

THE RIGHT TO DIE WITH DIGNITY:
DEATH, YOUR BODY, AND PRIVACY

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INTRODUCTION

Bob Dent was the first person in the world to die via legal voluntary euthanasia.¹ Mr. Dent battled prostate cancer for five years, enduring multiple surgeries and a partially collapsed lung.² When Mr. Dent chose to end his life, he was bedridden and in immeasurable pain.³ Prior to his death, Mr. Dent wrote a letter to his wife stating his belief that right to die legislation is the “most compassionate legislation in the world”⁴

Dr. Philip Nitschke, Australia’s leading right to die activist, fought for Mr. Dent’s right to end his life.⁵ Despite Dr. Nitschke’s strong convictions, he expressed fear and unease over assisting Mr. Dent with his death: “[m]y fears about the whole thing was that I was in the executioner’s role[;] . . . I realized what a grisly business it is.”⁶

At a media conference the day after Mr. Dent’s death, Dr. Nitschke could barely contain his tears.⁷ Dr. Nitschke stated his belief that assisting a death “takes a toll out of those people who are participating, but perhaps, ultimately, it is the greatest thing you can do for a

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¹ Richard Pallardy, *Bob Dent Dies: The First Legal Voluntary Euthanasia*, ENCYCLOPEDIA BRITANNICA BLOG (Sept. 22, 2011), <http://blogs.britannica.com/2011/09/bob-dent-dies-legal-voluntary-euthanasia/>.

² *Id.*

³ *Id.*

⁴ Sharon I. Fraser & James W. Walters, *Death—Whose Decision? Euthanasia and the Terminally Ill*, 26 J. MED. ETHICS 121,121 (2002).

⁵ Gay Alcorn, *The Fight to End a Life*, SYDNEY MORNING HERALD (Sept. 27, 1996), <http://www.smh.com.au/articles/2002/05/30/1022569809394.html>.

⁶ *Id.*

⁷ *Id.*

person.”⁸ Dr. Nitschke did not feel like he had done anything wrong by assisting Mr. Dent in dying.⁹

Physician-assisted suicide is currently legal in Oregon,¹⁰ Washington,¹¹ Montana,¹² Vermont,¹³ California,¹⁴ Colorado,¹⁵ and Washington, D.C.¹⁶ Since the 1990s, public opinion in the United States has remained in favor of legalizing assisted death, which encompasses both physician-assisted suicide and voluntary euthanasia.¹⁷ Advocates believe that the right to physician-assisted suicide should be protected as a fundamental right of privacy.¹⁸ They fear that outlawing physician-assisted suicide will force patients to commit suicide or undergo assisted suicide “behind closed doors,” similar to a woman undergoing an abortion procedure prior to its legalization in 1973.¹⁹ When the Supreme Court decided *Roe v. Wade*, only four states completely legalized abortion and fourteen states legalized abortion in some circumstances.²⁰ However, in *Roe v. Wade*, the Court determined abor-

⁸ *Id.*

⁹ *Id.*

¹⁰ Oregon legalized physician-assisted suicide in 1997 via the Oregon Death with Dignity Act. See OR. REV. STAT. §§ 127.800-127.995 (LexisNexis 2018).

¹¹ Washington legalized physician-assisted suicide in 2008 via the Washington Death with Dignity Act. See WASH. REV. CODE ANN. §§ 70.245.010-70.245.904 (LexisNexis 2018).

¹² Montana legalized physician-assisted suicide in 2009 via a court ruling in *Baxter v. State*. 254 Mont. 234, 250-51 (2009).

¹³ Vermont legalized physician-assisted suicide in 2013 via the Patient Choice at End of Life Act. See Patient Choice at End of Life Act, 18 VT. STAT. ANN. §§ 5281-5293 (2018).

¹⁴ California legalized physician-assisted suicide in 2015 via the End of Life Options Act. See CAL. HEALTH & SAFETY CODE § 443-443.22 (West 2018).

¹⁵ Colorado legalized physician-assisted suicide in 2016 via the End of Life Options Act. See COLO. REV. STAT. §§ 25-48-101-25-48-123 (West current through 2017 1st Reg. Sess.).

¹⁶ See Fenit Nirappil, *Assisted Suicide is Legal in D.C. – for now*, WASH. POST. (July 7, 2017), https://www.washingtonpost.com/local/dc-politics/dc-assisted-suicide-program-goes-live-as-threat-of-congressional-interference-looms/2017/07/17/f12c5bc4-6b18-11e7-b9e2-2056e768a7e5_story.html?utm_term=.6e161f51f10c.

¹⁷ See e.g., 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>; Scott Hensley, *Americans Support Physician-Assisted Suicide for Terminally Ill*, NPR (Dec. 28, 2012, 7:39 AM), <https://www.npr.org/sections/health-shots/2012/12/27/168150886/americans-support-physician-assisted-suicide-for-terminally-ill>.

¹⁸ See Erwin Chemerinsky, *Washington v. Glucksberg Was Tragically Wrong*, 106 MICH. L. REV. 1501, 1503 (2008).

¹⁹ Emily R. Manson, *Ignoring It Will Not Make it go Away: Guidelines for Statutory Regulation of Physician-Assisted Death*, 45 NEW ENG. L. REV. 139, 155 (2010) (citing *Compassion in Dying v. Washington*, 79 F.3d 790, 801 (9th Cir. 1996)).

²⁰ Sara Kiff, *CHARTS: How Roe v. Wade Changed Abortion Rights*, WASH. POST. (Jan 22, 2013), https://www.washingtonpost.com/news/wonk/wp/2013/01/22/charts-how-roe-v-wade-changed-abortion-rights/?utm_term=.dc76d4a7005f.

tion is a fundamental right after looking at the First, Fourth, Fifth, Ninth, and Fourteenth Amendments.²¹

Opponents of physician-assisted suicide believe that outlawing it appropriately keeps the focus on pain management rather than on death.²² They fear assisted death will be misused and forced upon the poor, the elderly, or the otherwise disenfranchised.²³ They also fear misdiagnosis and the eventual use of involuntary euthanasia.²⁴

This Comment will demonstrate that the Due Process Clause of the Fourteenth Amendment affords a constitutional right to privacy, and will argue that this right to privacy provides terminally ill patients with the choice of ending their suffering via physician-assisted suicide or euthanasia. Part I of this Comment provides background on physician-assisted suicide law. It briefly overviews the states that have legalized physician-assisted suicide and discusses the two physician-assisted suicide cases heard by the Supreme Court of the United States: *Washington v. Glucksberg*²⁵ and *Vacco v. Quill*.²⁶ Part I then discusses *Roe v. Wade*²⁷ in the context of *Glucksberg* and *Vacco*, setting up a comparison of the Court's treatment of abortion and physician-assisted suicide. Part II of this Comment argues that, in *Glucksberg*, the Court erred in holding that physician-assisted suicide is not protected under the Due Process Clause. It will then conclude that physician-assisted suicide and euthanasia should be analyzed under the same framework as abortion. Under this framework, the concerns regarding the legalization of physician-assisted suicide can be addressed and abated. Accordingly, so long as assisted death is strictly regulated, it should be protected under the Due Process Clause of the Fourteenth Amendment.

²¹ See *Roe v. Wade*, 410 U.S. 113, 120, 152 (1973).

²² Manson, *supra* note 19, at 155.

²³ *Id.* (citing *Washington v. Glucksberg*, 521 U.S. 702, 732 (1997)).

²⁴ *Id.* (citing *Washington v. Glucksberg*, 521 U.S. 702, 732 (1997)).

²⁵ See generally *Washington v. Glucksberg*, 521 U.S. 702 (1997).

²⁶ See generally *Vacco v. Quill*, 521 U.S. 793 (1997).

²⁷ See generally *Roe v. Wade*, 410 U.S. 113 (1973).

I. BACKGROUND

A. *Defining End of Life Care, Physician-Assisted Suicide, and Euthanasia*

1. End of Life Care

End-of-life care is closely related to physician-assisted suicide and euthanasia.²⁸ Many medical procedures fall under the category of end-of-life care, but only four forms are relevant for this discussion.²⁹ First, hospice care begins after treatment is stopped and when the patient's illness becomes terminal.³⁰ Typically, hospice care is offered when a person is expected to live for less than six months.³¹ Second, palliative care is an option for anyone living with a serious illness, and can be given during the treatment of a painful disease or during hospice care.³² Palliative care works to provide comfort by preventing or treating symptoms and side effects of the disease or its treatment.³³ The third and fourth forms, withdrawing life-sustaining treatment and withholding life-sustaining treatment, are very similar. Withdrawing life-sustaining treatment refers to the removal of medical equipment that is keeping the patient alive.³⁴ This is an option for patients who are on life support without realistic hope of recovery, when quality of life is unacceptable, or when the patient is suffering.³⁵ Similarly, withholding life-sustaining treatment refers to the conscious decision not to initiate life-sustaining measures.³⁶ Life-sustaining treatments are withheld, for example, after a patient signs a do-not-resuscitate order or when a patient decides against a potentially life-saving or life-

²⁸ See Lisa Schenecher, *Assisted-Suicide Debate Focuses Attention on Palliative, Hospice Care*, MOD. HEALTH CARE (May 16, 2015), <http://www.modernhealthcare.com/article/20150516/MAGAZINE/305169982>.

²⁹ See, e.g., *End of Life: Helping with Comfort and Care*, NATIONAL INSTITUTES OF HEALTH (2016), <https://www.nia.nih.gov/health/publication/end-life-helping-comfort-and-care/introduction> [hereinafter "End of Life"].

³⁰ Laura J. Martin, *What is Palliative Care?*, NATIONAL INSTITUTES OF HEALTH, MEDLINE PLUS (Feb. 2, 2016), <https://medlineplus.gov/ency/patientinstructions/000536.htm>.

³¹ *Id.*

³² *See id.*

³³ Martin, *supra* note 30.

³⁴ See Kathleen M. Stacy, *Withdraw of Life-Sustaining Treatment: A Case Study*, 32 CRITICAL CARE NURSE 14 (June 2012), <http://ccn.aacnjournals.org/content/32/3/14.full>.

