The "Right to Die" With Dignity: A Policy Evaluation Study of Assisted Suicide Laws in 20 Jurisdictions in the United States of America

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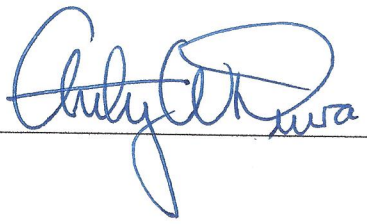
Signature 

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ABSTRACT

The phrase “Right to Die with Dignity” has long been a tag-line for the topic of assisted suicide. This dissertation tackles that topic through a qualitative policy evaluation study that includes a review and analysis of assisted suicide laws in 19 States in the United States, the District of Columbia, six countries other than the United States, and Supreme Court cases and other court decisions that are relevant to the topic. The dissertation also considers whether the time is right for assisted suicide policy development, based on recent court interpretations of the Fifth, Tenth and most specifically the Fourteenth Amendment(s) and how recent court decisions have been influenced by either the Constitution or public policy. The purpose of the dissertation is to recommend a public policy that establishes a new federal policy that represents a dignified, compassionate, and common-sense approach to assisted suicide.

The primary methodology is the use of the “legal lens of study approach,” which lays the foundational groundwork for the five research questions this dissertation explores. Analysis of the common elements of the existing laws was a first step in this policy evaluation and helped identify principles that should be included in any new policy. Also key to the analysis and the proposal of a new federal policy was the legal study of most relevant assisted suicide cases from several states and from the federal court system, including Supreme Court cases involving the Fourteenth Amendment in decisions concerning socially relevant issues that involve liberty interests and individual rights. Critical historical events concerning assisted suicide were uncovered in order to chronologically interpret the issue of assisted suicide over the past 45 years and how

these cases and more recent court decisions might create opportunities for policy changes.

Results indicate that leaving the issue of assisted suicide to be dealt with by each individual state or waiting for the Supreme Court to make a ruling that would finalize the issue on a national level has created an intolerably diverse quagmire for society as a whole and especially for those competent adult individuals who would prefer to choose this end-of-life option.

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ACKNOWLEDGMENTS

The next three+ pages herein entitled "Acknowledgments" are very personal to the writer of any dissertation and are more than likely boring to many others and therefore skimmed over by the majority of readers. I accept that. However, to me these pages tell a very important story worthy of the time and effort taken to recognize and thank the many individuals who have helped me get to this point. "This point" being defined as completion of my dissertation, graduation from the DPA program at Valdosta State University and reaching my 70th Birthday.

I owe a debt of gratitude to the late Dr. Nolan Argyle and Valdosta State University for my acceptance into the DPA program, the faculty in the Department of Political Science of the College of Humanities & Social Sciences, several of whom matched or surpassed the level of teaching acumen of those I learned from in law school, and fellow students who became much more than co-authors of papers, my journey-mates through most of the program (Rebecca, Pat and Carolann).

The order in which I have chosen to individually acknowledge and thank the following individuals does not mean that those listed toward the end are receiving any less of a heart-felt thanks. In my mind, the help I received is divided into three categories. The first is the "help for life" category which has allowed me to get to this point (see definition of "this point" above). The second is the "encouragement through words and actions" category which we certainly all need during different times in our lives. The third is the "actual hands-on working on the dissertation" category. So, without any further explanatory filibuster:

I thank God for his grace, mercy, love, healing power and wisdom for not only helping me through this process, but in my entire journey through the DPA program beginning in August 2012, as well as my journey through life. I know that many turn away from this type of specific acknowledgment or praise, but I offer no apology for it. I was very ill for almost two years during this entire academic process and it was only because of His grace, as well as the patience, support and understanding of my advisors, professors and committee members that I made it to this point.

Thanking a spouse offers a unique opportunity to say something you probably should have already said many times over. My wife of 48 years is unique. Diana is unique in an exceptionally good way. From the day I met her via a "blind date" in 1967 and experienced "love at first sight," through our entire lives together, she has exhibited five incredible traits that have guided our journey through life; honesty, character, integrity, loyalty and the gift of discernment. If I had just listened to her more often, there would have been fewer "downs" and more "ups" throughout our journey. I am reminded of a quote by Thomas Paine for it fits Diana so well, "Reputation is what men and women think of us: character is what God and angels know of us." God knows her character and is well-pleased. I therefore must do three things. First apologize for not listening more, secondly say thank you and thirdly say I love you.

I am prepared for many eyes to roll as this next "thank you" is read. I have a puppy named Beaux. He saved my life when I first became ill. I will spare you the details. My wife and I returned this loving magnanimous gesture when he fell ill at a little more than one-year old. But he saved me first. I will always remember that. Thank you, Beaux.

