilemma of Euthanasia*, 71 DENV. U. L. REV. 175, 189 (1993).
[59] *Id.* at 190.

individuals (both physicians and laypersons) were prosecuted for assisting suicides.[60] The public's attitude toward the issue vacillated based on the current political climate; for instance, euthanasia was utilized quite frequently in Nazi Germany, leading many Americans to abhor physician-assisted suicide as tantamount to the same horrible practice.[61] As the right to refuse life-saving medical treatment began to develop, public opinion began to shift as well, with constituents beginning to more actively discuss the issue.[62] In fact, a Gallup poll conducted in 1973 reported an increase in favorable views toward physician-assisted suicide.[63]

Of course, no discussion of physician-assisted suicide would be complete without the man who invokes a knee-jerk thought when the practice is discussed – Dr. Jack Kevorkian.[64] The publication of Dr. Kevorkian's activism and criminal prosecution sparked a fair amount of public discourse.[65] Dr. Kevorkian's arguably most famous statement, taken (almost ironically) from a book on Christian ethics, perhaps best embodies the attitude of the states that have legalized physician-assisted suicide since 1994 – "Dying is not a crime."[66]

A. Progression of Valid Physician-Assisted Suicide Laws

In 1994, Oregon became the first state to allow its residents suffering from terminally ill diseases or conditions to obtain lethal doses of medication from their treating physicians for the purposes of self-administering the doses and thereby ending their own lives.[67] Oregon accomplished this through the establishment of the aptly-named "Oregon Right to Die" political committee, consisting of various businessmen, lawyers, and medical professionals.[68] The committee drafted several variations of the bill before settling on

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[60] *Id.*
[61] *Id.* at 199.
[62] *Id.* at 206.
[63] *Id.*
[64] *Id.* at 212-13. Dr. Jack Kevorkian was an American pathologist who rose to infamy by assisting terminally ill patients with ending their lives. He had a significant impact on the modern debate about physician-assisted suicide.
[65] *Id.* at 213.
[66] Samuel Wells & Ben Quash INTRODUCING CHRISTIAN ETHICS. 329 (John Wiley and Sons 2010).
[67] *See* Center for Disease Prevention & Epidemiology – Oregon Health Division, *Physician-Assisted Suicide*. 1997. http://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/CDSummaryNewsletter/Documents/1997/ohd4623.pdf (published on November 11, 1997).
[68] *See* Death with Dignity, *Oregon Death with Dignity Act: A History*. https://www.deathwithdignity.org/oregon-death-with-dignity-act-history/ (last visited February 17, 2017).

"Measure 16," which is what is now referred to as the "Death with Dignity Act."[69] Oregon voters approved of the Death with Dignity Act by a margin of 51.31% to 48.69%.[70] The Act made physician-assisted suicide legal within the state of Oregon under certain circumstances, and it provided a number of safeguards to prevent abuse, mistake, and coercion.[71]

The Oregon Death with Dignity Act (the "Act") allows a patient to request a prescription for a lethal dose of medication that would terminate the patient's life.[72] A patient requesting this must have been diagnosed with a terminal illness that would otherwise kill the patient within six months, and the request must be made twice orally and once in writing.[73] The two oral requests must be separated by a period of at least 15 days, and the written request must be signed in the presence of two witnesses.[74] The requests must all be voluntary and initiated by a competent patient who has reached the age of majority.[75] The physician who will prescribe the medication must consult with another physician to determine the diagnosis of the illness as terminal.[76] Moreover, a medical professional potentially involved in this process is allowed to refuse to participate on moral grounds.[77] The request must be attested to by two disinterested witnesses, one of whom must not be a family member.[78] There are various procedural safeguards in place to ensure that the terminally ill patient is making this decision voluntarily and competently.[79] Further, the patient may retract the request at any time during the process.[80]

As mentioned above, the enactment of the Act was accomplished through a ballot measure. A subsequent ballot measure to overturn the prior one was unsuccessful.[81] In fact, the margin by which the measure to repeal the Act passed was greater than the initial measure.[82] Initially, a federal district court judge placed a temporary injunction on the implementation of the Act; the

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[69] OR. REV. STAT. § 127.800 (2016).
[70] Oregon Secretary of State, *Initiative, Referendum and Recall: 1988-1995*, Oregon Blue Book. http://bluebook.state.or.us/state/elections/elections21.htm (last visited February 20, 2017) [hereinafter "Initiative, Referendum and Recall"].
[71] *See generally* OR. REV. STAT. § 127.800 *et seq.* (West 2017).
[72] OR. REV. STAT. § 127.800 § 2.01 (West 2017).
[73] OR. REV. STAT. § 127.800 § 3.06 (West 2017).
[74] OR. REV. STAT. § 127.800 § 3.08-.09 (West 2017).
[75] OR. REV. STAT. § 127.800 § 2.01 (West 2017).
[76] OR. REV. STAT. § 127.800 § 3.02 (West 2017).
[77] OR. REV. STAT. § 127.800 § 4.01 (West 2017).
[78] OR. REV. STAT. § 127.800 § 3.09 (West 2017).
[79] OR. REV. STAT. § 127.800 § 3.01-.14 (West 2017).
[80] OR. REV. STAT. § 127.800 § 3.07 (West 2017).
[81] *See* Initiative, Referendum and Recall, *supra* note 69.
[82] *Id.*

injunction became permanent in August 1995, and both parties appealed on various legal issues.[83] In 1997, the United State Court of Appeals for the 9th Circuit dismissed the claim on jurisdictional grounds, effectively terminating the injunction and deferring to Oregon's right to develop its own laws.[84] Although there have been various attempts to repeal the Act or withhold the lethally prescribed drugs, Oregon's Death with Dignity Act remains the law.