³⁵ *Id.*

³⁶ See Richard J. Ackermann, *Withholding and Withdrawing Life-Sustaining Treatment*, AM. FAM. PHYSICIAN (Oct. 1, 2000), <http://www.aafp.org/afp/2000/1001/p1555.html>.

extending surgery.³⁷ Withdrawing life-sustaining treatment and withholding life-sustaining treatment are occasionally referred to as passive euthanasia—although this classification is controversial because people do not like the stigma associated with the term euthanasia.³⁸ Withdrawing life-sustaining treatment and withholding life-sustaining treatment are typically seen as distinct from physician-assisted suicide and euthanasia because they are marked by inaction.³⁹

2. Physician-Assisted Suicide

Physician-assisted suicide is defined as a suicide whereby a physician provides the means necessary for a patient to end his life.⁴⁰ When a patient chooses to end his life by physician-assisted suicide, his physician will provide a prescription for medication that can be taken at a time of the patient's choosing.⁴¹ Accordingly, the physician is giving the patient the means necessary to end his life.⁴² Without the physician's participation, an individual could commit suicide without legal implications.⁴³ Therefore, it is the physician's participation, not the patient's actions, that is at issue.⁴⁴

When a patient meets the criteria for physician-assisted suicide, his physician will write a prescription for a lethal dose of sedatives or a combination of medications that contain a high dosage of sedatives.⁴⁵ Secobarbital, originally developed as a sleeping pill, is the most commonly used drug in physician-assisted suicide.⁴⁶ Secobarbital works quickly and painlessly, causing "people [to] fall asleep with no complications."⁴⁷ A lethal dose of secobarbital is 100 capsules.⁴⁸

³⁷ See *id.*

³⁸ Bernard Gert et al., *Distinguishing Between Active and Passive Euthanasia*, 2 *CLINICAL GERIATRIC MED.* 29 (February 1986).

³⁹ See *Cruzan v. Mo. Dep't. of Health*, 497 U.S. 261, 296 (1990).

⁴⁰ David A. Pratt, *Too Many Physicians: Physician-Assisted Suicide After Glucksberg/Quill*, 9 *ALB. L.J. SCI. & TECH.* 161, 166-67 (1999) (citing *Decisions Near the End of Life*, 267 *JAMA* 2229, 2231 (1992)).

⁴¹ *Physician Assisted Suicide and the Right to Die with Assistance*, 105 *HARV. L. REV.* 2021, 2023 (1992).

⁴² See *id.*

⁴³ See *id.* at 2024.

⁴⁴ *Id.*

⁴⁵ See April Dembrosky, *Drug Company Jacks Up Cost of Aid-in-Dying Medication*, NPR (Mar. 23, 2016), <http://www.npr.org/sections/health-shots/2016/03/23/471595323/drug-company-jacks-up-cost-of-aid-in-dying-medication>.

⁴⁶ *Id.*

⁴⁷ *Id.*

Secobarbital has recently become significantly more expensive, with a price of less than \$200 in 2009 increasing to more than \$3,000 in early 2016.⁴⁹ Although some health insurance companies cover the cost of secobarbital, many patients must pay out of pocket.⁵⁰

3. Euthanasia

The American Medical Association's Council on Ethical and Judicial Affairs states that euthanasia is the "administration of a lethal agent in order to relieve a patient's intolerable and untreatable suffering."⁵¹ Euthanasia differs from physician-assisted suicide because a physician or other individual directly causes an individual's death instead of taking a more passive role.⁵² When a patient dies via euthanasia, they are typically incapable of swallowing the medication that is required for physician-assisted suicide.⁵³ Due to the inability to swallow, euthanasia typically occurs when the physician injects the patient with medication that will end the patient's life or when the physician attaches the patient to a machine that will administer a fatal dose of medication.⁵⁴ This is more controversial and garners significantly less support than physician-assisted suicide because there is the fear that individuals will die without fully consenting.⁵⁵ Two forms of euthanasia are responsible for these concerns.⁵⁶

Voluntary euthanasia is euthanasia conducted after a terminally ill patient requests to die.⁵⁷ For some terminally ill or permanently disabled patients, voluntary euthanasia is the only option available to them because they are incapable of swallowing medication, which is

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ T. Howard Stone, *Physician-Assisted Suicide and Euthanasia in the United States: Legal and Ethical Observations*, 16 J. LEGAL MED. 481, 483 (1995) (quoting American Medical Association Council on Ethical and Judicial Affairs, *Decisions Near the End of Life*, 267 JAMA 2229, 2231 (1992)).

⁵² Kathy L. Cerminara, *Therapeutic Death: A Look at Oregon's Law*, 6 PSYCHOL. PUB. POL'Y & L. 503, 506 (2000).

⁵³ *People v. Kevorkian*, 639 N.W.2d 291, 305-06 (Mich. Ct. App. 2001).

⁵⁴ See e.g., *People v. Kevorkian*, 639 N.W.2d 291, 298 (Mich. Ct. App. 2001).

⁵⁵ David Orentlicher, *The Alleged Distinction Between Euthanasia and the Withdrawal of Life-Sustaining Treatment: Conceptually Incoherent and Impossible to Maintain*, 1998 U. ILL. L. REV. 837, 858 (1998).

⁵⁶ See *Voluntary and Involuntary Euthanasia*, BBC News (Jan. 2014), <http://www.bbc.co.uk/ethics/euthanasia/overview/volinvol.shtml> [hereinafter "Euthanasia"].

⁵⁷ Euthanasia, *supra* note 56.

necessary for physician assisted suicide.⁵⁸ Mr. Dent died via voluntary euthanasia with the help of Dr. Nitschke and a computer.⁵⁹ Dr. Nitschke attached Mr. Dent to an IV that administered a fast-acting barbiturate after Mr. Dent tapped the space bar of a computer.⁶⁰ After Mr. Dent was asleep, the computer automatically administered a slower-acting barbiturate.⁶¹ The final medication was a muscle relaxant, leading to a peaceful and painless death.⁶² When discussing the legalization of euthanasia, advocates are specifically referring to voluntary euthanasia.⁶³

Non-voluntary euthanasia, on the other hand, is euthanasia conducted when an individual cannot make the decision to end his life or cannot have his wishes known.⁶⁴ For example, non-voluntary euthanasia occurs when the patient is brain-dead and does not have a do-not-resuscitate order but his family decides to withdraw life saving measures.⁶⁵ Involuntary euthanasia occurs when the person wants to live but is nevertheless killed.⁶⁶ Involuntary euthanasia is usually classified as murder.⁶⁷

B. *Physician-Assisted Suicide Is Legal in Six U.S. States and the District of Columbia*

Euthanasia is not legal in any of the states that have legalized physician-assisted suicide.⁶⁸ For a patient to legally end his life via physician-assisted suicide in the United States, he must live in a state where physician-assisted suicide is legal.⁶⁹ If he does not live in Oregon, Washington, Montana, Vermont, California, Colorado, or Wash-

⁵⁸ Bollman, *infra* note 63, at 396.

⁵⁹ Alcorn, *supra* note 5.

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² *Id.*

⁶³ See, e.g., Cyndi Bollman, *A Dignified Death? Don't Forget About the Physically Disabled and Those Not Terminally Ill: An Analysis of Physician-Assisted Suicide Laws*, 34 S. ILL. U. L.J. 395 (2010).

⁶⁴ Euthanasia, *supra* note 56.

⁶⁵ *Id.*

⁶⁶ *Id.*

⁶⁷ See *id.*

⁶⁸ See, e.g., OR. REV. STAT. § 127.880 (LexisNexis 2017).

⁶⁹ See, e.g., OR. REV. STAT. § 127.805 (LexisNexis 2017).

ington, D.C., he must either establish residency in one of these states or travel to a foreign country to die via physician-assisted suicide.⁷⁰

Switzerland has become a popular destination for those looking to die via physician-assisted suicide.⁷¹ Switzerland has a long and progressive relationship with assisted suicide and euthanasia.⁷² Dignitas, a Swiss nonprofit group dedicated to providing assisted suicide for terminal or severe illnesses, allows foreigners to receive counseling and end-of-life services at its facility outside of Zurich.⁷³ Switzerland has developed a suicide tourism industry because of the large number of foreigners traveling to Dignitas in order to die.⁷⁴

In 2012, 21 Americans traveled to Switzerland for end-of-life counseling.⁷⁵ End-of-life counseling refers to the process of determining whether an individual is eligible for assisted suicide or euthanasia.⁷⁶ A patient who receives end-of-life counseling is not necessarily eligible for assisted suicide or euthanasia, and, even if he is, he may decide against taking the final step to end his life.⁷⁷

To die at Dignitas, the patient must pay approximately \$5,300.⁷⁸ This does not include the cost of airfare, lodging, and other miscellaneous travel expenses.⁷⁹ Additionally, the patient must be healthy enough to travel to Switzerland.⁸⁰

It is significantly less expensive for a patient to die via assisted death if physician-assisted suicide or euthanasia is legal in the state

⁷⁰ 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, 699 (2014).

⁷¹ See Penny Sarchet, *Tourism to Switzerland for Assisted Suicide is Growing, Often for Nonfatal Diseases*, WASH. POST (Sept. 22, 2014), https://www.washingtonpost.com/national/health-science/tourism-to-switzerland-for-assisted-suicide-is-growing-often-for-nonfatal-diseases/2014/09/22/3b9de644-2a14-11e4-958c-268a320a60ce_story.html?utm_term=.fafa9d285950.

⁷² See Alex Mauron and Samia Hurst, *Assisted Suicide and Euthanasia in Switzerland: Allowing a Role for Non-Physicians*, BMJ (Feb. 1, 2003), <http://www.bmj.com/content/326/7383/271>.

⁷³ Andrew Gregory, *Dignitas Suicide: British Man Ends His Life at Swiss Clinic as He Could Not Face Dementia*, MIRROR (May 30, 2013), <http://www.mirror.co.uk/news/uk-news/dignitas-suicide-british-man-ends-1920713>.

⁷⁴ See Sarchet, *supra* note 71.

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ See Michael Haederle, *Why End-of-Life Counseling Matters*, AARP (August 2009), https://www.aarp.org/relationships/grief-loss/info-08-2009/end_of_life_counseling_why_it_really_matters.html.

⁷⁸ Gregory, *supra* note 73.

