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**The Ethics of Physician-Assisted Suicide -  
Disposal People:   
Physician-Facilitated and Vulnerable Populations**

Professor Browne Lewis

**Introduction**

According to Isaac Asimov, “Life is pleasant. Death is peaceful. It’s the transition that’s troublesome.” For many people, that transition includes mental and physical pain and suffering. When I was a child, I often heard my grandmother say, “It’s not death, but dying that I fear.” Unless a person dies instantly, dying is a process over which the person has no control. People have a legal right to refuse life-sustaining treatment. Should they have the right to obtain life-ending treatment?[[1]](#footnote-1) If so, what form should that treatment take? Passive euthanasia?[[2]](#footnote-2) Active euthanasia?[[3]](#footnote-3) Physician-facilitated suicide?[[4]](#footnote-4) End-of-life costs continue to soar because even unhealthy people are living longer.[[5]](#footnote-5) Therefore, the debate about whether or not to legalize physician-facilitated suicide will continue. The purpose of my talk is not to debate the morality, practicality or the legality of physician facilitated-suicide. There are hundreds of books and articles dealing with that issue. My objective is to analyze the current legal regime in place to determine if it adequately addresses some of the ethical concerns that have been raised by both opponents and proponents of physician-facilitated suicide.

First, I will discuss the history and the evolution of the right to die movement in the United States. Second, I will explain the current legal landscape in the United States. Lastly, I will examine some of the relevant ethical concerns caused by the availability of physician-facilitated suicide. My examination will primarily focus on the Oregon statute because it is the oldest physician-facilitated suicide in the United States and it has served as a model for laws in the United States and abroad. For example, Lord Falconer’s Bill, which was defeated by the British Parliament, was modelled after Oregon’s Death with Dignity Act.[[6]](#footnote-6) Most of the misgivings about the legalization of physician-facilitated suicide stem from the belief that persons whom society deems to be disposal because of things like their age, disability, race and economic status will be adversely impacted. Persons who share that point of view were instrumental in stopping the passage of the British law.[[7]](#footnote-7) In addition, this sentiment was expressed by the New York Task Force on Life and the Law when it issued a report in 1994 unanimously recommending that New York laws prohibiting assisted suicide and euthanasia not be modified.[[8]](#footnote-8)

**The History and Evolution of the Right to Die Movement**

The physician-facilitated suicide battle has been and continues to be fought in the legal court and in the court of public opinion. After the United States Supreme Court held that a person does not have a fundamental right to determine the time and manner of his or her death[[9]](#footnote-9), the proponents of physician-facilitated suicide used the media to take the fight to the people. Persons on both sides of the debate have spent a lot of time and resources lobbying law makers. They have also expended a great deal of money waging media campaigns to garner public support for their respective positions. Both sides have used terminology in an attempt to control the manner in which the public perceives the process that permits a licensed physician to write a prescription for lethal medication so a terminally-ill person can end his or her life.[[10]](#footnote-10)

Opponents of the procedure often refer to it as physician-assisted suicide with emphasis on the word “suicide”. They hope to conjure up the image of physicians helping patients to commit suicide. The word “suicide” has a negative connotation to most people. Historically, committing suicide was a criminal offense. The punishment was the denial of a proper burial for the deceased and the inability of the decedent’s family to inherit his or her property.[[11]](#footnote-11) Currently, persons who commit suicide may be denied the right to be buried in consecrated ground. Most states no longer classify suicide or attempted suicide as a crime. However most American states[[12]](#footnote-12) and some countries impose criminal liability on a person who aides or abets a suicide.[[13]](#footnote-13) Suicide clauses are included in some life insurance policies.[[14]](#footnote-14) Proponents of the procedure want it to be called physician-aided dying. Their objective is to get the public to see the physician as a comforter who is helping the patient to die with dignity. They argue that suicide is not involved because the patient is already dying; the physician’s action just hastens the dying process, so the patient can avoid unnecessary suffering.[[15]](#footnote-15)

The main opponents of the legalization of physician-facilitated suicide are religious organizations, including the Roman Catholic Church, and the American Medical Association (AMA).[[16]](#footnote-16) The Disability Rights Education & Defense Fund and other advocates for persons with disabilities also oppose the legalization of physician-facilitated suicide.[[17]](#footnote-17) According to Catholic Doctrine, suicide is a mortal sin, so the Church strongly opposes any attempt to legalize physician-facilitated suicide. In fact, Pope Francis denounced the right to die movement, stating that it is a “false sense of compassion” to deem euthanasia as an act of dignity because it is a sin against God and creation.”[[18]](#footnote-18) The Church of England actively opposed the assisted suicide bill introduced into to Parliament. Prior to the vote on the bill, the Church’s website stated “The value of individuals' lives, protection of the vulnerable and respect for the integrity of the doctor-patient relationship are central to the Church of England's concerns about any proposal to change the law.”[[19]](#footnote-19) The AMA issued an opinion stating its opposition to physician-facilitated suicide. The AMA explained its position by stating “Physician-assisted suicide is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks.”[[20]](#footnote-20)