Over a decade passed before physician-assisted suicide was legalized in another state. In 2008, Washington submitted for a vote "Initiative 1000," which is what is now referred to as Washington's own "Death with Dignity Act."[85] Unlike the initial ballot measure in Oregon, Initiative 1000 was approved by a greater margin – 57.82% to 42.18%.[86] A similar measure submitted to the public in 1991 had been rejected by the voters[87], but unlike that measure, which would allow the physicians to administer the lethal doses of medication, Initiative 1000 required the patient to self-administer the medication.[88]

The law contains similar procedural safeguards to the Oregon Act and some opt-outs.[89] For instance, individual hospitals can choose to refuse to participate in physician-assisted suicide as long as it explicitly states its position to do so in the policies and procedures that the hospital makes available to its staff.[90] Like the Oregon statute, the Washington Death with Dignity Act contains requirements of competency, a series of requests, and some waiting periods between requests and prescription of the medication.[91] Upon a close reading of Washington's Act, it appears that it closely mirrors the Oregon Act due to similarly tracked language.

The next state to legalize physician-assisted suicide, Montana, did so in a different way – through a court ruling. Robert Baxter was an elderly, retired truck driver residing in Montana who had been diagnosed with terminal lymphocytic leukemia.[92] As he

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[83] *See* Lee v. Oregon, 869 F.Supp. 1491 (D. Or. 1994; *affirmed by* 891 F.Supp. 1439 (D. Or. 1995).
[84] *See* Lee v. Oregon, 107 F.3d 1382 (9th Cir. 1997).
[85] *See generally* R.W.C.A. § 70.245 *et seq.* (West 2017).
[86] *See* Washington Secretary of State, *Initiative Measure 1000 concerns allowing certain terminally ill competent adults to obtain lethal prescriptions,* http://results.vote.wa.gov/results/20081104/Initiative-Measure-1000-concerns-allowing-certain-terminally-ill-competent-adults-to-obtain-lethal-prescriptions.html (last visited February 15, 2017).
[87] *See* Death With Dignity, *Washington Death with Dignity Act: A History*, https://www.deathwithdignity.org/washington-death-with-dignity-act-history/ (last visited February 15, 2017).
[88] R.W.C.A. § 70.245.010 (West 2017).
[89] R.W.C.A. § 70.245.190 (West 2017).
[90] *Id.*
[91] R.W.C.A. § 70.245.020 to .130 (West 2017).
[92] Baxter v. Montana, 354 Mont. 234, 237 (2009).

began to receive chemotherapy treatments, they became less and less effective.[93] Without a cure and with no prospect for recovery, Mr. Baxter wanted to ingest a lethal dose of medication that he could self-administer at the time of his choosing in order to end his pain and suffering.[94] He filed an action along with four physicians and an organization called "Compassion & Choices" seeking to establish a constitutional right to receive and provide aid in dying.[95] The state argued that Montana's constitution conferred no such right.[96] The district court ruled in favor of the plaintiffs, and Mr. Baxter died that same day.[97] The district court held that "constitutional rights of individual privacy and human dignity, taken together, encompass the right of a competent, terminally-ill patient to die with dignity."[98]

The Montana Supreme Court vacated the district court's resolution of the constitutional issues and declined to state its holding on that basis. Rather, it based its holding on an alternate statutory basis.[99] Namely, the court said that physicians may use the state's consent statute as a defense, stating, "[t]he consent of the victim to conduct charged to constitute an offense or to the result thereof is a defense."[100] The court dismissed the Appellants' argument that the exception to this type of consent as "against public policy" was inapplicable because "courts that have considered this issue yields unanimous understanding that consent is rendered ineffective as 'against public policy' in assault cases characterized by aggressive and combative acts that breach public peace and physically endanger others."[101] The court stated that there was "nothing in Montana Supreme Court precedent or Montana statutes indicating that physician aid in dying is against public policy."[102] Although there have been attempts to circumvent the 'court's determination through the legislature, these have been unsuccessful, and physician-assisted suicide remains legal at common law.

A few years after the Montana decision, Vermont became the fourth state to legalize the practice.[103] Prior to the passage of the law, a poll conducted indicated that 74% of voters in that state favored "mentally competent, terminally ill patients with less than six months to live to be able to end their life in a humane and dignified manner, using prescription medications they can self-

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[93] *Id.*
[94] *Id.* at 238.
[95] *Id.*
[96] *Id.*
[97] *Id.*
[98] *Id.*
[99] *Id.* at 250-51.
[100] *Id.* at 239; *See also* MONT. CODE ANN. § 45-2-211 (West 2017).
[101] *Id.* at 241.
[102] *Id.* at 250.
[103] 12 V.S.A. § 5281 *et. seq.* (West 2017).

administer."[104] Unlike Oregon and Washington, however, Vermont did not put it to a vote of the people. In May 2013, the Vermont General Assembly voted to approve "Act 39," which is more commonly referred to as the "Patient Choice and Control at the End of Life Act."[105] This was a departure from the practice of citizens drafting the bill and proposing it as a ballot measure. Instead, it was designed by lawmakers and put to a vote in the state legislature.[106]

This Act is also extremely similar to the statutes passed in Oregon and Washington. The various waiting periods and methods of requesting the prescription, as well as the physician's role in the process, bear a striking resemblance to the related statutes in those two other states.[107] Like the other two states that had legalized physician-assisted suicide prior to Vermont's Act, the Vermont required residency and stated that insurance companies may not deny benefits that would be otherwise conferred simply because a patient acts in accord with the Act.[108] However, a patient loses his or her protections if he or she takes the prescribed medication outside of Vermont's jurisdiction.[109] This might implicate the patient's insurance rights, as the death may be ruled a suicide in a state where ingesting the medication is illegal.