⁷⁹ See *id.*

⁸⁰ *Id.*

where they live.⁸¹ If the patient lives in Oregon, Washington, Montana, Vermont, California, Colorado, or Washington, D.C., their main expense is the medication, which costs approximately \$3,000.⁸² Medical insurances typically cover at least a portion of the cost, making it substantially cheaper than traveling to Dignitas.⁸³

1. Oregon⁸⁴

Oregon became the first state to legalize physician-assisted suicide in 1997 through the passage of the Oregon Death with Dignity Act (the Oregon Act).⁸⁵ Oregon voters approved the first version of the Oregon Act in 1994 through a referendum, but implementation of the Oregon Act was barred for three years due to a constitutional challenge.⁸⁶

In *Lee v. Oregon*, the plaintiffs—doctors, patients, and residential care facilities—filed a class action lawsuit challenging the validity of the Oregon Act.⁸⁷ The plaintiffs alleged that the Oregon Act violated the First and Fourteenth Amendments to the U.S. Constitution.⁸⁸ The District Court held that the Oregon Act violated the Equal Protection Clause of the Fourteenth Amendment and permanently enjoined its enforcement after finding that the Oregon Act “provides a means to commit suicide to a severely overinclusive class who may be competent, incompetent, unduly influenced, or abused by others.”⁸⁹ The Ninth Circuit Court of Appeals vacated and remanded the case with instructions to dismiss, holding that the federal courts did not have jurisdiction to hear the plaintiffs’ claim.⁹⁰

In November 1997, following the Ninth Circuit’s decision in *Lee*, Oregon reaffirmed the Oregon Act.⁹¹ Oregon’s success followed

⁸¹ See Dembrosky, *supra* note 45.

⁸² *Id.*

⁸³ *See id.*

⁸⁴ OR. REV. STAT. §§ 127.880-127.892 (LexisNexis 2017).

⁸⁵ OR. REV. STAT. § 127.805 (1997); Raphael Cohen-Almagor and Monica G. Hartman, *The Oregon Death with Dignity Act: Review and Proposals for Improvement*, 27 J. LEGIS. 269, 271 (2001).

⁸⁶ OR. REV. STAT. § 127.800 (1997); *see Lee v. Oregon*, 107 F. Supp. 1382 (D. Or. 1997); Cohen-Almagor, *supra* note 85, at 27.

⁸⁷ *Lee v. Oregon*, 891 F. Supp. 1429, 1431 (D. Or. 1995).

⁸⁸ *Id.*

⁸⁹ *Id.* at 1437.

⁹⁰ *Lee v. Oregon*, 107 F.3d 1382, 1386 (9th Cir. 1997).

⁹¹ OR. REV. STAT. § 127.800 (1997); Cohen-Almagor, *supra* note 85, at 274.

failed attempts in Washington in 1991 and California in 1992.⁹² As with the other five states and Washington, D.C., that legalized physician-assisted suicide, the Oregon Act does not legalize euthanasia.⁹³

Despite the reaffirmation in November 1997, the federal government essentially halted the Oregon Act.⁹⁴ In April 1997, President Bill Clinton signed the Federal Assisted Suicide Restriction Act of 1997, which stated that federal funds cannot be used to pay for physician-assisted suicide.⁹⁵ The administrator of the Drug Enforcement Administration (DEA) then issued a letter stating that a physician who prescribed life-ending medication under the Oregon Act would violate the Federal Controlled Substances Act.⁹⁶ The Oregon Medical Association advised physicians to refrain from writing prescriptions under the Oregon Act until the United States Department of Justice (DoJ) reviewed the statute.⁹⁷ In June 1998, the DoJ determined that the DEA did not have the authority to hold physicians liable for prescribing medications under the Oregon Act.⁹⁸ Following this determination, Oregon began to practice physician-assisted suicide.⁹⁹

Under the Oregon Act, the patient must be a resident of Oregon¹⁰⁰ and at least eighteen years old.¹⁰¹ Their illness must be terminal,¹⁰² which is defined as an incurable disease that will cause death within six months.¹⁰³ Additionally, the patient must be capable,¹⁰⁴ defined as having the ability to make and communicate health care decisions.¹⁰⁵ If those requirements are met, an attending physician and a consulting physician must confirm the patient's terminal diagnosis,¹⁰⁶ the patient must make an informed decision after a discussion

⁹² Tucker, *supra* note 70, at 687-88 (citing *Chronology of Assisted Dying*, DEATH WITH DIGNITY NAT'L CENTER, <https://www.deathwithdignity.org/assisted-dying-chronology> (last visited Jan. 26, 2018)).

⁹³ See OR. REV. STAT. § 127.880 (1997).

⁹⁴ See Cohen-Almagor, *supra* note 85, at 274-75.

⁹⁵ *Id.* at 275.

⁹⁶ *Id.* at 275-76.

⁹⁷ *Id.* at 276.

⁹⁸ *Id.*

⁹⁹ *Id.* at 277-78.

¹⁰⁰ OR. REV. STAT. § 127.805 (1997).

¹⁰¹ OR. REV. STAT. § 127.800 (1997).

¹⁰² OR. REV. STAT. § 127.805 (1997).

¹⁰³ OR. REV. STAT. § 127.800 (1997).

¹⁰⁴ OR. REV. STAT. § 127.805 (1997).

¹⁰⁵ OR. REV. STAT. § 127.800 (1997).

¹⁰⁶ OR. REV. STAT. §§ 127.815, 127.820 (1997).

with the physician;¹⁰⁷ the patient must make an oral request and a written request for physician-assisted suicide,¹⁰⁸ witnessed by two individuals who are not the patient's physician or family members-physicians,¹⁰⁹ and the patient must reiterate the oral request fifteen days after the initial oral request.¹¹⁰ When the patient makes the second oral request, the physician must offer the patient an opportunity to rescind the request.¹¹¹ The patient can rescind his request at any time and in any manner.¹¹² Additionally, the physician must recommend that the patient notify his next of kin,¹¹³ and, if the physician believes the patient may be suffering from a psychological disorder or depression, he must refer the patient to counseling before taking further action.¹¹⁴ No less than 48 hours can elapse between the patient's written request and the writing of the prescription and no less than fifteen days shall elapse between the patient's initial oral request and the writing of the prescription.¹¹⁵

From 1998 through 2017, medical professionals wrote prescriptions for 1,967 patients under the Oregon Act and 1,275 of those patients died as a result of using those prescriptions.¹¹⁶ The number of patients receiving prescriptions each year has steadily increased between 1998 and 2017. In 1998, 24 patients received prescriptions and 16 of those patients chose to die from the medication; in 2017, 218 patients received prescriptions and 143 of those patients chose to die from the medication.¹¹⁷

The Oregon Act received the most backlash from the public, physicians, and federal government.¹¹⁸ After overcoming these hurdles, the Oregon Act stands as a model for states that are considering legalizing physician-assisted suicide.¹¹⁹

¹⁰⁷ *Id.*

¹⁰⁸ OR. REV. STAT. § 127.840 (1997).

¹⁰⁹ OR. REV. STAT. § 127.810 (1997).

¹¹⁰ OR. REV. STAT. § 127.840 (1997).

¹¹¹ *Id.*

¹¹² OR. REV. STAT. § 127.845 (1997).

¹¹³ OR. REV. STAT. § 127.835 (1997).

¹¹⁴ OR. REV. STAT. §§ 127.815, 127.825 (1997).

¹¹⁵ OR. REV. STAT. § 127.850 (1997).

¹¹⁶ *Oregon Death with Dignity Act: 2017 Data Summary* OR. PUB. HEALTH DIVISION (Feb. 9, 2018), <http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year20.pdf>

¹¹⁷ *Id.*

¹¹⁸ See Manson, *supra* note 19, at 155.

¹¹⁹ *Id.* at 159-60.

2. Washington¹²⁰

Washington legalized physician-assisted suicide in 2008 through the passage of the Washington Death with Dignity Act (the Washington Act).¹²¹ This followed a failed attempt in 1991, when Washington tried to legalize euthanasia via a lethal injection.¹²² Although the passage of the Washington Act was controversial, the federal government did not react to its passage.¹²³

Washington used the Oregon Act as a model, and there are only subtle differences between the two.¹²⁴ The most significant difference is that the Oregon Act requires the Oregon Health Authority to conduct an annual review *of a sample of the records* while the Washington Act requires the Washington Department of Health to conduct an annual review *of all records*.¹²⁵

In 2009, 63 patients received prescriptions under the act and 36 of these individuals died from the medication.¹²⁶ In 2016, 248 patients received prescriptions and 192 of those individuals died after ingesting the medication.¹²⁷

3. Montana¹²⁸

Montana effectively legalized physician-assisted suicide in 2009 through the Montana Supreme Court ruling in *Baxter v. State*.¹²⁹ In *Baxter*, Robert Baxter, four physicians, and Compassion & Choices, a nonprofit dedicated to expanding end of life options, brought an action challenging “the constitutionality of the application of Montana homicide statutes to physicians who provide aid in dying to mentally competent, terminally ill patients.”¹³⁰ Mr. Baxter was terminally ill

¹²⁰ WASH. REV. CODE. §§ 70.245.010-70.245.903 (2009).

¹²¹ *Id.*

¹²² *Washington Death with Dignity Act: A History*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/washington-death-with-dignity-act-history/> (last visited Jan. 26, 2018).

¹²³ See Manson, *supra* note 19, at 153-57.

¹²⁴ *Id.* at 152.

¹²⁵ *Id.* at 153.

¹²⁶ Washington State Department of Health 2009 Death with Dignity Act: Executive Summary (Feb. 3, 2010), <https://www.doh.wa.gov/portals/1/Documents/5400/DWDA2009.pdf>.

¹²⁷ Washington State 2016 Death with Dignity Act Report (Sept. 2017), <https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2016.pdf>.

¹²⁸ *Baxter v. State*, 224 P.3d 1211, 1222 (Mont. 2009).

¹²⁹ *Id.* at 1214.

¹³⁰ *Id.*

with lymphocytic leukemia.¹³¹ He underwent multiple rounds of chemotherapy and suffered from numerous debilitating symptoms from the cancer and treatments.¹³² Mr. Baxter knew he would die and he wanted the option of ingesting a lethal dose of medication at a time of his choosing.¹³³

The Montana Supreme Court held that there was no indication that physician-assisted suicide for terminally ill, mentally competent adults was against public policy.¹³⁴ The court distinguished between a direct act that causes harm and a physician who is not directly involved in the final decision or act.¹³⁵ With physician-assisted suicide, the court found that the physician provides the means for an individual to die but the patient makes the life-ending decision.¹³⁶ In this manner, the patient and the physician work together to ensure that the patient is in control of his death.¹³⁷

4. Vermont¹³⁸

In 2013, the Vermont legislature enacted the Patient Choice at End of Life Act (the Vermont Act).¹³⁹ The Vermont Act presents a different approach to physician-assisted suicide.¹⁴⁰ For the first three years, Vermont's physician-assisted suicide regulations were to operate under a structure borrowed from the Oregon Act.¹⁴¹ Then, most of the statutory mandates would expire and default to the professional practice standards of the medical profession, with doctors making their own judgment calls as they do with all medical decisions.¹⁴² This was a compromise between legislators who wanted to adopt the Oregon Act and those who wanted less government intrusion.¹⁴³

¹³¹ *Id.*

¹³² *Id.*

¹³³ *Id.*

¹³⁴ *Baxter v. State*, 224 P.3d 1211, 1215 (Mont. 2009).