My sons, Brian and Tysen have become better men and better lawyers than I am and ever was. I could not be prouder of them and the way they have lived their lives. When I informed them as to what I was going to do in getting this degree, they encouraged me without hesitation. My daughters-in-law, Ingrid and Julie, did the same. I am fond of saying that "I married up!" Perhaps all three of us did. Thank you so much Brian, Tysen, Ingrid, and Julie.

Dr. James W. Peterson has been the consummate, quintessential, dictionary definition of a committee Chair. His vast knowledge of political science subjects, public administration, the writing of a dissertation, as well as the process, his leadership and orchestration abilities are unparalleled. Thank you for being the masterful and gifted conductor of this slow-moving, yet purposeful train that has finally arrived at the right station.

Dr. Bonnie E. Peterson was a professor of mine for several courses. From the beginning of our relationship, I was amazed and so appreciative of her willingness to help each student get the most out of every class. She was kind, considerate and would take the extra time if necessary to help any student who was not grasping everything the course had to offer. As a committee member, our relationship continued to grow, albeit in a different direction. I began to refer to her (only to myself) as the "Warrior Queen." For me, this was a term of endearment. She often led the charge (writing process) with the approach of a benevolent head of state, but several times she needed to look her army (me) in the eye (via email) and say (indirectly between the lines), "I know you can do better than this first draft. Stay the course. I know you can do this." Thank you so much.

Dr. Mary Eleanor Wickersham is the type of person who is good at everything. It doesn't matter what "it" is; she is really good at it. She has always reminded me of the kid in little league who was just better than everyone else. He/she could catch, pitch, play shortstop and seemed to know as much as the coach, even though he/she was only 11 years old. But unlike many 11 year-olds, Dr. Wickersham never displayed any "attitude" as she read, taught, instructed, edited, researched, corrected, suggested, reminded, recommended, advocated, directed, enlightened, trained, tutored, guided, informed and educated me through this entire process. Thank you so much for being a committee member and sharing your brilliance and expertise with all of us.

Dr. Christine A. James became my fourth committee member when I needed an expert in methodology for a qualitative dissertation. Dr. James Peterson suggested that I contact Dr. James since he felt that her expertise in methodology was extraordinary. Boy was he right! To continue with another baseball analogy (I apologize to those who do not

like sports), Dr. James was like the all-star pitcher with a fantastic ERA who was on a team that was not going to make the playoffs and I traded for her right before the trading dead-line, so she could help me win the pennant (finish my proposal). I will define the trading deadline as producing Chapter III, so my proposal would be accepted and I could move on to completing my dissertation. She joined the team, brought her accolades (read her vitae – WOW), suited up, jumped in and struck everyone out (that is a good thing because she was on my team!). I am unable to thank you enough for what you have done.

Emily Cofield Rogers was my editor. I fancy myself a writer. I have one novel and a children's book which have been on hold for several years as I wrote this dissertation. I say that to illustrate that I can only imagine how David Baldacci or John Grisham must have felt when they were writing their first novel and needed an editor. I am sure when they asked an extremely gifted, talented, skilled, virtuoso-like, first-rate individual to help them, they were absolutely thrilled when they agreed to do so, as was I. Thank you, Emily. I could not have done this without you.

I have a friend. Actually, she was Diana's (wife) friend first. Her name is Angela Ashmore Bryant. She is a Millennial who is more like a Baby Boomer in thoughts, actions and personality characteristics (that is a huge compliment by the way). I love her, and just not because she thinks like my wife and me. She is a software expert, explicator (artist), formatting expert and has the ability and acumen to transform one's attempt to deliver an imperfect and flawed document into near perfection. I thank you Angela for helping my dissertation rise way above the norm.

Dr. Robert P. Yehl became my adviser after Dr. Nolan Argyle retired. His stories about his own adventurous dissertation journey are legendary. Thank you for your guidance, your expertise and your willingness to help me make it through the VSU educational maze of courses, writing and graduating from the DPA program.

I would like to thank Dr. Gerald A. Merwin for being the "best administrator ever." My apologies to my grand-children for using this phrase, but it fits so well. As the MPA/DPA Program Coordinator, he couples his education, administrative expertise, practical management experience in public administration and public sector policy wisdom to orchestrate the overall program and guide all students through the entire process with a caring, kind and genuine concern for our success. Thanks so much, Dr. Merwin.

Faculty member Dr. Leigh R. Swicord (Stafford) was an inspiration to me and I am sure she doesn't even know it. There is no historical back-story (that I am aware of) behind the word "inspiration" such as "Dr. Swicord had to walk five miles to and from school every day with no shoes in the snow" or something such as that. I met her for a second time in the program when I was starting to get sick. I was taking the course "Information & Data Management" at the time. She helped me through the course, not by cutting me any slack, but by inspiring me with her attitude, kindness and understanding. Thanks, Dr. Swicord.

