# DEATH WITH DIGNITY: TERMINALLY ILL(INOIS)

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## INTRODUCTION

On November 22, 1998, *60 Minutes* viewers watched as Dr. Jack Kevorkian injected Thomas Youk with potassium chloride.[2] Within a few minutes, Youk's heart stopped, ending his life.[3] Youk suffered from amyotrophic lateral sclerosis ("ALS")[4] and had requested Dr. Kevorkian's help in ending his suffering by hastening his death.[5]

Prior to Youk's death, Dr. Kevorkian assisted over one hundred and thirty patients with the same request, ending their suffering by physician-assisted suicide ("PAS").[6] He assisted them by setting up a device that provided the patient with the ability to administer a lethal substance to themselves.[7] Thus, the patient—not Dr. Kevorkian—was committing the final act of ending their own life.[8] The procedure in Youk's case was different. For the first time, Dr. Kevorkian—not the patient—committed the final act, and the entire process was filmed, including the moment of death.[9]

From 1990 to 1996, Dr. Kevorkian was charged with multiple counts of murder for assisting patients in suicide.[10] Every case ended in either an acquittal, mistrial, or dismissal.[11] In Youk's case, he filmed the final act and Youk's moment of death because he wanted to force his own arrest.[12] Dr. Kevorkian hoped it would lead to a trial, where a court would finally decide

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1 J.D. Candidate, Southern Illinois University School of Law, Class of 2022. Thank you to Professor Cynthia Fountaine, my Note advisor, for her support throughout the drafting process of this Note. Also, thank you to members of the Southern Illinois University Law Journal for their incredible help editing this Note.

2 Interview by Mike Wallace with Dr. Jack Kevorkian, M.D., 60 Minutes CBS (Nov. 22, 1998).

3 *Id.*

4 *What is ALS?*, ALS ASS'N, https://www.als.org/understanding-als/what-is-als (last visited Oct. 20, 2021) (ALS is a progressive neurodegenerative disease that affects nerve cells responsible for voluntary muscle movement that currently has no cure).

5 Interview by Mike Wallace with Dr. Jack Kevorkian, M.D., *supra* note 2.

6 *Id.*

7 Allen Pusey, *Nov. 20, 1998: Kevorkian's Last Suicide*, ABAJOURNAL (Nov. 1, 2016, 12:30 AM CDT), https://www.abajournal.com/magazine/article/kevorkian60minutessuicide.

8 Interview by Mike Wallace with Dr. Jack Kevorkian, M.D., *supra* note 2.

9 *Id.*

10 Pusey, *supra* note 7.

11 *Id.*

12 Interview by Mike Wallace with Dr. Jack Kevorkian, M.D., *supra* note 2.

the permissibility of PAS and euthanasia.[13] In 1999, he was convicted of second-degree murder for the death of Youk and sentenced to ten to twenty-five years in prison.[14]

Today, twelve million adults in the United States are living with a serious illness.[15] Advancements in medicine have made it possible to extend life "far past its natural end."[16] Prolonged suffering at the end of life has become more common since individuals now live long enough to experience this extended suffering.[17] Today, prior to death, members of the aging population experience one or more chronic illnesses more frequently than they had in the past.[18] With this increase in prolonged end-of-life suffering, some terminally ill individuals would prefer to hasten death rather than subject themselves to extreme physical and psychological suffering.[19] For example, Craig Ewert, a Chicago native suffering from ALS, traveled to Switzerland for access to PAS since it was unavailable in Illinois.[20]

Currently, patients have some control over their end-of-life medical care decisions.[21] As it stands today, terminally ill individuals have a right to refuse unwanted medical treatment.[22] Additionally, advance directives[23] provide patients the ability to direct how their end-of-life medical care decisions are to be decided in the event they later become incapacitated.[24] However, only a minority of states allow terminally ill patients to legally use

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13 *Id.* See *infra* Part 1 for the distinction between PAS and euthanasia.

14 Pusey, *supra* note 7 (after serving eight years of his sentence, Dr. Kevorkian was released in 2007 on the promise he would no longer assist in suicides).

15 R. Sean Morrison et al., *America's Care of Serious Illness: A State-by-State Report Card on Access to Palliative Care in Our Nation's Hospitals*, J. PALLIAT MED., Oct. 2011, at 1094.

16 Joseph T. Monahan & Elizabeth A. Lawhorn, *Life-Sustaining Treatment and the Law: The Evolution of Informed Consent, Advance Directives and Surrogate Decision Making*, 19 ANNALS HEALTH L. 107, 107 (2010).

17 Tamie Bryant, *Aid-in-Dying Nonprofits*, 57 SAN DIEGO L. REV. 147, 153 (2020) (citing JESSICA NUTIK ZITTER, EXTREME MEASURES: FINDING A BETTER PATH TO THE END OF LIFE 303-04 (2017)).

18 Lynn Hallarman et al., *Blueprint for Success: Translating Innovations from the Field of Palliative Medicine to the Medical-Legal Partnership*, 35 J. LEGAL MED. 179, 181-82 (2014).

19 Thaddeus Mason Pope, *Medical Aid in Dying: Key Variations Among U.S. State Laws*, 14 J. HEALTH & LIFE SCI. L. 25, 30-31 (2020); *see* Janet L. Abrahm, *Patient and Family Requests for Hastened Death*, AM. SOC'Y HEMATOLOGY, Jan. 2008, at 475, 475.

20 *Frontline: The Suicide Tourist* (PBS television broadcast Mar. 2, 2010).

21 Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261 (1990).

22 *Id.* at 278. However, the liberty interest creating the right to refuse treatment must be balanced against any competing state interests. *Id.* at 279; *In re* Quinlan, 355 A.2d 647, 663 (N.J. 1976).

23 Examples of advance directives include a living will, a health care power of attorney, and Practitioner Orders for Life-Sustaining Treatment. *See Types of Advance Directives*, AM. CANCER SOC'Y (May 13, 2019), https://www.cancer.org/treatment/treatments-and-side-effects/planning-managing/advance-directives/types-of-advance-health-care-directives.html.

24 *Advance Directives*, ILL. DEP'T OF PUB. HEALTH, https://www.dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives (last visited Oct. 20, 2021).

PAS.[25] Courts and state legislatures have struggled in balancing the right to decide end-of-life medical care against legitimate state interests (e.g., the preservation of human life), making the legalization of PAS challenging.[26] Furthermore, ethical implications, the risks of mistake, and the potential for abuse make PAS controversial.[27]

Prior to PAS's notoriety, even though most states classified assisting suicide as manslaughter or murder,[28] prosecutorial discretion and judicial leniency allowed physicians to provide PAS without legal punishment.[29] Today, most states, including Illinois, have laws that either implicitly or explicitly prohibit PAS or assisted suicide generally.[30] The Illinois legislature considered two companion PAS bills in 1997, but both were quickly dismissed.[31] That year, ten other states introduced legislation to legalize PAS, but none were successful.[32]

In 1994, Oregon citizens approved a ballot measure legalizing PAS, and in 1997, Oregon officially became the first state to implement regulation permitting PAS, through the Oregon Death With Dignity Act.[33] It would be over a decade later before another state successfully legalized the practice.[34] Today, a total of ten states and the District of Columbia have legalized PAS through legislation or the state judiciary.[35] The majority of this legalization has occurred over the past six years,[36] which indicates an increasing number of states are considering permitting PAS, and more state action is expected

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25 Casey Leins, *States with Aid-in-Dying Laws*, U.S.NEWS (Aug. 1, 2019), https://www.usnews.com/news/best-states/slideshows/these-states-have-aid-in-dying-laws?slide=10. These states are California, Colorado, Hawaii, Maine, Montana New Jersey, New Mexico, Oregon, Vermont, and Washington. *Id.* The District of Columbia also permits PAS. *Id.*

26 Monahan & Lawhorn, *supra* note 16.

27 *See* T. Howard Stone & William J. Winslade, *Physician-Assisted Suicide and Euthanasia in the United States*, 16 J. LEGAL MED. 481, 495-506 (1995).

28 Peter G. Daniels, *An Illinois Physician-Assisted Suicide Act: A Merciful End to a Terminally Ill Criminal Tradition*, 28 LOY. U. CHI. L.J. 763, 766 (1997).

29 *Id.*; Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 502 (2002).

30 Katherine Ann Wingfield & Carl S. Hacker, *Physician-Assisted Suicide: An Assessment and Comparison of Statutory Approaches Among the States*, 32 SETON HALL LEGIS. J. 13, 23-44 (2007).

31 H.B. 691, 90th Gen. Assemb., Reg. Sess. (Ill. 1997); S.B. 948, 90th Gen. Assemb., Reg. Sess. (Ill. 1997). The only documents available are these two bills introduced; there are no supporting documents (committee hearings, revisions, etc.). *90th General Assembly, Summary of HB0691*, ILL. GEN. ASSEMBLY, https://www.ilga.gov/legislation/legisnet90/summary/900HB0691.html (last visited Feb. 24, 2022); *90th General Assembly, Summary of SB0948*, ILL. GEN. ASSEMBLY, https://www.ilga.gov/legislation/legisnet90/summary/900SB0948.html (last visited Feb. 24, 2022). This implies the bills were quickly dropped.

32 Russell Korobkin, *Physician-Assisted Suicide Legislation: Issues and Preliminary Responses*, 12 NOTRE DAME J.L., ETHICS & PUB. POL'Y 449, 450 (1998).

33 Leins, *supra* note 25.

34 *Id.*

35 *Id.* California, Colorado, Hawaii, Maine, New Jersey, New Mexico, Oregon, Vermont, Washington, and the District of Columbia have all legalized PAS through legislation. *Id.* Montana has legalized PAS through a Montana Supreme Court ruling. *Id.*

36 *Id.*

in the near future.[37] In fact, several states are currently considering PAS bills.[38] However, despite the recent increase in PAS legalization, Illinois is not currently considering legalizing PAS and has not done so since rejecting the bills introduced in 1997.[39]

Part I of this note will define and differentiate euthanasia and PAS. Understanding how the two practices differ will help avoid confusion and clarify why PAS is legal in some states while general euthanasia is illegal in every state. Part II will examine landmark court decisions clarifying the legality of PAS on the federal and state levels. Part III will discuss current end-of-life medical care decision-making options in Illinois. Part IV will offer a few arguments for legalization in Illinois. Part V will explore two paths for legalization—the Illinois court system and the Illinois legislature—and which path is most likely to lead to legalization. Part VI will conclude this note.

