

LOOKING FOR A “GOOD DEATH”: THE ELDERLY TERMINALLY ILL’S RIGHT TO DIE BY PHYSICIAN-ASSISTED SUICIDE

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An unforeseen consequence of the relatively recent advancement of medicine is that individuals with terminal illnesses are able to extend their lives beyond what was possible only a few years ago. However, this extension sometimes brings with it significant physical pain and decreased quality of life for the patient, raising the question of what rights a mentally competent, terminally ill patient has in terminating her life. Currently, courts permit such individuals to refuse life-sustaining treatment, but prohibit doctors from actively assisting individuals in ending their lives absent a state statute legalizing such activities. This Note argues that physician-assisted suicide should be permitted under the same rationales used to justify an individual’s right to refuse life-sustaining treatment and that the right to physician-assisted suicide in the case of terminally ill patients is a constitutionally protected right. Because the end result of refusing life-sustaining treatment and physician-assisted suicide is the same—the death of the terminally ill patient—there is no substantive basis for distinguishing between the two.

I. Introduction

In 1990, the U.S. Supreme Court decided in *Cruzan v. Director, Missouri Department of Health* that patients have the

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constitutional right to refuse unwanted medical treatment.¹ While this judicial stamp of approval on the right to refuse medical treatment was a great victory for right-to-die advocates, the Supreme Court's unwillingness to extend the right to die to include physician-assisted suicide has unfairly limited elderly, mentally competent, terminally ill patients' ability to choose how they die. These patients have a right to choose physician-assisted suicide as a way to end their pain and suffering because constitutional language affords them the right to choose physician-assisted suicide² and because the personal interest in looking for a "good death"³ and dying with dignity outweighs so-called legitimate state interests.⁴

This Note argues that elderly, mentally competent, terminally ill patients have a constitutional right to choose physician-assisted suicide as a way to end their lives and that the U.S. Supreme Court's distinction between discontinuing unwanted life support and physician-assisted suicide is both arbitrary and unconstitutional.⁵ Part II examines the history and legal tradition in the United States regarding suicide and physician-assisted suicide and discusses the Supreme Court's decisions about physician-assisted suicide. Part III explores how the Due Process and Equal Protection Clauses of the Fourteenth Amendment afford the right to choose physician-assisted suicide to mentally competent, terminally ill patients based on the rights of privacy and self-determination. This Part further discusses how the Supreme Court's distinction between refusing life-sustaining treatment and assisting suicide is unconstitutional and how the personal interest in choosing physician-assisted suicide outweighs "legitimate" state interests that are hostile to legalizing assisted suicide. Part IV recommends that the Supreme Court hold that mentally competent, terminally ill patients have a constitutional right to choose physician-assisted suicide, as it has already hinted in its *Washington v. Glucksberg*

1. Cruzan *ex rel.* Cruzan v. Mo. Dep't of Health, 497 U.S. 261, 278–79 (1990).

2. See *infra* Part III.A.

3. Melvin I. Urofsky, *Do Go Gentle into That Good Night: Thoughts on Death, Suicide, Mortality and the Law*, 59 ARK. L. REV. 819, 829 (2007).

4. See *infra* Part III.B.

5. This Note discusses and analyzes the rights of mentally competent, terminally ill patients, referred to as "terminally ill patients" throughout the piece. This Note does not address the rights of mentally incompetent, terminally ill patients. For a discussion of mentally incompetent, terminally ill patients' rights to die, see Urofsky, *supra* note 3, at 824–26.

and *Vacco v. Quill* decisions.⁶ This Part further recommends that states wishing to legalize physician-assisted suicide by statute follow the example set by Oregon with the Oregon Death with Dignity Act.⁷

II. Background

A. The Historical and Legal Tradition in the United States Regarding Suicide and Physician-Assisted Suicide

Anglo-America inherited a common-law tradition from England that penalized both those who committed suicide and those who assisted suicide.⁸ In medieval England, suicide was actually considered a "punishable felony" for which the suicide decedent's real and personal property "were forfeit to the king."⁹ Sir William Blackstone condemned suicide as "self-murder" many centuries later in his *Commentaries on the Laws of England*, but noted that while "the law has . . . ranked [suicide] among the highest crimes," the consequential cruel punishments "borde[r] a little upon severity."¹⁰ However, disapproval and punishment of suicide and assisting suicide persisted in England, and the American colonies eventually inherited this tradition.¹¹

Today, almost every state in the United States criminalizes assisted suicide.¹² New York enacted the first state statute explicitly banning assisting suicide in 1828,¹³ and at the time the Fourteenth Amendment was ratified, most states prohibited assisting suicide.¹⁴ The state statutes banning assisting suicide express a "longstanding commitment" to preserving life, one of the foremost state interests.¹⁵

6. Bryan Hilliard, *The Politics of Palliative Care and the Ethical Boundaries of Medicine: Gonzales v. Oregon as a Cautionary Tale*, 35 J.L. MED. & ETHICS 158, 161 (2007).

7. OR. REV. STAT. §§ 127.800–.995 (2007).

8. *Washington v. Glucksberg*, 521 U.S. 702, 711 (1997).

9. *Id.* (citing 2 BRACON ON LAWS AND CUSTOMS OF ENGLAND 423 (G. Woodbine ed., S. Thorne trans., 1968)).

10. *Id.* at 712 (quoting WILLIAM BLACKSTONE, 4 COMMENTARIES *189–90).

11. See generally *id.* at 712–14 (discussing the evolution of the English common-law prohibitions of suicide and assisting suicide and the adoption of this approach in the American colonies).

12. *Id.* at 710.

13. *Id.* at 715.

14. *Cruzan ex rel. Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 294–95 (1990) (Scalia, J., concurring).

15. *Glucksberg*, 521 U.S. at 710. Other compelling state interests include preventing suicide, preserving the integrity of the medical profession, protecting vulnerable groups (including children and the elderly), and avoiding the slippery slope to voluntary or involuntary euthanasia. *Id.* at 728–33.

The U.S. Supreme Court noted in *Cruzan v. Director, Missouri Department of Health* that “[t]he States . . . demonstrate their commitment to life by treating homicide as a serious crime,” and many states impose criminal penalties on those who assist suicide.¹⁶ Thus, opposition to and condemnation of both suicide and assisting suicide are “consistent and enduring themes” of the “philosophical, legal, and cultural heritages” in the United States.¹⁷

Over the years, medical and technological advances have changed the way that Americans die.¹⁸ While only one century ago, most Americans died at home “of illnesses that medicine could do little to defeat,” death in the modern United States is now much more complicated.¹⁹ Technology has added new dimensions to the dying process, raising questions about “human dignity and what constitutes a ‘good death.’”²⁰ As the Supreme Court remarked in *Cruzan*, with “the advance of medical technology capable of sustaining life well past the point where natural forces would have brought certain death in earlier times, cases involving the right to refuse life-sustaining treatment have burgeoned.”²¹

Because Americans today are more likely to die from chronic illnesses while being treated in medical institutions,²² changing attitudes about end-of-life care have caused some states to amend or enact laws that meet the varying needs of particular patients, such as “dignity and independence,” including laws that allow patients to have living wills or to refuse life-sustaining medical treatment.²³ The majority of states, however, continue to criminalize physician-assisted suicide.²⁴

16. *Cruzan*, 497 U.S. at 280.

17. *Glucksberg*, 521 U.S. at 711.

18. *Id.* at 716.

19. Public Agenda Issue Guide, Right to Die: Overview, <http://www.publicagenda.org/citizen/issueguides/right-to-die/overview> (last visited Jan. 20, 2009).

20. *Id.*

21. *Cruzan*, 497 U.S. at 270.

22. *Glucksberg*, 521 U.S. at 716 (citing PRESIDENT’S COMM’N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. & BIOMEDICAL & BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 16–18 (1983)).

23. *Id.*

24. *Id.* As of 2001, forty-five states specifically prohibit physician-assisted suicide. Public Agenda, Assisted-Suicide Laws in the U.S., <http://www.publicagenda.org/charts/assisted-suicide-laws-US> (last visited Jan. 20, 2009). Of these, thirty-eight expressly prohibit physician-assisted suicide by statute: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Oklahoma, Pennsylvania, Rhode Isl-

Distinguishing between the types of assisted death is a significant part of the right-to-die debate, and the next section explains these methods.

B. The Three Methods of Assisted Death

One of the many contentious aspects of the right-to-die debate is the disagreement over the legality of the different methods of assisted death available to terminally ill patients. There are three kinds of assisted death. First, there is "active euthanasia," which involves a doctor "perform[ing] an affirmative act, such as injecting a lethal dose of opiates into the patient, with the intent of causing the patient's death."²⁵ Second, there is "passive euthanasia," by which a terminally ill patient dies because of "a physician's inaction or omission, such as withholding life-sustaining hydration and nutrients or refusing to initiate potentially life-threatening therapies."²⁶ The third kind of assisted death is physician-assisted suicide, which, unlike active or passive euthanasia, depends not on a doctor's "action or inaction," but on her "provision of means" to end the terminally ill patient's life.²⁷ The doctor assists suicide by offering her medical knowledge, but does not actively or passively participate in the actual event of death.²⁸

The legality of the different methods of assisted death is an important part of the right-to-die debate. The following section explains that while terminally ill patients have the constitutional right to die by passive euthanasia,²⁹ such patients have no constitutional right to

and, South Carolina, South Dakota, Tennessee, Texas, Virginia, Washington, and Wisconsin. *Id.* Seven states criminalize physician-assisted suicide through adopted case law or interpretations of their homicide statutes: Alabama, Idaho, Massachusetts, North Carolina, Ohio, Vermont, and West Virginia. *Id.* Finally, only Hawaii, Nevada, Utah, and Wyoming have neither a statutory nor a common-law prohibition of physician-assisted suicide. *Id.* Today, Oregon and Washington are the only states that have legalized physician-assisted suicide by statute. *Id.*; Washington Death with Dignity Act, Washington Initiative Measure No. 1000 (2008), <http://www.secstate.wa.gov/elections/initiatives/text/i1000.pdf>.