The two non-profit organizations going around the country advocating for the legalization of physician-assisted suicide are Compassion and Choices and the Death with Dignity National Center. According to its website, Compassion and Choices “helps people plan for and achieve a good death.”[[21]](#footnote-21) The Death with Dignity National Center claims that its mission is “to promote Death with Dignity laws based on the model Oregon Death with Dignity Act, both to provide an option for dying individuals and to stimulate nationwide improvements in end-of-life care.”[[22]](#footnote-22)

Even in the states where physician-facilitated suicide is permitted the availability of the procedure is limited. American legislatures are often influenced by public opinion when making laws that impact personal decision-making. For instance, the victory that gays and lesbians won to have same-sex marriages legally recognized in all fifty states[[23]](#footnote-23) might not have occurred had the American people not changed their stance on the issue.[[24]](#footnote-24) Likewise, the reluctance on the part of the courts and legislatures to conclude that persons have a fundamental right to assisted suicide[[25]](#footnote-25) may stem from the fact that assisted suicide has not been widely embraced by the American people. However, the tide may be turning.[[26]](#footnote-26) The Catholic Church, a key opponent of physician-facilitated suicide, appears to be losing its ability to influence the way social issues like abortion and same-sex marriages are viewed.[[27]](#footnote-27) When the public sees these issues as personal choices instead of moral concerns, opinions are likely to shift towards respecting the rights of people to make their own decisions with regards to these matters.

In fact, in 2004, the Hemlock Society, one of the main proponents of physician-facilitated suicide merged with an organization called Compassion in Dying. After the merger, the name of the organization was changed to Compassion and Choices. The original members of the non-profit organization emphasized the right to die. The current members have attempted to change the tone of the conversation by stressing that their mission is for patients to have the choice to decide how and when they die. In addition, media coverage of the topic may have impacted the manner in which members of the public feel about the “right to die” movement. In the beginning, the face of the movement was Dr. Jacob “Jack” Kevorkian, a self-proclaimed euthanasia activist who invented a “suicide machine”.[[28]](#footnote-28) After several arrests for assisting in suicides, Kevorkian was convicted of second degree murder for administering lethal drugs to a patient suffering from Lou Gehrig’s disease.[[29]](#footnote-29) During Kevorkian’s trial, the media reported that he had been nicknamed “Doctor Death” and speculated that he was a little too aggressive when it came to assisting in suicides.[[30]](#footnote-30) Consequently, persons who opposed physician-facilitated suicide were able to convinced members of the public that the legalization of the procedure would lead to doctors coercing patients, especially the elderly and disabled, to end their lives.[[31]](#footnote-31) Kevorkian died on June 3, 2011, so any damage his actions may have done to the “right to die” movement has faded.[[32]](#footnote-32) Persons advocating for the legalization of physician-facilitated suicide now have a new “poster person” in the form of Brittany Maynard.[[33]](#footnote-33) When she was newly married, twenty-nine year old Maynard was diagnosed with aggressive cancer. After a few unsuccessful treatments, Maynard’s doctors told her that her brain tumor was inoperable and that she had only six months to live. Maynard and her family decided that physician-facilitated suicide was the best option for her.[[34]](#footnote-34) Since Maynard lived in California, a state that had not legalized physician-facilitated suicide, she and her family relocated to Oregon where she could legally end her life.[[35]](#footnote-35) Maynard received support from Compassion and Choices. Prior to her death, Maynard gave numerous interviews arguing that every terminally-ill patient should have the right to choose when and how they die.[[36]](#footnote-36)

**The Legal Landscape**

The majority of states in the United States have not taken steps to legalize physician-facilitated suicide. The process is probably illegal in those jurisdictions because of the existence of blanket manslaughter statutes. Five states have explicitly criminalized the process by statute.[[37]](#footnote-37) Terminally-ill patients in Hawaii live in a state of limbo because, even though physician-facilitated suicide has not been legalized in that state, there is not a criminal prohibition against the process.[[38]](#footnote-38) Currently, only five American states permit physicians to prescribe lethal medication for terminally-ill patients who want to end their live. Physician-facilitated suicide was legalized in Oregon and Washington by public initiatives.[[39]](#footnote-39) Legislatures in Vermont and California enacted statutes making physician-facilitated suicide legal for residents of those states. A Montana court made lethal medication available to terminally-ill patients in that state by preventing the conviction of doctors who prescribe the lethal medication. Thus, physician-facilitated suicide is judicially recognized as a valid statutory defense to homicide in Montana.[[40]](#footnote-40)