On June 9, 2016, the California legislature passed the "End of Life Option Act," making it the fifth state to legalize physician-assisted suicide.[110] In November 2016, Colorado joined the fold as the sixth state and its citizens approved ""the "End of Life Options Act," with 64.87% of those who voted in favor of the ballot measure.[111] Polling in both of these jurisdictions indicated that a majority of the voters polled supported physician-assisted suicide in the circumstances anticipated by the statutory language.[112] These Acts also contained the same requirements and safeguards as those of other states, and they were mainly guided by those states in both

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[104] *See* Compassion & Choices, *Polling on Voter Support for Medical Aid in Dying for Terminally Ill Adults*, https://www.compassionandchoices.org/wp-content/uploads/2016/07/FS-Medical-Aid-in-Dying-Survey-Results-FINAL-7.21.16-Approved-for-Public-Distribution.pdf (July 21, 2016).
[105] *See* Vermont Department of Health, *The Patient and Control at End of Life Act, Frequently Asked Questions*, http://www.healthvermont.gov/sites/default/files/documents/2016/11/Act39_faq.pdf (revised June 2015).
[106] 2013 VERMONT LAWS NO. 39 (S. 77) (2013).
[107] *See* VT. STAT. ANN. tit. 18, § 5281 *et. seq.* (West 2017).
[108] 12 V.S.A. § 5287 (West 2017).
[109] *Id.*
[110] CAL. HEALTH & SAFETY CODE § 443.1 *et. seq.* (West 2017).
[111] COLO. REV. STAT. § 25-48-101 *et. seq.* (West 2017).
[112] *See supra* note 105.

the drafting of the legislative/ballot measures and the implementation thereafter.[113]

Finally, the most recent jurisdiction to legalize physician-assisted suicide was the District of Columbia. The bill, named the Death with Dignity Act, was introduced in the Council of the District of Columbia (the unicameral legislative body of that district),[114] signed by the Mayor, and sent to the United States Congress for review. Ultimately, attempts to oppose the bill's passage were unsuccessful, and the law became effective on February 20, 2017.[115] It is worth noting that, as of the date of this Note, seven jurisdictions have legalized the practice of physician-assisted suicide, and six of these have done so within the past decade. So, it appears that the momentum of legalizing physician-assisted suicide is on the rise, at least for now.

In all other jurisdictions, physician-assisted suicide remains prohibited under state law. Before examining the various justifications and defenses both in favor of and against the practice, it is necessary to briefly examine the current legal status of physician-assisted suicide in all jurisdictions but these seven.

B. Prohibitions Against Physician-Assisted Suicide

In January 2014, New Mexico looked as if it would join Montana as the second state to have physician-assisted suicide legalized at common law.[116] The plaintiffs were physicians and a patient who was currently in remission from uterine cancer, but feared its return and wanted the "'peace of mind' of knowing that aid in dying would be an option available to her if she [found] her suffering in the terminal stage of her cancer unbearable."[117] The State objected and emphasized that the state had a compelling interest in criminalizing physician aid in dying.[118] A district court judge ruled that physicians who rendered aid in dying to their patients could not be prosecuted under the state's Assisted Suicide Statute.[119] The court 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 competent, terminally

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[113] *See* CAL. HEALTH & SAFETY CODE § 443.1 *et. seq.* (West 2017); COLO. REV. STAT. § 25-48-101 *et. seq.* (West 2017).
[114] D.C. ST. 7-661.01 *et. seq.* (West. 2017).
[115] *Id.*
[116] Morris v. Brandenberg, 2014 WL 10672986 *2 (N.M. Dist. 2014).
[117] *Id.*
[118] *Id.* at *7.
[119] *Id.*

> ill patient to choose aid in dying. . . . If decisions made in the shadow of one's imminent death regarding how they and their loved ones will face that death are not fundamental and at the core of these constitutional guarantees, then what decisions are?"[120]

Several days later, the court entered a declaratory judgment and an injunction to that effect.[121] The State of New Mexico appealed, and the Court of Appeals of New Mexico held that physician-assisted suicide was neither a fundamental liberty interest protected by due process nor inherent in an individual's right to life, liberty, and happiness.[122] Upon writ of certiorari to the Supreme Court of New Mexico, that court affirmed the decision of the appellate court below, and thus physician-assisted suicide was prohibited by court ruling on June 30, 2016.[123]

On January 30, 2017, a "death with dignity" bill, styled the "End of Life Options Act," was introduced in the New Mexico House of Representatives.[124] A companion bill was also introduced in the New Mexico Senate.[125] As of the date of this Note, no significant developments have taken place with respect to the progression of this legislation.[126]

In all other states, physician-assisted suicide remains illegal. If a physician gives renders any assistance to a patient in terminating the patient's own life, the physician can be (and most assuredly will be) both criminally and civilly liable. In the states where all physician-assisted suicide is against the law, the debate rages on, with those on both sides of the issue approaching it from various angles.

i. Arguments Against Legalization

The arguments against the legalization of physician-assisted suicide are not merely moral or religious objections. The potential for fraud and abuse, as well as the possible difference in statutory interpretations that might be given where the statute is ambiguous, are worthy of attention and belong in any discussion about whether the practice should be legalized in that particular jurisdiction.

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[120] *Id.*
[121] Morris v. Brandenburg, 2014 WL 10672977 (N.M. Dist. 2014).
[122] 356 P.3d 564, 585 (N.M. Ct. App. 2015).
[123] 376 P.3d 836, 857 (N.M. 2016).
[124] 2017 NM H.B. 171 (January 18, 2017).
[125] *Id.*
[126] *See* New Mexico Legislature, *https://www.nmlegis.gov/Legislation/Legislation?chamber=H&legType=B&legNo=171&year=17* (last visited March 2, 2017).

Of course, there is the moral opposition to the procedure, and in a nation that is vastly religious (whether it be Christian or otherwise), the gravity of that certainly should not be downplayed as (at the very least) a passive influence on opponents of physician-assisted suicide and the debate in general. Various denominations and sects are split on their views regarding the practice of physician-assisted suicide.[127] Most adherents to Christianity oppose the practice, claiming that God is the ultimate judge and that the determination of when and in what manner to die is left to Him, not human preferences.[128] Buddhists believe that assisted suicide runs contrary to the basic tenet of Buddhism that one should not kill another living being, but followers of the religion recognize feel differently about refusal of medical treatment, especially when pointless.[129] Several other religions also decry the practice under a "slippery-slope" argument, whereby physician-assisted suicide could extend from the very terminally ill to other vulnerable populations based on preconceived notions of self-worth and social status.[130]

Unrelated to moral and religious objections are the practical difficulties that may arise; for instance, determining the competency of individuals. What distinguishes a competent individual from an incompetent one can sometimes be easy. For example, an ambulatory person with terminal cancer may still be able to speak and reason, and so would likely be competent, whereas the injured in Cruzan was in a permanent vegetative state and obviously

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[127] *See infra* note 129, 130, 131.

