

A DIGNIFIED DEATH? DON'T FORGET ABOUT THE PHYSICALLY DISABLED AND THOSE NOT TERMINALLY ILL: AN ANALYSIS OF PHYSICIAN-ASSISTED SUICIDE LAWS

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I. INTRODUCTION

On November 22, 1998, millions of Americans watched an episode of "60 Minutes" which will likely never be forgotten. During the show, Dr. Jack Kevorkian, a.k.a. "Dr. Death," blocked the camera's view as he injected his incurably ill patient, Thomas Youk, with lethal drugs.¹ Mr. Youk, who could be seen sitting upright, wearing glasses and a plaid shirt, was given a sedative and his head lolled back out of the camera's range.² Dr. Kevorkian could be overheard saying "he's dying now" in response to a reporter's question about whether Mr. Youk was dead.³ Mr. Youk was a fifty-two year old man suffering from severe degeneration caused by ALS (also known as Lou Gehrig's disease).⁴ It was this shocking videotape which sparked a national debate over the legalization of physician-assisted suicide⁵ for terminally ill patients. While Dr. Kevorkian's assistance of Mr. Youk's suicide was illegal at the time, and would be illegal even under today's existing physician-assisted suicide laws, it revitalized the battle over physician-assisted suicide.

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1. Caryn James, *Critic's Notebook: '60 Minutes,' Kevorkian and a Death for the Cameras*, N.Y. TIMES, Nov. 23, 1998, available at <http://www.nytimes.com/1998/11/23/us/critic-s-notebook-60-minutes-kevorkian-and-a-death-for-the-cameras.html>

2. *Id.*

3. *Id.*

4. James, *supra* note 1; ALS Association Web site, *What is ALS?*, <http://www.alsa.org/als/what.cfm> (last visited Apr. 2, 2010). (Amyotrophic Lateral Sclerosis (ALS) is a progressive neurodegenerative disease that affects nerve cells in the brain and spinal cord. When motor neurons die, the ability of the brain to initiate and control muscle movement is lost. With voluntary muscle action progressively affected, patients in the later stages of the disease may become totally paralyzed.)

5. "Physician-assisted suicide" has also been called "assisted death," "aid in dying," or "patient assisted death."

Imagine suffering from a debilitating disease, such as Lou Gehrig's disease, Parkinson's disease,⁶ or Huntington's disease⁷ in which one no longer has sufficient control over her own bodily movements and functions. All of these diseases affect one's ability to control her own body, rendering her, in many situations, physically incapacitated to the point that she is unable to ingest medications on her own. It is these people who can suffer tremendous physical pain, who may have the strongest desire to end their lives, but who are prevented from doing so under the present physician-assisted suicide laws. These laws fail to provide an avenue for individuals who may have the strongest will to end their suffering to do just that. Instead, the laws simply ban these people from dying with dignity, forcing them instead to face a life (and death) without dignity in the time when they seek control of their uncertain future.

Under the physician-assisted suicide statutes in Oregon and Washington, a person who suffers from a physically debilitating ailment is unable to be assisted by her physician in committing suicide because she does not have the capacity to ingest the lethal prescription herself. Because she is unable to take the medication herself, she will be forced to live out her days in a hospital bed with no chance of ever living a normal life again. The current physician-assisted suicide statutes in Oregon and Washington do not permit a physically disabled person to be assisted by her doctors in committing suicide because she is unable to ingest the medications on her own. Further, the laws are limited to only those patients who are terminally ill, despite the fact that many patients suffer from long-lasting painful diseases which progressively become more unbearable, disqualifying them from being permitted to die with the assistance of their physician.

Mr. Youk was mentally able to make the decision to have his doctor assist him in suicide yet, he would not qualify under the Oregon or Washington physician-assisted suicide laws because he was not "terminally ill." However, he was suffering tremendously and expressed an irreversible desire to end his suffering and to be free from his physical and mental pain.

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6. National Institute of Neurological Disorders and Stroke, NINDS Parkinson's Disease Information Page, http://www.ninds.nih.gov/disorders/parkinsons_disease/parkinsons_disease.htm (last visited Apr. 2, 2010) (Parkinson's disease results from the loss of dopamine-producing brain cells. Patients may have difficulty walking, talking, or completing other simple tasks. Other symptoms may include difficulty in swallowing, chewing, and speaking.).
 7. National Institute of Neurological Disorders and Stroke, NINDS Huntington's Disease Information Page, <http://www.ninds.nih.gov/disorders/huntington/huntington.htm> (last visited Apr. 2, 2010) (Huntington's disease results from genetically programmed degeneration of brain cells in certain areas of the brain, which causes uncontrolled movements, loss of intellectual faculties, and emotional disturbance. As the disease progresses, a patient may have difficulty feeding himself or herself and swallowing.).

Despite this conscious and competent decision, the laws prohibit him from terminating his own life with the assistance of his physician. This inconsistency demonstrates the need for more guidelines regarding who should be permitted to be assisted in committing suicide and who should not. However, the thorny question still remains: Where do we draw that line? Should someone who is physically incapable of ingesting life-ending drugs be unable to end her life and be forced to live in constant pain, while someone who is suffering from the same terminal illness, but who is still physically capable of administering the medication, be permitted to end her life, even though both individuals are competent to decide that they want to end their lives? Similarly, should someone who is suffering, but who is given only three months to live, be allowed to terminate her life while someone suffering equally, but whose prognosis is more than a year, be prevented from doing so?

This Comment provides an in-depth analysis of the application of the Oregon and Washington physician-assisted suicide statutes to individuals who are physically incapable of self-administering life-ending drugs and those who are not terminally ill. Section II of this Comment explains the history of physician-assisted suicide laws in the United States. In particular, Section II focuses on the Oregon Death With Dignity Act (ODWDA), the Washington Death With Dignity Act (WDWDA), and the recent decision in Montana, which held that the state's constitution provides the right of a patient to commit suicide with the aid of a physician. Section III discusses the arguments for and against prohibiting physically disabled, yet mentally competent, individuals from physician-assisted death. Additionally, Section III sets forth the leading arguments for eliminating the terminal illness requirement from physician-assisted suicide statutes. Section III argues that these laws are inadequate because they fail to provide those who are suffering, but not terminally ill, and those who are physically incapable of ending their own lives with an avenue for a dignified death.