In order to understand the ethical concerns that will be discussed later, it is necessary to comprehend the manner in which the physician-facilitated process works. The Oregon, Washington, Vermont and California statutes contain similar provisions, so the information in this section is applicable to all of those states.[[41]](#footnote-41) The statutes permit a capable, terminally ill adult resident to request a prescription for lethal medication from a willing physician.[[42]](#footnote-42) If the physician is not willing to write the prescription, he or she must refer the patient to another physician.[[43]](#footnote-43) Once the patient receives the medication, he or she can take it if and when he or she wishes. The statutes forbid lethal injection, so the patient must be able to ingest the medication without assistance.[[44]](#footnote-44) In order to be eligible to receive the prescription for the medication, the patient must satisfy the requirements listed in the statutes and adhere to the procedures mandated by the statutes.

The statute only applies to cases involving adult patients, so the person must be over the age of eighteen.[[45]](#footnote-45) In addition, the person must be capable of making health care decisions and of communicating those decisions to the appropriate health care provider.[[46]](#footnote-46) In order to be deemed to have that capacity, the person must be of sound mind. This standard is relatively low because the decision can be made by the person’s primary care physician without the benefit of any type of psychological evaluation. In fact, prior to requesting the prescription, the person does not have to undergo any type of counseling. However, if the physician suspects that the person is suffering from a psychiatric or psychological disorder or depression that impairs his or her judgment, the physician must refer that person to counseling before proclaiming him or her to be competent to receive the prescription.[[47]](#footnote-47)A person does not have to be mentally competent to withdraw his or her request for the prescription for the medication.[[48]](#footnote-48)

In order to request a prescription for the lethal medication, the patient must be a resident of the state.[[49]](#footnote-49) The patient must establish a connection to the state to be recognized as a resident. At the time the patient requests the medication, he or she must provide proof of residency. The following are acceptable forms of proof: (1) a state driver’s license, (2) a state voter’s registration card, (3) a deed or lease showing ownership or rental of real estate in the state, or (4) a recent state income tax return.[[50]](#footnote-50) Moreover, the patient must have been diagnosed with an “incurable and irreversible” disease.[[51]](#footnote-51) The patient’s physician must predict that the patient will die within six months of the diagnosis in order for the patient to satisfy the terminal illness requirement.[[52]](#footnote-52)

Patients deemed eligible to make the request must follow the procedure set forth in the statutes. Traditionally, when the law sets forth requirements for a person to make a life-changing decision, the execution process is rigid. For instance, a person making a will must usually have it signed, witnessed and/or acknowledged. The Oregon and Washington statutes require the patient seeking life-ending medication to follow a set procedure; the mandated process is actually similar to the will execution process.

After the patient meets the initial statutory capacity mandates, the patient’s decision to request the lethal medication must be informed, and the request must be executed in conformance with the statutory requirements.[[53]](#footnote-53) The patient cannot make an informed decision unless the physician makes sure that the patient understands the medical diagnosis and prognosis; the potential risks and probable results of taking the medication; and the other available options including comfort care, hospice care and pain control.[[54]](#footnote-54) This informed consent is similar to the consent a patient has to give before a physician can perform a medical procedure on the patient. The purpose is to ensure that the patient has all of the relevant facts before making the decision to request the lethal medication.

The patient must also sign and date the written request for the medication. In the patient’s presence, at least two persons must attest that “to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request.”[[55]](#footnote-55) The law restricts the pool of persons who can serve as witnesses to protect the interests of the patient. Thus, one of the witnesses must be disinterested.[[56]](#footnote-56) Further, the doctor caring for the patient is not permitted to act as a witness to the request.[[57]](#footnote-57) Nevertheless, when the patient is a resident of a long-term care facility, one of the witnesses must be a person designated by the facility.[[58]](#footnote-58) After the request is made, another physician must examine the patient’s medical records to confirm the diagnosis.[[59]](#footnote-59)

**Ethical Issues**

The Oregon statute turns twenty in 2017. During that time, many dying patients have ended their lives using lethal doses of medication prescribed by their doctors. The Oregon statute has not undergone any major revisions since its enactment. Thus, most of the ethical concerns that have been raised have gone unresolved. Most persons who are critical of the current physician-facilitated legal regimen that exists in the United States argue that it does not contain enough safeguards to protect terminally-ill patients who are vulnerable because of factors other than their illnesses, including age, disability, race and economic status. Some proponents of physician-facilitated suicide have written these concerns off as speculative because they have not been presented with evidence of wide-spread abuse of persons included in these so called “disposal” groups. However, with the exception of California, the states where the process is legal are some of the least diverse areas in the country. Some persons maintain that it is unethical to include certain vulnerable groups in the pool of persons who can choose physician-facilitated suicide without affording them special protections. There are also people who argue that it is unethical to deprive some vulnerable patients of the opportunity to die with dignity.