A sincere shout-out thank you to Stanley Jones and the entire Office of the Registrar team, the support folks in the VSU Information Technology Department, Tina Wright in IRB, Naomi D. Parker in Dr. Merwin's office and of course Julienne W. Jackson, who expertly ran the DPA show for so long and kept us all straight, including Dr. Argyle. Thank you all for always being ready to help and never getting tired of answering my questions or listening to my reasoning and requests.

DEDICATION

This dissertation is dedicated to my late father-in-law, Clyde Frederick Bennett (1910–1995), who spent his 85 years on this earth working (ever since he was 5 years old), teaching by example and even in the hardest of times, believing in the Lord to guide, help and protect him and his family. He was the smartest man I ever met, degreed or not. To quote Shakespeare (Hamlet), "He was a man, take him for all in all, I shall not look upon his like again." He was the original Papa and my hero. I am now his unworthy replacement as the family patriarch, Papa Tony.

Chapter I

INTRODUCTION

This dissertation will develop and propose a public policy healthcare model for allowing assisted suicide decisions to be made without fear of prosecution and/or the exhaustive use of protracted civil litigation, using a dignified, compassionate and common-sense approach. In order to develop and propose a compassionate and common-sense approach, this study will analyze and evaluate assisted suicide laws in nineteen states of the United States of America, plus the District of Columbia. The states of California, Colorado, Hawaii (law goes into effect on 1-1-2019), Montana, Oregon, Vermont, Washington and the District of Columbia were selected because they have laws that allow "qualified terminally ill adults" to voluntarily request and receive a prescription medication to hasten their deaths. In the case of Montana, the state Supreme Court has ruled that "physician-assisted dying" is legal (Starks, 2016, p. 1). The other 12 states (Alabama, Arizona, Florida, Georgia, Illinois, Maryland, Mississippi, Missouri, New Jersey, New York, Texas and Utah) were chosen at random after all 50 states were divided into six geographical categories and after removing the afore-mentioned seven states which have made statutory allowance for assisted suicide.

The most current legislation enacted (and in effect) is the Death with Dignity Act (physician-assisted suicide law) passed by the District of Columbia Council in December 2016 with an effective date of February 17, 2017 (Richardson, 2017). On July 14, 2017, the House Appropriations Committee of Congress advanced a measure to repeal the

District's assisted suicide law. The measure failed; therefore, under the law's current implementation timeline, terminally ill District of Columbia residents are able to legally end their lives with the help of a physician beginning in late September 2017. The state of Hawaii passed legislation allowing for physician-assisted suicide, which became law on April 5, 2018. However, the law does not take effect until January 1, 2019 (Stutsman & Foster, 2018, p. 1).

General overview, explanation of the issue and conceptual framework

The topic of assisted suicide is one of those controversial social issues that seems to ebb and flow in the minds of the general public, not only as to importance, but also as to acceptance. According to Neil M. Gorsuch, the newest Associate Supreme Court Justice, in his 2006 book, *The Future of Assisted Suicide and Euthanasia*, "Whether to permit assistance in suicide and euthanasia is among the most contentious legal and public policy questions in America today" (Gorsuch, 2006, p. 1). As the academic and public discussions of assisted suicide have grown over the years, the issue most always brings about increased political and legal activism. As to political activism, beginning in 1988 and continuing for a period of 10 years, more than 50 bills were introduced to legalize assisted suicide or euthanasia in at least 19 state legislatures, and several voter referenda were attempted in order to bypass these state house and senate chambers (Gorsuch, 2006, p. 3). Legal activism hit an all-time high during the 15-year period of 1991 to 2006. The first wave of the legal onslaught was carried out by proponents filing federal lawsuits in Washington State and New York. They sought to have statutes banning assisted suicide declared unconstitutional. Some of these cases made it all the way to the United States Supreme Court. The opinions of the lower courts, as well as

concurring opinions and minority opinions of some of the justices on the Supreme Court, signaled to all that the debate over assisted suicide was far from definitively over, and in fact had just begun.

For this policy evaluation study dissertation, the topic of assisted suicide will be viewed mainly through a legal lens of study approach. The legal lens of study approach allows for the use of one of the broadest, most insightful and comprehensive qualitative research methods. The "legal lens of study approach" is defined as being the best and most studious qualitative research method that allows for locating, reading and understanding the investigative road map that will insure the discovery of the best primary sources of legal materials (cases, statutes and laws) and other secondary sources covering the topic being evaluated and analyzed.