With the prospect of legalizing physician-assisted suicide in more states, it is important to assess each of the statutes already enacted to ensure that those laws guarantee the well-being and safety of any person who chooses to end her life under such laws. The ODWDA and the WDWDA lack safeguards with respect to people who are physically incapable of committing suicide without the assistance of their physician. Furthermore, the presently enacted laws only permit individuals who are expected to die within six months to enlist a physician's aid in their death. In actuality, both Death Without Dignity statutes fail to set a sufficient standard under which mental illness can be diagnosed and treated before a person can opt to end her life under the physician-assisted suicide laws. Additionally, these laws facially fail to permit a person who suffers from a physically debilitating illness to get assistance

from her physician to aid in her death. As such, it is important for these states to re-evaluate the restrictions placed on their already existing Death with Dignity statutes and for states in the future to consider providing an opportunity to die with dignity to patients who are not terminally ill or who are physically incapable of ending their own lives. These laws should provide equal treatment for individuals who are not terminally ill or who are physically incapable of ending their own lives by giving them the option to end their suffering, thereby granting them the same dignity as those who already qualify for a dignified death.

II. BACKGROUND

Over the past decade, there has been an expanding opportunity to grant Americans who are terminally ill a choice between life and death. Oregon was the first state to legalize physician-assisted suicide, followed by Washington and Montana. These states now offer an avenue for terminally ill patients to end their lives in a humane and dignified manner.

A. Physician-Assisted Suicide in the United States

Historically, American law has not recognized a legal right to receive assistance in committing suicide. In what appears to be a very slow moving shift away from this long-established stance, three states have now legalized physician-assisted suicide. In 1994, the state of Oregon was the first state to permit physician-assisted suicide and, more than ten years later, Washington and Montana have joined Oregon in allowing the controversial practice.

1. *The Difference Between Physician-Assisted Suicide and Euthanasia*

“Physician-assisted suicide occurs when a physician provides the means with which a patient . . . [performs the act of ending] his or her life.”⁸ Physician-assisted suicide is most commonly associated with the act of a physician prescribing medication with the knowledge that the recipient of that prescription intends to use it to commit suicide.⁹ In the case of physician-

8. Kathy L. Cerminara, *Therapeutic Death: A Look at Oregon's Law*, 6 PSYCHOL. PUB. POL'Y & L. 503, 506 (2000) (examining the laws legalizing physician-assisted suicide through a therapeutic jurisprudence lens). See also BLACK'S LAW DICTIONARY 1571 (9th ed. 2009) (defining “physician-assisted suicide” as “the intentional act [by a doctor to] provid[e] a person with the medical means or the medical knowledge to commit suicide”).

9. Cerminara, *supra* note 8, at 506.

assisted suicide, it is the patient who decides when and whether to ingest the medication to terminate his or her life.¹⁰ By its very definition, a patient seeking to commit suicide with the assistance of her physician must retain the capacity and ability to affirmatively act in order to benefit from a law permitting physician-assisted suicide.¹¹ Therefore, a patient who is in a coma, completely paralyzed, or otherwise physically incapable, is unable to benefit from a law legalizing physician-assisted suicide.¹²

Euthanasia, on the other hand, involves a physician, or someone else, intentionally administering medication to cause a patient's death at the patient's explicit request and informed consent.¹³ Euthanasia requires the physician, or someone other than the patient, to take the final step leading to death.¹⁴ There are two specific types of euthanasia: passive and active. Passive euthanasia involves a "physician's inaction or omissions, such as withholding life-sustaining hydration and nutrients or refusing to initiate potentially life-sustaining therapies."¹⁵ Active euthanasia refers to the process of physician-assisted death where the physician performs an affirmative act with the intent to cause the patient's death.¹⁶ Patients in all 50 states and the District of Columbia possess the right to passive euthanasia, under the recognized constitutional right to refuse life-sustaining treatment.¹⁷

The distinction between physician-assisted suicide and euthanasia has significant legal implications. A physician who commits active euthanasia may be criminally charged with the patient's homicide in any state because the

10. *Id.*

11. *Id.*

12. *Id.*

13. *Id.* See also BLACK'S LAW DICTIONARY 634 (9th ed. 2009) (defining "euthanasia" as "the act or practice of killing or bringing about the death of a person who suffers from an incurable disease or condition, especially a painful one, for reasons of mercy").

14. Cerminara, *supra* note 8, at 506.

15. Glenn R. McMurry, *An Unconstitutional Death: The Oregon Death with Dignity Act's Prohibition Against Self-Administered Lethal Injection*, 32 U. DAYTON L. REV. 441, 449-50 (2007) (providing the judicial history of the ODWDA) (quoting Mason L. Allen, *Crossing the Rubicon: The Netherlands's Steady March Towards Euthanasia*, 31 BROOK. J. INT'L L. 535, 540 (2006)). See also BLACK'S LAW DICTIONARY 634 (9th ed. 2009) (defining "passive euthanasia" as "the act of allowing a terminally ill person to die by either withholding or withdrawing life-sustaining support such as a respirator or feeding tube").

16. McMurry, *supra* note 15, at 449. See also BLACK'S LAW DICTIONARY 634 (9th ed. 2009) (defining "active euthanasia" as "euthanasia performed by a facilitator (such as a healthcare practitioner) who not only provides the means of death but also carries out the final death-causing act").

17. McMurry, *supra* note 15, at 450. See *Cruzan v. Dir. Mo. Dep't of Health*, 497 U.S. 261 (1990) in which the Supreme Court held that the United States Constitution does not forbid the state of Missouri from requiring that evidence of an incompetent's wishes as to the withdrawal of life-sustaining treatment be proved by clear and convincing evidence.

physician has purposely and directly caused the death of the patient.¹⁸ A physician who does not perform the life-ending act, but who assists with a patient's suicide by providing the means or information necessary, can be criminally charged under laws specifically banning assisted suicide.¹⁹ In a state with legalized physician-assisted suicide, the physician cannot be held criminally liable for the patient's death.