¹³⁵ *Id.* at 1216-17.

¹³⁶ *See id.* at 1217.

¹³⁷ *Id.*

¹³⁸ Patient Choice at End of Life Act, 18 V.S.A. §§ 5281-5293 (2014).

¹³⁹ *Id.*

¹⁴⁰ Tucker, *supra* note 70, at 699.

¹⁴¹ *See id.* at 688.

¹⁴² *Id.*

¹⁴³ *Id.*

The second phase of the Vermont Act was scheduled to begin in July 2016.¹⁴⁴ Under phase two, certain patient protections, such as a requirement for psychiatric evaluation if there is any indication of impairment and a fifteen-day waiting period between a patient's first and second request for medication, were supposed to be removed.¹⁴⁵ However, in May 2015, S.108 made these sunset provisions permanent, causing Vermont's law to remain very similar to the Oregon Act.¹⁴⁶

5. California¹⁴⁷

In 2015, California legalized physician-assisted suicide through its End of Life Option Act (the California Act), which closely mirrors the Oregon Act.¹⁴⁸ Between June 9, 2016, and December 31, 2016, 191 patients received prescriptions under the California Act and 111 of these individuals died after ingesting the medication.¹⁴⁹

A group of physicians quickly moved to suspend the California Act and, on August 26, 2016, a California judge rejected their request.¹⁵⁰ The judge stated that the law would remain in effect but the physicians could "pursue their lawsuit claiming that the law lacks safeguards against abuse."¹⁵¹ Despite this ruling in favor of the California Act, it is still difficult to find access to physician-assisted suicide in California.¹⁵² Hospitals and pharmacies are refusing to participate,

¹⁴⁴ *Id.*

¹⁴⁵ *Death with Dignity in Vermont: A History*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/death-with-dignity-vermont-history/> (last visited Jan. 26, 2018).

¹⁴⁶ *Id.*

¹⁴⁷ CAL. HEALTH & SAFETY CODE § 443 (2015).

¹⁴⁸ See *State-by-State Guide to Physician-Assisted Suicide*, PROCON, <http://euthanasia.procon.org/view.resource.php?resourceID=000132> (last updated Feb. 21, 2017) [hereinafter *State-by-State*].

¹⁴⁹ California End of Life Option Act 2016 Data Report, <https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CDPH%20End%20of%20Life%20Option%20Act%20Report.pdf>.

¹⁵⁰ *California Judge Rejects Request to Suspend Assisted Suicide Law*, N.Y. TIMES (Aug. 27, 2016), http://www.nytimes.com/2016/08/28/us/california-judge-rejects-request-to-suspend-assisted-suicide-law.html?_r=0.

¹⁵¹ *Id.*

¹⁵² Paul Sisson, *A Year After Assisted Suicide Became Legal in California, Hurdles Remain*, SAN DIEGO UNION-TRIBUNE (July 2, 2017), <http://www.sandiegouniontribune.com/news/health/sd-me-end-life-20170702-story.html>.

the cost of the drugs used has risen drastically, and patients find it difficult to discuss with their family and medical providers.¹⁵³

6. Colorado¹⁵⁴

On November 8, 2016, Colorado voters approved the legalization of physician-assisted suicide through the Colorado End of Life Options Act, also known as Proposition 106 (the Colorado Act).¹⁵⁵ The Colorado legislature modeled this measure after the Oregon Act¹⁵⁶ and it went in to effect on December 16, 2016.¹⁵⁷ The Colorado Act garnered some support from physicians, with 56 percent of physicians in the Colorado Medical Society supporting physician-assisted suicide.¹⁵⁸ For physicians with training in palliative medicine, 56 percent of them support the Colorado Act and 39 percent oppose.¹⁵⁹

7. Washington, D.C.¹⁶⁰

In December 2016, Washington, D.C. passed the Death with Dignity Act of 2016 (the D.C. Act).¹⁶¹ The law went into effect on June 6, 2017.¹⁶² The D.C. Act has similar requirements as the Oregon Act: the patient must be 18 years of age or older; reside in Washington, D.C.; have less than six months to live; make two requests for medication at least fifteen days apart; and make a written request for medication at least 48 hours before the second oral request.¹⁶³ Because the

¹⁵³ *Id.*

¹⁵⁴ See State-by-State, *supra* note 148.

¹⁵⁵ Paige Winfield Cunningham, *Colorado Approves Doctor-Assisted Suicide*, WASHINGTON EXAMINER, (Nov. 8, 2016, 10:09 PM), <http://www.washingtonexaminer.com/colorado-approves-doctor-assisted-suicide/article/2606859>.

¹⁵⁶ Anna Staver, *Colorado Votes for Physician Assisted Suicide*, 9 NEWS, (Nov. 8, 2016), <http://www.9news.com/news/politics/elections/colorado-votes-for-physician-assisted-suicide/350168809>.

¹⁵⁷ *Colorado*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/states/colorado/> (last visited Jan. 26, 2018).

¹⁵⁸ *Physician-Assisted Death: Polls show a Divided Membership*, COLORADO MEDICAL SOCIETY (May 20, 2016), <http://www.cms.org/communications/physician-assisted-death-polling-shows-a-divided-membership>.

¹⁵⁹ *Id.*

¹⁶⁰ See generally *Death with Dignity: Patient Education Module*, DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH, (Jun. 27, 2017), https://doh.dc.gov/sites/default/files/dc/sites/doh/page_content/attachments/Patient%20Education%20Module.pdf.

¹⁶¹ *Id.*

¹⁶² *Id.*

¹⁶³ *Id.* at 3, 6.

D.C. Act is so new, it should be followed closely to see how it is received in Washington, D.C., and if organizations challenge its legality.

C. *Right to Die for Non-Terminally Ill Patients*

Under the laws and decisions that legalize physician-assisted suicide in Oregon, Washington, Montana, Vermont, California, Colorado, and Washington, D.C., a patient is not eligible to die if he is suffering from a debilitating disease that is not terminal but is progressive and debilitating.¹⁶⁴ Examples of diseases that are not covered under these acts include Lou Gehrig's disease, Parkinson's disease, and Huntington's disease.¹⁶⁵ Additionally, even if the patient is determined to have less than six months to live, many of these diseases render the patient incapable of ingesting medication, meaning that physician-assisted suicide would not be an option for these patients.¹⁶⁶

D. *Physician-Assisted Suicide Supreme Court Cases*

In 1997, the Supreme Court of the United States heard two cases on physician-assisted suicide: *Washington v. Glucksberg*¹⁶⁷ and *Vacco v. Quill*.¹⁶⁸ These cases did not determine that physician-assisted suicide as a practice was unconstitutional or illegal; they merely explained that it was not unconstitutional to ban physician-assisted suicide under the Due Process Clause¹⁶⁹ or the Equal Protection Clause.¹⁷⁰

1. *Washington v. Glucksberg*

In *Washington v. Glucksberg*, the Supreme Court of the United States held that Washington could outlaw physician-assisted suicide without violating the Due Process Clause of the Fourteenth Amendment.¹⁷¹ Washington law in 1997 stated that "a person is guilty of pro-

¹⁶⁴ *Bollman*, *supra* note 63, at 396.

¹⁶⁵ *Id.*

¹⁶⁶ *Id.*

¹⁶⁷ 521 U.S. 702 (1997).

¹⁶⁸ 521 U.S. 793 (1997).

¹⁶⁹ *Glucksberg*, 521 U.S. at 728.

¹⁷⁰ *Vacco*, 521 U.S. at 807-08.

¹⁷¹ *Id.*

moting a suicide attempt when he knowingly causes or aids another person to attempt suicide.”¹⁷² *Washington v. Glucksberg* overruled the Ninth Circuit Court of Appeal’s decision in *Compassion in Dying v. Washington*,¹⁷³ the first right-to-die case decided by a federal court of appeals.¹⁷⁴ Drs. Harold Glucksberg, Abigail Halperin, Thomas Preston, and Peter Shalit who practiced in Washington and occasionally treated terminally ill patients, filed a lawsuit after they were unable to assist their terminally ill patients in ending their lives.¹⁷⁵ Three of the patients were gravely ill and died before the case reached the Supreme Court.¹⁷⁶ The first patient suffered from terminal cancer and experienced constant pain,¹⁷⁷ the second patient was dying from AIDS,¹⁷⁸ and the third patient suffered from emphysema, “which cause[d] him a constant sensation of suffocating.”¹⁷⁹ The doctors “declared that they would assist these patients in ending their lives if not for Washington’s assisted suicide ban.”¹⁸⁰

In *Compassion in Dying*, the Ninth Circuit invoked a balancing test to determine “whether sufficient justification exists for the intrusion by the government into the realm of a person’s ‘liberty, dignity, and freedom.’”¹⁸¹ The court held that a ban on physician-assisted suicide for terminally ill adults violated the Due Process Clause of the Fourteenth Amendment.¹⁸² The court found that the choice to die should be determined by the individual, not by the government or a group of citizens.¹⁸³ Additionally, the Ninth Circuit determined that the right to die via physician-assisted suicide should be balanced with legitimate state regulations.¹⁸⁴

On appeal, the Supreme Court observed that in almost every state and in almost every western democracy, it was a crime to assist a

¹⁷² *Id.* at 707 (citing Wash. Rev. Code §9A.36.060(1) (1994)).

¹⁷³ *Washington v. Glucksberg*, 521 U.S. 702, 735-36 (1997).

¹⁷⁴ *Compassion in Dying v. Washington*, 79 F.3d 790, 794 (9th Cir. 1996).

¹⁷⁵ *Id.*

¹⁷⁶ *Id.*

¹⁷⁷ *Compassion in Dying v. Washington*, 79 F.3d 790, 794 (9th Cir. 1996).

¹⁷⁸ *Id.* at 795.

¹⁷⁹ *Id.*

¹⁸⁰ *Washington v. Glucksberg*, 521 U.S. 702, 707 (1997).

¹⁸¹ 79 F.3d at 799-800 (quoting *Cruzan v. Director, Mo. Dep’t of Health*, 497 U.S. 261, 280 (1990) (O’Connor, J., concurring)).

¹⁸² *Id.* at 793-94.

¹⁸³ *Compassion in Dying v. Washington*, 79 F.3d 790, 793-94 (9th Cir. 1996).