*The Elderly and Disabled*

Persons opposing the legalization of physician-facilitated suicide have argued that, to reduce end-of-life costs, doctors may pressure the elderly and the disabled to request the lethal medication. Some opponents also fear that the elderly and the disabled may be targeted as candidates for physician-facilitated suicide based solely upon their age and infirmities. They contend that physicians may aggressively encourage terminally-ill elderly or disabled patients to consider physician-facilitated suicide in cases where they would not do so with patients who are younger and/or able-bodied. In some cases, given the lack of quality of life, some doctors may assume that those patients would want to request the lethal medicine. Bioethicist Wesley J. Smith contends that the elderly and the disabled are often made to feel like they have a duty to die so they will not be a burden on society and their families.

The legislatures attempted to address these concerns. The statutes explicitly state that a patient’s eligibility for physician-facilitated suicide cannot be based solely on his or her age or disability. Hence, those characteristics alone should not result in the presumption that the patient would want physician-facilitated suicide. This clarification and other safeguards in the statutes may reduce the possibility that elderly and disabled patients will be sacrificed to save medical costs.

However, it is unclear if the language in the statutes is sufficient to address the concerns put forth by opponents of physician-facilitated suicide. For the statutory preclusion to mean anything, doctors must be better educated about the needs of elderly and disabled patients and must be taught that those lives have value.

*The Mentally Ill*

Some persons feel that citizens who are already suicidal because of mental illness might perceive legalized physician-facilitated suicide as the state giving its stamp of approval to suicide. They opine that once the stigma is removed from suicide, the practice might become widespread because some persons may be persuaded to commit suicide. They fear that the availability of physician-facilitated suicide may encourage terminally-ill persons who are clinically depressed to request the lethal medication instead of fighting the disease. This is a legitimate concern because the statutes do not require all patients to undergo counseling before they choose physician-facilitated suicide.

Currently, the law takes certain steps to prevent suicidal persons from taking their own lives. For instance, prisoners are placed on “suicide watch” if guards think that they are a danger to themselves. Ironically, prison guards take steps to prevent death row inmates from committing suicide. Authorities may also place persons who are suspected of being a danger to themselves and/or others on a seventy-two hour hold at a psychiatric facility. Members of the public may be uncomfortable with the possibility of the state helping a suicidal person commit suicide. It is too much like “suicide by cop” where a person pulls a loaded gun in order to get a police officer to kill him or her. Some people even believe that it is unethical for the state to execute death row inmates who ask to die.

The statutes attempt to deal with this issue by including several safeguards. If a health care professional thinks that the person is suffering from a mental illness or depression that impairs his or her judgment, the statutes require the physician to refer the person to counseling before providing the lethal medication. In addition, the person is permitted to rescind the request for the medication at any time. The statutes also mandate a waiting period between the request for the medication and the writing of the prescription which allows the physician to make sure that the patient is capable of making an informed decision about committing suicide.

*The Economically Disadvantaged and the Racially Diverse*

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The existence of inequalities in health care has been a concern in the United States for decades. Consequently, it is not surprising that some people are concerned that poor people and people of color may be disadvantaged by the existence of physician-facilitated suicide. Instead of investing resources to treat certain patients, physicians may decide that it is more cost effective to just write a prescription. Terminally ill low-income patients and patients of color often do not receive the same level of treatment as their counterparts. When the New York legislature explored the possibility of legalizing physician-facilitated suicide, this was a major concern of the members of the task force. To illustrate, the New York State Task Force on Life and the Law stated in its 1994 report on physician-assisted suicide and euthanasia:

The risk of harm is greatest for the many individuals in our society whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized social group. The risks of legalizing assisted suicide and euthanasia for these individuals, in a health care system and society that cannot effectively protect against the impact of inadequate resources and ingrained social disadvantages, would be extraordinary.

The members of the Task Force reasoned that if the law could not protect socially and economically disadvantaged persons from being given inadequate medical treatment, it could not protect them from abuses that might occur if physician-facilitated suicide was legalized.

The statutes do not specifically offer a solution to this perceived problem. Nonetheless, the concerns have been proven to be unfounded. According to the annual reports, the typical patient requesting physician-facilitated suicide in Oregon and Washington is white, married, college educated, and over the age of 65; the patient also has some kind of cancer, has private health insurance, is enrolled in hospice care, is concerned primarily about the loss of autonomy, and dies at home. Given the demographics of the persons requesting the lethal medication, it appears that the existence of physician-facilitated suicide has not unduly burdened poor people and people of color. Nonetheless, it should be noted that the populations of Oregon and Washington are predominately white.