2. *The Past and Present Laws Regarding Assisted Suicide*

In both legal and ethical aspects, assisted suicide has never been treated the same as suicide or attempted suicide. At common law, people who aided or abetted suicide were guilty of murder.²⁰ Presently, ten states construe assisted suicide as murder or manslaughter.²¹ Other states that criminalize assisted suicide characterize it as a separately graded felony.²² "The Model Penal Code also criminalizes assisted suicide, but differentiates between that which is purposely caused by 'force, duress or deception'²³ and that which results from the 'purposeful aid or solicitation'²⁴ of another."²⁵ Assisted suicide caused by "force, duress or deception" may result in a homicide conviction, while "a person who purposely aids or solicits another to commit suicide is guilty of a felony of the second degree."²⁶

There are currently nearly forty states which have an unequivocal statutory ban on physician-assisted suicide²⁷ and six states explicitly declare

18. T. Howard Stone & William J. Winslade, *Physician-Assisted Suicide and Euthanasia in the United States*, 16 J. LEGAL MED. 481, 484 (1995) (discussing United States law regarding physician-assisted suicide and euthanasia).

19. *Id.*

20. *Id.* at 485.

21. International Task Force.org, Assisted Suicide Laws, <http://www.internationaltaskforce.org/about.htm> (last visited Apr. 2, 2010) ("The International Task Force on Euthanasia and Assisted Suicide is an international leader in the ever-increasing debate over assisted suicide and euthanasia."). The 10 states are: Alaska, Arizona, Arkansas, Colorado, Connecticut, Florida, Hawaii, Missouri, New York, and Oregon.

22. Stone & Winslade, *supra* note 18, at 485.

23. MODEL PENAL CODE § 210.5(1) (1962).

24. *Id.* § 210.5(2).

25. Stone & Winslade, *supra* note 18, at 485.

26. *Id.* citing MODEL PENAL CODE § 210.5(1)-(2) (1962).

27. McMurry, *supra* note 15, at 444 n.20. See ALASKA STAT. § 11.41.120 (2009); ARIZ. REV. STAT. ANN. § 13-1103 (2009); ARK. CODE ANN. § 5-10-104 (2009); CAL. PENAL CODE § 401 (West 2009); COLO. REV. STAT. § 18-3-104 (2009); CONN. GEN. STAT. § 53a-56 (2009); DEL. CODE ANN. tit. 11, § 645 (2009); FLA. STAT. § 782.08 (2009); GA. CODE ANN. § 16-5-5 (2009); HAW. REV. STAT. § 707-702 (2009); 720 ILL. COMP. STAT. § 5/12-31 (2008); IND. CODE ANN. § 35-42-1-25 (West 2009); IOWA CODE § 707A.2 (2009); KAN. STAT. ANN. § 21-3406 (2009); KY. REV. STAT. ANN. § 216.302 (West 2009); LA. REV. STAT. ANN § 14:32.12 (2009); ME. REV. STAT. ANN. tit. 17, § 204 (2009); MD. CODE

that they do not condone or authorize the practice in their respective health care laws.²⁸ For example, in Colorado, a person who “intentionally causes or aids another person to commit suicide” commits the crime of manslaughter, which is a class-four felony.²⁹ Likewise, California law explicitly states that “[e]very person who deliberately aids, or advises, or encourages another to commit suicide, is guilty of a felony.”³⁰ However, the past decade has seen a slight shift toward the legalization of physician-assisted suicide. While Oregon and Washington are the only two states to affirmatively enact laws recognizing physician-assisted suicide as a medical benefit, a Montana District Court judge ruled that the State’s Constitution includes the right to assisted suicide.³¹ The Montana Supreme Court ultimately avoided the direct Constitutional question but stated that while the Constitution may not guarantee the right to be assisted by a physician in death, there is “nothing in Montana Supreme Court precedent or Montana statutes indicating that physician aid in dying is against public policy.”³²

The majority of the American public endorses the legalization of physician-assisted suicide.³³ Surveys reveal that approximately sixty percent of American physicians endorse physician-assisted suicide, however, only half of the physicians surveyed would provide physician-assisted suicide to their patients.³⁴ As states begin to recognize this desire for the legalization of physician-assisted suicide, it is essential that the legislation enacted in Oregon and Washington be thoroughly reviewed to ensure that these laws truly allow patients who wish to end their suffering may die with dignity.

ANN. CRIM. LAW § 3-102 (West 2009); MICH. COMP. LAWS § 750.329a (2009); MINN. STAT. § 609.215 (2009); MISS. CODE ANN. § 97-3-49 (2009); MO. REV. STAT. § 565.023 (2009); MONT. CODE ANN. § 45-5-105 (2009); NEB. REV. STAT. § 28-307 (2009); N.H. REV. STAT. ANN. § 630:4 (2009); N.J. STAT. ANN. § 2C:11-6 (West 2009); N.M. STAT. § 30-2-4 (2009); N.Y. PENAL LAW § 125.15 (McKinney 2009); N.D. CENT. CODE § 12.1-16-04 (2009); OKLA. STAT. tit. 21, § 813 (2009); 18 PA. CONS. STAT. § 2505 (2009); R.I. GEN. LAWS § 11-60-3 (2009); S.C. CODE ANN. § 16-3-1090 (2009); S.D. CODIFIED LAWS § 22-16-37 (2009); TENN. CODE ANN. § 39-13-216 (2009); TEX. PENAL CODE ANN. § 22.08 (Vernon 2009); WASH. REV. CODE § 9A.36.060 (2009); WIS. STAT. § 940.12 (2009).

28. See ALA. CODE § 22-8A-10 (2009); IDAHO CODE ANN. § 56-1022 (2009); NEV. REV. STAT. § 449.670 (2009); OHIO REV. CODE ANN. § 3795.02 (West 2009); W. VA. CODE § 16-30-2 (2009); WYO. STAT. ANN. § 35-22-414 (2009).