25. Glen R. McMurry, Comment, *An Unconstitutional Death: The Oregon Death with Dignity Act's Prohibition Against Self-Administered Lethal Injection*, 32 DAYTON L. REV. 441, 449 (2007) (quoting Mason L. Allen, *Crossing the Rubicon: The Netherlands' Steady March Toward Involuntary Euthanasia*, 31 BROOK. J. INT'L L. 533, 540 (2006)).

26. *Id.* at 449–50 (quoting Mason L. Allen, *Crossing the Rubicon: The Netherlands' Steady March Toward Involuntary Euthanasia*, 31 BROOK. J. INT'L L. 533, 540 (2006)).

27. *Id.* at 450.

28. *Id.*

29. *Cruzan ex rel. Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 281 (1990).

choose physician-assisted suicide,³⁰ and Oregon and Washington are the only states that legalize physician-assisted suicide by statute.³¹

C. The U.S. Supreme Court's Stance on Physician-Assisted Suicide

Oddly enough, the U.S. Supreme Court has decided only four cases regarding the right to die, three of which address physician-assisted suicide in some way.³²

1. *CRUZAN V. DIRECTOR, MISSOURI DEPARTMENT OF HEALTH*

The Supreme Court first addressed the right to die in *Cruzan v. Director, Missouri Department of Health*, and the Court's holding set the stage for the current debate over the constitutional right to physician-assisted suicide. After a car accident in which she sustained severe injuries, Nancy Beth Cruzan was rendered incompetent and had to be kept alive by artificial feeding and hydration.³³ When doctors realized that Nancy would never recover from her persistent vegetative state³⁴ and regain her cognitive faculties, her parents decided to obtain a court order that would direct the removal of Nancy's artificial life support.³⁵

The Supreme Court of Missouri, however, determined that because there was no "clear and convincing evidence" that Nancy would want to be removed from artificial life support if she were in a persistent vegetative state, her parents could not obtain the court order.³⁶ While acknowledging that a right to refuse medical treatment correlated with the common-law right of informed consent, the court was unsure whether this doctrine applied to the facts of Nancy's case and whether there was a constitutional right to refuse life-sustaining treatment.³⁷

30. *Washington v. Glucksberg*, 521 U.S. 702, 728 (1997).

31. See OR. REV. STAT. §§ 127.800–885 (2003); Washington Death with Dignity Act, Washington Initiative Measure No. 1000 (2008), <http://www.secstate.wa.gov/elections/initiatives/text/i1000.pdf>.

32. See *Gonzales v. Oregon*, 546 U.S. 243 (2006); *Vacco v. Quill*, 521 U.S. 793 (1997); *Glucksberg*, 521 U.S. at 702; *Cruzan*, 497 U.S. at 261.

33. *Cruzan*, 497 U.S. at 265.

34. The Supreme Court in *Cruzan* described a "persistent vegetative state" as "a condition in which a person exhibits motor reflexes but evinces no indications of significant cognitive function." *Id.* at 266.

35. *Id.* at 265.

36. *Id.*

37. *Id.* at 268.

The U.S. Supreme Court granted certiorari and addressed whether Nancy had a constitutional right to withdraw life-sustaining treatment because she was in a persistent vegetative state.³⁸ After analyzing several cases holding that patients have a constitutional right to refuse treatment based on the rights to privacy and self-determination,³⁹ the Court concluded that the Fourteenth Amendment Due Process Clause also affords competent patients a "constitutionally protected liberty interest in refusing unwanted medical treatment."⁴⁰

While this holding established a constitutional right to refuse unwanted medical treatment, the patient's "liberty interest" to refuse treatment must also be balanced "against relevant state interests."⁴¹ Because Nancy's persistent vegetative state left her incompetent, she could not make an "informed and voluntary choice" whether to exercise her right to refuse treatment.⁴² The Missouri Supreme Court had required "clear and convincing evidence" of an incompetent's desire to withdraw treatment, a standard that the U.S. Supreme Court approved as an appropriate constitutional safeguard to protect state interests.⁴³ Because Nancy's "oral testimony" before she became incompetent did not qualify as "clear and convincing evidence" of her desire to withdraw life-sustaining treatment, the Court held that Nancy's parents could not effectuate their daughter's wish to remove artificial life support.⁴⁴ Thus, the essential holding of *Cruzan* extends the constitutional right to refuse unwanted medical treatment only to the mentally competent.

38. *Id.* at 269.

39. The Supreme Court in *Cruzan* discussed the holdings of, among others, Superintendent of Belchertown State School v. Saikewicz, 370 N.E.2d 417, 424 (Mass. 1977) (Massachusetts Supreme Court held that the right to privacy and the right to informed consent allow withholding chemotherapy from a mentally retarded, sixty-seven-year-old man who had leukemia); *In re Conroy*, 486 A.2d 1209, 1223 (N.J. 1985) (New Jersey Supreme Court held that the right to refuse medical treatment is based on the common-law rights to self-determination and informed consent); *In re Quinlan*, 355 A.2d 647, 662–64 (N.J. 1976) (New Jersey Supreme Court held that a patient's right to refuse medical treatment is based on the constitutional right to privacy); and *In re Storar*, 420 N.E.2d 64, 70 (N.Y. 1981) (New York Court of Appeals held that the right to refuse medical treatment is based on the constitutional right to privacy). *Cruzan*, 497 U.S. at 270–77.

40. *Cruzan*, 497 U.S. at 278.

41. *Id.* at 279 (quoting *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982)).

42. *Id.* at 280.

43. *Id.* at 280–85.

44. *Id.* at 284–87.

2. WASHINGTON V. GLUCKSBERG AND VACCO V. QUILL

The U.S. Supreme Court specifically addressed the right to physician-assisted suicide in two cases decided on the same day, *Washington v. Glucksberg*⁴⁵ and *Vacco v. Quill*.⁴⁶ In analyzing whether mentally competent, terminally ill patients have a constitutional right to physician-assisted suicide, the Court assessed first whether the challenged state statute that criminalized physician-assisted suicide was constitutional and then whether its prohibition of physician-assisted suicide was rationally related to a legitimate state interest.⁴⁷

In *Washington v. Glucksberg*, three Washington physicians sought a declaration that a Washington statute⁴⁸ criminalizing physician-assisted suicide violated the Due Process Clause of the Fourteenth Amendment.⁴⁹ Three mentally competent, terminally ill patients, who died before the case reached the Supreme Court, and Compassion in Dying, a nonprofit organization that advises those contemplating physician-assisted suicide, joined the physicians in the statutory challenge.⁵⁰ The plaintiffs argued that mentally competent, terminally ill patients have a Fourteenth Amendment due process "liberty interest" in the right to choose physician-assisted suicide.⁵¹

The Supreme Court held that because the Due Process Clause does not provide a "fundamental liberty interest" in physician-assisted suicide, the Washington statute was not unconstitutional.⁵² The Court further held that the statute was "reasonably related"⁵³ to furthering Washington's compelling state interests, including protecting life, preventing suicide, preserving the integrity of the medical profession, protecting vulnerable groups (such as children and the el-

45. 521 U.S. 702 (1997).

46. 521 U.S. 793 (1997).

47. See, e.g., *id.* at 799–806 (1997). In analyzing whether New York's statutory prohibition of physician-assisted suicide violated the Fourteenth Amendment Equal Protection Clause and was related to legitimate state interests, the U.S. Supreme Court noted that the New York statute allows "everyone to refuse unwanted medical treatment" and prohibits "anyone from assisted suicide," which was a "logical and rational distinction" that did not violate equal protection. *Id.*

48. See WASH. REV. CODE § 9A.36.060(1) (2003).

49. *Glucksberg*, 521 U.S. at 705–07. This case was initially filed in the U.S. District Court in the Western District of Washington and was decided as *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1459 (W.D. Wash. 1994).

50. *Glucksberg*, 521 U.S. at 708.

51. *Id.*

52. *Id.* at 728.

53. *Id.* at 735.

derly), and avoiding the slippery slope to voluntary and involuntary euthanasia.⁵⁴

In *Vacco v. Quill*, several New York public officials, joined by three mentally competent, terminally ill patients who died before the case reached the Supreme Court, argued that a New York statute⁵⁵ criminalizing physician-assisted suicide violated the Equal Protection Clause of the Fourteenth Amendment.⁵⁶ The statute prohibited mentally competent, terminally ill patients from choosing physician-assisted suicide as a way to end their lives but allowed them to refuse life-sustaining treatment, and the plaintiffs argued that such refusal was "essentially the same thing" as physician-assisted suicide.⁵⁷ The Court of Appeals for the Second Circuit agreed with the plaintiffs, noting that "the ending of life [by withdrawal of life support systems] is nothing more nor less than assisted suicide."⁵⁸

The Supreme Court, however, upheld the distinction between refusing life-sustaining treatment and physician-assisted suicide, asserting that "[e]veryone, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; no one is permitted to assist a suicide."⁵⁹ Thus, the Court held that the New York statute did not violate the Equal Protection Clause and that it was related to "some legitimate end," upholding the same compelling state interests that the Court discussed in *Glucksberg*.⁶⁰

While the Supreme Court has declined to recognize a constitutional right to physician-assisted suicide, the *Glucksberg* and *Vacco* decisions do not entirely defeat a constitutional argument for this method of assisted death.⁶¹ The concurring opinions of several Justices remained "sympathetic to the possibility that terminally ill, competent patients, who were suffering great pain, might enjoy a constitutional right to adequate palliative care, even if such care directly hastened

54. *Id.* at 728–33.