¹⁸⁴ *See id.*

suicide.¹⁸⁵ By outlawing physician-assisted suicide, the Court explained, states were showing their “commitment to the protection and preservation of all human life.”¹⁸⁶ Although the Due Process Clause protects the “traditional right to refuse unwanted lifesaving medical treatment,” the Court held it does not extend to the right of physician-assisted suicide.¹⁸⁷ The Court looked at whether the practice of physician-assisted suicide is deeply rooted in our nation’s history, instead of looking at physician-assisted suicide as a personal decision or a medical decision.¹⁸⁸

The Court had “always been reluctant to expand the concept of substantive due process,” and it adhered to that pattern in *Glucksberg*.¹⁸⁹ The Court did not want to assert the additional right of physician-assisted suicide because it believed that, by asserting this right, the issue would be removed from public debate.¹⁹⁰

The Court lists two primary features of the established method of substantive Due Process analysis.¹⁹¹ First, the Due Process Clause specifically protects fundamental rights and liberties that were “deeply rooted in this Nation’s history and tradition”¹⁹² and “‘implicit in the concept of ordered liberty,’ such that ‘neither liberty nor justice would exist if they were sacrificed.’”¹⁹³ Because there was a consistent and universal tradition of rejecting physician-assisted suicide, the Court found that physician-assisted suicide was not part of the United States’s history.¹⁹⁴ Second, substantive Due Process cases require a “careful description of the asserted fundamental liberty interest.”¹⁹⁵ The Court held that the asserted rights for physician-assisted suicide are not substantial enough to meet this test.¹⁹⁶ These “guideposts for responsible decision making” led the Court to hold that assisted sui-

¹⁸⁵ 521 U.S. at 710 (citing *Compassion in Dying*, 79 F.3d at 847).

¹⁸⁶ *Id.* at 710 (citing *Cruzan v. Director, Mo. Dep’t of Health*, 497 U.S. 261, 280 (1990)).

¹⁸⁷ *Washington v. Glucksberg*, 521 U.S. 702, 719 (1997) (citing *Cruzan*, 497 U.S. at 278-379).

¹⁸⁸ *Id.* at 720-21.

¹⁸⁹ *Id.* at 720 (quoting *Collins v. City of Harker Heights, Tex.*, 503 U.S. 115, 125 (1992)).

¹⁹⁰ *Washington v. Glucksberg*, 521 U.S. 702, 720 (1997).

¹⁹¹ *Id.* at 720-21.

¹⁹² *Id.* (quoting *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934)).

¹⁹³ *Id.* at 721 (quoting *Palko v. Connecticut*, 302 U.S. 319, 325, 326 (1937)).

¹⁹⁴ *Id.* at 724-25.

¹⁹⁵ *Id.* at 721 (quoting *Reno v. Flores*, 507 U.S. 292, 302 (1993)).

¹⁹⁶ *See Washington v. Glucksberg*, 521 U.S. 702, 722-23 (1997).

cide does not meet the requirements for a right guaranteed under the Due Process Clause of the Fourteenth Amendment.¹⁹⁷

The opinion concluded by adding that this “holding permits this debate to continue, as it should in a democratic society.”¹⁹⁸ The Court’s decision allows the legalization of physician-assisted suicide to remain in flux by failing to address the entirety of the issue. The Court merely held that it is not illegal to forbid physician-assisted suicide under a Due Process analysis.¹⁹⁹

2. *Vacco v. Quill*²⁰⁰

In *Vacco v. Quill*, the Court held that New York’s law forbidding physician-assisted suicide did not violate the Equal Protection Clause of the Fourteenth Amendment.²⁰¹ Physician-assisted suicide was illegal in New York in 1997.²⁰² Three terminally ill patients faced with the severe pain and suffering wanted a physician’s help in taking their lives.²⁰³ New York law permitted a competent person to refuse life-sustaining medical treatment and the patients believed physician-assisted suicide was “essentially the same thing.”²⁰⁴ The patients died as a result of their diseases before the case reached the Supreme Court.²⁰⁵

The respondents—Drs. Timothy E. Quill, Samuel C. Klagsbrun, and Howard A. Grossman—argued that “although it would be ‘consistent with the standards of [their] medical practice[s]’ to prescribe lethal medication for ‘mentally competent, terminally ill patients’ who are suffering great pain and desire a doctor’s help in taking their own lives, they are deterred from doing so by New York’s ban on assisting suicide.”²⁰⁶ They argued that New York’s assisted suicide ban violated the Equal Protection Clause because physician-assisted suicide is equivalent to the refusal of medical treatment.²⁰⁷

¹⁹⁷ *Id.* at 720, 735 (citing *Collins v. Harker Heights* 503 U.S. 115, 125(1992)).

¹⁹⁸ *Glucksberg*, 521 U.S. at 735.

¹⁹⁹ *Id.* at 710.

²⁰⁰ *See generally Vacco v. Quill*, 521 U.S. 793 (1997).

²⁰¹ *Id.* at 797.

²⁰² *Id.* at 797-98.

²⁰³ *Id.* at 797.

²⁰⁴ *Id.* at 798.

²⁰⁵ *Id.* at 797.

²⁰⁶ *Vacco v. Quill*, 521 U.S. 793, 796 (1997).

²⁰⁷ *Id.* at 798.

The Court disagreed, holding that the New York statute forbidding physician-assisted suicide addressed matters of significance for everyone in New York, noting that everyone was entitled to refuse life-sustaining medical treatment but no one was entitled to assist a suicide.²⁰⁸ The Court further held that distinguishing between physician-assisted suicide and withdrawing life-sustaining treatment is logical, rational, and important.²⁰⁹ The Court reasoned that, by withdrawing life-sustaining treatment, the patient is dying from the underlying fatal disease.²¹⁰ In contrast, the Court found that by ingesting a lethal medication prescribed by a physician, the patient dies directly from the medication.²¹¹ The Court believed this was a crucial distinction.²¹²

Notably, the Court declined to declare either physician-assisted suicide or euthanasia unconstitutional.²¹³ Rather, the Court addressed the narrow issue before it, holding that outlawing physician-assisted suicide did not violate the Equal Protection Clause.²¹⁴

E. *The Supreme Court and the Legal Right to Your Body*

In *Roe v. Wade*, a plurality of the Supreme Court of the United States held that the right to privacy found in the Due Process Clause of the Fourteenth Amendment “is broad enough to encompass a woman’s decision whether or not to terminate her pregnancy” but this right “must be considered against important state interests in regulation.”²¹⁵

Jane Roe wished to terminate her pregnancy by an abortion “performed by a competent, licensed physician, under safe, clinical conditions[,]” but the laws in Texas, where she lived, authorized abortions only if the mother’s life was at risk.²¹⁶ Roe argued that the right to terminate a pregnancy was embodied in the Fourteenth Amendment’s

²⁰⁸ *Id.* at 799-800.

²⁰⁹ *Id.* at 800-01.

²¹⁰ *Id.* at 801.

²¹¹ *Id.*

²¹² See *Vacco v. Quill*, 521 U.S. 793, 801 (1997).

²¹³ *Id.* at 809.

²¹⁴ *Id.*

²¹⁵ *Roe v. Wade*, 410 U.S. 113, 153-54 (1973).

²¹⁶ *Id.* at 120.

Due Process Clause.²¹⁷ She claimed that the Texas statute was vague and that it invaded her right to personal privacy.²¹⁸

The plurality agreed, holding that a woman's right to an abortion should be balanced with the government's legitimate interest in regulation by creating different standards depending on the trimester of the woman's pregnancy.²¹⁹ Under the plurality's approach, the pregnant woman's physician may decide if abortion is a safe and reasonable option during the first trimester.²²⁰ During the second trimester, the state may choose to regulate the abortion procedures if the regulations are related to maternal health.²²¹ During the third trimester, the state can regulate and forbid abortions except where it is necessary to preserve the life of the mother.²²²

The plurality looked at the history of the criminalization of abortions, finding that criminalization stemmed from three concerns.²²³ The first concern, which dealt with discouraging illicit sexual activity, was not advanced by Texas and therefore not discussed.²²⁴ The plurality found that the second concern—to protect women from hazardous medical procedures—is less relevant than it used to be because of advancements in medicine.²²⁵ States no longer have an interest in protecting the woman from an inherently dangerous procedure, but they do have a legitimate interest in seeing that the abortion is performed under safe conditions.²²⁶ The third concern—protecting prenatal life—remains highly disputed.²²⁷ The plurality chose to honor this concern by creating different regulations depending on how far the pregnancy had progressed.²²⁸

The plurality held that the right of privacy is broad enough to encompass the right to terminate a pregnancy.²²⁹ This privacy right is not absolute; it was limited by the Court depending on the trimester of

²¹⁷ *Id.* at 129.

²¹⁸ *Id.* at 121.

²¹⁹ *Id.* at 164-65.

²²⁰ *Id.*

²²¹ *Roe v. Wade*, 410 U.S. 113, 164 (1973).

²²² *Id.* at 164-65.

²²³ *Id.* at 148-52.

²²⁴ *Id.* at 148.

²²⁵ *Id.* at 148-49.

²²⁶ *Id.* at 149-50.

²²⁷ *See Roe v. Wade*, 410 U.S. 113, 150-52 (1973).

²²⁸ *Id.* at 164-65.

²²⁹ *Id.* at 153.

the pregnancy.²³⁰ The Court noted that the state courts considering abortion law challenges have reached different decisions but most courts “have agreed that the right of privacy, however based, is broad enough to cover the abortion decision.”²³¹

II. ANALYSIS

Assisted death and abortion are closely related as they both raise issues of life and death, contain similar religious and moral concerns,²³² and present basic questions regarding an individual’s right to choose and right to authority over their body.²³³ Assisted death should be analyzed under the same framework that the Supreme Court of the United States applied to abortion in *Roe v. Wade*. The Court should regulate assisted death depending on the prognosis of the illness and the method used to cause death, similar to how the Court chose to regulate abortions according to the trimester of the pregnancy before its decision in *Planned Parenthood v. Casey*.²³⁴

A. *Assisted Death, the Right to Privacy, and the Legal Right to Your Body*

The Constitution of the United States of America “protects fundamental aspects of personal autonomy, even though privacy and these rights are not enumerated in the Constitution.”²³⁵ Although textualists may argue there is no right to privacy under the Constitution because the Constitution does not explicitly grant this right, this mode of interpretation should not preclude the right to physician-assisted suicide.²³⁶

²³⁰ *Id.* at 154, 164-65.

²³¹ *Id.* at 155.

²³² *See id.* at 116 (As the Plurality stated in *Roe*: “[O]ne’s religious training, one’s attitudes toward life and family and their values, and the moral standards one establishes and seeks to observe, are all likely to influence and to color’s one’s thinking and conclusions about abortion.”).