29. COLO. REV. STAT. ANN. § 18-3-104 (West 2008).

30. CAL. PENAL CODE § 401 (West 2008).

31. Baxter v. State of Montana, No. ADV-2007-787, 2008 WL 6627324 (Mont. 1st Dist. Dec. 5, 2008).

32. Baxter v. State of Montana, 224 P.3d 1211, 1222 (Mont. 2009).

33. Kelly Green, *Physician-Assisted Suicide and Euthanasia: Safeguarding Against the “Slippery Slope”-The Netherlands Versus the United States*, 13 IND. INT’L & COMP. L. REV. 639, 661 (2003).

34. *Id.* at 661-62.

a. Oregon Death With Dignity Act (ODWDA)

By a margin of only 31,962 votes, Oregon became the first state to take a leap in a new direction by legalizing physician-assisted suicide.³⁵ However, the ODWDA was not enacted without opposition and, as a result, it took almost three years for the ODWDA to take effect. While the initiative passed during the general election in November 1994, the Act did not become law until October 27, 1997.³⁶ The delay was a result of temporary and permanent injunctions issued by a federal district court in a string of cases known as *Lee v. Oregon*.³⁷ These cases challenged the ODWDA on constitutional grounds alleging potential violations of the Equal Protection clause, Due Process clause, and the First Amendment.³⁸ In November 1997, a measure was placed on the general election ballot to repeal the Act; however, Oregon voters chose to retain the ODWDA by a margin of twenty percent.³⁹

The ODWDA faced one more significant battle when, in 2001, the U.S. Attorney General challenged the ODWDA on the ground that “assisting suicide is not a ‘legitimate medical purpose’” under the Controlled Substances Act.⁴⁰ The Supreme Court, however, affirmed the Ninth Circuit decision holding that the Controlled Substances Act was promulgated to combat drug abuse and the Secretary of Health and Human services, not the Attorney

35. Oregon Secretary of State, Oregon Blue Book, Initiative, Referendum and Recall, 1988-1995, available at <http://bluebook.state.or.us/state/elections/elections21.htm> (last visited Apr. 2, 2010). Oregon Blue Book is the official state directory and fact book about the government of Oregon, including all election results for the state. On November 8, 1994, the state of Oregon passed an initiative which permits “terminally ill adults to obtain prescription for lethal drugs” by a vote of 627,980 (fifty-one percent) to 596,018 (forty-nine percent).

36. State of Oregon, FAQs About the Death with Dignity Act, <http://www.oregon.gov/DHS/ph/pas/faqs.shtml> (last visited Apr. 2, 2010) (hereinafter Oregon FAQs).

37. McMurry, *supra* note 15, at 445 n.27–28. See *Lee v. Oregon*, 869 F. Supp. 1491 (D. Or. 1994); *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995); *Lee v. Oregon*, 891 F. Supp. 1439 (D. Or. 1995); *Lee v. Oregon*, 107 F.3d 1382 (9th Cir. 1997).

38. McMurry, *supra* note 15, at 445 n.27–28. See *Lee*, 869 F. Supp. 1491 (decision granting preliminary injunction against the ODWDA after a determination of probable success on Equal Protection and First Amendment claims); *Lee*, 891 F. Supp. 1429 (granting a final resolution of the Equal Protection claim in favor of the ODWDA challengers); *Lee*, 891 F. Supp. 1439 (issuing permanent injunction ordering ODWDA to become active Oregon legislation).

39. Oregon FAQs, *supra* note 36 (the results were sixty percent in favor to forty percent opposed).

40. McMurry, *supra* note 15, at 447 (citing 66 Fed. Reg. 56,607 (Nov. 9, 2001)) (Attorney General John Ashcroft explained that “administering federally controlled substances to assist suicide violates [the Controlled Substances Act]” and that “this conclusion applies regardless of whether state law authorizes or permits such conduct.”).

General, had the authority to make decisions regarding the practice of medicine as delegated by the Federal government.⁴¹

In pertinent part, the ODWDA provides that

an 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, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner.⁴²

The ODWDA defines the term capable as “the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient’s manner of communicating if those persons are available.”⁴³ Terminal disease is defined as an “incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.”⁴⁴

Upon the successful petition for medication for the purpose of ending life, the attending physician shall dispense the medication directly to the patient or, upon the patient’s consent, directly to a pharmacist who will dispense the medication to the patient.⁴⁵ After this point, it is up to the patient to decide if, and when, to ingest the prescribed medication to terminate her life. Following Oregon’s lead, Washington enacted a statute containing very similar provisions, legalizing physician-assisted suicide.

b. Washington Death With Dignity Act (Washington Initiative 1000) (WDWDA)

In November 2008, Washington followed in Oregon’s footsteps and became the second state to legalize physician-assisted suicide. A state measure, known as Initiative 1000, passed with a margin of eighteen percent (fifty-nine percent to forty-one percent) making it legal for doctors to prescribe

41. Oregon v. Ashcroft, 368 F.3d 1118 (9th Cir. 2004), *aff’d sub nom.* Gonzales v. Oregon, 546 U.S. 243 (2006).

42. OR. REV. STAT. ANN. § 127.805(1) (West 2008).

43. *Id.* § 127.800(3).

44. *Id.* § 127.800(12).

45. *Id.* § 127.815(1)(L)(A)-(B).

a lethal dose of medication for patients with less than six months to live.⁴⁶ The law became effective on March 5, 2009 in the state of Washington.⁴⁷

In relevant part, the WDWA provides that

an adult who is competent, is a resident of Washington state, 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, may make a written request for medication that the patient may self-administer to end his or her life in a humane and dignified manner.⁴⁸

The Act defines competent as “a patient [who] has the ability to make and communicate an informed decision to health care providers, including communication through persons familiar with the patient’s manner of communicating if those persons are available.”⁴⁹ The law further defines terminal disease as an “incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.”⁵⁰

Upon the successful request for medication for the purpose of ending life, the attending physician shall dispense the medication directly to the patient or, upon the patient’s written consent, directly to a pharmacist to dispense the medication.⁵¹ As with the Oregon law, it is up to the patient to decide if, and when, to ingest the prescribed medication to terminate her life.

c. *Baxter v. Montana* and The Right to Physician-Assisted Suicide

In December 2008, a Montana District Court judge ruled that the state’s Constitution includes the right to assisted suicide.⁵² The plaintiff in that case was a seventy-five year old retired truck driver suffering from lymphocytic leukemia with diffuse lymphadenopathy, a terminal form of cancer, who wanted the option of assisted death when his suffering became unbearable.⁵³

46. Jacob Goldstein, *Washington Passes Initiative 1000, Legalizing Physician-Assisted Suicide*, WALL ST. J., Nov. 5, 2008, available at <http://blogs.wsj.com/health/2008/11/05/washington-passes-initiative-1000-legalizing-physician-assisted-suicide/>.