## I. EUTHANASIA VERSUS PHYSICIAN-ASSISTED SUICIDE

Advocates for PAS legalization have adopted replacement terminology to distinguish euthanasia from PAS.[40] *Medical aid in dying* ("MAID") is one of the preferred alternatives.[41] To refrain from assigning any positive or negative connotation, I will use "PAS/MAID" for the remainder of this note.

The distinction between *physician-assisted suicide* ("PAS/MAID") and *euthanasia* may appear insignificant or lead to confusion and misunderstanding. Without first understanding the difference between the two concepts, it can be difficult to appreciate the legality of PAS/MAID and the illegality of euthanasia.

### A. Euthanasia

Euthanasia has been defined in a multitude of ways, but every definition shares the same notion. In its most basic terms, euthanasia is the hastening of

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37 *See Toward the Tipping Point: Death with Dignity in 2018*, DEATH WITH DIGNITY (Jan. 17, 2018), https://www.deathwithdignity.org/news/2018/01/death-with-dignity-in-2018/.

38 *See Bills We Are Tracking*, DEATH WITH DIGNITY (Jan. 17, 2018), https://deathwithdignity.org/resources/current-legislative-session/ (denoting different states with legislation awaiting vote).

39 *Illinois*, DEATH WITH DIGNITY, https://deathwithdignity.org/states/illinois/ (last visited Oct. 20, 2021); H.B. 691, 90th Gen. Assemb., Reg. Sess. (Ill. 1997); S.B. 948, 90th Gen. Assemb., Reg. Sess. (Ill. 1997).

40 *See Medical Aid in Dying is Not Assisted Suicide, Suicide, or Euthanasia*, COMPASSION & CHOICES, https://compassionandchoices.org/about-us/medical-aid-dying-not-assisted-suicide/ (last visited Oct. 20, 2021); *Terminology of Assisted Dying*, DEATH WITH DIGNITY, https://www.deathwithdignity.org/terminology/ (last visited Oct. 20, 2021); Lydia S. Dugdale et al., *Pros and Cons of Physician Aid in Dying*, 92 YALE J. BIOLOGY & MED. 747, 747 (2019).

41 *Medical Aid in Dying is not Assisted Suicide, or Euthanasia*, *supra* note 40; *Terminology of Assisted Dying*, *supra* note 40.

a patient's death to prevent further suffering.[42] A more precise definition depends on the circumstances.[43] These circumstances can be dissected into voluntary, involuntary, and non-voluntary euthanasia, which can further be categorized as passive or active.[44]

*1. Voluntary, Involuntary, & Non-voluntary*

Voluntary euthanasia is typically defined as euthanasia with a competent patient's expressed consent.[45] The patient makes it known, either verbally or in writing (e.g., a living will),[46] that it is the patient's wish to die.[47] Involuntary euthanasia occurs in the absence of the patient's consent.[48] In other words, the patient is competent to make the decision, but the patient's life is ended by an act of euthanasia without the patient being consulted.[49] Non-voluntary euthanasia occurs in the absence of competency.[50] The patient is most likely in a comatose state, lacking mental capacity, or unable to express their wishes.[51]

*2. Passive & Active*

Voluntary, involuntary, and non-voluntary euthanasia can each be active or passive.[52] Active euthanasia occurs when a physician deliberately performs an act to ensure the end of an incurably or terminally ill patient's life.[53] The physician's act is most commonly the administration of a lethal drug.[54] In contrast, passive euthanasia refers to a physician deliberately

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42 *See* DVK Chao et al., *Euthanasia Revisited*, FAM. *PRAC.*, Apr. 2002, at 128; *see also* CODE OF MED. ETHICS ch. 5.8 (AM. MED. ASS'N 2019), https://www.ama-assn.org/system/files/2019-06/code-of-medical-ethics-chapter-5.pdf (discussing the consequences of permitting physicians to perform euthanasia).

43 Chao et al., *supra* note 42.

44 *Id.*; Peter B. Terry, *Euthanasia and Assisted Suicide*, 70 MAYO CLINIC PROC. 189, 189 (1995).

45 Chao et al., *supra* note 42.

46 A living will is a document executed by an individual directing desired medical care in the event the individual is incapacitated and can no longer make the decisions. *See* 755 ILL. COMP. STAT. 35/1 (2021). It permits the declarant to provide instructions for his or her physician to withhold or withdraw death delaying procedures in the event of a terminal condition. *See id.*

47 Robert Ho & Natalie Chantagul, *Support for Voluntary and Involuntary Euthanasia: What Roles do Conditions of Suffering and the Identity of the Terminally Ill Play?*, 70 J. DEATH & DYING 251, 253 (2015).

48 Chao et al., *supra* note 42.

49 *Id.*

50 *Id.*

51 *Id.*

52 *Id.*

53 Kalaivani Annadurai et al., *Euthanasia: Right to Die with Dignity*, 3 J. FAM. MED. & PRIM. CARE 477, 477 (2014).

54 *Id.*

omitting to act, resulting in the patient's death.[55] This omission is in the form of withholding treatment or withdrawing administration of further treatment.[56] So, while active euthanasia can be described as an act of "killing," passive euthanasia is merely "letting a patient die."[57] Although some argue passive and active euthanasia are essentially indistinguishable because they both result in the patient's death,[58] voluntary passive euthanasia is legally accepted in most countries, including the United States.[59] In fact, under the Fourteenth Amendment, a competent adult in the United States has a constitutionally protected liberty interest in refusing medical treatment.[60] Whereas, a physician who performs active euthanasia runs the risk of being criminally charged with homicide[61] because the physician purposely and directly ended the patient's life.[62]

B. Physician-Assisted Suicide and Medical Aid In Dying

PAS/MAID refers to a physician facilitating a patient's death by prescribing a lethal dose of medication, enabling a terminally ill patient to voluntarily perform the life-ending act by self-administration.[63] PAS/MAID is almost always defined as involving a competent patient's voluntary choice.[64] An increasing number of states continue to legalize this practice, but it remains illegal in the majority of jurisdictions through laws that either explicitly or implicitly proscribe PAS/MAID, or assisted suicide in general.[65] Despite the American Medical Association's ("AMA") determination that both euthanasia and PAS/MAID are "fundamentally incompatible with the physician's role as a healer"[66] and its illegality in most states, surveys have

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55 Chao et al., *supra* note 42.

56 *Id*.

57 Ho & Chantagul, *supra* note 47.

58 *See* James Rachels, *Active and Passive Euthanasia*, 292 NEW ENG. J. MED. 78 (1975) (describing the moral difference between "killing" someone and "letting die").

59 Annadurai et al., *supra* note 53, at 478. Voluntary passive euthanasia is commonly implemented through advance directives such as living wills and "do not resuscitate" orders (DNRs) in the United States. *Id*.

60 Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261 (1990); *In re* Quinlan, 355 A.2d 647, 663 (N.J. 1976).

61 Stone & Winslade, *supra* note 27, at 482-84.

62 *Id*. at 484.

63 CODE OF MED. ETHICS ch. 5.8 (AM. MED. ASS'N 2019), https://www.ama-assn.org/system/files/2019-06/code-of-medical-ethics-chapter-5.pdf; Ewen C. Goligher et al., *Physician-Assisted Suicide and Euthanasia in the Intensive Care Unit: A Dialogue on Core Ethical Issues*, 45 CRITICAL CARE MED. 149, 150 (2017); *see* Dugdale et al., *supra* note 40 (recognizing the various terms for "physician-assisted suicide").

64 *E.g.*, David Orentlicher et al., *Clinical Criteria for Physician Aid in Dying*, 19 J. PALLIATIVE MED. 259, 259 (2016).

65 Wingfield & Hacker, *supra* note 30.

66 CODE OF MED. ETHICS ch. 5.8 (AM. MED. ASS'N 2019), https://www.ama-assn.org/system/files/2019-06/code-of-medical-ethics-chapter-5.pdf.

shown that physicians continue to honor patients' PAS/MAID requests—even in states where it is prohibited.[67]

From these definitions, you can see the similarities and differences between PAS/MAID and all forms of euthanasia. Both involve ending a patient's life to keep that patient from further suffering.[68] However, PAS/MAID requires a competent patient to commit the final act of administering the means to facilitate that patient's death.[69] Whereas, euthanasia requires the physician to either omit from performing, or withhold, treatment or perform the final act.[70]

It is evident from these definitions that PAS/MAID is not synonymous with euthanasia[71] and advocates for the legalization of PAS/MAID want the distinction to be clear.[72] Advocates have even adopted replacement terminology in an attempt to further distinguish the practice of euthanasia from PAS/MAID.[73] "Medical-aid-in-dying," "assisted dying," and "death with dignity" are a few examples of preferred alternatives.[74]

## II. SIGNIFICANT COURT DECISIONS

In addition to developing an understanding of how euthanasia and PAS/MAID are defined and what makes them distinct, this Part will consider how PAS/MAID has been treated by courts in the United States. The following court decisions establish that the right to PAS/MAID is not

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67 Diane E. Meier et al., *A National Survey of Physician-Assisted Suicide and Euthanasia in the United States*, 338 NEW ENG. J. MED. 1193, 1193 (1998) [hereinafter Meier et al., *A National Survey of Physician-Assisted Suicide and Euthenasia in the United States*]; Ezekiel J. Emanuel et al., *The Practice of Euthanasia and Physician-Assisted Suicide in the United States: Adherence to Proposed Safeguards and Effects on Physicians*, 280 J. AM. MED. ASS'N 507, 508 (1998); *see* Diane E. Meier et al., *Characteristics of Patients Requesting and Receiving Physician-Assisted Death*, 163 *ARCHIVES INTERNAL MED.* 1537, 1538 (2003) [hereinafter Meier et al., *Characteristics of Patients Requesting and Receiving Physician-Assisted Death*]; *see also* Ezekiel J. Emanuel et al., *Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public*, 347 LANCET 1805, 1809 (1996) [hereinafter Emanuel et al., *Euthanasia and Physician-Assisted Suicide*] (noting that a "[s]ubstantial numbers of oncologists and patients in the USA have considered, prepared for, or carried out euthanasia or physician-assisted suicide, even though these interventions were illegal. . . . Almost one in seven oncologists said they had participated in these interventions"). *Id.*

68 Chao et al., *supra* note 42.

69 Orentlicher et al., *supra* note 64.

70 Annadurai et al., *supra* note 53.

71 *Id.* at 478. (citing Chao et al., *supra* note 42).