55. See N.Y. PENAL LAW § 125.15 (McKinney 2003).

56. *Vacco v. Quill*, 521 U.S. 793, 797–98 (1997).

57. *Id.*

58. *Id.* at 798 (quoting *Quill v. Vacco*, 80 F.3d 716, 729 (2d Cir. 1996)).

59. *Id.* at 800.

60. *Id.* at 808–09. The Supreme Court in *Vacco* reiterated the legitimate state interests at stake when conducting a constitutional analysis of a state statute that prohibits physician-assisted suicide: "prohibiting intentional killing and preserving life; preventing suicide; maintaining physicians' role as their patients' healers; protecting vulnerable people from indifference, prejudice, and psychological and financial pressure to end their lives; and avoiding a possible slide towards euthanasia." *Id.*

61. See Hilliard, *supra* note 6, at 161.

death.”⁶² Their sympathy extended from “adequate palliative care” to physician-assisted suicide, which several Justices seemed “quite comfortable” to consider as “within the acceptable boundaries of medicine.”⁶³ Even Chief Justice Rehnquist, the author of both unanimous opinions, left to the states the democratic option of wrangling with their own medical policies and laws regarding the right to physician-assisted suicide.⁶⁴ Thus, while the holdings in *Glucksberg* and *Vacco* did not recognize a constitutional right to physician-assisted suicide, neither did they effectuate a total ban, keeping the door open for state democratic processes to determine policies and laws for end-of-life care.⁶⁵

3. GONZALES V. OREGON

*Gonzales v. Oregon*⁶⁶ stands uniquely among the right-to-die cases. The U.S. Supreme Court inadvertently addressed the right to physician-assisted suicide by ruling on the validity of Oregon’s Death with Dignity Act,⁶⁷ one of two state statutes that legalize physician-assisted suicide.⁶⁸ The statute allows Oregon physicians to prescribe lethal drugs to mentally competent, terminally ill patients and protects them from civil or criminal liability for assisting suicide.⁶⁹ The issue in *Gonzales* was the authority of the Attorney General to interp-

62. *Id.* The concurrences of Justices Breyer, Ginsburg, O’Connor, Souter, and Stevens all acknowledge that in certain cases, a plaintiff can successfully claim a “constitutionally cognizable liberty interest” in physician-assisted suicide. *Id.* at 161 n.30.

63. *Id.* at 161. Justices Stevens’s and O’Connor’s concurrences in *Glucksberg* are particularly sympathetic to legalized physician-assisted suicide. See *id.* at 161 n.31.

64. *Id.* at 161.

65. *Id.* In her concurring opinions for *Washington v. Glucksberg* and *Vacco v. Quill*, Justice O’Connor noted that

[e]very one of us at some point may be affected by our own or a family member’s terminal illness. There is no reason to think the democratic process will not strike the proper balance between the interests of terminally ill, mentally competent individuals who would seek to end their suffering and the State’s interests in protecting those who might seek to end life mistakenly or under pressure. As the Court recognizes, States are presently undertaking extensive and serious evaluation of physician-assisted suicide and other related issues.

Washington v. Glucksberg, 521 U.S. 702, 737 (1997) (O’Connor, J., concurring).

66. *Gonzales v. Oregon*, 546 U.S. 243 (2006).

67. *Id.* at 249.

68. *Id.*

69. See OR. REV. STAT. §§ 127.800–995 (2007).

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ret the Controlled Substances Act (CSA),⁷⁰ the federal statute that regulates the lethal drugs that Oregon doctors can prescribe to assist suicide under the Death with Dignity Act.⁷¹

The Federal Department of Justice (DOJ) claimed that the CSA prohibited Oregon doctors from prescribing Schedule II medications to their terminally ill patients to assist in their suicides.⁷² John Ashcroft, then the Attorney General, argued that he had the authority to interpret the CSA's regulatory language, especially the phrases *public interest, public health and safety, and legitimate medical purpose.*⁷³ He then issued an Interpretive Rule holding that "assisting suicide is not a 'legitimate medical purpose' within the meaning of [the CSA], and that prescribing, dispensing, or administering federally controlled substances to assist suicide violates the [CSA]."⁷⁴

In the lower courts, the DOJ lost challenges against the Interpretive Rule brought by Oregon doctors, pharmacists, and terminally ill patients.⁷⁵ The U.S. Supreme Court granted certiorari in February 2005 to decide whether the CSA allowed Attorney General Ashcroft to prevent doctors from prescribing federally regulated drugs to assist in the suicides of their mentally competent, terminally ill patients, despite its allowance by Oregon's statute.⁷⁶ While acknowledging the current debate over the "morality, legality, and practicality" of physician-assisted suicide,⁷⁷ Justice Kennedy chose to resolve the issue based on statutory interpretation and "established guidelines for showing deference toward executive actions."⁷⁸

The Supreme Court first held that because Ashcroft's Interpretive Rule merely "parrot[ed]" the original statutory language in the

70. See 21 U.S.C. §§ 801–971 (2000). Enacted in 1970, the purpose of the Controlled Substances Act is to control the "manufacture, distribution, dispensing, and possession of drugs and other substances deemed dangerous to individuals and to the public health and welfare." Hilliard, *supra* note 6, at 160.

71. The Supreme Court in *Gonzales* noted that, "[t]he CSA allows these particular drugs to be available only by a written prescription from a registered physician. In the ordinary course the same drugs are prescribed in smaller doses for pain alleviation." *Gonzales*, 546 U.S. at 249.

72. *Id.* at 252–53; see also Hilliard, *supra* note 6, at 159. Schedule II of the Controlled Substances Act regulates controlled substances that are only available by a written, nonrefillable prescription from a physician. 21 U.S.C. § 829(a).

73. Hilliard, *supra* note 6, at 159.

74. *Gonzales*, 546 U.S. at 253–54 (quoting Dispensing of Controlled Substances to Assist Suicide, 66 Fed. Reg. 56,607, 56,608 (Nov. 9, 2001)).

75. Hilliard, *supra* note 6, at 161.

76. *Gonzales*, 546 U.S. at 248–49.

77. *Id.* at 249 (quoting *Washington v. Glucksberg*, 521 U.S. 702, 735 (1997)).

78. Hilliard, *supra* note 6, at 162.

CSA, it did not actually interpret the federal statute and should not be afforded *Chevron* deference.⁷⁹ The Court then concluded that the CSA did not authorize Attorney General Ashcroft to proscribe doctors from prescribing federally regulated drugs to terminally ill patients to assist their suicides.⁸⁰ While the Supreme Court did not squarely address the right to physician-assisted suicide, preventing Attorney General Ashcroft from interpreting the CSA to prohibit Oregon doctors from prescribing federally regulated drugs under the Death with Dignity Act was a victory for physician-assisted suicide supporters.

While the historical and legal tradition in the United States demonstrates a social and political aversion to physician-assisted suicide, the fact that the Supreme Court remained open to the inadequacy of palliative care and the possibility of a constitutional right to physician-assisted suicide in *Glucksberg* and *Vacco* suggests that the Court might be willing to acknowledge this right in future cases. The next Part analyzes the constitutional right to physician-assisted suicide, how the personal interest in physician-assisted suicide outweighs "legitimate" state interests, and the physician-assisted suicide experience in Oregon.

III. Analysis

The U.S. Supreme Court's distinction between refusing life-sustaining treatment and physician-assisted suicide is both arbitrary and unconstitutional. Both are methods of assisted death and, based on the rights to privacy and self-determination, terminally ill patients should have a constitutional right to choose either method to end their lives. Not only do the Due Process and Equal Protection Clauses of the Fourteenth Amendment protect these patients' "liberty interest" in the right to choose physician-assisted suicide, the personal interest in

79. See *Gonzales*, 546 U.S. at 255–67 (discussing whether Ashcroft's Interpretive Rule actually interprets the Controlled Substances Act and should be accorded the deference due to federal regulations). The Supreme Court in *Gonzales* noted that "[a]n administrative rule may receive substantial deference if it interprets the issuing agency's own ambiguous regulation." *Id.* at 255 (citing *Auer v. Robbins*, 519 U.S. 452, 461–63 (1997)). Further, "[a]n interpretation of an ambiguous statute may also receive substantial deference." *Id.* at 255 (citing *Chevron U.S.A. Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842–45 (1984)); see also *Hilliard, supra* note 6, at 162–63 (discussing the Supreme Court's analysis of the Interpretive Rule's interpretation of the Controlled Substances Act).

80. *Gonzales*, 546 U.S. at 274–75.

physician-assisted suicide also outweighs so-called legitimate state interests.