On the other hand, members of those populations may have a greater need for physician-facilitated suicide. Studies have shown that low-income people and people of color often receive inadequate pain treatment. Therefore, when they are diagnosed with terminal illnesses, members of those populations frequently are forced to tolerate significant pain. The availability of physician-facilitated suicide may offer them a way out of their horrible circumstances. The good news is that insurance companies have shown a willingness to pay for the lethal medication. The bad news is that the insurance company may refuse to pay for other forms of treatment that are more expensive that physician-facilitated suicide.

*Minors*

Unfortunately, persons under the age of eighteen suffer from terminal illness. In 2012, Belgium reported the age-restriction and made physician-facilitated suicide available to minors. In the United States, a terminally-ill patient must be an adult in order to be eligible to request a prescription for lethal medication. Some people contend that, since pain and suffering does not respect age, minors should be permitted to die with dignity. There are others who argue that a minor who is suffering from a terminal illness is older than his or her chronological age. Nevertheless, even persons who advocate for the legalization of physician-facilitated suicide are uncomfortable with the thought of children committing suicide. Before minors can be included in the group that can choose physician-facilitated suicide, a lot of questions must be answered and numerous safeguards must be put in place.

*Nonterminal Patients*

The current system in place fails to serve the needs of two categories of patients. Some patients, who suffer from diseases that destroy the physical body, are not considered terminal because their doctors predict that they will survive longer than six months. In those cases, the doctors use their medical judgments to conclude that the patients will die at some specified time in the future. A patient in that class has a predicted expiration date, but that date is too far in the future for the patient to be labeled as terminal. Another group of patients suffer from progressive, irreversible brain disorders that gradually destroy their memories and their abilities to learn, reason, and make decisions. Those patients can physically survive their conditions for an indeterminate period of time. Therefore, for purposes of requesting physician-facilitated suicide, those patients are not recognized as being terminal.

Some people argue that the law needs to be expanded to serve the needs of patients in both of those groups. The primary goals cited for legalizing physician-facilitated suicide include the following: permitting terminally ill patients to die before they lose autonomy, easing the pain and suffering of terminally ill patients, and reducing the costs of end-of-life care. Expanding the availability of physician-facilitated suicide is consistent with those objectives.

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1. Cruzan v. Dir. Mo. Dep’t of Health, 497 U.S. 261 (1990); In re Quinian, 355 A.2d 647 (N.J. 1976). [↑](#footnote-ref-1)
2. Passive euthanasia occurs when a physician omits treatment and permits the patient to succumb to the disease. [↑](#footnote-ref-2)
3. Active euthanasia refers to direct actions a doctor takes to end the patient’s life. [↑](#footnote-ref-3)
4. Because the doctor’s role in the process is limited to just writing the prescription for the lethal medication I refer to the process as physician-facilitated suicide. I believe that the correct name for the process is suicide because the patient uses the lethal medication to end his or her life. [↑](#footnote-ref-4)
5. Erin Taylor, “Keep Medicare Alive and Well: Reforming end-of-life care will benefit Medicare for years to come, at [www.usnews.com](http://www.usnews.com) (July 30, 2015). [↑](#footnote-ref-5)
6. In September of 2015, 118 MPs voted in favor of the bill and 133 MPs voted against it. [↑](#footnote-ref-6)
7. Fiona Bruce, the MP for Congliton said that the proposed bill did not include safeguards to protect vulnerable people. [↑](#footnote-ref-7)
8. **In 1995, Governor Mario Cuomo appointed the members of the Task Force to review the law and end-of-life issues. The Task Force issued its first report in 1994. That report was supplemented in 1997 and updated in 2000. The 1994 Report contained the following statement: “The** risks would extend to all individuals who are ill. They would be most severe for those whose autonomy and well-being are already compromised by poverty, lack of access