47. Compassion & Choices of Washington State, *Washington Death with Dignity Act – Initiative 1000*, <http://www.candcofwa.org/initiative.html> (last visited Apr. 2, 2010).

48. WASH. REV. CODE ANN. § 70.245.020(1) (West 2008) (effective March 5, 2009).

49. *Id.* § 70.245.010(3).

50. *Id.* § 70.245.010(13).

51. *Id.* § 70.245.040(1)(i)-(ii).

52. *Baxter v. State of Montana*, No. ADV-2007-787, 2008 WL 6627324, (Mont. 1st Dist. Dec. 5, 2008).

53. *Id.* Plaintiff was treated with multiple rounds of chemotherapy, which typically becomes less and less effective as time passes. As a result of his disease and the treatment necessary to combat it, he suffered from many symptoms including anemia, chronic fatigue and weakness, nausea, night sweats,

The judge declared that the “Montana constitutional rights of individual privacy and human dignity, taken together, encompass the right of a competent terminally ill patient to die with dignity.”⁵⁴ “The patient may use the assistance of his physician to obtain a prescription for a lethal dose of medication that the patient may take on his own if and when he decides to terminate his life.”⁵⁵ The judge further declared that “doctors who ‘help’ their patients die would not be subject to prosecution.”⁵⁶

In early January 2009, the same judge rejected the state attorney general’s request that her order be stayed until the Montana Supreme Court considered the case on appeal.⁵⁷ The judge’s order denying the request avowed that issuing a stay would “deny the fundamental right of Montanans to die with dignity for a lengthy period of time while the case is being appealed” and “that there [was] a very good chance that the Montana Supreme Court [would] affirm the decision of this [c]ourt.”⁵⁸

In fact, in December 2009, the Montana Supreme Court subsequently avoided the Constitutional question of whether the right to physician-assisted death exists; however, the court stated that there is “nothing in Montana Supreme Court precedent or Montana statutes indicating that physician aid in dying is against public policy.”⁵⁹ Interestingly, the court held that under Montana statutes,⁶⁰ “a terminally ill patient’s consent to physician aid in dying constitutes a statutory defense to a charge of homicide against the aiding

intermittent and persistent infections, massively swollen glands, easy bruising, significant ongoing digestive problems, and generalized pain and discomfort. These symptoms, and others, were expected to increase in frequency and intensity as the chemotherapy lost its effectiveness and the disease progressed. There is no cure and no prospect of recovery. *Id.*

54. Liz Townsend, *Assisted Suicide Legalized in Montana; Attorney General to Appeal*, National Right to Life, Dec. 11, 2008, http://www.nrlc.org/News_and_VIEWS/Dec08/nv121108part2.html; *See Baxter*, 2008 WL 6627324.

55. *Baxter*, 2008 WL 6627324.

56. Townsend, *supra* note 54; *See Baxter*, 2008 WL 6627324 (“The patient’s right to die with dignity includes protection of the patient’s physician from liability under the State’s homicide statutes.”).

57. Kevin B. O’Reilly, *Montana Judge Rejects Stay of Physician-Assisted Suicide Ruling*, AMERICAN MEDICAL NEWS, Jan. 29, 2009, available at <http://www.ama-assn.org/amednews/2009/01/26/prsd0129.htm>.

58. *Baxter*, 2008 WL 6627324.

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

60. “Section 45-5-102(1) [of the Montana Codes Annotated], states that a person commits the offense of deliberate homicide if ‘the person purposely or knowingly causes the death of another human being’ Section 45-2-211(1) [] establishes consent as a defense, stating that the ‘consent of the victim to conduct charged to constitute an offense or to the result thereof is a defense.’ Thus, if the State prosecutes a physician for providing aid in dying to a mentally competent, terminally ill adult patient who consented to such aid, the physician may be shielded from liability pursuant to the consent statute. This consent defense, however, is only effective if none of the statutory exceptions to consent applies.” *Id.* at 1215.

physician when no other consent exceptions apply.”⁶¹ The court subsequently found that none of the statutory consent exceptions applied to physician aid in dying and the court specifically stated that the “against public policy” exception to consent has been interpreted as applicable to violent breaches of the public peace—which physician aid in dying does not satisfy.⁶² Essentially, the court, while not granting a Constitutional right to physician-assisted death, has presented the justifiable defense of consent by physicians who engage in assisting their patients in death.

III. ANALYSIS

Unfortunately, people who are physically incapable of ingesting life-ending medications are forced to live their life in a way that no one should be forced to live, especially those who are mentally competent to make such an important decision. Additionally, patients who are suffering from painful and debilitating diseases or conditions should be granted the same rights as those who are expected to die within six months. There is little justification for preventing terminal patients from ending their own suffering, particularly when they are expected to suffer significantly for an undetermined amount of time. Essentially, Death With Dignity statutes (DWDAs), as they currently exist, draw arbitrary lines and fall short of protecting those who need it most by failing to provide particular groups of competent individuals the opportunity to die with dignity.

A. The Impact of the DWDAs on Physically Disabled Patients and Those Who Are Not Terminally Ill

The DWDAs prohibit patients who are physically incapable of self-administering the life-ending prescription from terminating their lives with the assistance of their physician. There are many patients who, though physically incapable of self-administering or ingesting the drugs, are suffering terribly and desire to permanently end their pain. The presently enacted physician-assisted suicide laws preclude an individual who is not expected to die within six months from enlisting her physicians to aid in her death. These laws fail to consider the desires of these two fully competent subsets of patients who should have the right to terminate their lives and end their suffering, should they decide to do so.