The following sections address the constitutional right to physician-assisted suicide, how the personal interest in physician-assisted suicide outweighs state interests, and the success of legalized physician-assisted suicide in Oregon.

A. The Constitutional Right to Physician-Assisted Suicide

1. THE SUPREME COURT'S DISTINCTION BETWEEN REFUSING MEDICAL TREATMENT AND PHYSICIAN-ASSISTED SUICIDE

Before analyzing the constitutional right to physician-assisted suicide, the Supreme Court's distinction between refusing unwanted medical treatment and physician-assisted suicide should be discussed. In *Cruzan*, the Court ruled that "a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment" based on the right of bodily integrity and the right to be free from unwanted touching.⁸¹ Despite the Court's approval of the constitutional right to refuse life-sustaining treatment, such a death is both protracted and undignified because withdrawing life support involves the "passive" action of a doctor of removing artificial hydration or nutrition, after which the patient starves to death.⁸²

While allowing mentally competent, terminally ill patients to choose physician-assisted suicide is humane and dignified, the Supreme Court refuses to acknowledge such patients' constitutional right to physician-assisted suicide and has argued, among other things, that legitimate government interests outweigh the personal interest in physician-assisted suicide⁸³ and that terminally ill patients have the constitutional right to refuse medical treatment but not to assisted suicide.⁸⁴ The Court used rational basis review in its *Glucksberg* and *Vacco* decisions to determine whether the challenged Washington

81. *Cruzan ex rel. Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278–79 (1990).

82. See *McMurtry, supra* note 25, at 449–50.

83. *Washington v. Glucksberg*, 521 U.S. 702, 728–32 (1997). The legitimate state interests that outweigh a terminally ill patient's right to choose physician-assisted suicide include preserving life, preventing suicide, preserving the integrity of the medical profession, and protecting vulnerable groups, including the elderly, children, and innocent third parties. *Id.*

84. *Vacco v. Quill*, 521 U.S. 793, 807 (1997). The Supreme Court noted in *Vacco* that refusing life-sustaining treatment is not tantamount to suicide and that there is a difference between a doctor letting a patient die and making a patient die. *Id.*

and New York statutes that criminalized physician-assisted suicide violated due process and equal protection, respectively.⁸⁵ It determined first whether mentally competent, terminally ill patients have a "fundamental liberty interest" in physician-assisted suicide and, if not, then whether the state statutes prohibiting physician-assisted suicide were "rationally related" to "legitimate state interests,"⁸⁶ concluding in both cases that terminally ill patients have no fundamental liberty interest in physician-assisted suicide and that the state statutes were related to legitimate state interests.⁸⁷

Distinguishing between the right to refuse life-sustaining treatment and the right to physician-assisted suicide, however, is *not* rationally related to legitimate state interests because they are simply different methods of assisted death.⁸⁸ Terminally ill patients should not have the constitutional right to one method but not the other. Because the constitutional right to privacy affords terminally ill patients the right to refuse medical treatment, one method of assisted death, then this right to privacy should also afford terminally ill patients the right to choose physician-assisted suicide, another method. Therefore, the Supreme Court's distinction between refusing life-sustaining treatment and physician-assisted suicide is arbitrary and unconstitutional because terminally ill patients have a "fundamental liberty interest" in the right to choose any method of assisted death, not just one. The end result is the same: a terminally ill patient exercises her

85. *Vacco*, 521 U.S. at 809 ("New York's reasons [for distinguishing withdrawal of treatment and physician-assisted suicide] . . . easily satisfy the constitutional requirement that a legislative classification bear a rational relation to some legitimate end."); *Glucksberg*, 521 U.S. at 728 ("The constitution also requires, however, that Washington's assisted-suicide ban be rationally related to legitimate government interests.").

86. McMurry, *supra* note 25, at 453.

87. See *Vacco*, 521 U.S. at 798, 808–09 (reasoning that while mentally competent, terminally ill patients have a "fundamental liberty interest" in refusing life-sustaining treatment, there is no such right to physician-assisted suicide, and hence the New York statute is rationally related to legitimate state interests); *Glucksberg*, 521 U.S. at 728, 780 (using a historical argument to justify Washington's interest in protecting life and preventing suicide and to dismiss the plaintiffs' argument that mentally competent, terminally ill patients have a "fundamental liberty interest" in physician-assisted suicide); see also McMurry, *supra* note 25, at 452–56 (discussing the holdings of *Glucksberg* and *Vacco* and the Supreme Court's analysis of due process and equal protection rational basis review).

88. See *supra* Part II.B.

right to die.⁸⁹ The following section further discusses how the constitutional right to privacy extends to physician-assisted suicide.

2. THE CONSTITUTIONAL RIGHT TO PRIVACY

Among the first things to consider when analyzing the right to physician-assisted suicide is the constitutional right to privacy. Justice Brandeis acknowledged the constitutional right to privacy in 1928,⁹⁰ and the U.S. Supreme Court sanctioned and enlarged this right in two later landmark decisions, *Griswold v. Connecticut*⁹¹ and *Roe v. Wade*.⁹² The right to privacy includes "control over one's bodily autonomy," and such control presumably extends to the right to die and the decision to refuse life-sustaining treatment.⁹³ The Supreme Court verified this assumption in 1990 when it decided its first right-to-die case,⁹⁴ *Cruzan v. Director, Missouri Department of Health*, reasoning that the right to privacy, as well as the rights to self-determination and informed consent, allow mentally competent, terminally ill patients to choose to withdraw unwanted life support.⁹⁵ Because the right to privacy extends to one method of assisted death, it should extend to another, but the Supreme Court refused to acknowledge the constitutional right to physician-assisted suicide in *Glucksberg* and *Vacco*.⁹⁶ Distinguishing one method of assisted death from another in order to prevent terminally ill patients from choosing physician-assisted suicide as the way to seek a "good death" is arbitrary and unconstitutional.

89. See Urofsky, *supra* note 3, at 834. Urofsky maintains that the Supreme Court's distinction between letting someone die and killing "is a distinction without a difference." *Id.* at 833.

90. *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting).

91. *Griswold v. Connecticut*, 381 U.S. 479 (1965).

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

93. Urofsky, *supra* note 3, at 823.

94. *Id.*

95. *Cruzan ex rel. Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 269, 273, 278 (1990); see also *supra* Part II.C.1.

96. See *Vacco v. Quill*, 521 U.S. 793, 800, 807–08 (1997) (holding that the New York statute criminalizing physician-assisted suicide does not violate equal protection and that terminally ill patients have a constitutional right to withdraw life support but not to choose physician-assisted suicide); *Washington v. Glucksberg*, 521 U.S. 702, 705, 728 (1997) (holding that the Washington statute criminalizing physician-assisted suicide does not violate due process because terminally ill patients have no constitutional right to physician-assisted suicide); see also *supra* Part II.C.3.

Not only does the right to privacy enable mentally competent, terminally ill patients to choose physician-assisted suicide; both the Due Process and Equal Protection Clauses of the Fourteenth Amendment also afford these patients the right to physician-assisted suicide. The following section addresses how allowing terminally ill patients to choose one kind of assisted death and not the other is not rationally related to a legitimate state interest and violates due process, and how affording terminally ill patients a constitutional right to refusing life-sustaining treatment while refusing to acknowledge a right to physician-assisted suicide violates equal protection.

3. THE FOURTEENTH AMENDMENT DUE PROCESS AND EQUAL PROTECTION CLAUSES

The Fourteenth Amendment of the U.S. Constitution provides, in pertinent part, that “[n]o State shall . . . deprive any person of life, liberty, or property, without due process of law; nor deny to any person . . . the equal protection of the laws.”⁹⁷ In the realm of the right-to-die debate, the U.S. Supreme Court’s decision in *Cruzan* established that a mentally competent, terminally ill patient has a “constitutionally protected liberty interest” in choosing to refuse unwanted medical treatment.⁹⁸ Not only do such patients have the right to refuse medical treatment based on the rights to privacy and self-determination; the Due Process Clause also affords them the right to choose physician-assisted suicide.

For example, the plaintiffs in *Glucksberg* argued fiercely that the Due Process Clause protects the right to physician-assisted suicide by reasoning that their Fourteenth Amendment “liberty interest” affords mentally competent, terminally ill patients the right to choose how to die.⁹⁹ The District Court for the Western District of Washington agreed with the plaintiffs, adopting the reasoning of *Cruzan* to hold that Washington’s statutory ban of physician-assisted suicide was unconstitutional because it “place[d] an undue burden on the exercise of [that] constitutionally protected liberty interest.”¹⁰⁰ The U.S. Supreme Court disagreed and held that the Washington statute does *not* place

97. U.S. CONST. amend. XIV, § 1.

98. *Cruzan*, 497 U.S. at 278.

99. See *Glucksberg*, 521 U.S. at 708 (citing *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1459 (W.D. Wash. 1994)).

100. *Id.* (quoting *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1465 (W.D. Wash. 1994)).

an "undue burden" on any "liberty interest" because there is no constitutional right to physician-assisted suicide.¹⁰¹

But if mentally competent, terminally ill patients have a "liberty interest" in refusing unwanted medical treatment, they should have a corresponding "liberty interest" in choosing physician-assisted suicide. Not only are refusing medical treatment and physician-assisted suicide both two means to the same end—the assisted death of a mentally competent, terminally ill patient—these patients have a right to determine the method of their deaths based on the rights to privacy and self-determination. Therefore, state statutes that allow terminally ill patients to choose one but not another method of assisted death violate due process by imposing an "undue burden" on their "liberty interest" in choosing how to die.