   to good medical care, or membership in a stigmatized social group. The risks of legalizing assisted suicide and euthanasia for these individuals, in a health care system and society that cannot effectively protect against the impact of inadequate resources and ingrained social disadvantage, are likely to be extraordinary.” ***When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*, New York: New York State Task Force on Life and the Law, 1994.** [↑](#footnote-ref-8)
9. *Washington v. Glucksberg*, 521 U.S. 702 (1997). [↑](#footnote-ref-9)
10. Eliyahu Federman, Physician-Assisted Suicide Debate: Are We Using the Right Language? [www.forbes.com](http://www.forbes.com) (Oct. 27, 2014). [↑](#footnote-ref-10)
11. The body of the person who committed suicide was placed on the side of the road to rot. The person’s property escheated to the state. Rebecca C. Morgan, Thomas C. Marks, Barbara Harty-Golder*, The Issue of Personal Choice: The Competent Incurable Patient and the Right to Commit Suicide,* 57 Mo. L. Rev. 1, 5-8 (Winter 1992) [↑](#footnote-ref-11)
12. M.C.L.A. § 752.1027 (”(1) A person who has knowledge that another person intends to commit or attempt to commit suicide and who intentionally does either of the following is guilty of criminal assistance to suicide, a felony punishable by imprisonment for not more than 4 years or by a fine of not more than $2,000.00, or both: (a) Provides the physical means by which the other person attempts or commits suicide. (b) Participates in a physical act by which the other person attempts or commits suicide.” SDCL § 22-16-37 “Any person who intentionally in any manner advises, encourages, abets, or assists another person in taking or in attempting to take his or her own life is guilty of a Class 6 felony.”); West’s Ann. Cal. Penal Code § 401 (“Every person who deliberately aids, or advises, or encourages another to commit suicide, is guilty of a felony.”) [↑](#footnote-ref-12)
13. The Suicide Act of 1961 makes it a crime to encourage or assist a suicide or suicide attempt in England and Wales. Northern Ireland has a similar law. [↑](#footnote-ref-13)
14. Kelly S. Noble, Accidental Death or Was it?: The Question of Suicide in Life Insurance and Accidental Death Insurance, 39 Sum Brief 50, 51-53 (Summer 2010). [↑](#footnote-ref-14)
15. Kathryn L. Tucker, *When Dying Takes Too Long: Activism For Social Change to Protect and Expand Choice At the End of Life,* 33 Whittier L. Rev. 109 (Fall 2011). [↑](#footnote-ref-15)
16. K.K. DuVivier, *Fast-Food Government and Physician-Assisted Death: The Role of Direct Democracy in Federalism,* 86 Or. L. Rev. 895 (2007). [↑](#footnote-ref-16)
17. Anna Gorman, “Why Disability Rights Advocates Are Fighting Doctor-Assisted Suicide”, at [www.theatlantic.com](http://www.theatlantic.com) (June 30, 2015). [↑](#footnote-ref-17)
18. Filippo Monteforte, Pope says assisted suicide is a “sin against God”, at [www.cbsnews.com](http://www.cbsnews.com) (November 15, 2014). [↑](#footnote-ref-18)
19. www.churchofengland.org (last visited January 14, 2016). [↑](#footnote-ref-19)
20. Opinion 2.211 issued June 1994 based on the reports “Decisions Near the End of Life” adopted June 1991 and “Physician-Assisted Suicide” adopted December 1993 (JAMA 1992; 267: 2229-33). [↑](#footnote-ref-20)
21. [www.compassionandchoices.org](http://www.compassionandchoices.org) (last visited Jan. 15, 2016). [↑](#footnote-ref-21)
22. [www.deathwithdignity.org](http://www.deathwithdignity.org) (last visited Jan. 15, 2016). [↑](#footnote-ref-22)
23. *Obergefell et.al. v. Hodges*, 135 S.Ct. 2584 (June 26, 2005). [↑](#footnote-ref-23)
24. “Changing Attitudes on Gay Marriage”, [www.pewforum.org](http://www.pewforum.org) (June 8, 2015). [↑](#footnote-ref-24)
25. *Washington v. Glucksberg*, 117 S.Ct. 2259 (1997)’ Yale Kamisar, Foreward: *Can Glucksberg Survive Lawrence? Another Look at the End of Life and Personal Autonomy*, 106 Mich. L. Rev. 1453, 1453 (June 2008). [↑](#footnote-ref-25)
26. Frank Newport, Americans Continue to Shift Left on Key Moral Issues, Gallup, [www.gallup.com/poll](http://www.gallup.com/poll) (May 26, 2015) (According to a Gallup poll, in 2001, 49% of Americans found assisted suicide to be morally acceptable. That percentage increased to 56% in 2015). [↑](#footnote-ref-26)