61. *Id.* at 1222.

62. *Id.*

1. Physically Incapable Patients Should Be Allowed to Die with Dignity

There are many patients who are physically disabled but who have the mental capacity to decide whether they want to end their lives under the physician-assisted suicide laws. To be able to commit suicide under the ODWDA and the WDWDA with the assistance of a physician, however, the patient must self-administer the life-ending drugs. The physician is unable to assist in this feat beyond providing the patient with the drugs. Consequently, this eliminates the option of physician-assisted suicide for any person who is suffering from a physical disability which renders them unable to self-administer the drugs, even though they are terminally ill and mentally competent and satisfy the other statutory requirements. Essentially, the provisions of the DWDAs discriminate against those who are physically disabled and unable to self-administer the prescription to end their own life. Moreover, they force someone who is unable to ingest the drugs on their own to live out their life while suffering from severe pain. Meanwhile, someone who is suffering from the same disease and pain, but who is capable of ingesting the drugs, may end her suffering.

The already deeply divisive topic of physician-assisted suicide is further complicated by the history of polarization in the community of people with disabilities.⁶³ The disability rights community has historically taken a strong stand against the legalization of physician-assisted suicide for people with disabilities. This stance has been based on the recognition of the marginalized status of people with disabilities as a vulnerable population in American society due to well-documented historical and continuing stigmatization and discrimination.⁶⁴ It has been argued that legislation permitting death with dignity or physician-assisted suicide would deny fair and equitable life choices to people with disabilities, and so would lead toward a slippery slope resulting in unwanted and unnecessary deaths within this population.⁶⁵

In a poll of 1011 adults, findings for the subset of 171 people with disabilities revealed that more than two-thirds (sixty-eight percent) would favor a law such as Oregon's, with twenty-nine percent opposing and three percent undecided.⁶⁶ However, presently enacted laws which prohibit individuals who are physically incapable of ending their own lives from committing physician-assisted suicide effectively prevent them from fulfilling

63. Pamela Fadem et al., *Attitudes of People with Disabilities Toward Physician-Assisted Suicide Legislation: Broadening the Dialogue*, 28 J. HEALTH POL. POL'Y & L. 977, 978 (2003).

64. *Id.*

65. *Id.*

66. *Id.*

their own life-ending wishes. People who are in the process of dying, and suffering intolerably according to their own assessment, should not be required by the government to live and suffer against their own desires.⁶⁷ “In particular, terminally ill people who are not physically capable of ending their own lives effectively should have the assistance of their physicians, if willing.”⁶⁸ It has been argued that the requirement that the life-ending medication be self-administered effectively denies choice to individuals whose disability prevents them from using their hands or in other ways complying with this aspect of the legislation.⁶⁹

Opponents of permitting physically disabled persons from committing suicide with the assistance of their physicians argue that people with disabilities should not have a right to physician-assisted suicide if they have not received adequate rehabilitation and other services necessary to become independent.⁷⁰ However, a physically disabled person’s right to refuse rehabilitation services does not justify the continual denial of a right to end his/her life with assistance.⁷¹ “At some point, all legally competent persons with disabilities have had adequate opportunity to assess the long-term prospects for their quality of life, and we must respect those determinations and the choices they make.”⁷² Furthermore, the fact that the patient’s self-perceived quality of life is likely to be affected by the way she has been treated by society does not justify denying her the right to cope with that social reality by ending her life.⁷³

As stated in *Baxter v. State*, “[g]iven a competent terminal patient’s right to determine the time to end his life, in consultation with his physician, the method of effecting the patient’s death with dignity [requires] the assistance of his medical professional.”⁷⁴ Furthermore, the physician-patient relationship enables the terminal patient to consult with her doctor as to the progression of the disease and expected suffering and discomfort and enables the doctor to prescribe the most appropriate drug for life termination, leaving the ultimate decision and timing up to the patient.⁷⁵ If not for this physician-patient relationship, a patient would increasingly become physically unable to

67. Andrew I. Batavia, *The Relevance of Data on Physicians and Disability on the Right to Assisted Suicide: Can Empirical Studies Resolve the Issue?*, 6 PSYCHOL. PUB. POL’Y & L. 546, 548 (2000).

68. *Id.* at 54849.

69. Fadem, *supra* note 63, at 988.

70. Batavia, *supra* note 67, at 551–52.

71. *Id.* at 552.

72. *Id.*

73. *Id.*

74. *Baxter v. State of Montana*, No. ADV-2007-787, 2008 WL 6627324, (Mont. 1st Dist. Dec. 5, 2008).

75. *Id.*

terminate her life, consequently defeating her constitutional right to die with dignity.⁷⁶ If a patient were to have no assistance from her doctor, she may be forced to kill herself sooner rather than later because of the anticipated increased disability with the progress of her disease.⁷⁷ Additionally, “the manner of the patient’s death would more likely occur in a manner that violates her dignity and peace of mind, such as by a gunshot or by an otherwise unpleasant method, causing undue suffering to the patient and her family.”⁷⁸

Denying physically disabled, yet mentally competent, patients the option to die with dignity under the DWDAs is unacceptable and results in unnecessary and prolonged suffering and pain. People with physical disabilities who are suffering terribly should also have a right to physician-assisted suicide under certain limited circumstances.⁷⁹ The alternative is that these individuals, who are often in as much pain as terminally ill patients and otherwise qualify under the statutes, will attempt to take their own lives, sometimes with disastrous results.⁸⁰ However, the legalization of physician-assisted suicide for physically disabled individuals requires extremely stringent safeguards.

The major concern with permitting physician-assisted suicide for individuals who are mentally competent, yet have been rendered physically incapable of self-administering life-ending drugs, is that these patients will be unduly pressured into ending their lives and, as a consequence, these drugs will be administered by a non-physician. This is a legitimate concern, however, because the presently enacted statutes prevent those who are otherwise capable of making decisions for themselves from dying with dignity.