72 *See Medical Aid in Dying is Not Assisted Suicide, Suicide, or Euthanasia*, *supra* note 40; *see also Terminology of Assisted Dying*, *supra* note 40 (explaining the differences between assisted dying terminology).

73 *Medical Aid in Dying is Not Assisted Suicide, Suicide, or Euthanasia*, *supra* note 40; *Terminology of Assisted Dying*, *supra* note 40; Dugdale et al., *supra* note 40.

74 *Medical Aid in Dying is Not Assisted Suicide, Suicide, or Euthanasia*, *supra* note 40; *Terminology of Assisted Dying*, *supra* note 40.

currently recognized as constitutionally protected[75] and that state law determines the issue.[76]

In 1997, two Supreme Court decisions were rendered that had a significant impact on the development of PAS/MAID in the United States.[77] These cases, *Washington v. Glucksberg* and *Vacco v. Quill*, established there is no federal constitutionally protected right to PAS/MAID under the Due Process and Equal Protection Clauses of the Fourteenth Amendment.[78]

### A. *Washington v. Glucksberg*

In *Glucksberg*, three terminally ill patients, four Washington physicians, and Compassion in Dying—a nonprofit organization—filed suit against the state of Washington seeking a declaration that Washington's assisted-suicide ban was unconstitutional.[79] The challenged law was Washington's statute prohibiting a person from knowingly causing or aiding another person to attempt suicide.[80] The physicians stated that if not for this ban, they would assist their terminally ill patients in ending their lives.[81]

In seeking the declaration, the plaintiffs asserted that the ban violated a liberty interest protected by the Fourteenth Amendment's Due Process Clause.[82] They claimed the liberty interest "extends to a personal choice by a mentally competent, terminally ill adult to commit physician-assisted suicide."[83] The Court defined the question at issue as whether the "liberty" protected by the Due Process Clause includes a right to commit suicide, which itself includes a right to assisted suicide.[84] In the opinion for the Court, Chief Justice Rehnquist pointed to the Court's reluctance to establish fundamental rights.[85] By declaring a protected right, the Court would be placing "the matter outside the arena of public debate and legislative action."[86]

To determine whether a fundamental right to assisted suicide exists, the asserted right must be "deeply rooted in this Nation's history and tradition"

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75 Washington v. Glucksberg, 521 U.S. 702, 735 (1997); Vacco v. Quill, 521 U.S. 793, 797-809 (1997).

76 *See* Gonzales v. Oregon, 546 U.S. 243 (2006) (discussing the state's police power to legislate the practice of medicine).

77 *Glucksberg*, 521 U.S. 702; *Vacco*, 521 U.S. 793.

78 *Glucksberg*, 521 U.S. at 707; *Vacco*, 521 U.S. at 797-809.

79 *Glucksberg*, 521 U.S. at 707-8.

80 WASH. REV. CODE. § 9A.36.060(1) (1994); *Glucksberg*, 521 U.S. at 707.

81 *Glucksberg*, 521 U.S. at 707.

82 *Id.* at 708.

83 *Id.*

84 *Id.* at 723.

85 *Id.* at 720.

86 *Id.*

and "implicit in the concept of ordered liberty."[87] The Court referenced an extensive history of common law tradition prohibiting assisted suicide and considered current state sentiments on the issue.[88] At the time, Oregon was the only state that had enacted legislation permitting PAS/MAID[89] while most states continued to enact laws that explicitly *prohibited* assisted suicide and voters consistently rejected PAS/MAID ballot initiatives.[90] Finding PAS/MAID as currently and historically illegitimate, the Court was reluctant to declare a fundamental right to assisted suicide.[91] They would be required to "reverse centuries of legal doctrine and practice, and strike down the considered policy choice of almost every State."[92]

Additionally, the Court distinguished the right to assisted suicide from the right to withdraw life-sustaining treatment acknowledged in *Cruzan v. Missouri, Department of Health*[93] and a woman's right to abortion before viability established in *Roe v. Wade* and *Planned Parenthood of Southeastern Pennsylvania v. Casey*.[94] The right to withdraw life-sustaining treatment was distinguished from the right to assisted suicide because the right to withdraw treatment possessed the "deeply rooted" requirement that right to assisted suicide lacked; this was premised on the common law rule of informed consent, that forced medication was battery, and the legal history of protecting the ability to refuse medical treatment.[95] In regard to *Casey*,[96] although the right to assisted suicide is similar to the right to abortion in that both are intimate, personal choices, the Court concluded that even though many protected rights and liberties rest on personal autonomy, this "does not warrant the sweeping conclusion that any and all important, intimate, and personal decisions are so protected."[97]

Having declined to recognize the right as fundamental, the *Glucksberg* Court reviewed the constitutionality of Washington's law under rational basis review.[98] Thus, Washington's law only needed to be rationally related to legitimate government interests.[99] Citing *Cruzan*, the Court stated Washington had an "unqualified interest in the preservation of human

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87 *Glucksberg*, 521 U.S. at 720-21.
88 *Id.* at 710-19.
89 *Id.* at 717.
90 *Id.* at 716-19.
91 *Id.* at 723.
92 *Id.* at 703.
93 Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 278 (1990).
94 *Glucksberg*, 521 U.S. at 722-27; Roe v. Wade, 410 U.S. 113, 153 (1973); Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 846 (1992).
95 *Glucksberg*, 521 U.S. at 724-27.
96 *Planned Parenthood of Se. Pa.*, 505 U.S. at 846.
97 *Glucksberg*, 521 U.S. at 727.
98 *Id.* at 728.
99 *Id.*

life,"[100] and that the ban "reflects and advances its commitment to this interest."[101] Moreover, Washington had several other legitimate interests: suicide prevention; protecting the integrity and ethics of the medical profession; protecting vulnerable groups from abuse, neglect, and mistakes; and avoiding a path that may lead to euthanasia.[102] The Court considered these interests "unquestionably important and legitimate" and that the ban on assisted suicide was "reasonably related to their promotion and protection."[103] Consequently, the majority declined to recognize the right to assisted suicide as a fundamental right protected by the Due Process Clause of the Fourteenth Amendment and held Washington's statute constitutional.[104]

Although Washington's ban was declared constitutional, the Court did not imply that states were incapable of legalizing PAS/MAID. Thus, by declining to recognize a fundamental right, the PAS/MAID issue remained determined by the state legislature and judiciary.

### B. *Vacco v. Quill*

On the same day the Supreme Court decided *Glucksberg*, they also decided *Glucksberg*'s companion case, *Vacco v. Quill*.[105] Again, the Court upheld the constitutionality of a state law criminalizing PAS/MAID.[106] Physicians and terminally ill patients claimed New York's assisted-suicide ban violated the Fourteenth Amendment's Equal Protection Clause.[107]

The challengers asserted that New York permitting a competent patient to refuse medical treatment is "essentially the same thing" as PAS/MAID and, therefore, New York's assisted suicide ban treated similarly situated patients unequally.[108] The Court disagreed.[109] According to the Court, New York's law permitting the refusal of medical treatment and its assisted suicide ban did not differentiate among patients because every competent adult has the ability to refuse unwanted medical treatment, while no person is allowed to assist a suicide.[110] Thus, because the laws treated everyone equally, New York's ban would only violate the Equal Protection Clause if the distinction

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100 *Id*.
101 *Id*.
102 *Id*. at 729-33.
103 *Glucksberg*, 521 U.S. at 735.
104 *Id*. at 702.
105 *See* Vacco v. Quill, 521 U.S. 793 (1997).
106 *Id*. at 809.
107 *Id*. at 797-98.
108 *Id*. at 798.
109 *Id*. at 800.
110 *Id*.

between the two laws was not rationally related to a legitimate government interest.[111]

The Court stated "[t]he distinction comports with fundamental legal principles of causation and intent."[112] When a patient refuses medical treatment, her death is caused by the underlying fatal condition, while a patient utilizing PAS/MAID is killed by the lethal substance ingested.[113] Moreover, a physician's intent when withdrawing or withholding medical treatment is simply to honor a patient's wish and refrain from administering insufficient treatments that no longer benefit the patient.[114] Conversely, the intent involved with PAS/MAID is to facilitate the patient's death.[115] Therefore, it was rational for states to permit a physician's withdrawal or withholding of medical treatment for a consenting patient but prohibit assistance in suicide.[116]

After clarifying the distinction, the Court reiterated the same legitimate state interests recognized in *Glucksberg*.[117] The Court found that these interests "easily satisfy the constitutional requirement that a legislative classification bear a rational relation to some legitimate end."[118] Accordingly, New York's assisted suicide ban was found constitutional and did not violate the Fourteenth Amendment's Equal Protection Clause.[119]

### C. *Gonzales v. Oregon*

In 1994, Oregon voters passed a ballot initiative legalizing PAS/MAID, the Oregon Death with Dignity Act ("ODWDA").[120] The ODWDA allowed physicians to prescribe a lethal dose of medication to terminally ill patients in Oregon wishing to end their lives.[121] Shortly after the ODWDA was passed, it was met with a legal injunction that delayed its implementation.[122] In 1997, the Ninth Circuit Court of Appeals lifted the injunction, and a month later, Oregon voters rejected a ballot measure asking to repeal the ODWDA.[123] For the first time in the United States, terminally ill patients

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111 *Vacco*, 521 U.S. at 799.
112 *Id.* at 801.
113 *Id.*
114 *Id.*
115 *Id.* at 802.
116 *Id.* at 808.
117 *Vacco*, 521 U.S. at 808-09.
118 *Id.* at 809.
119 *Id.* at 802 (explaining that a patient who commits suicide with a physician's assistance has the specific intent to die compared to a patient who refuses medical treatment).
120 ARTHUR EUGENE CHIN ET AL., OREGON'S DEATH WITH DIGNITY ACT: THE FIRST YEAR'S EXPERIENCE 1 (1999).
121 *Id.*
122 *Id.*
123 *Id.*

could request PAS/MAID and physicians could honor that request without fear of punishment—albeit in one state.[124]

The ODWDA was threatened again in 2001.[125] U.S. Attorney General John Ashcroft issued an Interpretive Rule declaring that physicians prescribing controlled substances pursuant to the ODWDA were violating the Controlled Substances Act ("CSA").[126] He stated that under the CSA, PAS/MAID was not a "legitimate medical purpose"[127] for prescribing controlled substances.[128] In addition, a physician prescribing controlled substances under the ODWDA was acting "inconsistent with the public interest" and would lose their ability to prescribe controlled substances.[129] By issuing this rule, the Attorney General essentially invalidated the ODWDA.[130]

The day after the rule was issued, the State of Oregon filed suit seeking declaratory and injunctive relief to prevent the rule's enforcement.[131] The U.S. District Court permanently enjoined the rule[132] and the U.S. Court of Appeals affirmed, finding the rule interfered with Oregon's ability to "regulate medical care within its borders and therefore 'alter[ed] the "usual constitutional balance between the States,"'"[133] "lack[ed] clear congressional authority,"[134] and "violate[d] the plain language of the CSA."[135] Attorney General Ashcroft appealed to the U.S. Supreme Court and was granted certiorari.[136]

In *Gonzales v. Oregon*,[137] the Supreme Court ruled that the CSA does not extend to substances physicians prescribe pursuant to the ODWDA.[138] Justice Kennedy stated that, under the CSA, Congress only authorized the Attorney General to make rules regarding the "registration" and "control" of the dispensing of controlled substances, and rules "necessary and appropriate

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124 Death with Dignity Act, OR. REV. STAT. ANN. § 127 (2021) (enacted Oct. 27, 1997).