²³³ *Roe v. Wade*, 410 U.S. 113, 154 (1973).

²³⁴ *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).

²³⁵ Chemerinsky, *supra* note 18, at 1503.

²³⁶ *Id.*

1. Unenumerated Rights

The liberty rights guaranteed by the Due Process Clause cannot be structured by the specific guarantees in the United States Bill of Rights, and the Court has not interpreted them in this manner.²³⁷ When America's founders discussed the adoption of a Bill of Rights, one serious concern was that, by listing some rights, other rights would be excluded.²³⁸ In order to appease these concerns, Congress drafted the Ninth Amendment, which states: "[t]he enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people."²³⁹ This amendment allows for unenumerated rights. In other words, even if a right is not listed in the Constitution, it is granted to the people if it can reasonably be inferred from the language of the Constitution.

Although the Constitution does not specifically grant the right to privacy, the Supreme Court of the United States recognizes this right.²⁴⁰ The Court has recognized many liberties under the right to privacy, including the right to marry,²⁴¹ the right to custody of one's children,²⁴² the right to keep a family together,²⁴³ the right to control the upbringing of one's children,²⁴⁴ the right to procreate,²⁴⁵ the right to purchase and use contraceptives,²⁴⁶ and the right to abortion.²⁴⁷

²³⁷ *Poe v. Ullman*, 367 U.S. 497, 543 (1961) (Harlan, J., dissenting from dismissal on jurisdictional grounds); *See also* *Roe*, 410 U.S. at 154; *Griswold v. Connecticut*, 381 U.S. 479, 484 (1965) (holding that the Bill of Rights does provide a right to privacy even where not directly stated); *Pierce v. Society of Sisters*, 268 U.S. 510, 534-35 (1925) (holding that an Oregon Statute that required all children to attend public school violated the Due Process Clause, even though the right to homeschool one's children was not directly stated in the Bill of Rights); *Meyer v. Nebraska*, 262 U.S. 390, 399-400 (1923) (holding that a Nebraska Law restricting foreign language education violated the Due Process Clause even though it was never directly stated as a right in the bill of rights).

²³⁸ *Ninth Amendment—Unenumerated Rights*, JUSTIA, <https://law.justia.com/constitution/us/amendment-09/>.

²³⁹ U.S. CONST. amend. IX.

²⁴⁰ *Griswold*, 381 U.S. at 484.

²⁴¹ *Chemersky*, *supra* note 18, at 1503 (2008) (citing *Loving v. Virginia*, 388 U.S. 1 (1967)).

²⁴² *Id.* (citing *Santosky v. Kramer*, 455 U.S. 745, 758-59 (1982), *Stanley v. Illinois*, 405 U.S. 645, 651 (1972)).

²⁴³ *Id.* at 1504 (citing *Moore v. City of E. Cleveland*, 431 U.S. 494 (1977)).

²⁴⁴ *Id.* (citing *Pierce v. Society of Sisters*, 268 U.S. 510 (1925); *Meyer v. Nebraska*, 262 U.S. 390 (1923)).

²⁴⁵ *Id.* (citing *Skinner v. Oklahoma*, 316 U.S. 535 (1942)).

²⁴⁶ *Id.* (citing *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Griswold v. Connecticut*, 381 U.S. 479 (1965)).

Alaska,²⁴⁸ Arizona,²⁴⁹ California,²⁵⁰ Florida,²⁵¹ Hawaii,²⁵² Illinois,²⁵³ Louisiana,²⁵⁴ Montana,²⁵⁵ South Carolina,²⁵⁶ and Washington²⁵⁷ specifically grant the right to privacy in their state constitutions. Other states have recognized the right to privacy in their state court decisions.²⁵⁸ By failing to adopt physician-assisted suicide as a right in *Glucksberg*, the Court went against long-standing precedent.²⁵⁹

2. Right to Privacy

In *Roe*, the Supreme Court determined that some laws that criminalized or restricted access to abortions infringed upon the right to privacy found in the Due Process Clause of the Fourteenth Amendment.²⁶⁰ The plurality stated that although the Constitution does not mention the right to privacy, the right exists in the First, Fourth, Fifth,

²⁴⁷ Chemerinsky, *supra* note 18, at 1503 (citing *Roe v. Wade* 410 U.S. 113, 154 (1973)).

²⁴⁸ ALASKA CONST. art. 1 § 22 (“The right of the people to privacy is recognized and shall not be infringed. The legislature shall implement this section.”).

²⁴⁹ ARIZ. CONST. art 2 § 8 (“No person shall be disturbed in his private affairs, or his home invaded, without authority of law.”).

²⁵⁰ CAL. CONST. art. 1 § 1 (“All people are by nature free and independent and have inalienable rights. Among these are enjoying and defending life and liberty, acquiring, possessing, and protecting property, and pursuing and obtaining safety, happiness, and privacy.”).

²⁵¹ FLA. CONST. art. 1 § 23 (“Every natural person has the right to be let alone and free from governmental intrusion into the person’s private life except as otherwise provided herein. This section shall not be construed to limit the public’s right of access to public records and meetings as provided by law.”).

²⁵² HAW. CONST. art. 1 §§ 6 (“The right of the people to privacy is recognized and shall not be infringed without the showing of a compelling state interest. The legislature shall take affirmative steps to implement this right.”).

²⁵³ ILL. CONST. art 1. § 6 (“The people shall have the right to be secure in their persons, houses, papers and other possessions against unreasonable searches, seizures, invasions of privacy . . .”).

²⁵⁴ LA. CONST. art 1 § 5 (“Every person shall be secure in his person, property, communications, houses, papers, and effects against unreasonable searches, seizures, or invasions of privacy . . .”).

²⁵⁵ MON. CONST. art. 2 § 10 (“The right of individual privacy is essential to the well-being of a free society and shall not be infringed without the showing of a compelling state interest.”).

²⁵⁶ S.C. CONST. art 1 § 10 (“The right of the people to be secure in their persons, houses, papers, and effects against unreasonable searches and seizures and unreasonable invasions of privacy shall not be violated.”).

²⁵⁷ WASH. CONST. art 1 § 7 (“No person shall be disturbed in his private affairs, or his home invaded, without authority of law.”).

²⁵⁸ See, e.g., *Pavesich v. New England Life Insurance Co.*, 50 S.E. 68, 69-70 (Ga. 1902).

²⁵⁹ *Id.* at 1504.

²⁶⁰ *Roe v. Wade*, 410 U.S. 113, 154 (1973).

Ninth, and Fourteenth Amendments.²⁶¹ They stated that “only personal rights that can be deemed ‘fundamental’ or ‘implicit in the concept of ordered liberty’ are included in this guarantee of personal privacy.”²⁶² The plurality noted that these rights are related to marriage, procreation, contraception, child care, and education.²⁶³ They ultimately found that the decision to terminate a pregnancy is found in the Fourteenth Amendment’s concept of liberty, but also accepted the District Court’s conclusion that the Ninth Amendment’s reservation of rights to the citizens was broad enough to allow abortions.²⁶⁴

Similar to the plurality’s analysis of abortion, the right to physician-assisted suicide should be protected by the Fourteenth Amendment. A patient should have the option of choosing the time and manner of his death when he is terminally ill. The right to a painless death is an essential aspect of personal autonomy, and personal autonomy is “implicit in the concept of ordered liberty.”²⁶⁵ As with abortion, choosing how and when to die is one of the “most intimate and personal choices a person may make in a lifetime.”²⁶⁶

Similar to how prohibitions against abortion can deny a woman the ability to take control of her body, denying someone the ability to end their painful and terminal life infringes upon the most basic part of their autonomy.²⁶⁷

By denying patients access to physician-assisted suicide, they are forced to live “wracked by pain and deprived of all pleasure.”²⁶⁸ When a patient is given the chance to decide whether to end his life under those conditions, it constitutes one of the most intimate and personal choices that a person can make.²⁶⁹ The right to make this decision is an essential aspect of liberty, which the Due Process Clause of the Fourteenth Amendment protects. Patients deserve to have the right to make this decision.

A terminally ill, capable adult has a strong interest in “choosing a dignified and humane death rather than being reduced at the end of

²⁶¹ *Id.* at 176.

²⁶² *Id.* (quoting *Palko v. Conn.*, 302 U.S. 319, 325 (1937)).

²⁶³ *Id.* at 152-53.

²⁶⁴ *Id.* at 177

²⁶⁵ Chemerinsky, *supra* note 18, at 1503.

²⁶⁶ *Compassion in Dying v. Washington*, 79 F.3d 790, 813-14 (9th Cir. 1996).

²⁶⁷ Chemerinsky, *supra* note 18, at 1503.

²⁶⁸ *Compassion in Dying*, 79 F.3d at 814.

²⁶⁹ *Id.* (quoting *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992)).

his existence to a childlike state of helplessness.”²⁷⁰ If a person cannot choose when to end his suffering, he lacks all aspect of control over his body.²⁷¹ With the right to die via assisted death, he regains some control over the body that is failing him.²⁷² As with a woman’s right to abortion, he is choosing what he does with his body.²⁷³

Accordingly, should the Court address physician-assisted suicide and euthanasia in a future decision, it should reverse its position in *Glucksberg* and instead follow its holding in *Roe* and the Ninth Circuit’s holding in *Compassion in Dying*, analyzing the issue under an objective analysis. The Supreme Court should find that the choice to die is a personal decision rooted in individual liberty and the decision can only be made by the patient, not by the government.²⁷⁴ Alternatively, the Court could address physician-assisted suicide under the *Glucksberg* test under the proper framework, which would force the Court to reverse *Glucksberg*.

B. *Glucksberg’s Two-Part Test*

When the Supreme Court decided *Glucksberg*, the “Constitution was interpreted as protecting basic aspects of personal autonomy as fundamental rights even though they are not mentioned in the text of the document.”²⁷⁵ Therefore, the Court had not adopted a reading that would preclude the legalization of physician-assisted suicide under the right to privacy.²⁷⁶ Unless the Court wanted to overrule its previous decisions to expand the right to privacy, it should have come to a different conclusion in *Glucksberg*.²⁷⁷

The Court in *Glucksberg* used a two-part test to assess the constitutionality of physician-assisted suicide.²⁷⁸ First, the Due Process Clause protects rights and liberties that are “deeply rooted in this Nation’s history and tradition”²⁷⁹ and “implicit in the concept of

²⁷⁰ *Id.* at 800-01.

²⁷¹ Chemerinsky, *supra* note 18, at 1503.

²⁷² *Id.* at 1506 (citing *Compassion in Dying v. Washington*, 79 F.3d 790, 839 (9th Cir. 1996)).