The Equal Protection Clause of the Fourteenth Amendment provides that "[n]o State shall deny to any person . . . the equal protection of the laws,"¹⁰² embodying "a general rule that States must treat like cases alike but may treat unlike cases accordingly."¹⁰³ In *Vacco v. Quill*, for example, the U.S. Supreme Court held that New York's ban on assisted suicide did not violate the Equal Protection Clause,¹⁰⁴ asserting that the challenged New York statute prohibiting physician-assisted suicide "neither infringe[d] fundamental rights nor involve[d] suspect classifications."¹⁰⁵ Because banning physician-assisted suicide while allowing the refusal of life-sustaining treatment does not "treat anyone differently than anyone else or draw any distinctions between persons,"¹⁰⁶ the Court held that the statutes were valid.¹⁰⁷

The New York statute, however, violates the Equal Protection Clause by allowing one terminally ill patient to refuse life-sustaining treatment and prohibiting another from choosing physician-assisted suicide. Because equal protection demands that "all persons similarly situated . . . be treated alike,"¹⁰⁸ letting one terminally ill patient exercise her right to die by choosing to refuse medical treatment while preventing another from exercising her right to die by choosing phy-

101. *Id.* at 728, 735; see also *supra* Part II.C.2.

102. U.S. CONST. amend. XIV, § 1.

103. *Vacco v. Quill*, 521 U.S. 793, 799 (1997).

104. *Id.* at 797; see also *supra* Part II.C.2.

105. *Vacco*, 521 U.S. at 799.

106. *Id.* at 800.

107. *Id.*

108. *Washington v. Glucksberg*, 521 U.S. 702, 708 (1997) (quoting *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1466 (W.D. Wash. 1994)) (internal quotations omitted).

sician-assisted suicide is unconstitutional because two "similarly situated" persons are being treated differently. Both terminally ill patients are "similarly situated" for equal protection purposes because both live with intractable pain, will die in six months or less, and desire to exercise their rights to privacy and to self-determination in choosing how to die.

As Justice Stevens asserted in his concurrence, the *Vacco* holding "does not foreclose the possibility that some applications of the New York statute may impose an intolerable intrusion on the patient's freedom."¹⁰⁹ Such an "intrusion" occurs when a state statute allows one terminally ill patient to choose one method of assisted death but prohibits another "similarly situated" patient from choosing another method. Therefore, the New York statute violates the Equal Protection Clause because it draws "distinctions" between "similarly situated" terminally ill patients and treats such patients "differently" by authorizing one and criminalizing another method of assisted death.

While the American Medical Association supports the distinction between refusing medical treatment and physician-assisted suicide by noting the "fundamental difference between refusing life-sustaining treatment and demanding a life-ending treatment,"¹¹⁰ the due process and equal protection arguments forwarded by the plaintiffs in *Glucksberg* and *Vacco*, respectively, should have convinced the U.S. Supreme Court to hold that the state statutes criminalizing physician-assisted suicide were unconstitutional. Based on the rights to privacy and self-determination, if a terminally ill patient has the constitutional right to refuse life-sustaining treatment, she should also have a constitutionally protected "liberty interest" in choosing physician-assisted suicide. Both are means to the same end: the patient, suffering intractable pain from a terminal illness, will die either once artificial hydration and nutrition are removed or once she takes the lethal dose of barbiturates prescribed by her physician.

109. *Vacco*, 521 U.S. at 809 n.13 (Stevens, J., concurring).

110. Council on Ethical & Judicial Affairs, Am. Med. Ass'n, *Report of the Council on Ethical and Judicial Affairs of the American Medical Association*, 10 ISSUES IN L. & MED. 91, 93 (1994).

B. The Personal Interest in Physician-Assisted Suicide Outweighs Legitimate State Interests

Most states do not support physician-assisted suicide and explicitly prohibit this method of assisted death through statutes or at common law.¹¹¹ Oregon and Washington remain the only states with statutes that officially legalize physician-assisted suicide.¹¹² As discussed above, the U.S. Supreme Court cited several state interests that outweigh the personal interest in physician-assisted suicide in its *Glucksberg* and *Vacco* decisions, including preserving life, preventing suicide, maintaining the integrity of the medical profession, protecting vulnerable groups (including children and the elderly), and avoiding the slippery slope to voluntary and involuntary euthanasia.¹¹³ This section argues that the personal interest in physician-assisted suicide outweighs these so-called legitimate state interests.

1. PRESERVING LIFE AND PREVENTING SUICIDE

The first state interests enumerated by the *Glucksberg* court were preserving life and preventing suicide.¹¹⁴ While opponents of physician-assisted suicide acknowledge the pain suffered by patients with terminal illnesses, many maintain that palliative care is good enough to alleviate these patients' suffering because it preserves life.¹¹⁵ Palliative care is enshrined in the "culture of life," a phrase first used by President George W. Bush in 2001: "The culture of life is a welcoming culture, never excluding, never dividing, never despairing and always affirming the goodness of life in all its seasons. In the culture of life, . . . [w]e must comfort the sick. We must care for the aged . . ."¹¹⁶ However, promoting palliative care and the "culture of life" both disrespects and harms terminally ill patients seeking to exercise their right to die by ending their suffering with a dignified death. As one commentator noted, "[t]hose knowledgeable in palliative medicine

111. Kelly Green, Note, *Physician-Assisted Suicide and Euthanasia: Safeguarding Against the "Slippery Slope"—The Netherlands Versus the United States*, 13 IND. INT'L & COMP. L. REV. 639, 651 n.101 (2003). For a breakdown of state legislation concerning physician-assisted suicide, see *supra* note 24.

112. See OR. REV. STAT. §§ 127.800–.995 (2007); Washington Death with Dignity Act, Washington Initiative Measure No. 1000 (2008), <http://www.secstate.wa.gov/elections/initiatives/text/i1000.pdf>; see also *infra* Part III.C.

113. See *supra* Part II.C.2.

114. *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997).

115. See Hilliard, *supra* note 6, at 166.

116. *Id.* at 165.

maintain that 'an epidemic of under-treated pain' now exists A significant number of patients experience unnecessary pain and suffering"¹¹⁷

Not only is palliative care simply insufficient to treat the pain suffered by terminally ill patients, it also has many other pitfalls, including burdensome costs and the fact that such care might be against a terminally ill patient's wishes.¹¹⁸ Terminally ill patients often have no real life at all because they suffer from the intractable pain caused by their illnesses. Therefore, for mentally competent, terminally ill patients, "suicide can be not only a logical but perhaps even the only way to end great suffering and maintain one's human dignity."¹¹⁹ Out of "respect for the individual," terminally ill patients should not only be allowed "to choose death, but to have assistance if necessary in carrying out that wish."¹²⁰

The personal interest in physician-assisted suicide also outweighs the state interests in preserving life and preventing suicide because terminally ill patients have the constitutional rights to self-determination and to refuse unwanted medical treatment.¹²¹ If mentally competent, terminally ill patients have the right to choose how they die and may refuse life-sustaining treatment, then these patients should also be able to choose physician-assisted suicide as another way to exercise their right to self-determination. The Oregon Death with Dignity Act, for example, legalizes physician-assisted suicide to offer "more humane options to those seeking a compassionate death."¹²²

However legitimate, the state interests of preserving life and preventing suicide do not supersede the personal interest in physician-assisted suicide because palliative care is insufficient, the "culture of life" is disrespectful and harmful, and terminally ill patients have constitutional rights to self-determination and to refuse medical treatment. Therefore, terminally ill patients should be able to seek a compassionate, dignified death by physician-assisted suicide.

117. *Id.*

118. Ctr. for Disease Prevention & Epidemiology, Or. Health Div., *Oregon's Death with Dignity Act: The Second Year*, CD SUMMARY, Apr. 11, 2000, at 1-2, available at <http://www.oregon.gov/DHS/ph/cdsummary/2000/ohd4908.pdf>.

119. Urofsky, *supra* note 3, at 830.

120. *Id.*

121. Delio v. Westchester County Med. Ctr., 516 N.Y.S.2d 677, 692 (App. Div. 1987).

122. McMurry, *supra* note 25, at 456.

2. MAINTAINING THE INTEGRITY OF THE MEDICAL PROFESSION

A second state interest is maintaining the integrity of the medical profession.¹²³ Opponents argue that legalizing physician-assisted suicide will both undermine the integrity of the medical profession and damage the relationships between doctors and their terminally ill patients.¹²⁴ Under the Hippocratic Oath, doctors swear to "do no harm to patients nor 'give a deadly drug to anybody if asked for it, nor . . . make a suggestion to this effect.'"¹²⁵ Accordingly, the American Medical Association officially refuses to support physician-assisted suicide because "physician-assisted suicide is fundamentally incompatible with the physician's role as healer."¹²⁶ Similar to the policies behind the state interests in preserving life and preventing suicide, the politics of palliative care maintains that "life is sacred" and that "sanctity of life can best be respected, *can only* be respected, if physicians do everything possible to keep patients alive."¹²⁷ Hence, to uphold the medical profession's integrity, doctors cannot ethically assist suicide.