125 *See* Dispensing of Controlled Substances to Assist Suicide, 66 Fed. Reg. 56,608 (Nov. 9, 2001) (to be codified at 21 C.F.R. 1306).

126 Dispensing of Controlled Substances to Assist Suicide, 66 Fed. Reg. 56,608.

127 21 C.F.R. § 1306.04 (2001).

128 Dispensing of Controlled Substances to Assist Suicide, 66 Fed. Reg. 56,608.

129 *Id*.

130 *Id*.

131 Oregon v. Ashcroft, 368 F.3d 1118 (9th Cir. 2003).

132 *Id*.

133 *Id*. at 1124 (quoting Gregory v. Ashcroft, 501 U.S. 452, 461 (1991)).

134 *Ashcroft*, 368 F.3d at 1125.

135 *Id*.

136 Gonzales v. Oregon, 546 U.S. 243, 250 (2006).

137 Attorney General Ashcroft retired the same day he appealed the Court of Appeals decision. Galit Avitan & Nick Wimbush, *Gonzales v. Oregon (formerly Oregon v. Ashcroft)*, *Legal Information Institute*, CORNELL L. SCH., https://www.law.cornell.edu/supct/cert/04-623 (last visited Feb. 24, 2022). He was replaced by Alberto Gonzales. *Id.* Thus, the case became *Gonzales v. Oregon*. *Id*.

138 *See Gonzales*, 546 U.S. 243.

for the efficient execution" of his CSA duties.[139] It did not give the Attorney General the power to criminalize medical practices or declare them illegitimate.[140]

In addition, the Court pointed out that the purpose of the CSA is to combat recreational drug abuse, and that Congress only "regulates medical practice insofar as it bars doctors from using their prescription-writing powers as a means to engage in illicit drug dealing and trafficking as conventionally understood."[141] The CSA was not intended to regulate the practice of medicine in general, which is an area traditionally regulated at the state level.[142]

These Supreme Court decisions in *Glucksberg*, *Vacco*, and *Gonzales* paved the way for state legalization and prohibition of PAS/MAID. These cases established that PAS/MAID is not a constitutionally protected right, clarified the distinction between the right to refuse medical treatment and the right to PAS/MAID,[143] and that, currently, the regulation of PAS/MAID is subject to state discretion.[144]

### D. *Baxter v. Montana*

Since *Gonzales*, eight states and the District of Columbia have legalized PAS/MAID by enacting Death with Dignity Acts.[145] In Montana, PAS/MAID is legal through the 2009 Montana Supreme Court decision in *Baxter* v. *Montana*.[146] The *Baxter* court ruled that physicians were not prohibited from honoring terminally ill patients' PAS/MAID requests.[147] The Court declined to decide if "a right to die with dignity" existed under the Montana Constitution, and instead resolved the case on statutory grounds.[148] They considered whether the Montana consent statute shields physicians practicing PAS/MAID from criminal liability, and if so, whether the patient's consent is ineffective under the "against public policy" exception in the statute.[149]

The Montana consent statute makes consent ineffective if "it is against public policy to permit the conduct or the resulting harm, even though

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139 *Id*. at 259.
140 *Id*. at 262.
141 *Id*. at 270.
142 *Id*.
143 *See* Washington v. Glucksberg, 521 U.S. 702 (1997); Vacco v. Quill, 521 U.S. 793 (1997).
144 *See Gonzales*, 546 U.S. at 270.
145 Leins, *supra* note 25. The eight states are California, Colorado, Hawaii, Maine, New Jersey, New Mexico, Vermont, and Washington. *Id*.
146 *See* Baxter v. State, 2009 MT 449, 354 Mont. 234, 224 P.3d 1211; Leins, *supra* note 25.
147 *See Baxter*, 2009 MT 449.
148 *Id*. ¶ 10.
149 *Id*. ¶¶ 11-14.

consented to."[150] Based on Montana precedent and a survey of other decisions from other states' courts, the Montana court determined the "against public policy" exception to the consent defense is applicable "to conduct that disrupts public peace and physically endangers others."[151] In prior cases, the exception applied when the defendants alone committed a direct and violent act that caused another harm.[152] The court believed PAS/MAID was not comparable to a violent act causing another harm.[153] The patient makes the final decision and commits the final act—not the physician—and the physician-patient interaction throughout the process is "private, civil, and compassionate."[154]

In addition, the court noted that the Montana Rights of the Terminally Ill Act protects physicians from liability when honoring a patient's end-of-life wishes, "even if the physician must actively pull the plug on a patient's ventilator or withhold treatment that will keep him alive."[155] There is nothing that indicates reduced physician involvement in the final act is against public policy.[156] In conclusion, the court ruled that physicians honoring a patient's PAS/MAID request can use patient consent as a defense to homicide because it is not against public policy.[157]

## III. CURRENT ILLINOIS END-OF-LIFE MEDICAL CARE DECISION MAKING ABILITY

As previously stated, Illinois has not legalized PAS/MAID.[158] However, Illinois law recognizes an individual's right to control every aspect of his or her medical care[159] and, in addition to the right to refuse medical treatment, provides patients the ability to make certain end-of-life decisions through the implementation of advance directives.[160] An advance directive is a patient-prepared written statement expressing how the patient's future medical decisions should be made if the patient becomes incapable of making those decisions.[161] Currently, Illinois provides four types of advance directives: a health care power of attorney; a living will; a mental health

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150 MONT. CODE ANN. § 45-2-211(2)(d) (2021).
151 *Baxter*, 2009 MT 449 ¶ 17.
152 *Id.*
153 *Id.* ¶ 21.
154 *Id.* ¶ 23.
155 *Id.* ¶ 50.
156 *Id.*
157 *Baxter*, 2009 MT 449.
158 *Illinois*, *supra* note 39.
159 755 ILL. COMP. STAT. 45/4-1 (2015).
160 *Advance Directives*, *supra* note 24.
161 *Id.*

treatment preference declaration; and a Do-Not-Resuscitate/Practitioner Orders For Life-Sustaining Treatment ("DNR/POLST").[162]

A. Health Care Power of Attorney

The Illinois Power of Attorney Act[163] allows an individual (principal) to designate health care decision-making authority to another person (agent) in the event the principal is no longer able to make those decisions for himself or herself.[164] The Act gives the principal broad discretion in determining what decisions the agent can make.[165] The principal can authorize the agent to make all health care decisions in general, or authorize the agent to make decisions concerning specific aspects of the principal's care.[166]

This authority is executed through a document, referred to as the "Illinois Statutory Short Form Power of Attorney for Health Care," or any substantially similar form.[167] The principal, or agent, must inform the principal's health care provider of the power of attorney and the provider must include a copy of the document in the principal's medical record.[168]

B. Living Will

Under Illinois law, the Living Will Act[169] is similar to a Power of Attorney of Health Care in that an individual (declarant) executes a document, referred to as a "declaration," directing desired medical care in the event the declarant is no longer able to make the decisions.[170] The main difference between a living will and a power of attorney of healthcare is the scope of the document.[171] A living will only empowers the declarant to provide instructions for his or her physician to withhold or withdraw death-delaying procedures in the event of a terminal condition.[172]

In addition to the narrow scope of the living will, it can also be limited by a co-existing Power of Attorney for Health Care.[173] If the agent for Power of Attorney for Health Care is available to make decisions regarding life-

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162 *Id.*
163 755 ILL. COMP. STAT. 45 (2015).
164 *Id.* § 4-1.
165 *Id.*
166 *Id.*
167 *Id.*
168 *Id.* § 4-7(a).
169 755 ILL. COMP. STAT. 35 (2021).
170 *Id.* at 35/1.
171 *See* 755 ILL. COMP. STAT. 35 (2021); 755 ILL. COMP. STAT. 45 (2015).
172 755 ILL. COMP. STAT. 35/1 (2021).
173 755 ILL. COMP. STAT. 45/4-11 (2015).

sustaining or death-delaying procedures, any living will would be superseded.[174]

C. Do-Not-Resuscitate/Practitioner Orders for Life Sustaining Treatment ("DNR/POLST")

Generally, an individual's consent to cardiopulmonary resuscitation ("CPR") is presumed because of the individual's incapacity and the likelihood of death resulting from failing to act.[175] However, individuals have the ability to execute a DNR/POLST order to express their wishes regarding CPR.[176] A DNR/POLST is a document stating the individual's wish to decline CPR in the event the individual's heart or breathing stops.[177] This advance initiative can also be used by the individual for stating their decisions regarding life-sustaining treatment.[178] A DNR/POLST also works in conjunction with other advance initiatives.[179] For example, an agent under a health care power of attorney can issue a DNR/POLST on behalf of the individual.[180] Unless a DNR/POLST is physically destroyed or orally revoked by the individual, it remains in effect.[181]

D. Mental Health Treatment Preference Declaration

Just like other advance directives, a mental health treatment preference declaration allows an individual to direct medical care in the event the individual becomes incapacitated.[182] However, as the name implies, the declaration only concerns mental health.[183] For example, it allows an individual (principal) to state their wishes regarding electroconvulsive treatment ("ECT"), psychotropic medicine, and admission to a mental health facility for up to seventeen days of treatment.[184] The declaration is only valid for three years.[185] However, if you are receiving mental health treatment, the declaration will not expire and cannot be revoked until after successful treatment is completed.[186]