[128] John B. Mitchell, *My Father, John Locke, and Assisted Suicide: The Real Constitutional Right*, 3 IND. HEALTH L. REV. 45, 92-93 (2006) ("In his work, John Locke specifically said that we have no right to commit suicide. In doing so, Locke had both a theological and a conceptual ground. The basis of this theological argument [is] a form of Thomas Aquinas' classic argument against suicide: Our lives are not ours, but are God's property.").

[129] Damien Keown, *Suicide, Assisted Suicide and Euthanasia: A Buddhist Perspective*, 13 J.L. & RELIGION 385, 404 (1998-99) ("Buddhism may thus be thought of as adopting a middle way between two opposing positions. The first is the doctrine of vitalism, which holds that life is an absolute value to be preserved at all costs. At the other extreme is the quality of life view, or the belief that life has no intrinsic value and can be disposed of when its quality drops below an acceptable level. Buddhism occupies the middle ground, holding that the value of life is neither absolute nor does it fluctuate. While life must never be intentionally destroyed, there is no obligation to preserve it at all costs.").

[130] Margaret Somerville, *Is Legalizing Euthanasia an Evolution or Revolution in Societal Values?*, 34 QUINNIPIAC L. REV. 747, 773 (2016) ("A chilling example of the logical slippery slope is the euthanizing, in December 2012, of 45 year old twins in Belgium. Deaf since childhood, Marc and Eddy Verbessem were facing the additional disability of blindness. Accepting that they were irremediably suffering, their physician euthanized them.").

incompetent.[131] However, difficulties arise when the lines are blurred. For instance, many individuals may experience periods called "lucid intervals" where they are fully competent for purposes of legal efficacy.[132] During a lucid interval, a person may fully understand the implications of his or her decision, as well as the gravity of his or her situation, and wish to seek aid in dying from the physician in a completely competent state.[133] There are obvious difficulties with this factual scenario that indicate that the presence of a cognitive disorder alone cannot be determinative of the competency level necessary to request physician-assisted suicide.[134]

The various areas of the law where a competency determination is a prerequisite for carrying out some sort of legally significant act does not bring clarification to this issue. There are varying degrees of competency required to enter into a contract, to marry, to divorce, to write a living will, etc.[135] Which one is the best, and why is it the best?[136] There are arguments to be made at all competency levels, and the fact that such arguments are out there introduces wrinkles into determining competency for such an irreversible decision.[137] Opponents of physician-assisted suicide

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[131] Cruzan v. Missouri, 497 U.S. 261, 277 (1990).

[132] Joshua C. Tate*, Personal Reality: Delusion in Law and Science*, 49 CONN. L. REV. 891, 929 (2017) ("As stated in the Restatement (Third) of Donative Transfers, an individual who is 'mentally incapacitated part of the time,' but has 'lucid intervals during which he or she meets the standard for mental capacity' has the power to execute a valid will during such a lucid interval.") (internal citations omitted).

[133] *Id.*

[134] Catherine S. Shaffer, Alana N. Cook, and Deborah A. Connolly, *A Conceptual Framework for Thinking About Physician-Assisted Death for Persons With A Mental Disorder*, 22 PSYCHOL. PUB. POL'Y & L. 141, 147 (May 2016) ("Moreover, although problems in decisional capacity have been demonstrated in those with a severe mental disorder, decisional capacity is relatively unimpaired in those with mild or moderate forms of mental disorders. Similarly, some individuals with a mental disorder may only have impaired decisional capacity when they are experiencing acute symptoms of their disorder and may otherwise be competent when experiencing a remission.").

[135] *Id.*

[136] *Id* at 147-48. ("The law recognizes numerous distinct competences (i.e., driving capacity, marriage capacity, testamentary capacity, financial capacity, criminal capacity) that differ based on the abilities required for the task and consequences of the decision. Given the gravity of end-of-life decisions, should we set a higher standard of competence for PAD decisions than other routine health care choices? If so, what criteria or standards should apply? Are different criteria and standards of competence justifiable in cases where a mental disorder is the primary or sole diagnosis versus when the individual is not suffering from a mental disorder?").

[137] *Id.* ("The standard of competence required to request PAD is heavily contested in the literature. If the bar is too high, an individual's decision-making autonomy is infringed upon. If the bar is too low, sufficient protection for incompetent decision-makers is not provided.").

maintain that these wrinkles bolster their reasoning for statutes against physician-assisted suicide, since "competency" is seemingly vague.

Many medical professionals consider the practice of physician-assisted suicide to violate the Hippocratic Oath.[138] The Oath states, "I will give no deadly medicine to anyone if asked, nor suggest any such counsel."[139] Opponents of physician-assisted suicide argue that the practice runs contrary to the Hippocratic Oath, which is prominently displayed to the public as well as revered by most who practice medicine.[140]

ii. Arguments in Favor of Legalization

Proponents of physician-assisted suicide contend that a person should be able to die with dignity.[141] The terminally ill cancer patient that continues to suffer day in and day out should be able to die on his or her own terms, not continue to suffer in front of family, friends, and caretakers, and thus be subjected to indignities. In fact, the legislation passed in Oregon, Washington, and the District of Columbia all contain the word "dignity" in the Act, and that is part of the justification given for their passage. Supporters of physician-assisted suicide laws argue that states should not force people to depend on others for even the most menial of tasks or to powerlessly sit by and watch the hours tick by as they count down to their impending demise.[142]

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[138] Dr. Raanan Gillon, *Physician Assisted Suicide—Sympathy and Skepticism*, 75 U. DET. MERCY L. REV. 499, 507.