The personal interest in physician-assisted suicide outweighs the state interest in maintaining the integrity of the medical profession because doctors' duties to their terminally ill patients transcend simply keeping them alive in the face of excessive pain and suffering. While patients normally depend on their doctors to "cure an illness, repair an injury, and mitigate pain," other situations arise in which "the illness is incurable, the injury beyond repair, the level of pain uncontrollable."¹²⁸ Justice Stevens even acknowledged in his *Vacco* concurrence that for a doctor to refuse to "dispense medication" to terminally ill patients "to ease their suffering and make their death tolerable and dignified would be inconsistent with the healing role."¹²⁹ Therefore, allowing a doctor to assist a terminally ill patient's death fulfills her professional obligation just as much as saving lives does.

The personal interest in physician-assisted suicide also outweighs the state interest in maintaining the integrity of the medical profession by upholding the doctor-patient relationship. As one commentator notes, "[m]edical ethicists and others worry that if the

123. Washington v. Glucksberg, 521 U.S. 702, 731 (1997); see also Hilliard, *supra* note 6, at 165–66.

124. See Urofsky, *supra* note 3, at 832.

125. *Id.*

126. AM. MED. ASS'N, CODE OF MEDICAL ETHICS § 2.211 (2004).

127. Hilliard, *supra* note 6, at 166.

128. Urofsky, *supra* note 3, at 832.

129. Vacco v. Quill, 521 U.S. 793, 809 (1997) (Stevens, J., concurring).

doctor becomes a dispenser of death, this will adversely affect the doctor-patient relationship, destroying the trust that is essential to good care."¹³⁰ But for terminally ill patients, the sanctity of the doctor-patient relationship cannot be maintained if the doctor cannot aid her patient's desire to seek a dignified death.¹³¹ In fact, assisting suicide "demonstrate[s] a commitment to the patient's well-being right up until the moment of death."¹³² Therefore, a physician who assists suicide does not undermine the doctor-patient relationship because such care fulfills her patient's wishes and maintains, not violates, her patient's trust.

Not all doctors feel hostile about assisting suicide, and some support legalizing physician-assisted suicide.¹³³ Polls indicate that the medical profession is greatly divided on this issue and that "only a minority" supports the American Medical Association's official stance.¹³⁴ For example, the *New England Journal of Medicine* published a survey in 1996 showing that 56% of responding Michigan doctors "preferred legalizing assisted suicide to an explicit ban."¹³⁵ In another 1996 survey published in the *New England Journal of Medicine*, 60% of responding Oregon doctors supported legalizing physician-assisted suicide for terminally ill patients.¹³⁶

Physician-assisted suicide does not undermine the integrity of the medical profession because this method of assisted death allows doctors to properly tend to their terminally ill patients' end-of-life needs, fulfills those patients' wishes for death with dignity, and preserves the sanctity of the doctor-patient relationship. Therefore, the personal interest in choosing physician-assisted suicide outweighs the state interest in maintaining the integrity of the medical profession.

130. Urofsky, *supra* note 3, at 832.

131. *Id.* at 832-33.

132. *Id.* at 833.

133. See Vacco, 521 U.S. at 809.

134. Urofsky, *supra* note 3, at 840 n.40 (citing Washington v. Glucksberg, 521 U.S. 702, 749 n.12 (1997) (Stevens, J., concurring)).

135. Jerald G. Bachman et al., *Attitudes of Michigan Physicians and the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia*, 334 NEW ENG. J. MED. 303, 303-09 (1996).

136. Melinda A. Lee et al., *Legalizing Assisted Suicide: Views of Physicians in Oregon*, 334 NEW ENG. J. MED. 310, 310-15 (1996).

3. PROTECTING VULNERABLE GROUPS AND AVOIDING SLIPPERY SLOPES

Final state interests include protecting vulnerable groups, including children and the elderly, and preventing the slippery slope to voluntary and involuntary euthanasia.¹³⁷ Slippery slope arguments posit that because accepting a certain desirable legal standard might lead to the acceptance of a similar standard that is "undesirable," the desirable standard "should not be accepted because it leads to the second, even if that is the only thing wrong with the first."¹³⁸ Hence, some opponents fear that the legalization of physician-assisted suicide will start the United States down the slippery slope towards the legalization of voluntary or even involuntary euthanasia¹³⁹ and that vulnerable groups might become "targets of involuntary euthanasia disguised as physician-assisted suicide."¹⁴⁰

Euthanasia involves "the act of one party upon another," including a doctor who assists the suicide of her terminally ill patient to "end the patient's suffering."¹⁴¹ As discussed above, "passive" euthanasia means that the doctor does not take "actions that might prevent death" by withdrawing artificial hydration and nutrition, while "active" euthanasia means that the doctor acts deliberately "for the purpose of causing death."¹⁴² Either passive or active euthanasia is "voluntary" if the patient desires the doctor's assistance in suicide, while it is "involuntary" if imposed on a mentally incompetent patient.¹⁴³

Euthanasia concerns some opponents of physician-assisted suicide because it "conjures up . . . images of the Nazis putting the elderly, the sick, and the retarded to death."¹⁴⁴ These opponents fear that the "legalization of assisted suicide will lead to acceptance of euthanasia."¹⁴⁵ While physician-assisted suicide often entails a doctor prescribing a lethal dose of a barbiturate to a terminally ill patient that the patient later administers herself, active euthanasia involves the doc-

137. See *Washington v. Glucksberg*, 521 U.S. 702, 731–32 (1997); *Delio v. Westchester County Med. Ctr.*, 516 N.Y.S.2d 677, 692 (App. Div. 1987).

138. Stephen W. Smith, *Evidence for the Practical Slippery Slope in the Debate on Physician-Assisted Suicide and Euthanasia*, 13 MED. L. REV. 17, 17 n.2 (2005).

139. See *Glucksberg*, 521 U.S. at 732.

140. Carrie H. Paillet, Comment, *Abortion and Physician-Assisted Suicide: Is There a Constitutional Right to Both?*, 8 LOY. J. PUB. INT. L. 45, 66 (2006).

141. Urofsky, *supra* note 3, at 829–30.

142. *Id.*

143. *Id.*

144. *Id.* at 828.

145. Penney Lewis, *The Empirical Slippery Slope from Voluntary to Non-Voluntary Euthanasia*, 35 J.L. MED. & ETHICS 197, 197 (2007).

tor's actual participation in the administration of the fatal dose.¹⁴⁶ Thus, legalizing physician-assisted suicide, which is neither active nor passive and might be desirable, could lead to the legalization of active euthanasia, which is morally "undesirable" and especially dangerous for vulnerable groups.

Allowing states to legalize physician-assisted suicide, however, will not initiate a slippery slide to the legalization of voluntary and involuntary euthanasia and abuse of the elderly.¹⁴⁷ Protecting the elderly from involuntary euthanasia is, of course, a perfectly legitimate state interest, but as studies in the Netherlands and Oregon, where physician-assisted suicide is legal, show, the "proper legislation" of physician-assisted suicide will safeguard this vulnerable group from involuntary euthanasia.¹⁴⁸ Additionally, as Justice Stevens noted in

146. See *supra* Part II.B; *infra* Part III.C.

147. See Hilliard, *supra* note 6, at 160–61.

148. Palet, *supra* note 140. Dutch "historical and empirical evidence" also "does not reflect a move from the legalization of assisted suicide to voluntary euthanasia." Lewis, *supra* note 145, at 198–99. For a discussion of the Oregon Death with Dignity Act and its safeguards, see *infra* Part III.C.1.

As for the Netherlands, it is one of the few countries that legalizes physician-assisted suicide, with a statute called the Termination of Life on Request and Assisted Suicide Act (Assisted Suicide Act). See Lewis, *supra* note 145, at 198; Ubaldus de Vries, *A Dutch Perspective: The Limits of Lawful Euthanasia*, 13 ANN. HEALTH L. 365, 376–77 (2004). The Dutch are more accepting of and open-minded about physician-assisted suicide; when the Assisted Suicide Act was passed in 2002, the Netherlands had already tacitly tolerated physician-assisted suicide for a decade. Palet, *supra* note 140, at 62. Additionally, the Assisted Suicide Act defines physician-assisted suicide more broadly than the Oregon Death with Dignity Act by legalizing what the United States traditionally considers euthanasia, "permitting the physicians to personally administer a lethal injection to a patient as opposed to solely providing the means for suicide." *Id.*

Not only does the more accepting Dutch perspective of physician-assisted suicide differ from that of Americans, procedural safeguards in the Assisted Suicide Act preserve the integrity of the medical profession and avoid the slippery slope to involuntary euthanasia. These safeguards allow Dutch doctors to assist the suicides of their terminally ill patients while upholding the integrity of the medical profession. See DeVries, *supra*, at 377–79. Dutch doctors, terminally ill patients, and society in general do not view the physicians who assist suicide by physician-assisted suicide or euthanasia as "moral cripples." Urofsky, *supra* note 3, at 833. As Urofsky explained, "[c]ertainly there is no indication that doctors in the Netherlands have lost the respect of their patients; rather, they are seen as trusted friends of the family, who stay with their patient in the final moments." *Id.*

Because the Assisted Suicide Act legalizes physician-assisted suicide and euthanasia, other countries like the United States also worry about the slippery slope to involuntary euthanasia in their own debates about the legalization of physician-assisted suicide. See Lewis, *supra* note 145, at 198. Opponents of physician-assisted suicide, however, need not worry about the slippery slope because, as one commentator noted, "[t]here is no evidence from the Netherlands that the legalization of voluntary euthanasia caused an increase in the rate of non-voluntary euthanasia." *Id.* at 205.

his *Vacco* concurrence, the state interest in preventing abuse of the elderly does not apply if the patient requesting physician-assisted suicide was not a victim of abuse or suffering from depression and made a "rational and voluntary decision to seek assistance in dying."¹⁴⁹

Because the proper safeguards in current physician-assisted suicide legislation protect the elderly from subjection to voluntary and involuntary euthanasia, there is no reason to fear legalizing physician-assisted suicide because of the potential legalization of euthanasia and consequent harm to the elderly. Therefore, the personal interest in physician-assisted suicide outweighs the state interests in protecting vulnerable groups and avoiding the slippery slope to voluntary and involuntary euthanasia.