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174 *Id.*
175 *See* Joseph Bernstein et al., *Presumed Consent: Licenses and Limits Inferred From the Case of Geriatric Hip Fractures*, 18 BIOMED CENT. MED. ETHICS 1 (2017).
176 755 ILL. COMP. STAT. 40/65(a) (2021).
177 *See id.*
178 *Advance Directives*, *supra* note 24.
179 *See* 755 ILL. COMP. STAT. ANN. 40/65 (2021).
180 755 ILL. COMP. STAT. 45/4-10(c) (2015).
181 ILL. ADMIN. CODE tit. 77, § 515.380(h)(1)-(2) (2018).
182 755 ILL. COMP. STAT. 43/10 (2021).
183 *See id.* § 10(1).
184 *Advance Directives*, *supra* note 24.
185 § 10(2).
186 *See id.*

E. Health Care Surrogate

In the absence of an advance directive, if an adult is incapable of making his or her own health care decisions, Illinois law allows a "surrogate" to be assigned under the Health Care Surrogate Act.[187] However, a surrogate has limited authority to act in the individual's best interests.[188] For example, a surrogate can only decide to have life-sustaining treatment withheld or withdrawn if the incapacitated individual has a "qualifying condition" (i.e., a terminal condition).[189] Additionally, the surrogate must make decisions for the incapacitated that conform "as closely as possible to what the patient would have done or intended under the circumstances, [considering] evidence that includes, but is not limited to, the patients personal, philosophical, religious, and moral beliefs and ethical values relative to the purpose of life, sickness, medical procedures, suffering, and death."[190]

## IV. SHOULD PAS/MAID BE AN OPTION FOR ILLINOIS' TERMINALLY ILL?

The "Baby Boomer" generation[191] is aging, and roughly twenty percent of the total U.S. population will be sixty-five years old or older by 2030.[192] The increase in the elderly population means the number of people who experience a terminal illness near the end of life is also increasing[193] and raises concerns regarding end-of-life care.[194] In Illinois, these individuals can determine their end-of-life care by refusing unwanted medical treatment[195] and preparing advance directives.[196] Nevertheless, refusing unwanted medical treatment and preparing medical decisions in advance of

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187 755 ILL. COMP. STAT. 40/20(b)(1) (2021).

188 *See id.* § 20.

189 *Id.* § 20(b)(1).

190 *Id.*

191 "Baby Boomers" are individuals born between 1946 and 1964. *Who Are the Baby Boomers?*, CORP. FIN. INST., https://corporatefinanceinstitute.com/resources/knowledge/other/baby-boomers/ (last visited Sept. 16, 2021). This time period is considered to be one of the largest population growth periods in U.S. history. *Id.*

192 Matthew E. Misichko, *A Help-Ing Hand: How Legislation Can Reform the Affordable Care Act and Hospice Care to Prioritize Comfort and Prepare for the Baby Boomer Generation*, 21 ELDER L.J. 419, 452 (2014).

193 *See Cancer, Key Statistics*, WHO, https://www.who.int/cancer/resources/keyfacts/en/ (last visited Dec. 30, 2020). It was estimated in 2010 that 6,000-18,000 additional physicians were needed to meet the national demand for palliative care. *Estimate of Current Hospice and Palliative Medicine Physician Workforce Shortage*, 40 J. PAIN SYMPTOM MGMT. 899, 899 (2010).

194 Naomi Cahn & Amy Ziettlow, *Religion and End-of-Life Decision-Making*, 2016 U. ILL. L. REV. 1713, 1723 (2016).

195 However, the liberty interest creating the right to refuse treatment must be balanced against any competing state interests. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 278-79 (1990); *In re* Quinlan, 355 A.2d 647, 661-64 (N.J. 1976).

196 *Advance Directives*, *supra* note 24.

incapacitation does not relieve the terminally ill of the potential for conscious end-of-life suffering, loss of autonomy, and loss of dignity—three concerns consistently referenced by PAS/MAID advocates and the terminally ill.[197]

### A. Palliative Care

For terminally ill patients, palliative care could be an option.[198] The goal of palliative care is to improve the quality of life for patients and their families while living with a life-threatening illness.[199] For individuals that have a terminal illness, the focus of end-of-life care is to provide comfort and support before death.[200] However, although palliative care has seen improvements and growth in recognition in recent years,[201] many individuals with life-threatening illnesses do not receive palliative care or receive palliative care on average only thirty-eight days before death.[202] Two major contributing factors are the shortage of physicians with palliative care training and a lack of available resources, specifically in community hospitals and rural areas.[203] Most physicians currently in practice have limited or no palliative care training;[204] this lack of training leads to negative outcomes for the patient and family.[205] In Illinois, there are roughly two certified palliative care providers per one hundred thousand residents, an insufficient number to meet Illinois' need.[206] In the next twenty years, the nationwide increase in the trained palliative care workforce is only expected to grow one percent, while the need will increase by a projected twenty percent.[207] This implies that in the near future the percentage of the terminally ill population requiring, but not receiving, palliative care will increase, and a

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197 PUB. HEALTH DIV., OREGON DEATH WITH DIGNITY 2020 DATA SUMMARY 12 (2020), https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf.

198 Palliative care is "specialized medical care for people living with a serious illness, such as cancer or heart failure." *What Are Palliative Care and Hospice Care?*, NAT'L INST. ON AGING (May 14, 2021), https://nia.nih.gov/health/what-are-palliative-care-and-hospice-care. For this Note, "palliative care" is a general term that encompasses both palliative and hospice care.

199 *Id.*

200 Amy S. Kelley & R. Sean Morrison, *Palliative Care for the Seriously Ill*, 373 NEW ENG. J. MED. 747, 747 (2015); *see* Pippa Hawley, *Barriers to Access to Palliative Care*, PALLIATIVE CARE: RSCH. AND TREATMENT, 2017, at 1.

201 Kelley & Morrison, *supra* note 200.

202 Hawley, *supra* note 200, at 2.

203 *Id.*

204 Kelley & Morrison, *supra* note 200, at 749.

205 *Id.* at 753.

206 *Illinois Palliative Care Report Card*, CTR. TO ADVANCE PALLIATIVE CARE (Dec. 13, 2019), https://reportcard.capc.org/state/illinois/.

207 Robert Bulanda, *A Step Toward Normalizing End-of-Life Care: Implications of the Palliative Care and Hospice Education and Training Act (PCHETA)*, 39 N. ILL. U. L. REV. 330, 338 (2019).

higher percentage of terminally ill patients experiencing end-of-life suffering, loss of autonomy, and loss of dignity.

In addition, for those who do receive palliative care, it may be considered insufficient.[208] It does not help relieve all types of suffering associated with terminal illnesses or the "irremediable existential angst associated with loss of autonomy and dignity."[209] Even if better palliative care was available, it would still be insufficient for those who primarily desire PAS/MAID because of loss of autonomy.[210]

B. Physician Compliance

It is difficult to know how many physicians are currently quietly practicing PAS/MAID in Illinois.[211] However, surveys have shown that even in states where PAS/MAID is illegal, and though the AMA considers PAS/MAID "fundamentally incompatible with the physician's role as a healer,"[212] some physicians still honor PAS/MAID requests from terminally ill patients.[213] If physicians are practicing PAS/MAID quietly, how can Illinois' residents requesting PAS/MAID know they are receiving quality assistance to ensure a smooth and painless death? How will the Illinois Medical Disciplinary and Licensing Boards know when a physician is using the necessary standards and safeguards to ensure only terminally ill patients who need PAS/MAID receive it and not vulnerable populations?[214]

Using Oregon's Death with Dignity Act as an example, the Oregon Health Authority is required to collect information about the patients and

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208 *See* Bryant, *supra* note 17.

209 *Id.*

210 *Id.*

211 Ezekiel J. Emanuel, *Euthanasia and Physician-Assisted Suicide: A Review of the Empirical Date from the United States*, 162(2) *ARCHIVES INTERNAL MED.* 142 (2002), jamanetwork.com/journals/jamainternalmedicine/fullarticle/214736.

212 CODE OF MED. ETHICS ch. 5.7-.8 (AM. MED. ASS'N 2019), https://www.ama-assn.org/system/files/2019-06/code-of-medical-ethics-chapter-5.pdf.

213 *See* Meier et al., *Characteristics of Patients Requesting and Receiving Physician-Assisted Death*, *supra* note 67; Ezekiel J. Emanuel et al., *The Practice of Euthanasia and Physician-Assisted Suicide in the United States: Adherence to Proposed Safeguards and Effects on Physicians*, 280 J. AM. MED. ASS'N 507, 508 (1998); Emanuel et al., *Euthanasia and Physician-Assisted Suicide*, *supra* note 67 (noting that "[s]ubstantial numbers of oncologists and patients in the USA have considered, prepared for, or carried out euthanasia or physician-assisted suicide, even though these interventions were illegal. . . . Almost one in seven oncologists said they had participated in these interventions"); Meier et al., *A National Survey of Physician-Assisted Suicide and Euthenasia in the United States*, *supra* note 67.

214 *See* Elizabeth Sidney, *Medical Aid in Dying Update: Right-to-Die Movement Looks to California*, CHI. MED. SOC'Y, http://www.cmsdocs.org/news/medical-aid-in-dying-update (last visited Apr. 5, 2021) (noting that "[a]dvocates say it is common for physicians to give life-ending medications, and medical aid-in-dying laws would simply codify and bring to light a practice already taking place").

physicians participating in PAS/MAID,[215] as well as monitor and identify any issues of noncompliance with the statutory requirements.[216] The Oregon Death with Dignity Act 2020 Data Summary shows that no Oregon physician was referred to the Oregon Medical Board for failure to comply with the Acts requirements.[217] There were a total of 142 physicians who wrote 370 prescriptions during 2020.[218]

C. Vulnerable Populations

One of the main concerns for opponents of PAS/MAID is that vulnerable populations will be disproportionately encouraged to use PAS/MAID.[219] Vulnerable populations could include those who are terminally ill with low socioeconomic status, physical or mental disabilities, psychological issues like depression; or even minors, racial and ethnic minorities, and the uninsured.[220] It is suggested that the poor and minorities will be susceptible to manipulation because they are less likely to receive adequate end-of-life pain control, and the physically and mentally disabled are vulnerable because of "societal indifference and antipathy."[221]

However, data collected by the State of Oregon for 2020 shows the demographics of those who chose PAS/MAID deaths and contradicts the concern of exploitation of vulnerable populations.[222] The data shows participants were overwhelmingly white (ninety-seven percent), had some form of insurance coverage (one-hundred percent), had a serious terminal illness (sixty-six percent had cancer, eight percent had a neurological disease, and six percent had a respiratory disease), were educated with at least some college (seventy-two percent), and the median age at death was seventy-four.[223] Additionally, the total number of PAS/MAID deaths in Oregon was minimal.[224] The estimated rate of the ODWDA deaths for 2020 was less than sixty-six per ten thousand total deaths.[225] Based on the data, the concern of

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215 OR. REV. STAT. § 127.865/3.11 (2021).