[139] *See supra* note 139 at footnote 20.

[140] Dwight G. Duncan and Peter Lubin, *The Use and Abuse of History in Compassion in Dying*, 20 HARV. J.L. & PUB. POL'Y 175, 182 (1996) ("The Oath expressly forbids administering poisons to patients even when requested. A clearer rejection of physician-assisted suicide cannot be imagined. What is important is not only the Oath itself, but also its wide acceptance, in so many countries, over so long a period, as the solemn accompaniment to full-fledged admission to the profession of medicine.").

[141] Kristen Loveland *Death and Its Dignities*, 91 N.Y.U. L. REV. 1279, 1311 (2016) ("Within the concept of individual dignity as it appears in the assisted suicide context may sit both a right to assisted suicide and a responsibility to the community that facilitates the individual's death. To the extent possible, then, an individual seeking assisted suicide should feel constrained by a responsibility to respect collective dignity in choosing how to die. Even as it provides for assisted suicide, a legislature may be justified in limiting the means by which it is achieved.").

[142] Leslie Meltzer Henry, *The Jurisprudence of Dignity*, 160 U. PA. L. REV. 169, 212 (2011) ("There is surely an argument that competent individuals who opt for a physician's assistance in ending their lives are defining their existence and unraveling 'the mystery of human life.'" [quoting Planned Parenthood v. Casey, 505 U.S. 833 (1992)]).

Moreover, autonomy in choosing when one will die, when it is determined that one will inevitably die within a specified time period, is important to advocates of physician-assisted suicide because it allows competent individuals to request the expedition of their death.[143] Terminally ill patients are already severely lacking in their own personal liberties, so extending this right to them as a form of liberty can be benign and sympathetic while also remaining within the constitutional confines of personal liberty.[144] Proponents of physician-assisted suicide liken prohibitions against terminally ill patients requesting aid in dying to be a severe deprivation of personal liberty: "The exercise of the right to privacy (in the personal autonomy sense), can become a means to protecting dignity, and protecting dignity in this context can assure that one of our most important private choices is secure. The two rights provide complementary protections."[145]

There are several procedural safeguards in the states that have extended the right to physician-assisted suicide, and several of them are identified above. These include: a minimum age, voluntariness with the opportunity to rescind, the requirement that the patient competently make the request more than once, encouragement to seek counseling, and several others.[146] While opponents of this idea have suggested that people will flock to these states—that reality is not borne out by the data—primarily because these state statutes also contain a residency requirement.[147] Moreover, the number of people that may seek physician-assisted suicide and obtain it is severely limited by the fact that at least one physician must diagnose the patient with a terminal illness that will kill the patient within six months.[148] These standards and requirements are so exacting and strong that they are subject to no more abuse than any other statute guaranteeing a personal liberty, and arguably, they are subject to less abuse.

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[143] *See supra* note 3.

[144] Erwin Chemerinsky, CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES 871, 876 (4th ed. 2011). ("Ultimately, the question of whether there should be a right to physician-assisted death, like all difficult constitutional questions, turns on one's view of constitutional interpretation and the role of the judiciary. Should this be regarded as one of the most important aspects of personhood and autonomy, as the Ninth Circuit concluded? Or is this a matter appropriately left to the political process, as the Supreme Court ruled?").

[145] Matthew O. Clifford and Thomas P. Huff, *Some Thoughts on the Meaning and Scope of the Montana Constitution's "Dignity" Clause with Possible Applications* 61 MONT. L. REV. 301, 330 (2000).

[146] OR. REV. STAT. § 127.800 *et seq.* (West 2017); R.W.C.A. § 70.245 *et seq.* (West 2017); 12 V.S.A. § 5281 *et. seq.* (West 2017); CAL. HEALTH & SAFETY CODE § 443.1 *et. seq.* (West 2017); COLO. REV. STAT. § 25-48-101 *et. seq.* (West 2017); D.C. ST. 7-661.01 *et. seq.* (West. 2017).

[147] *Id.*

[148] *Id.*

iii. Comparison with Other Legal Standards

In some states and countries, a criminal charged with an offense punishable by death may, once sentenced to death, forego all of his appeal rights and "volunteer" to let the death sentence be carried out.[149] Some scholarly articles have suggested that this act is comparable to physician-assisted suicide.[150] The death row inmate knows that, in all likelihood, he will presumably face death; he is statutorily allowed to face it as soon as plausible if he foregoes his appeal rights. That reasoning fits squarely with the terminally ill patient who knows she is about to die as well.[151] In order for a prisoner to abandon all appeals in this manner, the Supreme Court has required that he make a knowing, voluntary, and intelligent waiver of his rights to appeal and be mentally competent.[152] Mental competence is not a high bar.[153] The Supreme Court recognized that this standard permits even severely mentally ill defendants to be found competent to waive certain trial rights, even if they are otherwise mentally incompetent in other respects.[154] Thus, prisoners have less procedural protections than terminally ill patients seeking to die in states where physician-assisted suicide is legal, and yet courts have said that even these minimum protections for prisoners do not violate the Constitution.

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[149] Nicole F. Dailo, *"Give Me Dignity By Giving Me Death" Using Balancing to Uphold Death Row Volunteers' Dignity Interests Amidst Executive Clemency*, 23 S. CAL. REV. L. & SOC. JUST. 249, 293 (2014) (""Death row inmates, though convicted of perhaps the worst crimes imaginable, deserve to have their choices respected, particularly because an assertion of their dignity, expressed through their autonomous legal decisions, is often all they have left. Further, if our society values life as much as it claims, it must necessarily respect any individual's assessment and decision about the quality and direction of his or her life. For death row volunteers, this means providing them with the means to carry out their sentences, especially when a state's blanket reprieve or moratorium is problematic.'").