In sum, the personal interest in physician-assisted suicide outweighs "legitimate" state interests because exercising the right to death with dignity outweighs the state interests in preserving life and preventing suicide; physician-assisted suicide maintains, not undermines, the integrity of the medical profession; and legalizing physician-assisted suicide will not harm the elderly by inspiring the legalization of voluntary and involuntary euthanasia. The following section discusses legalized physician-assisted suicide in Oregon and how the Oregon Death with Dignity Act avoids the slippery slope to voluntary and involuntary euthanasia.

C. Physician-Assisted Suicide in Oregon

Oregon is one of two states with a statute that legalizes physician-assisted suicide.¹⁵⁰ State residents approved the Oregon Death with Dignity Act (ODWDA) by ballot measure in 1994 and again in 1997.¹⁵¹ Under the ODWDA, doctors can prescribe federally controlled substances to their terminally ill, mentally competent, adult patients free from criminal or civil liability as long as they follow the Act's procedures and safeguards.¹⁵² As of 2005, only 246 terminally ill patients had died in Oregon as a result of physician-assisted suicide.¹⁵³

149. *Vacco v. Quill*, 521 U.S. 793, 809 (1997) (Stevens, J., concurring).

150. See OR. REV. STAT. §§ 127.800–995 (2007); Hilliard, *supra* note 6, at 160.

151. *Gonzales v. Oregon*, 546 U.S. 243, 249 (2006); Hilliard, *supra* note 6, at 160.

152. *Gonzales*, 546 U.S. at 249; Hilliard, *supra* note 6, at 160.

153. Hilliard, *supra* note 6, at 160.

1. OREGON'S STATUTORY PROCEDURES AND SAFEGUARDS

The ODWDA establishes many procedures and safeguards to ensure that physician-assisted suicide is not abused by terminally ill patients or their doctors.¹⁵⁴ To qualify for physician-assisted suicide, the patient must be a mentally competent adult with a terminal illness who has voluntarily expressed the desire to end her life.¹⁵⁵ The patient may then fill out a request form for lethal medication, and two witnesses must verify that the patient is "capable, acting voluntarily, and is not being coerced" into making the application.¹⁵⁶ Requiring patients to doubly prove their voluntary desire to end their lives by physician-assisted suicide ensures that terminally ill patients or those trying to coerce such patients into choosing physician-assisted suicide will not abuse the ODWDA.

Oregon doctors must also follow several procedures and safeguards to comply with the ODWDA,¹⁵⁷ the most important of which is to get the confirmation of another physician that the patient seeking physician-assisted suicide has been properly diagnosed as suffering from terminal illness, is mentally competent and acting voluntarily, and has made an informed decision.¹⁵⁸ As for the prescription of the medication that will end the terminally ill patient's life, doctors can

154. *See id.*

155. OR. REV. STAT. § 127.805(1). The statute lists several criteria that interested patients must fulfill to qualify for physician-assisted suicide, the most important of which is that one who "may make a written request for medication" must be "[a]n adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die." *Id.*

156. *Id.* § 127.810(1). Witnesses must fulfill several criteria for the patient to qualify for physician-assisted suicide. One witness must not be related to the terminally ill patient by "blood, marriage, or adoption," entitled to "any portion of the estate of the qualified patient" upon his or her death, or an owner or employee of the health-care facility where the patient lives or receives medical treatment, and neither can be the patient's attending physician when the patient requests physician-assisted suicide. *Id.* § 127.810(2).

157. *Id.* § 127.815(1)–(2). Under this section of the ODWDA, the attending physician shall, among other things, determine initially whether the patient "has a terminal disease, is capable, and has made the request voluntarily" and request that the patient show Oregon residency. *Id.* The attending physician must also inform the patient of her medical diagnosis and prognosis, the "potential risks associated with taking the medication to be prescribed," the "probable result of taking the medication to be prescribed," and any "feasible alternatives" (such as "comfort care, hospice care and pain control") to ensure that the patient makes an "informed decision" about whether to request physician-assisted suicide. *Id.* The attending physician must also recommend that the patient seek counseling and notify her next of kin about the decision to request physician-assisted suicide. *Id.*

158. *Id.* § 127.820.

either "dispense medications directly"¹⁵⁹ or, if the patient gives written consent, notify a pharmacist of the prescription and deliver it "personally or by mail to the pharmacist."¹⁶⁰ Because doctors must comply with several procedures before they can prescribe lethal medication to assist suicide, these safeguards prevent abuse of the ODWDA by physicians who might overprescribe federally controlled substances.

The ODWDA also has safeguards to avoid the slippery slope to voluntary and involuntary euthanasia.¹⁶¹ Oregon doctors cannot "end a patient's life by lethal injection, mercy killing or active euthanasia"¹⁶² and may only prescribe "self-administered, ingestible medications"¹⁶³ to terminally ill patients who have properly complied with the procedures to obtain such medications. Thus, because the ODWDA "allows only a limited form of physician-assisted death" and "expressly prohibits active euthanasia,"¹⁶⁴ the Act avoids the slippery slope to voluntary and involuntary euthanasia.

2. OREGON DEATH WITH DIGNITY ACT STATISTICS

Despite the fervency of the slippery slope argument, statistical data show that the ODWDA has not harmed the elderly or other vulnerable groups. During the first six years of the statute's implementation, patients with undergraduate or graduate degrees were more likely to choose physician-assisted suicide over those with only high school diplomas.¹⁶⁵ Further, 90% of patients seeking physician-assisted suicide had Medicare or private health insurance, and 86% were receiving hospice care.¹⁶⁶ In the ODWDA's eighth year, data released by the Oregon Department of Health and Human Services showed that the majority of terminally ill patients seeking lethal doses of barbiturates were "white, highly educated, and had health insur-

159. *Id.* § 127.815(1)(L)(A). To prescribe the medications that will end the terminally ill patient's life, a doctor must be "registered as a dispensing physician with the Oregon Medical Board" and have "a current Drug Enforcement Administration certificate and compl[y] with any applicable administrative rule." *Id.*

160. *Id.* § 127.815(1)(L)(B)(i)–(ii). The pharmacist "will dispense the medications to either the patient, the attending physician or an expressly identified agent of the patient." *Id.*

161. See *supra* Part III.B.3.

162. OR. REV. STAT. § 127.880.

163. McMurry, *supra* note 25, at 443.

164. *Id.* at 450.

165. Hilliard, *supra* note 6, at 160.

166. *Id.*

ance.”¹⁶⁷ Therefore, because of the Act’s safeguards, fear that Oregon doctors would force terminally ill patients who “were poor, uneducated, uninsured, disabled, *elderly*, or otherwise vulnerable”¹⁶⁸ to commit suicide has never transpired.

3. ATTACKS ON THE OREGON DEATH WITH DIGNITY ACT

While the ODWDA prevailed against several minor attacks on its legality,¹⁶⁹ the attempt by former Attorney General John Ashcroft to invalidate the Act in 2002 eventuated in the favorable U.S. Supreme Court decision of *Gonzales v. Oregon*.¹⁷⁰ Ashcroft claimed that he had the authority to interpret the Controlled Substances Act in a way that prohibited Oregon doctors from prescribing Schedule II medications to their terminally ill patients.¹⁷¹ The Supreme Court, however, held that Ashcroft could not interpret the CSA, and while the Court based its reasoning on statutory interpretation and not on the constitutional right to physician-assisted suicide,¹⁷² the *Gonzales* decision tacitly endorsed the ODWDA.

The ODWDA properly safeguards elderly patients from abuse under the statute by mandating that the terminally ill patients seeking physician-assisted suicide and the Oregon doctors prescribing the lethal doses of barbiturates to these patients comply with specific procedures. Therefore, despite the slippery slope concerns of physician-assisted suicide opponents, the ODWDA does not infringe on the rights of the elderly or other vulnerable groups and is a good model for other states interested in enacting their own physician-assisted suicide statutes.

IV. Recommendation

A. The Supreme Court Should Acknowledge the Constitutional Right to Physician-Assisted Suicide

While the U.S. Supreme Court recognized the constitutional right of mentally competent, terminally ill patients to refuse life-

167. *Id.*

168. *Id.* (emphasis added).

169. See Brian Boyle, Comment, *The Oregon Death with Dignity Act: A Successful Model or a Legal Anomaly Vulnerable to Attack?*, 40 Hous. L. Rev. 1387, 1393–1414 (discussing challenges to the ODWDA).

170. See *supra* Part II.C.3.

171. See *supra* Part II.C.3.

172. See *supra* Part II.C.3.

sustaining treatment in *Cruzan*, it refused to acknowledge a constitutional right to physician-assisted suicide in *Glucksberg* and *Vacco*.¹⁷³ Perhaps the Supreme Court balked at placing its stamp of approval on the constitutional right to physician-assisted suicide because the issue is so controversial. While the Court traditionally avoids making constitutional decisions because the outcomes can be divisive and controversial,¹⁷⁴ in the realm of the right to die, the Court should expressly acknowledge a constitutional right to physician-assisted suicide because it is consistent with its holdings in *Cruzan* and *Gonzales v. Oregon*.