216 OREGON DEATH WITH DIGNITY 2020 DATA SUMMARY, *supra* note 197, at 4.

217 *Id.* at 7.

218 *Id.*

219 *See* Washington v. Glucksberg, 521 U.S. 702, 719 (1997) (discussing New York Task Force's conclusion that legalizing PAS/MAID would "pose profound risks to many individuals would are ill and vulnerable").

220 *See* Timothy Quill, *Physician Assisted Death in Vulnerable Populations*, 335 BRIT. MED. J. 621, 625-26 (2007); Browne C. Lewis, *A Graceful Exit: Redefining Terminal to Expand the Availability of Physician-Facilitated Suicide*, 91 OR. L. REV. 457, 472-77 (2012).

221 Laura Trenaman-Molin, *Physician-Assisted Suicide: Should Texas Be Different*, 33 HOUS. L. REV. 1475, 1489-90 (1997).

222 *See* OREGON DEATH WITH DIGNITY 2020 DATA SUMMARY, *supra* note 197, at 9-12.

223 *See id.*

224 *See id.* at 5.

225 *Id.*

exploitation of vulnerable populations is largely unfounded. In fact, from the data, there could be an argument that PAS/MAID availability in Oregon is overly exclusive, as the majority of participants were white, educated, insured, and elderly.[226]

## V. THE BEST PATH FOR LEGALIZATION

There is an increasing presence of support for PAS/MAID legalization in Illinois.[227] In early 2020, the Evanston City Council voted to send a resolution to the state legislature encouraging PAS/MAID legislation, but advocates requested to have the resolution withdrawn so they could have more time to discuss the topic with the community and educate people on misconceptions.[228] Moreover, a 2020 Gallup poll found that sixty-one percent of U.S. residents believe PAS/MAID should be legalized, a ten percent increase from 2013.[229] A 2020 Medscape poll found that only twenty-eight percent of physicians believe PAS/MAID for terminally ill individuals should remain illegal,[230] down from forty-one percent in 2010.[231] With the increasing support and the fact that the majority of state PAS/MAID legalization has occurred over the past six years,[232] Illinoisans could see a bill introduced in the near future.[233]

### A. Judicial Law Making: Would it be Successful in Illinois?

Notwithstanding the growing support for legislation in Illinois, other states' court decisions seem to demonstrate a positive judicial trend, implying there may be potential for an Illinois court to hold that PAS/MAID is

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226 Compare this to Oregon's total population, which is seventy-five percent white and thirty-three percent college-educated. *Oregon, Race and Hispanic Origin*, CENSUS.GOV, https://www.census.gov/quickfacts/OR (last visited Jan. 28, 2021).

227 *See* Jeffrey M. Jones, *Prevalence of Living Wills in U.S. Up Slightly*, GALLUP (June 22, 2020), https://news.gallup.com/poll/312209/prevalence-living-wills-slightly.aspx (showing an increase in U.S. resident support from 2013 to 2020); *Regina Stoops: Letting Go*, DEATH WITH DIGNITY (Mar. 1, 2016), https://www.deathwithdignity.org/stories/regina-stoops-letting-go/; *Home*, FINAL OPTIONS ILLINOIS, https://finaloptionsillinois.org/ (last visited Jan. 1, 2021). Final Options Illinois is a PAS/MAID advocacy group. *About Final Options Illinois*, FINAL OPTIONS ILLINOIS, https://finaloptionsillinois.org/about/about-final-options-illinois/ (last visited Feb. 24, 2022). Its YouTube channel has numerous stories of Illinois citizens desiring the option of PAS/MAID. *See Final Options Illinois*, YOUTUBE, https://www.youtube.com/channel/UCZTPVbLZR-Lkdi3FBVEgoew (last visited Feb. 24, 2022).

228 *See Evanston City Council Weighing Whether to Call For 'Dying with Dignity' Legislation for Illinois*, CBS CHI. (Feb. 10, 2020), https://chicago.cbslocal.com/2020/02/10/evanston-lawmakers-voting-on-whether-to-call-for-dying-with-dignity-legislation-for-illinois/.

229 *See* Jones, *supra* note 227.

230 LESLIE KANE, LIFE, DEATH, AND PAINFUL DILEMMAS: ETHICS 2020, MEDSCAPE 2 (2020).

231 SHELLY REESE, MEDSCAPE ETHICS REPORT 2016: LIFE, DEATH, AND PAIN 2 (2016).

232 Leins, *supra* note 25.

233 *See Toward the Tipping Point*, *supra* note 37.

permitted under certain circumstances,[234] but is it realistic? Following the United States Supreme Court decisions stating there is not a federal constitutionally protected right to PAS/MAID,[235] challengers have focused on asserting the right based on state constitutions or alleging that state statutes do not encompass PAS/MAID.[236]

*1. Equal Protection under the Illinois Constitution*

It is unlikely that an Illinois court would find that there is a right to PAS/MAID under the Illinois Constitution's Due Process and Equal Protection Clauses.[237] The Illinois Constitution, Article 1, section 2, reads in part, "[n]o person shall be . . . denied the equal protection of the laws."[238] Echoing the federal equal protection requirements, in the absence of a suspect class, equal protection in Illinois guarantees that similarly situated individuals will be treated in a similar fashion unless the government can demonstrate a rational basis for the difference in treatment.[239]

The challenger could attempt to assert that similarly situated individuals are treated differently within the Illinois Living Will Act, under which terminally ill individuals can choose to have death delaying procedures withheld or withdrawn—avoiding continued suffering.[240] The classifications would be terminally ill patients wanting to hasten their death by self-administration of drugs and those directing a physician to withdraw death delaying treatment. In both situations, the terminally ill individual needs physician assistance in ending their life.[241] Yet, PAS/MAID is prohibited in Illinois.[242]

However, an Illinois court would most likely not analyze this asserted equal protection violation further than determining whether the two classifications are similarly situated.[243] When faced with this assertion, other state courts have consistently determined the two classes are not similarly

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234 *See* Baxter v. State, 2009 MT 449, 354 Mont. 234, 224 P.3d 1211. The court required the patient to have a terminal illness and capacity to properly consent. *Id.*

235 *See* Washington v. Glucksberg, 521 U.S. 702 (1997); Vacco v. Quill, 521 U.S. 793 (1997).

236 *See* Krischer v. McIver, 697 So. 2d 97 (Fla. 1997); Sampson v. State, 31 P.3d 88 (Alaska 2001); *Baxter*, 2009 MT 449; People v. Kevorkian, 527 N.W.2d 714 (Mich. 1994).

237 *See Baxter*, 2009 MT 449; *Vacco*, 521 U.S. 793; *Sampson*, 31 P.3d 88; *See Krischer*, 697 So. 2d 97.

238 ILL. CONST. art. 1, § 2.

239 People of Ill. v. Jonathon C.B. (*In re* Jonathon C.B.), 958 N.E.2d 227, 252 (Ill. 2011); Kaczka v. Ret. Bd. of Policemen's Annuity and Benefit Fund of Chi., 923 N.E.2d 1282, 1287 (Ill. App. Ct. 2010).

240 *See* 755 ILL. COMP. STAT. 35/1 (2021).

241 *See id.* § 2.

242 720 ILL. COMP. STAT. 5/12-34.5 (1990); 755 ILL. COMP. STAT. 40/5 (2021); 755 ILL. COMP. STAT. 40/50 (2021).

243 *See* Baxter v. State, No. ADV-2007-787, 2008 Mont. Dist. LEXIS 482, at ¶ 19 (Mont. Dist. Ct. Dec. 5, 2008); Sampson v. State, 31 P.3d 88 (Alaska 2001).

situated.[244] Even under Montana's broad equal protection rights,[245] the trial court in *Baxter* stated the characteristics of the desired action differentiates the classes.[246] The patient who refuses or withdraws death delaying treatment can do so based on the right to be free from intrusion of bodily integrity without consent.[247] The individual seeks for the physician to curtail an action already taken, allowing nature to takes its course.[248] However, a patient requesting PAS/MAID seeks an affirmative action—prescribing lethal drugs—from his physician with the purpose of hastening death.[249] Thus, the distinction between affirmative action and forbearance/negative action differentiates the classes.[250]

In *McIver v. Kirscher*, a Florida Circuit Court found that there was no distinction between PAS/MAID and withholding or withdrawing treatment.[251] The main purpose of both is to cause the patient's death.[252] The only difference is the amount of time it takes the patient to "expire."[253] However, the court based this determination on the arguments in *Quill* before the case was heard, and ultimately overturned, by the U.S. Supreme Court.[254] Eventually, the *McIver* decision was reversed by the Florida Supreme Court.[255]

Although there has been a successful state constitutional equal protection challenge at the trial court level in Florida, it seems unlikely that the Illinois Supreme Court would reach a holding similar to that in *McIver*.[256]

*2. The Right to Privacy under the Illinois Constitution*

Other challenges have been brought asserting a state's PAS/MAID ban violates the challenger's state constitutional right to privacy.[257] The Illinois Constitution, Article 1, section 6, provides that individuals have the right to be free from unreasonable invasions of privacy.[258] The Illinois right to

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244 *See Baxter*, 2008 Mont. Dist. LEXIS 482; *Sampson*, 31 P.3d 88; Vacco v. Quill, 521 U.S. 793 (1997).

245 Bean v. State, 179 P.3d 524, 527 (Mont. 2008).

246 *See Baxter*, 2008 Mont. Dist. LEXIS at ¶ 19.

247 *Id.* at ¶ 35.

248 *Id.*

249 *Id.*

250 *Id.* at ¶ 32; *see* Sampson v. State, 31 P.3d 88 (Alaska 2001).

251 *See* McIver v. Kirscher, No. CL-96-1504-AF, 1997 WL 225878, at *10 (Fla. Cir. Ct. Jan. 31, 1997).

252 *Id.*

253 *Id.*

254 *See id.* at 10; Quill v. Vacco, 80 F.3d 716, 729 (2nd Cir. 1996); *see Vacco v. Quill*, 521 U.S. 793 (1997).