[150] *Id.*

[151] Jason Iuliano, *Why Capital Punishment is No Punishment At All"*, 64 AM. U. L. REV. 1377, 1411 (2015) (""As a society, we would not permit assisted suicide or voluntary euthanasia if we believed that the medications used in the procedure caused significant suffering. Today, seventy percent of Americans support euthanasia. Indeed, opponents of assisted death have advanced many arguments against the practice, but not a single one claims that assisted death should be banned because it causes the individual to experience pain. If we believe that euthanasia is a peaceful, humane exit for our close relatives and pets, there is no reason to believe that lethal injection is a painful event for criminals.'").

[152] *See generally* Godinez v. Moran, 509 U.S. 389 (1993).

[153] Meredith Martin Rountree, *Volunteers for Execution: Directions for Further Research into Grief, Culpability, and Legal Structures*, 82 U.K.M.C. L. REV. 295, 300 (2014).

[154] Indiana v. Edwards, 554 U.S. 164, 178 (2008).

Another area in which the law has developed more thoroughly in an analogous way is the issue of abortion rights.[155] As with physician-assisted suicide, abortion rights allow a woman to maintain autonomy in choosing the manner, method, and time in which to deliver her child (if she choose to do so at all). The Supreme Court uses the "fetal viability" standard to determine whether a woman's rights to seek an abortion are being infringed upon.[156] The rationale behind allowing abortion in limited circumstances (which many of the most staunch pro-life advocates offer as justifiable causes for doing so) – such as rape, incest, and the endangerment of the mother's life – can be properly extended to physician-assisted suicide as well because of the exigent circumstances that must exist (in the states that allow physician-assisted suicide) for a patient to request such action. Certainly, inherent in these exceptions that pro-life and pro-choice advocates have carved out is the "freedom to choose." The woman who was raped wants to be able to choose to have a child rather than have it foisted upon her; the woman who is having a child as a product of incest desires the freedom to have a baby that is healthy and without the many genetic abnormalities that are more likely to arise as a result of mating within one's own gene pool; and the mother whose life is in danger due to complications during delivery may wish to preserve her own life over the life coming into being. The reasoning is similar in that a patient knows that he is going to die, and he simply wants the freedom to choose a more expeditious death process.[157]

III. STATE PATHWAYS TO LEGALIZATION

Thinking back to Justice O'Connor's concurrence in *Cruzan*, she believed that states should be free to retain and develop a basic constitutional "right to die" that is inherent in due process considerations.[158] She believed the interpretation of this right,

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[155] Carrie H. Pailet, *Abortion and Physician-assisted Suicide: Is There a Right to Both?*, 8 LOY. J. PUB. INT. L. 45, 60 (2006) (""There is a legal link between abortion and physician-assisted suicide. Both procedures have relied on the same legal argument, that to prohibit either choice is a violation of an unspecified, constitutionally protected, liberty interest that one may make decisions affecting one's own body free from legal interference. The argument expounding a right to privacy gradually became focused as a right to autonomy - the right to make decisions regarding one's body and healthcare without interference from the State."").

[156] Planned Parenthood v. Casey, 505 U.S. 833, 870 (1992).

[157] *See generally Assisted Suicide and Reproductive Freedom: Exploring Some Connections*, 76 Wash. U. L.Q. 15 (1998).

[158] *Cruzan*, 497 U.S. at 292.

including how far to extend the right, is best left to the states.[159] This is markedly different than the Court's other forays into foisting the widespread adoption of certain liberties on all states through preempting state action through a court ruling.[160] In an age where the Tenth Amendment is mostly a truism due to federal regulation and oversight, leaving issues like this up to states is a means of giving the states back the powers that they should have rightly been exercising in the first place. There is an inevitable tension that arises when thinking about whether to expand a federal right, for expanding a federal right always places burdens upon states, as they must observe it regardless of their own statutes or state constitutions. As this issue has been left (at least for now) within the discretion of the states, the states that are considering whether to legalize the practice of physician-assisted suicide must decide the best approach to handling the issue, especially if a state's ultimate decision is to authorize the practice.

A. Legislative Action vs. Judicial Activism

There are two methods whereby physician-assisted suicide can be legalized – through legislative action (whether it be representative democracy or pure direct democracy) or through judicial review. Currently, only one state has indirectly authorized physician-assisted suicide in certain situations through the judiciary.[161] There is a separation of powers consideration inherent in discerning whether a constitutional issue like physician-assisted suicide should be decided by the legislature or the judiciary[162]. For a number of reasons, the judiciary is not the proper place to resolve this important question. Judicial action exists to determine the constitutionality and validity of laws,[163] but with a controversial

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[159] *Id.*

[160] *See* Roe v. Wade, 410 U.S. 113 (1973) (holding that all states must recognize a woman's right to seek an abortion prior to the third trimester of pregnancy); Obergefell v. Hodges, 135 S.Ct. 2584 (2015) (holding that all states must recognize a right to same-sex marriage).

[161] *See* Baxter, *supra* note 93

[162] Natalie Haag, *Separation of Powers: Is There Cause for Concern?*, 82- J. KAN. B.A. 30, 36 (2013) ("When state officials and legislators complain about "judicial activism" regarding a particular judicial opinion, they are really contending the judicial branch made law rather than interpreted the law passed by the legislature. If true, that would amount to an encroachment by the judicial branch into the powers of the legislative branch.").

[163] Martin Edelman *Written Constitutions, Democracy and Judicial Interpretation: The Hobgoblin of Judicial Activism*, 68 ALB. L. REV. 585, 588 (2005) ("[J]udicial review enlists the power of an independent judiciary to authorize or limit governmental action by virtue of its authority to interpret the fundamental law of the land.").

topic involving states' rights that are not necessarily well-settled, the more proper place is the legislature.[164]

Five states have now implemented ballot measures that have received a majority of votes in favor of physician-assisted suicide.[165] This is a states' rights issue, and the Supreme Court implicitly held as much in *Gonzales v. Oregon* when it deferred to Oregon's Death with Dignity Act.[166] The Act, contained in a ballot measure, came under fire with a subsequent attempt to repeal by another ballot measure three years later.[167] As the latter measure was rejected by a much greater margin than the first measure passed,[168] this is proof that the legislature embodies the will of the people, and as the country and states are founded on concepts of democracy, it would be best to let the people decide how to run their states.