In *Cruzan*, the Supreme Court approved of one method of assisted death, the right to refuse unwanted medical treatment, based on a "Fourteenth Amendment liberty interest."¹⁷⁵ Because these rights also convey to patients the right to physician-assisted suicide, the Court should not have refused to acknowledge a constitutional right to this other method of assisted death in *Glucksberg* and *Vacco*. While these decisions maintained the distinction between letting and making a patient die, refusing unwanted medical treatment and physician-assisted suicide are both means to the same end. Why approve one form of assisted death and not another? As the Second Circuit asserted, the removal of artificial hydration or nutrition by a terminally ill patient's doctor "is nothing more nor less than assisted suicide."¹⁷⁶ Not only do patients die by either method, but physician-assisted suicide allows doctors to better tend to their terminally ill patients' end-of-life wishes and affords them a more dignified death.

The Supreme Court should also make a constitutional decision about physician-assisted suicide because it tacitly approved the Oregon Death with Dignity Act in *Gonzales v. Oregon*.¹⁷⁷ If the Court truly

173. See *supra* Part II.C.1–2.

174. See William N. Eskridge, Jr. & Philip P. Frickey, *Quasi-Constitutional Law: Clear Statement Rules as Constitutional Lawmaking*, 45 VAND. L. REV. 596, 599–600 (1992).

175. *Cruzan ex rel. Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 279 n.7 (1990) ("But determining that a person has a 'liberty interest' under the Due Process Clause does not end the inquiry: 'whether respondent's constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests.'") (quoting *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982)).

176. *Vacco v. Quill*, 521 U.S. 703, 798 (1997) (quoting *Quill v. Vacco*, 80 F.3d 716, 729 (2d Cir. 1996)).

177. See *Gonzales v. Oregon*, 546 U.S. 243, 243–75 (2006). By the court deciding to directly interpret the statute, it provided support for the validity of the statute. See *id.*; see also *supra* Part II.C.3.

disapproved of physician-assisted suicide, it would have agreed that former Attorney General Ashcroft had the authority to interpret the Controlled Substances Act narrowly to prohibit Oregon doctors from prescribing federally regulated Schedule II medications to their terminally ill patients. However, using a statutory interpretation argument to deny Ashcroft this authority subtly indicated that the Supreme Court approved of the Oregon statute and physician-assisted suicide. While there is a difference between protecting a valid state statute from a narrow and unfair interpretation and expressly approving the right to physician-assisted suicide, that the Court did not strike down the statute or accept Ashcroft's Interpretive Rule indicates its willingness to consider physician-assisted suicide cases in the future.

The *Gonzales* decision was the perfect opportunity to acknowledge the constitutional right to physician-assisted suicide. In the future, if other cases arise with similar issues regarding death with dignity or the interpretation of state statutes legalizing physician-assisted suicide, the Supreme Court should grant certiorari to expressly recognize the constitutional right to physician-assisted suicide. Because the Supreme Court has already made constitutional decisions regarding methods of assisted death in *Cruzan* and *Gonzales*, it can make another without fear of judicial overreaching.

B. The Oregon Act Is a Good Model for State Statutes Legalizing Physician-Assisted Suicide

Although the U.S. Supreme Court ruled against the constitutional right to physician-assisted suicide in its 1997 *Glucksberg* and *Vacco* decisions,¹⁷⁸ the right to die issue has yet to be definitively resolved. As Justice Brandeis once noted, the states are the "laboratories of democracy."¹⁷⁹ Even if the Court remains unwilling to place a stamp of approval on a constitutional right to physician-assisted suicide, if enough states are interested in enacting legislation legalizing this form of assisted death, then perhaps the problem will take care of itself. After all, Chief Justice Rehnquist, the author of both unanimous opinions in *Glucksberg* and *Vacco*, left to the states the democratic option of wrangling with their own medical policies and laws regarding the

178. *Vacco*, 521 U.S. at 809; *Washington v. Glucksberg*, 521 U.S. 702, 708 (1997).

179. Urofsky, *supra* note 3, at 827.

right to physician-assisted suicide.¹⁸⁰ Further, that the Supreme Court in *Gonzales* refused to allow former Attorney General Ashcroft to interpret the Oregon Death with Dignity Act in such a narrow way as to render it ineffective tacitly endorsed the Act's provisions. Thus, while the holdings in *Glucksberg* and *Vacco* did not recognize a constitutional right to physician-assisted suicide, they did not effectuate a total ban either, opening the door for state democratic processes to determine policies and laws for end-of-life care.¹⁸¹

Once the Supreme Court officially acknowledges the constitutional right to physician-assisted suicide, other states interested in legalizing physician-assisted suicide should use the Oregon Death with Dignity Act as a model for their own statutes because the ODWDA's procedural safeguards avoid the slippery slope to voluntary and involuntary euthanasia. That the ODWDA successfully allows terminally ill patients to seek a dignified death and doctors to fulfill their duties to their patients is "undeniable."¹⁸² In California, for example, two state representatives have introduced legislation with language similar to the ODWDA that would legalize physician-assisted suicide.¹⁸³ According to one commentator, "California is among the most progressive states in the nation in improving pain care . . . [A]ll terminally ill patients receive care in an environment where provision of good pain and symptom management is recognized as essential and basic patient care."¹⁸⁴

180. See *Glucksberg*, 521 U.S. at 735. Chief Justice Rehnquist concluded the *Glucksberg* opinion with the observation that "[t]hroughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society." *Id.*; see also Hilliard, *supra* note 6, at 161. Hilliard notes that "Justice Rehnquist, in his unanimous rulings in *Glucksberg* and *Quill*, indicated that the individual states should be free to craft medical policies and to 'experiment' with laws and procedures surrounding end-of-life care." *Id.*

181. Hilliard, *supra* note 6, at 161.

182. *Id.* at 170.

183. Kathryn L. Tucker, *Federalism in the Context of Assisted Dying: Time for the Laboratory to Extend Beyond Oregon, to the Neighboring State of California*, 41 WILLAMETTE L. REV. 863, 864 (2005). In 2005, California State Representatives Berg and Levine introduced physician-assisted suicide legislation to the state legislature that is similar to the Oregon Death with Dignity Act. *Id.* The proposed California legislation "empower[s] terminally ill, mentally competent, adult Californians to control the timing and manner of their deaths, subject to careful procedures." *Id.* As Tucker notes, "[a] fraction of dying patients, even with excellent pain and symptom management, confront a dying process so prolonged and marked by such extreme suffering and deterioration that they determine that hastening impending death is the least worst alternative." *Id.*

184. *Id.* at 874.

Another victory for physician-assisted suicide supporters occurred during the 2008 presidential election when Washington voters passed Initiative 1000, the second state statute in the United States legalizing physician-assisted suicide.¹⁸⁵ Filed by Governor Booth Gardner, Initiative 1000 is modeled on the Oregon Death with Dignity Act and allows mentally competent, terminally ill Washington adults to "request and self-administer lethal medication" prescribed by a doctor.¹⁸⁶ Like the ODWDA, the new Washington law will prevent doctors assisting suicide from being prosecuted under state law and also includes "many safeguards."¹⁸⁷ Barbara Coombs Lee, the president of right-to-die organization Compassion and Choices, hopes to pass similar initiatives across America, noting that "[w]e think the citizens of all [fifty] states deserve death with dignity."¹⁸⁸ Indeed, other states should adopt statutes that legalize physician-assisted suicide as more terminally ill patients and their families pressure doctors to offer physician-assisted suicide as a way to end life.¹⁸⁹

V. Conclusion

Because the Supreme Court's distinction between the right to refuse unwanted life support and physician-assisted suicide is arbitrary and unconstitutional, the time has come in the right-to-die debate to properly acknowledge the constitutional right of mentally competent, terminally ill patients to choose physician-assisted suicide as a way to end their lives. In a country where we value the right to be independent thinkers who determine our own lives' paths, that we are denied the right to determine the end of that path is unfair and contrary to the fundamental American concepts of individualism and self-determination. These rights are at the heart of death with dignity:

185. Washington Death with Dignity Act, Washington Initiative Measure No. 1000 (2008), <http://www.secstate.wa.gov/elections/initiatives/text/i1000.pdf>; Janet I. Tu, *Assisted Suicide Measure Passes; Initiative 1000*, SEATTLE TIMES, Nov. 5, 2008, at A3, available at http://seattletimes.nwsource.com/html/nationworld/2008352350_assistsuicide05m.html.

186. Tu, *supra* note 185; see also About I-1000, YES! on I-1000 Death with Dignity, <http://www.yeson1000.org/default.aspx?ID=3> (last visited Jan. 20, 2009).

187. Tu, *supra* note 185.

188. *Id.*

189. Hilliard, *supra* note 6, at 170. See generally Diana Hassel, *Sex and Death: Lawrence's Liberty and Physician-Assisted Suicide*, 9 U. PA. J. CONST. L. 1003, 1021 n.107 (2007) (discussing proposed physician-assisted suicide legislation in Hawaii, Arizona, Wisconsin, California, Maine, Michigan, and Washington).

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the right to choose, the rights to privacy and self-determination, and the right to look for a "good death."