²⁷³ *Id.* at 1504.

²⁷⁴ *Id.* at 1506 (citing *Compassion in Dying*, 79 F.3d at 839).

²⁷⁵ *Id.* at 1504.

²⁷⁶ *Id.*

²⁷⁷ Chemerinsky, *supra* note 18, at 1504.

²⁷⁸ *Washington v. Glucksberg*, 521 U.S. 702, 720 (1997).

²⁷⁹ *Id.* at 721 (quoting *Moore v. East Cleveland*, 431 U.S. 494, 502 (1977) (plurality opinion)).

ordered liberty,’ such that ‘neither liberty nor justice would exist if they were sacrificed.’”²⁸⁰ Second, it requires a “careful description of the asserted fundamental liberty interest.”²⁸¹ Using this framework, the Court in *Glucksberg* ruled that prohibitions against physician-assisted suicide does not violate the Due Process Clause.²⁸² However, looking at it as a medical and personal decision, it becomes clear that physician-assisted suicide can be legalized, even though physician-assisted suicide itself is not deeply rooted in our nation’s history.

While physician-assisted suicide does not have roots in our nation’s history, the ability to make medical decisions and the right to make personal decisions are deeply rooted in U.S. tradition.²⁸³ If the Court in *Glucksberg* had analyzed physician-assisted suicide under a much broader, and more appropriate, framework by looking at physician-assisted suicide under the right to privacy—which encompasses the right to make personal decisions and the right to make health care decisions—the Court would have come to a different conclusion.

1. Right to Make Personal Decisions

The ability to make personal decisions is deeply entrenched in our nation’s history.²⁸⁴ In 1891, in *Union Pacific Railroad Company v. Botsford*, the Supreme Court stated that “[n]o right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.”²⁸⁵

Under the right to privacy, the Court has recognized the right to make many personal decisions: the right to marry,²⁸⁶ the right to custody of one’s children,²⁸⁷ the right to keep a family together,²⁸⁸ the right to control the upbringing of one’s children,²⁸⁹ the right to procre-

²⁸⁰ *Id.* (quoting *Palko v. Connecticut*, 302 U.S. 319, 325, 326 (1937)).

²⁸¹ *Id.* (quoting *Reno v. Flores*, 507 U.S. 292, 302 (1993)).

²⁸² *Id.* at 735.

²⁸³ *Washington v. Glucksberg*, 521 U.S. 702, 715-16 (1997).

²⁸⁴ *Chemerinsky, supra* note 18, at 1503.

²⁸⁵ *Union Pac. R. Co. v. Botsford*, 141 U.S. 250, 251 (1891).

²⁸⁶ *Chemerinsky, supra* note 18, at 1503 (2008) (citing *Loving v. Virginia* 388 U.S. 1 (1967)).

²⁸⁷ *Id.* (citing *Santosky v. Kramer*, 455 U.S. 745, 758-59 (1982), *Stanley v. Illinois*, 405 U.S. 645, 651 (1972)).

²⁸⁸ *Id.* at 1504 (citing *Moore v. City of E. Cleveland*, 431 U.S. 494 (1977)).

²⁸⁹ *Id.* (citing *Pierce v. Society of Sisters*, 368 U.S. 510 (1925), *Meyer v. Nebraska*, 262 U.S. 390 (1923)).

ate,²⁹⁰ the right to purchase and use contraceptives,²⁹¹ and the right to abortion.²⁹² In *Roe*, the Court noted that these privacy rights concern marriage, procreation, contraception, child care, and education.²⁹³ Although physician-assisted suicide does not fall neatly into one of these categories, neither did abortion when the Court held it fell within the ambit of the Due Process protections. These privacy rights are all a type of personal right. Physician-assisted suicide and the decision to end a painful life is a personal choice that falls in line with the privacy rights that the Court has acknowledged.

2. Right to Make Health Care Decisions

Even though physician-assisted suicide has not historically been embraced by the citizens or courts of the United States, the ability to make your own health care decisions is strongly rooted in our nation's history and tradition.²⁹⁴ The right to make medical decisions has been justified under the common law right to informed consent and the right to privacy under the Constitution.²⁹⁵

In *Vacco*, the Court decided that outlawing physician-assisted suicide did not violate the Equal Protection Clause of the Fourteenth Amendment because no one was allowed access to physician-assisted suicide in New York.²⁹⁶ The Court found significant distinctions between dying as a result of a fatal disease and dying as a result of a physician's action.²⁹⁷ The Court stated that "a physician who withdraws, or honors a patient's refusal to begin, life-sustaining medical treatment purposefully intends, or may so intend, only to respect his patient's wishes"²⁹⁸ On the other hand, the Court stated that the primary intent when assisting a suicide is to kill the patient.²⁹⁹ However, a physician who assists with a suicide has the same intention as the physician who withdraws or withholds life-sustaining medical

²⁹⁰ *Id.* (citing *Skinner v. Oklahoma ex. rel. Williamson*, 316 U.S. 535 (1942)).

²⁹¹ *Id.* (citing *Eisenstadt v. Baird*, 405 U.S. 438 (1972), *Griswold v. Connecticut*, 381 U.S. 479 (1965)).

²⁹² *Chemerinsky, supra* note 18, at 1503 (citing *Roe v. Wade* 410 U.S. 113 (1973)).

²⁹³ *Roe*, 410 U.S. at 176.

²⁹⁴ *Cruzan v. Dir., Mo. Dept. of Health*, 497 U.S. 261, 271 (1990).

²⁹⁵ *Id.*

²⁹⁶ *Vacco v. Quill*, 521 U.S. 793, 807 (1997).

²⁹⁷ *Id.* at 800-01.

²⁹⁸ *Id.* at 801.

²⁹⁹ *Id.* at 802.

treatment: providing the patient with the care that he requests. These actions each expedite death and is what the patient requests. Therefore, the distinction that the Court makes in *Vacco* is not an accurate depiction of the physician's intent. The decision to die by physician-assisted suicide is a medical decision that the patient should have the ability to make.

Every person "has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable for damages."³⁰⁰ Therefore, under the right to informed consent, before a physician can treat a patient, the patient must consent to the treatment.³⁰¹ In order for the patient's consent to be sufficient, the patient must have access to all information regarding his diagnosis and the risks and expected rewards of the treatment. With this information, the patient has the ability to make an informed decision about his medical treatment. The Supreme Court has held that if the patient possesses the right to consent to treatment, he also possesses the right not to consent, or the right to refuse treatment.³⁰² This right "is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life."³⁰³

The right to make medical decisions is an essential part of individual autonomy, and therefore it is included in the constitutional right to privacy.³⁰⁴ A patient has the right to preserve his "right to privacy against unwanted infringements of bodily integrity in appropriate circumstances," such as when a patient refuses medical treatment.³⁰⁵

Physician-assisted suicide should be treated as a medical option. Along with the right to refuse medical treatment, a terminally ill patient should have the right to physician-assisted suicide. Therefore, if a terminally ill patient decides to end his life, this decision should be treated as a health care choice, and the ability to make your own health care decisions is deeply rooted in our history.

³⁰⁰ *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (1914).

³⁰¹ Robert Gatter, *The Mysterious Survival of the Policy Against Informed Consent Liability for Hospitals*, 81 NOTRE DAME L. REV. 1203, 1204 (2006).

³⁰² *Id.*

³⁰³ *Belchertown State School v. Saikewicz*, 370 N.E.2d 417, 426 (1977).

³⁰⁴ *See Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 275 (1990).

³⁰⁵ *Belchertown State School*, 373 Mass. at 739 (citing *In re Quinlan*, 70 N.J. 10, 38-39 (1976)).

If the first part of the *Glucksberg* test is met, so is the second. Physician-assisted suicide can be described as a fundamental liberty interest: the interest in making personal decisions as well as a patient's own medical decisions. Therefore, to protect patients in the United States, physician-assisted suicide must be embraced. If a terminally ill patient cannot choose to end his life painlessly, he loses his personal autonomy. A patient deserves to make this decision, and he has no liberty if he is forced to live in pain with inadequate relief.

C. *Concerns Regarding the Legalization of Physician-Assisted Suicide*

1. Public Debate and Scrutiny

In *Washington v. Glucksberg*, the Court was reluctant to recognize assisted suicide as a constitutionally protected right because it did not want to remove the issue from public debate.³⁰⁶ However, legalizing physician-assisted suicide would not remove the issue from public debate.

When the Court decided *Roe v. Wade* in 1973, "most states severely restricted or banned the practice of abortion."³⁰⁷ Effectively legalizing abortion was a major shift in America and this major shift continues to inspire heated debates, despite, or perhaps because of, protection against total prohibition³⁰⁸ As one scholar wrote: "American culture has played tug-of-war for centuries with the topic of abortion with zealous supporters flanking both sides of the issue."³⁰⁹ Clearly, given the current political climate and American culture, the constitutional protection against the prohibition of abortion has not removed the topic from public debate.

Physician-assisted suicide is undoubtedly controversial: "People of good will can and do passionately disagree about the proper result, perhaps even more intensely than they part ways over the constitutionality of restricting a woman's right to have an abortion."³¹⁰ If the Court afforded physician-assisted suicide constitutional protection, it

³⁰⁶ *Washington v. Glucksberg*, 521 U.S. 702, 720 (1997).

³⁰⁷ Alex McBride, *Landmark Cases, Roe v. Wade*, PBS, (December 2006), http://www.pbs.org/wnet/supremecourt/rights/landmark_roe.html.

³⁰⁸ *Id.*

³⁰⁹ Carrie H. Paillet, *Abortion and Physician-Assisted Suicide: Is There a Constitutional Right to Both?* 8 LOY. J. PUB. INT. L. 45, 45 (2006).

³¹⁰ *Compassion in Dying v. Washington*, 79 F.3d 790, 793 (1996).

would likely follow a path similar to that of abortion: while it would be legal, it would still remain deeply debated, analyzed, and scrutinized by the American people.

Physician-assisted suicide, as with abortion, should never be removed from public debate. Continuing public debate will ensure that physician-assisted suicide remains in the forefront of the minds of the American people. These debates should be welcomed; as constant discussions can help ensure that physician-assisted suicide is not abused. These discussions will force patients and physicians to abide by the strict and necessary regulations that the state governments should impose on physician-assisted suicide.