A statutory expansion to permit these patients to commit physician-assisted suicide would have to be carefully created to ensure that all the necessary safeguards are in place. One suggestion is to provide an alternative method for performing the suicide. Rather than using a pill which requires coordination, physical capacity, strength to move extremities, and the ability to swallow, an injectable poison may be a better solution. While the challenge of injecting the syringe exists, the legislature could consider an alternative which permits a physically incapable person to simply push a button, similar to the contraption used by Dr. Kevorkian. Dr. Kevorkian set up a machine which permitted the patient to pull a string, push a button, or flip a switch.

76. *Id.*

77. *Id.*

78. *Id.*

79. Batavia, *supra* note 67, at 549.

80. *Id.*

While this also requires some physical coordination, it is much less than what is required to lift one's hand up to his or her mouth and to swallow the pill. Furthermore, there is always the option of permitting the physician to actually administer the drugs. Of course, this would negate the term "suicide;" however, it would provide an avenue for physically incapable individuals to die with dignity. Stringent safeguards should be in place before such a dramatic option should be available; however, it is something for a state to consider in attempting to provide competent individuals with a dignified death.

2. Non-Terminally Ill Patients Should Be Permitted to Die With Dignity

The ODWDA and the WDWDA both require that the patient be suffering from an incurable and irreversible disease which will produce death within six months. However, this extremely stringent standard precludes individuals who are expected to endure years and years of pain and anguish from dying with dignity. Particularly, the exclusive nature of the statutory language restricts not only individuals who are physically incapable of ingesting the medication, but also those who are not expected to die within six months. Consequently, the statutes forbid patients suffering from endless physical and mental pain from terminating their lives with the assistance of their physician. While this standard is objective, a more subjective standard is appropriate because quality of life concerns and the desire to end pain and suffering are so completely personal and individualized. It is "not possible to construct an objective definition that [is] not overly restrictive as to the patients who would meet it."⁸¹ Some critics argue that this is not a situation for a subjective determination because of the severity of any repercussions for a blurry line and that therefore a distinct, clear line should be drawn to protect everyone. However, this distinct, clear line would unfairly prevent certain individuals, including those who are not expected to die within six months, from dying with dignity.

Advocates and opponents of physician-assisted suicide have been battling over this alleged "safeguard." Notably, in the Netherlands, physician-assisted death is available to individuals who have irremediable and severe suffering, whether or not they are terminally ill.⁸² "The Harvard Model Law would allow physician-assisted death for people who have an intractable and unbearable

81. Charles Baron et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 HARV. J. ON LEGIS. 1, 11 (1996).

82. Martin Gunderson & David J. Mayo, *Restricting Physician-Assisted Death to the Terminally Ill*, HASTINGS CENTER. REP., Nov.-Dec. 2000, at 18.

illness as well as for people who are terminally ill.”⁸³ “Compassion for suffering and respect for patient autonomy serve as the basis for the strongest arguments in favor of legalizing physician-assisted suicide.”⁸⁴

a. Compassion for Patients

There are many arguments advanced by individuals who oppose the requirement that someone participating in physician-assisted death be terminally ill. One of the strongest arguments is for compassion, which suggests that it is important to enhance others’ well-being and help minimize pointless suffering.⁸⁵ As a result, physicians’ duties are not limited to curing and treating, but include alleviating the suffering of patients beyond the reach of effective treatment.⁸⁶ Sadly, terminal illness often involves intolerable suffering, including mental anguish that is beyond the scope of even optimal palliative care.⁸⁷ There is reliable evidence that people who have sought physician-assisted suicide have been motivated by mental deterioration more than by physical pain.⁸⁸ Terminally ill patients often fear the disintegration not only of their bodies but of their minds and their overall happiness during the remainder of their life.⁸⁹ Much more can, and should, be done to attend to the physical and mental conditions and suffering of the terminally ill.⁹⁰ Significant mental anguish associated with terminal illness goes beyond the typical “treatable depression.”⁹¹

Critics of the terminal illness requirement point out that similar considerations apply equally to persons who are likely to live with and suffer from debilitating diseases for years to come.⁹² If it is permissible, and

83. *Id.*; see Baron et al., *supra* note 81, at 25. (“The principal purpose of this Act is to enable an individual who requests it to receive assistance from a physician in obtaining the medical means for that individual to end his or her life when he or she suffers from a terminal illness or from a bodily illness that is intractable and unbearable.” The Model Act goes on to define terminal illness as a “bodily disorder that is likely to cause a patient’s death within six months” and defines an intractable and unbearable illness as “a bodily disorder (1) that cannot be cured or successfully palliated, and (2) that causes such severe suffering that a patient prefers death.”)

84. Herbert Hendin, *The Case Against Physician-Assisted Suicide: For the Right to End-of-Life Care*, PSYCHIATRIC TIMES, Feb. 1, 2004, at 1, available at <http://www.psychiatrictimes.com/display/article/10168/54071>.

85. Gunderson & Mayo, *supra* note 82, at 18.

86. *Id.*

87. *Id.*

88. *Id.*

89. *Id.*

90. *Id.*

91. *Id.*

92. *Id.*

compassionate, to help a dying person avoid a final few days or weeks of suffering, it would seem that it is much more compassionate to accommodate a similar request from a patient whose anticipated suffering is measured in years.⁹³ This argument demonstrates that these laws fail to accommodate individuals who are in desperate search of a way to end their pain. A patient facing the terrifying prospect of year after year of pain and inability to control her bodily functions and movements should be granted the same opportunities as individuals facing shorter periods of suffering. It is understandable that one of the legislature's reasons for supporting the six month time-frame for a terminal illness is due to the constant improvements of medical technology and treatments. Permitting a patient to terminate her life, years before the disease would cause her to succumb, would clearly prevent her from being able to enjoy a potential cure or treatment. However, it is only reasonable to assume that a competent patient facing such a difficult and profound decision would have considered these options prior to choosing to terminate her life under the physician-assisted suicide laws.

b. Autonomy for Patients

Another compelling argument in favor of physician-assisted suicide is respect for the patient's autonomy.⁹⁴ Bioethicists are generally committed to the notion that competent individuals have the right to determine their own fates, especially with regard to personal matters of profound individual importance, so long as the rights of others are not violated in the process.⁹⁵ One of the most basic values that supports and guides all health care decision making is respecting a patient's self-determination or autonomy.⁹⁶ Some patients are facing severe suffering and an unbearable and meaningless existence, as well as the reality that no life-sustaining treatment is available to be forgone or that forgoing such treatment will result in a prolonged, unbearable, and inhumane dying process.⁹⁷ Even when one receives optimal care intolerable distress may remain and, consequently, patients may rationally conclude that hastening death is the only appropriate goal.⁹⁸ For these patients, a more effective avenue of hastening death is necessary, one which respects the patients' self-determination.⁹⁹ As illness begins to seriously compromise

93. *Id.*

94. *Id.*

95. *Id.*

96. Baron et al., *supra* note 81, at 45.

97. *Id.* at 5.