By now, states like Oregon and Washington have empirical data on the usage and effects of the legislative measures they have passed legalizing physician-assisted suicide in certain circumstances. Contrary to the argument that residents would flock to utilize these procedures en masse, since 1997, only 1,749 people have been prescriptions written under Oregon's statute; only 1,127 of those have died as a result of consuming the prescribed dose (64.4%).[169] With respect to more recent data obtained in Oregon, in 2016, only 204 people received lethal doses of medication in compliance with the statute.[170] During that year, 133 people died as a result of ingesting this medication; of those, 19 that died has been prescribed the medication during previous years.[171] During 2016, the patients who received the prescriptions were mainly those 65 years of age or older (80.5%) and (likely with some overlap) those suffering from a terminal form of cancer (78.9%).[172] The data showed that the three most frequently mentioned end-of-life concerns for patients who obtained prescriptions in 2016 were loss of autonomy (89.5%), decreasing ability to participate in activities

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[164] Erwin Chemerinsky, *The Vanishing Constitution*, 103 HARV. L. REV. 43, 77, 103 ("In developing a theory of judicial review, the crucial question is which issues are best suited to legislative, executive, or judicial resolution. . . .Particularly for constitutional norms that the judiciary does not enforce, legislative and executive implementation becomes imperative.").
[165] *See supra* note 147.
[166] *See* Lee, *supra* note 85.
[167] *Id.*
[168] *See* Initiative, Referendum and Recall, *supra* note 69.
[169] Pub. Health Div., Ctr. for Health Statistics, Oregon Death with Dignity Act, Data summary 2016, OREGON HEALTH AUTHORITY (Feb. 10, 2017). https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year19.pdf (February 10, 2017).
[170] *Id.*
[171] *Id.*
[172] *Id.*

that made life enjoyable (89.5%), and loss of dignity (65.4%).[173] This is consistent with data from previous years.[174] Most notably, in 2016, *zero* physicians were referred to the Oregon Medical Board for failure to comply with statutory requirements.[175]

Although Washington's Death with Dignity Act was passed more recently, annual reports can still be found containing somewhat similar data. From 2009 (the first year the medication was available) until 2015 (the most recent obtainable data), 938 people received prescriptions for the medication.[176] Of those, 917 ingested the medication and died (97.8%).[177] This is somewhat higher than Oregon, but there appears to be no reason why some take the medication and some do not.[178] During 2015, the patients who received the prescriptions were mainly those 65 years of age or older (73.9%) and (likely with some overlap) those suffering from a terminal form of cancer (72%).[179] The data showed that the three most frequently mentioned end-of-life concerns for patients who obtained prescriptions in 2016 were loss of autonomy (85.8%), decreasing ability to participate in activities that made life enjoyable (86.3%), and loss of dignity (68.5%); this is consistent with data from previous years.[180] No data was available to determine whether any physicians had been referred to the Washington Medical Board for failure to comply with statutory requirements.[181]

The laws passed in Vermont, California, Colorado, and the District of Columbia are simply too recent and simply do not have enough data to conduct a proper analysis of the law's' effects. It will be interesting to see if these states produce reports bearing similarities to Oregon and Washington as the conversation continues in states where the practice is still against the law. Similar data would indicate the propriety of leaving the legalization of physician-assisted suicide in the hands of the legislature.

By contrast, medical professionals in the State of Montana have been left in a situation tantamount to "legal purgatory,"

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[173] *Id.*
[174] *Id.*
[175] *Id.*
[176] *See*.Wash. State Dep't of Health *Washington State Department of Health 2015 Death with Dignity Act Report, Executive Summary*, WASHINGTON STATE DEPARTMENT OF HEALTH, http://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2015.pdf (2015).
[177] *Id.*
[178] *Id.*
[179] *Id.*
[180] *Id.*
[181] *Id.*

because there is no guidance.[182] As the *Baxter* case did not decide the constitutional question, but rather focused on determination guided by public policy in the absence of statutory language or case law on the issue, there are no clear standards by which a physician can be sure that his conduct in rendering physician-assisted suicide to a patient does not violate a criminal or civil statute. Unlike the procedural safeguards in Oregon, Washington, etc. that guide the physician in complying fully with constitutional and statutory law, there is no guidance under this nebulous court ruling. Even though the Journal of Palliative Medicine has undertaken to give physicians in Montana some guidance, there is still no legal regulatory framework for medical professionals practicing in that state to follow.[183]

Seven years have now passed since Montana's highest court decided the case, and it is becoming clear now that the lack of data and analysis of the effects of the case stem from the physicians making individual choices, under the circumstances, with no regulatory scheme to direct them. There are no reports, and thus no data to express demographics, prevalence of the practice, or a patient's underlying motivations for seeking the procedure.

Because of the disparity in analyzing the effects of the legalization of physician-assisted suicide in jurisdictions where it is a statutory right versus the jurisdiction where it is legal at common law, legislation is a preferable approach, as it creates a framework for discussions among medical professionals as well as society-at-large.