27. “Liberals, Moderates and Conservative Catholics All See Pope Francis As Aligned With Their Politics, Majority See Catholic Church As Out Of Touch And Far To The Right” [www.shrivermedia.com/snapshot](http://www.shrivermedia.com/snapshot) (Sept. 2, 2015). [↑](#footnote-ref-27)
28. Annette E. Clark, *Autonomy and Death*, 71 Tul. L. Rev. 45, 93-94 (Nov. 1996). [↑](#footnote-ref-28)
29. William H. Colby, *Society’s Challenge: Finding a Better Way to Die*, 82-APR Wis. Law 6, 8 (April, 2009). [↑](#footnote-ref-29)
30. Lora L. Manzione, *Is There a Right to Die?: A Comparative Study of Three Societies (Australia, Netherlands, United States),* 30 Ga. J. Int’l & Comp. L. 443, 463 (2002). [↑](#footnote-ref-30)
31. Wesley Smith’s book *Forced Exit: Euthanasia, Assisted Suicide and the New Duty to Die* (1997, Times Books), a broad-based criticism of the right to die movement because a best seller. [↑](#footnote-ref-31)
32. Jack Kevorkian, Convicted in assisted suicides, dies at 83, [www.nbcnews.com](http://www.nbcnews.com) (June 3, 2011). [↑](#footnote-ref-32)
33. David Bryant, *The Need For Legalization and Regulation of Aid-in-Dying and End-of-Life Procedures in the United States*, 18 Quinnipac Health L.J. 287, 288-289 (2015). [↑](#footnote-ref-33)
34. Brittany Maynard, My right to die with dignity at 29, [www.edition.cnn.com](http://www.edition.cnn.com) (Nov. 2, 2014). [↑](#footnote-ref-34)
35. *Id.* [↑](#footnote-ref-35)
36. *Id.* [↑](#footnote-ref-36)
37. A.C.A § 5-10-106 (“(b) It is unlawful for any physician or health care provider to commit the offence of physician-assisted suicide by: (1) prescribing any drug, compound, or substance to a patient with the express purpose of assisting the patient to intentionally end the patient’s life; or (2) Assisting in any medical procedure for the express purpose of assisting a patient to intentionally end the patient’s life.”); Ga. Code Ann. § 16-5-5 (“(b) Any person with actual knowledge that a person intends to commit suicide who knowingly and willfully assists such person in the commission of such person's suicide shall be guilty of a felony and, upon conviction thereof, shall be punished by imprisonment for not less than one no more than ten years.”); I.C. §18-4017 (“(1) A person is guilty of a felony if such person, with the purpose of assisting another person to commit or to attempt to commit suicide, knowingly and intentionally either: (a) Provides the physical means by which another person commits or attempts to commit suicide; or (b) Participates in a physical act by which another person commits or attempts to commit suicide.”); N.D.C.C. § 12.1-16-04 (“1. Any person who intentionally or knowingly aids, abets, facilitates, solicits, or incites another person to commit suicide, or who provides to, delivers to, procures for, or prescribes for another person any drug or instrument with knowledge that the other person intends to attempt to commit suicide with the drug or instrument is guilty of a class C felony. 2. Any person who, through deception, coercion, or duress, willfully causes the death of another person by suicide is guilty of a class AA felony.”); Gen. Laws R.I. § 11-60-3 (“An individual or licensed health care practitioner who with the purpose of assisting another person to commit suicide knowingly:(1) Provides the physical means by which another person commits or attempts to commit suicide; or (2) Participates in a physical act by which another person commits or attempts to commit suicide is guilty of a felony and upon conviction may be punished by imprisonment for up to ten (10) years, by a fine of up to ten thousand dollars ($10,000) or both.”). [↑](#footnote-ref-37)
38. In Hawaii, a person commits manslaughter if he or she intentionally causes another person to commit suicide. H.R.S. § 707-702. This appears to deal with situations where a person is forced to commit suicide. It seems to require more aggressive action than just assisting with a suicide. [↑](#footnote-ref-38)
39. Initiatives allow citizens to propose their own laws. An initiative has the same force and effect as any act of the legislature. Thomas M. Carpenter*, In Whose Court is the Ball?: The Scope of the People’s Power of Direct Legislation,* 28-SPG Ark. Law 35, 36 (Spring 1994)(explaining the difference between a referendum and an initiative). [↑](#footnote-ref-39)