98. *Id.*

99. *Id.*

the quality of a person's life, few issues could be more profound and personal for that individual than determining the point at which his or her life is no longer worth living.¹⁰⁰ If adversity drains a patient's life of meaning and transforms it into a burden, the patient should have the right to determine when the time to die has come.¹⁰¹

The right to refuse life-sustaining treatment has been established for nearly two decades.¹⁰² This right demonstrates the depth of respect society holds for the value of autonomy in determining one's own "medical" fate, including the determination that "enough is enough."¹⁰³ This right should be extended to include patients who are terminally ill but who are not treatment-dependent.¹⁰⁴

Opponents of the terminal illness requirement argue that the autonomy rationale for physician-assisted suicide extends beyond the requirement of terminal illness and suggest that non-terminal and terminal patients both have the right to refuse life-sustaining treatment.¹⁰⁵ Continuing this argument, the same logic applies equally to terminal and non-terminal patients who have freely decided that their lives are no longer worth living.¹⁰⁶

There are many people in the United States who are endlessly suffering as a result of one disease or another. Individuals who have the intense desire to end their suffering by terminating their lives should not be prohibited from doing so, so long as sufficient safeguards are implemented with regard to their physician-assisted death. Whether the patient's prognosis is three months or three years, if one decides to rid herself of unbearable and untreatable pain, she should be permitted to have the option of suicide with her physician's assistance. Even assuming that non-terminally ill patients would be more vulnerable to the suggestion of hastening death, these patients would still be better served by expanding their legal rights to determine their own ultimate

100. Gunderson & Mayo, *supra* note 82, at 18.

101. *Id.*

102. *Cruzan v. Dir. Mo. Dep't of Health*, 497 U.S. 261 (1990) (Nancy Cruzan was in an automobile accident in which she was thrown from the car and landed face down in a water-filled ditch. Paramedics found her with no vital signs but were able to resuscitate her. After a few weeks of being in a coma, she was diagnosed as being in a persistent vegetative state and a feeding tube was inserted for her long-term care. Without anything in writing, Nancy's parents sought to introduce statements she made to a housemate concerning her wishes to withdraw life-sustaining treatment should she endure such a condition. *Id.*). *See also* Gunderson & Mayo, *supra* note 82, at 19 n.15.

103. Gunderson & Mayo, *supra* note 82, at 19.

104. *Id.*

105. *Id.*

106. *Id.*

fates than by paternalistically protecting them from the risk of making unwise decisions.¹⁰⁷

Under both the Oregon and Washington DWDAs, a person who is chronically ill but who is not expected to die within six months is precluded from terminating her suffering and forced to face an unknown future. However, Oregon provides for the option of advanced directives pertaining to a person's health.¹⁰⁸ Specifically, it gives a person the opportunity to direct that they do not want life support.¹⁰⁹ In essence, these laws allow an individual to plan her death in the event that she suffers from a disease or injury which would, at that time, render her mentally unable to make such a decision. For this same reason, namely respect for a patient's personal autonomy and decision-making ability, a patient should be permitted to have her physician's assistance in achieving a dignified death.

Additionally, it is a valid concern that patients who are suffering from a disease which will eventually cause their death may feel like a "money pit" due to the substantial expenses associated with continuing their life, and could feel pressured to end their life prematurely as a result. That is, they are costing themselves, their future estate, and their family significant amounts of money for treating a disease from which they will never recover. However, it is important to remember that these patients are legally competent and able to make their own decisions, including the decision to terminate their lives, regardless of internal or external pressures. The argument can also be made that a person who completes a valid advance directive under which she directs that she not be put on life-sustaining support was under pressure at the time of the execution of that document. However, we do not question this person's decision when the time comes to abide by their wishes.

Consequently, legislatures should amend the statutory language relating to terminal disease or illness to include diseases or conditions which have been medically confirmed as irreversible and which, within reasonable medical judgment, will produce death. Further, the law should specify that death does not have to be within six months, but rather, that death should be caused either directly or indirectly by the irreversible disease. This expansion of the statute provides an opportunity for individuals who will suffer tremendously and who are likely to succumb to the disease, its complications, or another incurable ailment as a result of the original disease, to terminate their lives with dignity. While the fear of a slippery slope is a rational one, it does not justify the

107. *Id.*

108. OR. REV. STAT. ANN. § 127.531 et seq. (West 2008).

109. *Id.*

refusal of a dignified death to those who deserve it most—patients who are enduring unbearable pain and face a long future of progressive deterioration.

IV. CONCLUSION

In today's society, with the reasonable expectation that the legalization of physician-assisted suicide will spread across more jurisdictions, it is important to determine whether the already enacted statutes provide sufficient guidance for legislatures or whether there is room for improvement. In the all-too-common situations where a patient is physically incapable of ingesting the drugs which will terminate her life, the presently-enacted DWDAs in Oregon and Washington fail to provide an avenue for ending her suffering. Similarly, the laws fail to consider cases involving patients whose prognoses are terminal but who are expected to survive longer than six months and who also have the real and justifiable desire to end their prolonged suffering. As additional states continue to face the reality of deciding whether to legalize physician-assisted suicide, those states should be sure to consider the rights of individuals who are competent to decide that they want to die to end their pain but who do not otherwise fit within the statutory requirements established by Oregon and Washington. These laws are designed to allow people to humanely and safely end their own lives when faced with an untreatable or physically debilitating disease. However, these statutes, as enacted, fail to do that for which they are designed—provide a dignified death.