255 *See* Krischer v. McIver, 697 So. 2d 97, 100 (Fla. 1997).

256 *See id.*

257 Baxter v. State, No. ADV-2007-787, 2008 Mont. Dist. LEXIS 482 (Mont. Dist. Ct. Dec. 5, 2008); Sampson v. State, 31 P.3d 88 (Alaska 2001).

258 ILL. CONST. art. 1, § 6.

privacy is not governed by the rational basis, strict scrutiny, or undue burden tests, but rather by whether the State's invasion of an individual's right to privacy is reasonable.[259] This "reasonableness" test balances the individual's interest against the State's interest.[260] Thus, the Illinois Constitution provides more protection than the federal Constitution, and that protection is stated broadly and without limiting the types of privacy intended to be protected.[261]

A terminally ill Illinoisan could attempt to assert that Illinois' PAS/MAID ban violates his or her right to privacy under the Illinois Constitution and that a terminally ill patient's decision whether to hasten death or continue living when death is imminent is one of personal autonomy and privacy. If Illinois' interests in prohibiting PAS/MAID included protecting vulnerable populations from potential abuse and protecting the integrity of the medical profession, an argument could be made that these interests would be better served by enacting statutory requirements and protections, instead of completely prohibiting PAS/MAID.

In *Baxter*, the Montana court agreed with this assertion and ruled that a terminally ill patient does have a right to PAS/MAID, and Montana's PAS/MAID ban violated that right.[262] However, "[M]ontana adheres to one of the most stringent protections of its citizens' right to privacy in the United States."[263] Montana's Constitution's privacy clause states: "[t]he right of individual privacy is essential to the well-being of a free society and shall not be infringed without the showing of a compelling state interest."[264] Although the Illinois Constitution provides more protection than the federal Constitution, Illinois' right to privacy seems to be more focused on the right to be free from unreasonable searches, seizures, and interceptions, instead of broad personal autonomy.[265] Additionally, an Illinois court could refuse to include the right to PAS/MAID within the right to privacy based on the failure of Illinois PAS/MAID bills introduced in 1997.[266] The fact that the bills were introduced and quickly dismissed could be used as evidence of the legislature believing PAS/MAID is not a right.

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259 *See* People v. Cornelius, 821 N.E.2d 288, 298 (Ill. 2004).

260 *See* Hope Clinic for Women Ltd. v. Adams, 955 N.E.2d 511, 530 (Ill. App. Ct. 2011).

261 *See Kunkel v. Walton*, 689 N.E.2d 1047, 1055 (Ill. 1997); People v. Nesbitt, 938 N.E.2d 600, 604 (Ill. App. Ct. 2010).

262 *See Baxter*, 2008 Mont. Dist. LEXIS at ¶ 64.

263 Armstrong v. State, 989 P.2d 364, 373 (Mont. 1999).

264 MONT. CONST. art. II, § 10.

265 *See* ILL. CONST. art. I, § 6; Barbara Kritchevsky, *What States Can and Cannot Do*, 19 HUM. RTS. 16, 17 (1992).

266 *See* Sampson v. State, 31 P.3d 88, 93 (Alaska 2001).

B. Legislation: Illinois Death with Dignity Act?

Considering the unlikelihood of legalization through the Illinois courts, legalization through the legislature should be the anticipated path. As stated above, with the rising support for PAS/MAID legislation, and the fact that the majority of state PAS/MAID legislation has been enacted over the past six years,[267] Illinoisans could see a bill introduced in the near future.[268]

The question becomes what type of bill would be most likely to pass through the Illinois legislature while also providing a legitimate benefit to Illinois' residents desiring PAS/MAID. Some bills to consider are Illinois' Legalize Assisted Suicide bill (from the 1997 Illinois General Assembly), a bill modeled after the ODWDA, an ODWDA with expanded circumstances to permit voluntary active euthanasia, and an ODWDA with expanded availability to accommodate specific individuals not considered "terminally ill" under the current ODWDA definition.

*1. Illinois' Legalize Assisted Suicide Bill*

In 1997, the Illinois legislature introduced the Legalize Assisted Suicide bill ("LAS") to legalize PAS/MAID.[269] However, the bill did not receive meaningful consideration and was quickly dismissed.[270] The lack of interest could have been the result of an inadequate bill. Several provisions were ambiguous, posed risks of abuse, or allowed the potential for voluntary active euthanasia.[271]

For example, the bill provided adult patients with a terminal condition the ability to request a physician to provide medical means of hastening death.[272] "Terminal condition" was defined as "an illness or injury for which . . . death is *imminent*."[273] Additionally, "imminent" was "a determination . . . that death will occur in a *relatively short period of time*."[274] This *imminent* standard creates a higher level of uncertainty for physicians and patients compared to the "six-month" standard (i.e., death will likely occur within six months as a result of the condition) used in other state statutes.[275] Under LAS, a "relatively short period of time" could be interpreted as three months or,

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267 Leins, *supra* note 25.

268 *See Toward the Tipping Point*, *supra* note 37.

269 *See* H.B. 691, 90th Gen. Assemb., Reg. Sess. (Ill. 1997).

270 The only document available is the bill itself. *See 90th General Assembly, Summary of HB0691*, *supra* note 31. There are no supporting documents (committee hearings, revisions, etc.). *Id.*

271 *See generally* H.B. 691.

272 *Id.*

273 *Id.* (emphasis added).

274 *Id.* (emphasis added).

275 OR. REV. STAT. § 127.800(12) (2021); VT. STAT. ANN. tit. 18, § 5281 (2013); WASH. REV. CODE § 70.245.010(13) (2008).

possibly, three years. The ambiguity could make the practice of PAS/MAID more difficult to regulate and create hesitation by physicians to engage in PAS/MAID.

Furthermore, LAS contained no residency requirement.[276] Thus, terminally ill residents from other states would have been able to travel to Illinois specifically for the purpose of hastening their death. This could frustrate the public policy of surrounding states that have not legalized PAS/MAID. In contrast, every state that has enacted legislation has included a requirement that the patient must be a resident of the state in order to utilize PAS/MAID.[277]

Lastly, LAS included a provision that allowed physicians to be present at the time the patients used the medical means of hastening death (the final act) and even allowed physicians to "*assist* . . . the patient make use of those means, provided that the actual use of those means is the knowing, intentional, and voluntary physical act of the patient."[278] Permitting physicians to "assist" (even with the knowing, intentional, and voluntary physical act of the patient requirements) creates a higher probability of physicians crossing the line into voluntary active euthanasia, a practice currently illegal in every state.[279] Considering the qualifications, safeguards, and requirements included in current PAS/MAID statutes, a bill similar to LAS would likely not pass through the current Illinois legislature.

*2. Oregon Death With Dignity Act ("ODWDA")*

Since its enactment, other states have routinely used the ODWDA as a model for legislation,[280] and advocacy groups have continued to encourage ODWDA-like bills.[281] The twenty-three years of reporting by the Oregon Health Authority has allowed observers to examine the Act's perceived success and conclude that it has continued to produce the intended results.[282]

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276 H.B. 691.

277 OR. REV. STAT. § 127.805(2) (2021); VT. STAT. ANN. tit. 18, § 5281(8) (2013); WASH. REV. CODE. § 70.245.130 (2009); CAL. HEALTH & SAFETY CODE § 443.2(a)(3) (West 2018); COLO. REV. STAT. § 25-48-103(1) (2016); N.J. STAT. ANN. § 26:16-4 (West 2019); ME. STAT. tit. 22, § 2140(4) (2019); HAW. REV. STAT. § 327L-2 (2019).

278 H.B. 691 (emphasis added).

279 See discussion *supra* Part I.

280 Bryant, *supra* note 17, at 180-81.

281 *The Illinois Patient Choices at End of Life Act Briefing Paper*, FINAL OPTIONS ILL. (Sept. 24, 2015), http://ilendoflife.org/IL-DWDbill-BriefingPaper.pdf; *Evanston City Council Weighing Whether to Call For 'Dying With Dignity' Legislation For Illinois*, *supra* note 228; *Illinois*, *supra* note 39.

282 *Latest Report on Oregon Death with Dignity Act Shows Law Continues to Work As Intended*, DEATH WITH DIGNITY (Mar. 11, 2020), https://www.deathwithdignity.org/news/2020/03/2019-report-on-oregon-death-with-dignity-act/; *see* Luai Al Rabadi et al., *Trends in Medical Aid in Dying in Oregon and Washington*, JAMA NETWORK OPEN, Aug. 9, 2019, at 1, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2747692?utm_campaign=articlePDF&utm_medium=articlePDFlink&utm_source=articlePDF&utm_content=jamanetworkopen.2019.8648.

The ODWDA has detailed qualifications, safeguards, and reporting requirements designed to permit patient access to PAS/MAID while minimizing physician liability and protecting patients from abuse and mistake.[283] To qualify for PAS/MAID, the patient must be at least eighteen years of age and a resident of Oregon; be determined to be mentally competent by a physician, psychiatrist, or psychologist; have the ability to make and communicate health care decisions to health care providers; and possess an incurable and irreversible disease that has been medically confirmed and will, within a reasonable degree of medical judgment, produce death within six months.[284]

If a patient meets these preliminary qualifications, the patient can make an initial oral request for medication for the purpose of ending his or her life.[285] After the initial request, the patient must make a written request using a specific form provided in the ODWDA that is witnessed by at least two individuals, attesting to the best of their knowledge and belief that the patient is capable, acting voluntarily, and acting without coercion.[286] One witness must not be a relative of the patient, a beneficiary of any portion of the patient's estate, or an agent of the health care facility where the patient is receiving medical care.[287] The ODWDA also requires that the patient must reiterate the oral request no less than fifteen days after the initial request.[288] This means that the patient will have a waiting period of at least fifteen days before being prescribed the medication.[289]

After making the written request and prior to receiving the medication, the physician and patient must satisfy several safeguards.[290] The physician must first ensure the patient is making an informed decision.[291] This requires informing the patient of his or her medical diagnosis and prognosis, the potential risks associated with taking the prescribed medication, the probable result of taking the medication, and feasible alternatives—including comfort care, hospice care and pain control.[292] The physician must then refer the patient to a consulting physician for confirmation of the diagnosis and that the patient is capable and acting voluntarily.[293] Additionally, if either physician believes the patient's judgment may be impaired due to a

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283 Raphael Cohen-Almagor & Monica G. Hartman, *The Oregon Death with Dignity Act: Review and Proposals for Improvement*, 27 J. LEGIS. 269, 271 (2001).