40. *Baxter v. State*, 224 P.3d 1211 (Mont. 2009). [↑](#footnote-ref-40)
41. The California Act is being challenged and not yet effective, so I have not included citations from that legislation. [↑](#footnote-ref-41)
42. *See* e.g, Or. Rev. Stat. ch. 127.805 § 2.01(1) (2016); Wash. Rev. Code Ann § 70.245.190 (1)(d) (West 2016). [↑](#footnote-ref-42)
43. Or. Rev. Stat. ch. 127.855 § 4.01(4) (2016); Wash. Rev. Code Ann. § 70.245.190 (1)(d) (West 2016); 18 V.S.A. ch. 113 § 5285 (a)(West 2016). [↑](#footnote-ref-43)
44. Or. Rev. Stat. ch. 127.880 § 3.14 (2016); Wash. Rev. Code Ann. § 70.245.80(1) (West 2016); 18 V.S.A. ch. 113 § 5292 (West 2016). [↑](#footnote-ref-44)
45. Or. Rev. Stat. ch. 127.800 § 1.01(1) (2016); Wash. Rev. Code Ann. § 70.245.010 (1) (West 2016); 18 V.S.A. ch. 113 § 5281 (a)(8) (West 2016). [↑](#footnote-ref-45)
46. Or. Rev. Stat. ch. 127.800 §1.01(3) (2016)(“’Capable’ means that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has 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.”); 18 V.S.A. ch. 113 § 5281(2)(“’Capable’ means that a patient has the ability to make and communicate health care decisions to a physician, including communication through persons familiar with the patient’s manner of communicating if those persons are available.”); Wash. Rev. Code Ann § 70.245.010 (3) ("’Competent’ means that, in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist, or psychologist, a patient 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.”). [↑](#footnote-ref-46)
47. Or. Rev. Stat. ch. 127.825 § 3.03 (West 2016); ch. 127.800 § 1.10(5)( "’Counseling’" means one or more consultations as necessary between a state licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is capable and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.”); Wash. Rev. Code Ann. § 70.245.06018; Wash. Rev. Code Ann. § 70.245.010 (5) ("’Counseling’ means one or more consultations as necessary between a state licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is competent and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.”); V.S.A. ch. 113 § 5283(a)(8)(West 2016) [↑](#footnote-ref-47)
48. Or. Rev. Stat. ch. 127.845 § 3.07 (2016); Wash. Rev. Code Ann. § 70.245.100 (West 2016); 18 V.S.A. ch. 113 § 5283 (a)(10) (West 2016). [↑](#footnote-ref-48)
49. Or. Rev. Stat. ch. 127.860 § 3.10 (2016); Wash. Rev. Code Ann. § 70.245.040 (1)(b) (West 2016); 18 V.S.A. ch. 113 § 5283 (a)(5)(E) (West 2016) [↑](#footnote-ref-49)
50. Or. Rev. Stat. ch. 127.860 § 3.10 (1)-(4) (2016); Wash. Rev. Code Ann. § 70.245.130(1)-(3) (West 2016); [↑](#footnote-ref-50)
51. Or. Rev. Stat. ch. 127.815 § 3.01(a) (2016); Wash. Rev. Code Ann. § 70.245.010(13) (West 2016); 18 V.S.A. ch. 113 § 5283 (a)(5)(A) (West 2016). [↑](#footnote-ref-51)
52. Or. Rev. Stat. ch. 127.800 § 1.01(12) (2016); Wash. Rev. Code Ann. § 70.245.040 (1)(a) (West 2016); 18 V.S.A. ch. 113 § 5281(a)(10) [↑](#footnote-ref-52)
53. Or. Rev. Stat. ch. 127.860 § 3.10 (2016); Wash. Rev. Code Ann. § 70.245.070 (West 2016); 18 V.S.A. ch. 113 § 5283 (a)(5)(E) (West 2016). [↑](#footnote-ref-53)
54. Or. Rev. Stat. ch. 127.860 § 3.10 (2016); Wash. Rev. Code Ann. § 70.245.040 (1)(c)(i)-(v) (West 2016); 18 V.S.A. ch. 113 § 5283 (a)(5)(E) (West 2016). [↑](#footnote-ref-54)
55. Or. Rev. Stat. ch. 127.860 § 3.10 (2016); Wash. Rev. Code Ann. § 70.245.030 (1) (West 2016); 18 V.S.A. ch. 113 § 5283 (a)(5)(E) (West 2016). [↑](#footnote-ref-55)
56. Or. Rev. Stat. ch. 127.860 § 3.10 (2016); Wash. Rev. Code Ann. § 70.245.030 (2)(a)-(c) (West 2016); 18 V.S.A. ch. 113 § 5283 (a)(5)(E) (West 2016). [↑](#footnote-ref-56)
57. Or. Rev. Stat. ch. 127.860 § 3.10 (2016); Wash. Rev. Code Ann. § 70.245.030 (3) (West 2016); 18 V.S.A. ch. 113 § 5283 (a)(5)(E) (West 2016). [↑](#footnote-ref-57)
58. Or. Rev. Stat. ch. 127.860 § 3.10 (2016); Wash. Rev. Code Ann. § 70.245.030 (4) (West 2016); 18 V.S.A. ch. 113 § 5283 (a)(5)(E) (West 2016). [↑](#footnote-ref-58)
59. Or. Rev. Stat. ch. 127.860 § 3.10 (2016); Wash. Rev. Code Ann. § 70.245.050 (3) (West 2016); 18 V.S.A. ch. 113 § 5283 (a)(5)(E) (West 2016). [↑](#footnote-ref-59)