B. Representative Democracy vs. Direct Democracy

Several mechanisms exist by which a bill can become a law, but the fundamental democratic dichotomy is whether to create a statutory right through representative democracy or pure democracy. The six jurisdictions with statutes providing for physician-assisted suicide are split in the manner in which they got there. Oregon, Washington, and Colorado instituted their laws through ballot measures drafted by experienced professionals and submitted to the people for a vote.[184] Vermont, California, and the District of Columbia drafted bills and introduced them directly to

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[182] Sen. Jim Shockley & Margaret Dore, *No, Physician-assisted Suicide is Not Legal in Montana*, 37- MONT. LAW. 7, 25 (2011) ("Baxter has created confusion in the law, which has put Montana citizens at risk. Neither the legal profession nor the medical profession has the necessary guidance to know what is lawful.").
[183] David Orentlicher, Thaddeus Mason Pope, and Ben A. Rich, *Clinical Criteria for Physician Aid in Dying*, J. OF PALLIATIVE MED., Vol. 16, No. 3 259, 260 (2016).
[184] OR. REV. STAT. § 127.800 *et seq.* (West 2017); R.W.C.A. § 70.245 *et seq.* (West 2017); COLO. REV. STAT. § 25-48-101 *et. seq.* (West 2017).

their respective legislative houses.[185] While there are certainly valid concerns regarding representative democracy, pure democracy was not envisioned by the Framers of the Constitution.[186] Senator John C. Calhoun once put this consternation quite succinctly, when he said, "The Government of the absolute majority instead of the Government of the people is but the Government of the strongest interests; and when not efficiently checked, it is the most tyrannical and oppressive that can be devised."[187] Although certainly special interest groups and political contributions are concerns of representative democracy, James Madison considered a republican form of government the most desirable form of government for checking the power of democracy.[188] Further, the right to every state to have a "republican form of government" is manifested explicitly in the United States Constitution.[189] If the Framers of the Constitution considered representative democracy the best form of state governance, then it seems that representative legislative action is more suitable to decide a constitutional issues left to the discretion of the states than pure direct democracy.

C. Potential Positive Future Effects of Widespread Adoption

Up until this point, this Note has not opined about the effects of widespread adoption among the states of physician-assisted suicide in certain circumstances and subject to the various procedural safeguards provided above. However speculative an analysis of these possible effects may be, there is at least some indication that providers and patients alike have benefitted in the jurisdictions where the possibility of physician-assisted suicide is available.

Although it may seem initially insensitive, there can be no doubt that health care costs remain high within the United States, and long-term care costs pose a problem in particular.[190] This is not to suggest that an individual should take into consideration the

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[185] 12 V.S.A. § 5281 *et. seq.* (West 2017); CAL. HEALTH & SAFETY CODE § 443.1 *et. seq.* (West 2017); D.C. ST. 7-661.01 *et. seq.* (West. 2017).
[186] Steve C. Briggs, *Colorado Bar Association President's Message to its Members*, 33COLO. LAW. 47, 47 (2004).
[187] *Id.* (quoting John C. Calhoun, "Against the Force Bill," speech given on the Senate floor (Feb. 16, 1833)).
[188] *Id.*
[189] U.S. Const. Art. IV § 4.
[190] Eriko Sase and Christopher Eddy, *The Millennials in an Aging Society: Improving End-of-Life Care by Public Policy*, 21 GEO. PUB. POL'Y REV. 1, (2016) ("Millennials may also be personally affected by the relative unaffordability of long-term care insurance, coupled with the shift towards chronic, debilitating disease that is a consequence of increasing lifespans and lifestyles.").

effects of his cost burden on American society when determining whether to request a lethal dose of medication for his terminal illness. It is simply a note that allowing individuals in certain circumstances, many of whom do require quite expensive long-term care, will have an incidental effect of decreasing long-term health care costs in the long run, as the medication itself is relatively inexpensive by comparison.[191] A widespread adoption could plausibly lead to lower long-term health care costs as people exit the market.

Widespread adoption could also decrease forum shopping. Although states statutes do thus far contain a residency requirement, the actual determination of whether a person is a resident for purposes of the statute is left to the physician's discretion. For example, in Oregon, such factors include: "an Oregon Driver License, a lease agreement or property ownership document showing that the patient rents or owns property in Oregon, an Oregon voter registration, or a recent Oregon tax return."[192] Additionally, there is no minimum residency requirement.[193] Although the data does not show thousands of terminally ill people flocking to Oregon or Washington to establish residency for the sole purpose of obtaining lethal medication, it is certainly reasonable to posit that at least a few have done so.[194] A widespread adoption would reduce forum shopping or "doctor shopping," and those who truly wish to end their lives in a dignified and autonomous manner would be able to do so with physicians who have been treating them from the onset of their respective illnesses.

Although this list is certainly not an exhaustive inventory of the prospective benefits of widespread adoption, one final consideration is allowing physicians more mobility. A physician who primarily provides long-term care may receive several requests from patients with terminal illnesses (who meet all the criteria discussed earlier) to help them end their lives. However, in jurisdictions where such a remedy is unavailable, the physician will be unable to comply with the patient's request. The physician may not wish to move to any of the seven jurisdictions where the practice is legal. A widespread adoption by the states of physician-assisted suicide legislation would give physicians autonomy and, as noted in the statutes above, physicians who have moral objections would be able to remove themselves from the process without fear of

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[191] Death with Dignity, *FAQs*, https://www.deathwithdignity.org/faqs/ (last visited March 3, 2017).
[192] Oregon Public Health Initiative, *FAQs about the Death with Dignity Act*, https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/faqs.pdf (last visited March 3, 2017).
[193] *Id.*
[194] *See supra* note 6.

retribution. There are still other considerations (and of course, accompanying counter-arguments), but a widespread adoption would leave state autonomy intact while providing both direct and incidental benefits on federal and state levels.

IV. CONCLUSION

Physician-assisted suicide is a controversial issue that implicates significant constitutional issues, and the United States Supreme Court has indicated that it is best left to each state to determine whether and to what extent the "right to die" within that state encompasses physician-assisted suicide. After seeing how it has played out in the jurisdictions that have legalized the practice, the best option seems to be to pass a legislative measure codifying the methods and procedures whereby physician-assisted suicide may be legally carried out. Not only does this offer guidance for physicians contemplating whether they are able to be involved in such a practice, but it provides empirical data and statistical analysis in a way that a nebulous legal status at common law is simply unable to do. The information gathered from a jurisdiction that guides its physicians in this limited-circumstance implementation will serve to guide other jurisdictions as they continue to have conversations, about whether the "right to die" should allow a patient to die with dignity. Perhaps this issue could even serve as a reminder of the importance of state autonomy, and maybe then, the Tenth Amendment could come back into greater focus as more than just a truism.