2. Protecting Human Life

In *Roe v. Wade*, the Court determined that the government had a legitimate interest in protecting human life.³¹¹ Therefore, different protocols were put in place depending on the stage of fetal development.³¹²

With physician-assisted suicide, although there is a compelling government interest in protecting and preserving human life, context is crucial.³¹³ A terminally ill patient likely will die soon.³¹⁴ Denying them the right to die will ensure that they live for only a short period of time.³¹⁵ These months are not likely to be productive to society or pleasurable for the individual.³¹⁶ In contrast, a patient who is not suffering from a debilitating illness will likely have a long life.³¹⁷ These years or decades could be productive and pleasurable. Therefore, the government has different interests in preserving the life of a terminally ill person and the life of a person who is not terminally ill.³¹⁸

The Supreme Court has already recognized that the government's interest in protecting human life does not extend to preventing people from withdrawing life-supporting medical treatment.³¹⁹ Thus, the Court has already made the distinction between preserving the life of

³¹¹ *Roe v. Wade*, 410 U.S. 113, 150-51 (1973).

³¹² *See id.* at 163-64.

³¹³ Chemerinsky, *supra* note 18, at 1509.

³¹⁴ *Id.*

³¹⁵ *See id.*

³¹⁶ *See id.*

³¹⁷ *Id.*

³¹⁸ *Id.*

³¹⁹ *See Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 275 (1990).

someone who will live a long and productive life and someone who will soon die.³²⁰ This distinction should be applied to the use of physician-assisted suicide.

If a distinction is made between a terminally ill patient and a non-terminally ill patient, the government's interest in preserving human life can be protected.³²¹ By instilling a framework modeled after *Roe*, the government's interest and the terminally ill patient's right to die can be protected concurrently.

3. Protection Against Dangerous Medical Procedures

Physician-assisted suicide should be legalized; however, implementation of strict guidelines designed to protect people from unwanted, unwarranted, or unnecessary death is essential.

In *Roe v. Wade*, the Court determined that, while abortions could be hazardous, that is not a reason to ban them.³²² Historically, abortions were often performed under dangerous conditions that could kill the mother.³²³ Due to advancements in medicine, the state's interest in the medical aspect of abortion remains only in ensuring that abortions are "performed under circumstances that ensure maximum safety for the patient."³²⁴ With this model, a woman's right to terminate her pregnancy is balanced with the state's interest in safe medical procedures.³²⁵

Similarly, physician-assisted suicide has potential risks.³²⁶ Many people, including advocates, fear that the system will be abused.³²⁷ However, if physician-assisted suicide is not legalized, terminally ill patients have an incentive to end their life on their own. This could have devastating consequences, such as intense suffering, prolonged suffering, and trauma for their family.³²⁸ As with all medical procedures, physician-assisted suicide should be regulated to ensure that the patient dies safely. By imposing regulations that change because

³²⁰ Chemerinsky, *supra* note 18, at 1509.

³²¹ *Id.*

³²² *Roe v. Wade*, 410 U.S. 113, 150-51 (1973).

³²³ *See id.*

³²⁴ *Id.*

³²⁵ *See id.*

³²⁶ *See, e.g.,* Manson, *supra* note 19, at 155.

³²⁷ *See id.*

³²⁸ *Left Behind After Suicide*, HARVARD WOMEN'S HEALTH WATCH (July 2009), https://www.health.harvard.edu/newsletter_article/Left-behind-after-suicide.

of the severity or characteristics of the patient's illness, like regulating based on the trimester of the pregnancy, the government can ensure that neither the rights of the patient nor the intentions of the system will be abused.

4. State Regulation of Physician-Assisted Suicide

The states should primarily regulate physician-assisted suicide, similarly to how the states regulate abortions.³²⁹ States have vastly different rules and regulations for abortions, ranging from requiring licensed physicians to perform abortions, requiring a waiting period, requiring an abortion be performed in a hospital, restricting coverage of abortions in private insurance plans, and mandating counseling before an abortion.³³⁰

States have significant discretion in regulating abortions, and they should have comparable discretion in regulating physician-assisted suicide. Although the Oregon Act provides a great framework, each state should consider their own values before deciding how to regulate physician-assisted suicide.

D. *Model Framework*

There needs to be a framework for the constitutional protection of physician-assisted suicide and euthanasia, should the issue come before the Court. The Oregon Act provides a good basis for this framework as it has already served as a model for states that have legalized physician-assisted suicide via legislation.³³¹

In *Roe v. Wade*, the plurality held that abortion is legal under the right to privacy and it is subject to different degrees of regulation depending on how far the pregnancy has progressed.³³² Assisted death should be regulated in a similar manner. If a person who is capable of ingesting medication has a right to die under certain circumstances, a person who cannot ingest medication should have the same right.³³³

³²⁹ *An Overview of Abortion*, GUTTMACHER INSTITUTE, (Jan. 1, 2018), <https://www.guttmacher.org/state-policy/explore/overview-abortion-laws>.

³³⁰ *Id.*

³³¹ See Tucker, *supra* note 70, at 699.

³³² *Roe v. Wade*, 410 U.S. 113, 164-65 (1973).

³³³ See Bollman, *supra* note 63, at 397.

To give more patients access to assisted death, “terminally ill” needs to be redefined. In the states that legalize physician-assisted suicide, terminally ill is currently defined as having less than six months to live.³³⁴ This definition should be modified to include patients who are suffering from debilitating and life-long diseases.³³⁵ Under this new definition, patients suffering from progressive and incurable diseases will be able to end their lives even if they may have more than six months to live. Individuals with these diseases suffer significantly, and there is little justification for preventing them from ending their own suffering if that is what they want to do.³³⁶

1. Physician-Assisted Suicide

If the patient is terminally ill under the new definition and able to ingest medication, they should be eligible for physician-assisted suicide under the Oregon Act framework.³³⁷ Following the *Roe* model, these patients fall into the first category, or the first trimester, where state regulation should be minimal. Because the Oregon Act has significant success in protecting patients and has served as a model for other states which enacted physician-assisted suicide laws, it is the logical place to start with a nation-wide implementation of physician-assisted suicide.

2. Voluntary Euthanasia

If the terminally ill patient cannot swallow or place a pill in his mouth, he should be able to choose death via euthanasia.³³⁸ Euthanasia is illegal in the states that legalized assisted death, making patients who are incapable of taking the final step to end their life unable to take advantage of the laws.³³⁹ If a patient is terminally ill under the new definition and suffering from a debilitating and life-long disease, he should be eligible to die via euthanasia.

The framework for euthanasia should also follow the Oregon Act.³⁴⁰ As the Oregon Act stands now, patients suffering from incur-

³³⁴ See, e.g., OR. REV. STAT. § 127.800 (1997).

³³⁵ See Bollman, *supra* note 63, at 397.

³³⁶ *Id.*

³³⁷ See OR. REV. STAT. § 127.805 (1997).

³³⁸ Bollman, *supra* note 63, at 408.

³³⁹ *Id.*

³⁴⁰ *Id.*

able, progressive, or deteriorating diseases are effectively discriminated against because they are unable to end their lives under the current law.³⁴¹ The Act should be modified to ensure that euthanasia is available to everyone suffering from a painful, life-long disease. Additionally, the new regulations should mandate stricter steps for the physician to follow. These regulations should mirror the government's interests in the second and third trimester of a woman's pregnancy under *Roe*.³⁴²

First, the physician should not suggest voluntary euthanasia to the patient.³⁴³ Such a suggestion may undermine the patient's will to live and could greatly impact his decision.³⁴⁴ Many patients with debilitating conditions find joy in life, and this is something that should be encouraged and celebrated. By withholding suggestions of voluntary euthanasia, patients will not be swayed by a physician, ensuring that the decision is theirs alone.

Second, there should be an additional emphasis on the ability of the patient to reassess his decision. The physician should continually make it clear that the patient can change his mind at any time without consequence. The physician should not sway the patient in any direction, but rather support the decision that the patient makes while informing him that there is no objectively right answer and that the patient can change his mind, even after he fills the prescription.

Third, the patient must explicitly make the request in a manner they are capable of, such via a computer-based communication system or by a handwritten statement.³⁴⁵ The patient should not be barred from euthanasia simply because he cannot speak or convey his wishes without the assistance of technology.

Fourth, at least three physicians, two of whom are in different practices, should review the patient's diagnosis and prognosis. This will ensure that the patient has access to reliable information before deciding if death is his best course of action.

³⁴¹ *See id.*

³⁴² *Roe v. Wade*, 410 U.S. 113, 164-65 (1973).

³⁴³ *See* Cohen-Almagor, *supra* note 85, at 293 (advocating that physicians should not suggest physician-assisted suicide to a patient).

³⁴⁴ *Id.* at 293-94.

³⁴⁵ *See, e.g.*, Stephen Hawking, *My Computer*, STEPHEN HAWKING, <http://www.hawking.org.uk/the-computer.html>.

Fifth, the patient's request for euthanasia should be reviewed by a committee of doctors.³⁴⁶ This will ensure that access to euthanasia will not be abused. This review should take place as soon as possible to ensure that the patient does not have a significantly long wait between his request for euthanasia and his ability to carry out his wishes.

Sixth, euthanasia should be performed via a lethal injection. If the patient can move his fingers, the physician should insert an IV tube that will inject the medication when the patient presses a button on the computer. If the patient is incapable of such movement, the physician should directly administer the lethal injection.

The regulations should not advocate for the use of euthanasia for all terminal or debilitating life-long diseases. Rather, they should present euthanasia as a valid choice along with hospice care and palliative care.

CONCLUSION

Assisted death is constitutional under the right to privacy of the Due Process Clause of the Fourteenth Amendment. Under this clause, the Supreme Court has recognized many rights, including the right to abortion. Similar to the right to terminate a pregnancy, the right to privacy should also cover the right to die. However, the Court refused to recognize an additional right in *Glucksberg* by holding that physician-assisted suicide is not protected under the Due Process Clause.

Assisted death can be legalized in a manner that protects the right of patients while simultaneously protecting the legitimate interests of the government. By legalizing physician-assisted suicide and euthanasia, the state governments can regulate how a patient dies. The legalization and subsequent regulation are essential in ensuring that everyone's rights are protected.

Oregon, California, Montana, Vermont, California, Colorado, and Washington, D.C., demonstrate that physician-assisted suicide can successfully be legalized in the United States.³⁴⁷ The right to assisted-death should be guaranteed for every individual who is suffering from

³⁴⁶ See Cohen-Almagor, *supra* note 85, at 296 (advocating for a committee of doctors for physician-assisted suicide).

³⁴⁷ *Patients' Rights to Self-Determination at the End of Life*, AM. PUB. HEALTH ASS'N (Oct. 28, 2008), <http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1372>.

a debilitating and life-long disease, regardless of when the patient will die from the disease. If the patient is ineligible for physician-assisted suicide because he cannot ingest the medication, the patient should have the option of choosing euthanasia.