284 OR. REV. STAT. § 127.800-.805 (2021).

285 *Id.* § 127.840.

286 *Id.* § 127.810.

287 *Id.*

288 *Id.* § 127.840.

289 *Id.* § 127.850.

290 § 127.800-.880.

291 *Id.* § 127.815(1)(c).

292 *Id.*

293 *Id.* § 127.815(1)(d).

psychiatric or psychological disorder or depression, the patient must be referred for counseling.[294] If the patient is referred to counseling, no life-ending medication will be prescribed until the counselor determines the patient's judgment is not impaired.[295] The physician must also recommend that the patient notify next of kin about their decision to obtain PAS/MAID, inform the patient that he or she has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind the request at the time the patient makes the reiterating oral request.[296] Immediately prior to writing the prescription, the physician must again verify that the patient is making an informed decision and ensure documentation of all the above-mentioned steps is included in the patient's medical record.[297] After the process of satisfying these safeguards, the physician can prescribe the patient life-ending medication to be self-administered at a time of the patient's choosing.[298]

The ODWDA also offers physicians and others immunities for good faith compliance.[299] It provides that no person will be subject to legal liability or professional disciplinary action for participating in good faith compliance with the Act, including being present when the patient administers the life-ending medication.[300] However, although the physician and others may be present at the time of self-administration, they are not immune from liability if they assist in the physical administration of the medication.[301] The ODWDA specifically states that nothing in the Act "shall be construed to authorize . . . lethal injection, mercy killing or *active euthanasia*."[302]

Lastly, the Oregon Health Authority is required to collect participating patient and physician information regarding compliance.[303] This information is used to monitor compliance and generate a detailed publicly available annual statistical report.[304]

### *3. Oregon Death With Dignity Act Plus Active Euthanasia*

Some supporters of an Illinois Death With Dignity Act ("IDWDA") argue that the Act should be modeled after the ODWDA but with a

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294 *Id.* § 127.825.
295 *Id.*
296 § 127.815(1)(f).
297 *Id.* § 127.815(1)(i)-(k).
298 *Id.* § 127.815(L)(A)-(B).
299 *Id.* § 127.885.
300 *Id.* § 127.885(1).
301 *See id.* § 127.885.
302 § 127.880 (emphasis added).
303 *Id.* § 127.865; OREGON DEATH WITH DIGNITY 2020 DATA SUMMARY, *supra* note 197, at 3.
304 § 127.865; *See* OREGON DEATH WITH DIGNITY 2020 DATA SUMMARY, *supra* note 197, at 3.

substantial addition—voluntary active euthanasia.[305] The argument for the inclusion of voluntary active euthanasia is centered around the idea that some terminally ill patients are incapable of self-administering the means of hastening their death, and without the physical assistance of a physician, will be left to needlessly suffer.[306] Thus, the physician should be permitted to perform the final act. However, PAS/MAID nonprofit advocate groups believe the "self-administration" requirement enabled the enactment of the current laws.[307]

The more physician involvement with the final act, the more concerns are raised (e.g., the risks of mistake, abuse, and coercion). For example, if the patient changed their mind immediately before the physician performed the final act, but the patient was incapable of quickly communicating his change of heart[308] and the act was ultimately carried out, was the patient's final wish really being honored? Distinguishing between deaths that were truly voluntary and those that were involuntary would be difficult. Additionally, physician assistance with the final act could increase the physician's risk of liability.

In 2017, Oregon considered amending the ODWDA to essentially include active euthanasia.[309] The bill would have permitted patients to prepare an advance directive naming another individual who would be responsible for performing the final act in the event the patient was unable to do so.[310] The bill was a failure.[311] If Oregon (the only state that has over two decades of experience with regulating and reporting the PAS/MAID practice) decided against an ODWDA amendment permitting active euthanasia through an advance directive, it is safe to assume that a bill including active euthanasia would not be successfully passed in Illinois. Additionally, voluntary active euthanasia is still illegal in every state.

*4. Oregon Death With Dignity Act Plus Those Not "Terminally Ill"*

Another option proposed is an act that expands the availability of PAS/MAID to those suffering from an incurable illness expected to result in death and those suffering from progressive, irreversible brain disorders.[312]

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305 Michael Weiss, *Illinois Death with Dignity Act: A Case for Legislating Physician Assisted Suicide and Active Euthanasia*, 23 ANNALS HEALTH L. ADVANCE DIRECTIVE 13, 21 (2014).

306 *Id.* at 24-25.

307 Bryant, *supra* note 17, at 183.

308 Examples of this may be patients diagnosed with ALS or Parkinson's who are in the last six months of their lives and have lost the physical ability to quickly communicate.

309 S.B. 893, 79th Leg. Assemb., Reg. Sess. (Or. 2017).

310 *Id.*

311 *Oregon Senate Bill 893*, LEGISCAN, https://legiscan.com/OR/bill/SB893/2017 (last visited Nov. 6, 2021).

312 Lewis, *supra* note 220, at 486, 490.

Many individuals suffer from illnesses that will inevitably result in death, but it is uncertain when death will occur. For those, end-of-life suffering may begin long before their last six months of life. In addition, those suffering from progressive, irreversible brain disorders also experience end-of-life suffering or indignity that can be as, if not more, severe than terminally ill patients with less than six months to live.[313] Both groups suffer seriously diminished quality of life; allowing these individuals access to PAS/MAID is consistent with the primary goals of permitting patients to die before they lose autonomy and dignity, easing the psychological and physical suffering, and reducing the costs of care.[314]

In order to expand the availability of PAS/MAID to these two groups, supporters suggest redefining "terminal illness" and defining "death."[315] In the ODWDA, "terminal illness" is defined as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months."[316] Instead, the suggested definition removes "within six months" and includes an incurable and irreversible condition that has been *medically predicted to result in death*.[317] In addition, "death" would be defined to include mental death.[318]

However, expanding availability to those suffering from an incurable illness that a physician expects to result in death and those suffering from progressive, irreversible brain disorders exacerbate PAS/MAID opponents' concerns of abuse, mistake, and coercion. Because some illnesses and diseases progress over extended periods of time, the continuous financial obligations for the patient and the patient's family, and the ongoing grief experienced, can significantly impact the family members' quality of life. In these cases, some family members might feel incentivized to pressure the patient into requesting PAS/MAID—even though death from the illness may not occur for years. Additionally, studies have shown that the longer the prognosis, the more the accuracy of expected death is diminished.[319] Considering the difficulty of determining an accurate longer prognosis, some patients may be under the impression that death is somewhat looming—within a few weeks, months, or even years—when in fact death may not occur for much longer. Having this mistaken impression may encourage patients to utilize PAS/MAID long before they experience loss of autonomy and dignity and suffering. Furthermore, a patient suffering from an irreversible brain disorder such as Alzheimer's may have already developed

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313 *See id.* at 488-90.
314 *See id* at 484-90.
315 *Id.* at 486-90.
316 OR. REV. STAT. § 127.800(12) (2021).
317 Lewis, *supra* note 220, at 487-88.
318 *Id.* at 489.
319 *See* Paul Glare et al., *A Systematic Review of Physicians' Survival Predictions in Terminally Ill Cancer Patients*, 327 BRIT. MED. J. 195 (2003).

a state of sustained diminished mental capacity. If this occurs, determining if the patient is competent, capable, and acting voluntarily without coercion will be much more difficult and increases the risk of mistake.

*5. A Solution: Oregon Death With Dignity Act - Plus Mandatory Psychiatric Consultation*

It may seem logical to expand availability to patients incapable of physically committing the final act and patients that fall outside the different existing PAS/MAID acts' definitions of "terminally ill;" however, expanding the availability would decrease the likelihood of legalization in Illinois. It is likely an expanded act would only increase opposition because of increased risks of abuse, mistake, and coercion, as mentioned above. It could even cause some current supporters to defect.

Considering opponents' concerns and the Illinois legislature's lack of response to the call for an ODWDA-like bill, a possible solution might be an ODWDA-like bill *plus* an additional patient safeguard: a mandatory psychiatric consultation. This additional safeguard would help ease PAS/MAID opponents' fears of patient mistreatment and encourage the Illinois legislature to seriously consider PAS/MAID legalization.

The ODWDA provides that if either the attending physician or consulting physician believes that the patient's judgment is impaired from a psychiatric or psychological disorder or depression, the patient must be referred for counseling.[320] Thus, a physician must first determine whether the patient's judgment may be impaired prior to referring to counseling. However, in many instances, a physician might not be the best candidate to make this determination.[321] Although a physician may diagnose a mental disorder, most lack the experience, understanding and specific training that psychiatrists have.[322] Implementing a mandatory psychiatric consultation would ensure a sound determination of the patient's judgment.

In addition to determining if the patient's judgment is impaired from a psychiatric or psychological disorder or depression, the consulting psychiatrist should have similar responsibilities as the consulting physician. That is, the consulting psychiatrist should confirm, in writing, that the patient is capable, acting voluntarily, and has made an informed decision.[323] Mandating this third confirmation would further diminish the risks of abuse,

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320 § 127.825.

321 *See* Laurel Nowak, *Who Can Diagnose Mental Illness?*, BRIDGES TO RECOVERY (Dec. 13, 2018), https://www.bridgestorecovery.com/blog/who-can-diagnose-mental-illness/#:~:text=A%20general%20practitioner%20is%20technically%20qualified%20to%20diagnose%20mental%20disorders.

322 *Id.*

323 § 127.820.

mistake and coercion and help guarantee the patient is qualified for PAS/MAID. With this extra layer of assurance and protection, the risks would be diminished, availability would not be sacrificed, and the legislation would garner more support. Thus, this may be a more viable option for Illinois.

## VI. CONCLUSION

The issue of PAS/MAID will always remain one with ethical and moral concerns for those opposing the practice. However, given the above-mentioned reasons for PAS/MAID legalization, it is difficult to deny that Illinois' terminally ill would benefit from having access to the option of hastening their death with PAS/MAID. Challengers could potentially try to obtain a favorable judgment in the Illinois court system, but the potential of success is minimal, if not non-existent. Nonetheless, it seems only a matter of time before the debate is taken back to the legislature and a bill is seriously considered. To reduce opposition of legalization, the bill should be modeled after the ODWDA, plus an additional safeguard—a mandatory psychiatric consultation. Proactively addressing the common concerns about PAS/MAID before introducing a bill would increase its chances of success and accelerate the drafting process to finally provide Illinois residents the opportunity to die with dignity.