This study technique provides an all-embracing approach. Judges, public administrators, attorneys, physicians and healthcare experts often use legal arguments to advance their positions, but many reference other approaches including moral, ethical, religious, political, psychological and financial arguments, which many times are included in the legal lens of study approach.

In analyzing assisted suicide through the legal lens of study approach, a conceptual framework was developed and implemented in this dissertation to provide a wide basis of support for the relevance and importance of the issue of assisted suicide. The systematic and categorical approach to assisted suicide used herein is the foundational bedrock of the legal lens of study method. Information has been researched, studied and evaluated in order to fully explain the subject matter from several important perspectives.

Several groups, including healthcare professionals, public administrators, federal and state legislators, constitutional purists, academic scholars and legal experts, support legalizing assisted suicide. They advance their positions through lawsuits, articles, books, legislation, open debate forums, essays and social media. Using the legal lens of study approach and assimilating all this information through comprehensive research provided a specific directional path to an acceptable public policy healthcare model for dealing with assisted suicide.

Many individuals within the same categories mentioned above are against assisted suicide. The extensive legal research using the methodology enumerated below and with specificity in Chapter 3 explains their reasons and reasoning that supports their point of view. Using this objective and inclusive legal lens of study approach, it also illustrates how the myriad of thoughts, emotions and feelings that comprise public opinion conflict and counteract each other when governments ignore issues of extreme importance and modern-day relevance such as assisted suicide.

The topic of this dissertation is captivating to health care professionals and public administrators alike. It is a significant, socially relevant modern-day controversial topic that concerns and touches citizens all over the United States. The main concerns and arguments put forth by proponents and opponents of assisted suicide are many times based on religious, moral and ethical philosophies. The legal lens of study approach, as defined herein, provides a glimpse of the different kinds of reasoning used by administrators, lawyers, judges and jurists to explain, bolster or justify their diverse legal arguments.

Purpose of the study

Many in the healthcare and public administration arenas believe the issue of assisted suicide is as relevant and important in today's society as Medicare, Social Security, the economy, immigration reform or the selection of Supreme Court justices. The purpose of this policy evaluation dissertation is to thoroughly examine the laws pertaining to assisted suicide in the 20 jurisdictions selected; compare and contrast the similarities and differences in those laws; examine and explain the most important state, federal and Supreme Court case rulings about assisted suicide; and study the theoretical underpinnings that have the greatest effect on the subject matter in order to structure a public policy healthcare model for dealing with assisted suicide.

The findings through the legal lens of study approach concerning assisted suicide reveal not only how major portions of our governmental policies, laws and directives were formulated and why, but how they are working, what changes can make them better and the best pathway to make these necessary changes.

Five research questions have been formulated and will be answered in the body of this work in order to comprehensively analyze and explain the issue of assisted suicide. Those research questions are as follow:

1. What major similarities and differences are there in the current assisted suicide laws and statutes in effect in the 20 jurisdictions selected for this study?
2. What major similarities and differences are there in the current assisted suicide laws in the six countries other than the United States selected for this study?

3. Are there universal language elements in the assisted suicide laws of the 20 jurisdictions and in the six countries other than the United States selected for this study?
4. Over the past 45 years, how do the rulings of the United States Supreme Court in Fourteenth Amendment cases using the doctrines of equal protection and substantive due process as applied to assisted suicide laws reflect public opinion of the citizenry of the United States as reported in opinion polls?
5. A. Does evidence in case law support Rohr's "regime value/constitutionally-directed" theory or Toobin's more recently formulated theory that justices of the Supreme Court are increasingly motivated not by the Constitution but by politics and personal ideology when deciding Fourteenth Amendment cases? Can both theories co-exist and not be in conflict?

   B. What does the answer to part A suggest about the future of assisted suicide laws in the United States?

Definition of terms

There are three definitions that are extremely important to the understanding of the flow and the contents of this dissertation. They are not complex definitions, but strategically important nonetheless.

1. Legal lens of study approach—the best and most studious qualitative research method that allows for locating, reading and understanding the investigative road map that will insure the discovery of the best primary sources of legal materials (cases, statutes and laws) and other secondary sources covering the topic being evaluated and analyzed.

2. Shepardize or shepardizing—In the legal research field, Shepard's is the most highly regarded citation index. It allows researchers to track particular judicial decisions, statutes, and other legal resources as they are invoked at different historical moments for a range of purposes. Shepard's citations provide references to when and how cases and law review articles were cited by other sources. Citations exist for both federal and state courts. This type of legal research will reveal if a case has been reaffirmed, followed, applied, questioned, modified, distinguished, overturned or generally cited in later cases, thus upholding, modifying or adding some additional parameters to the ruling of the case (Shepard's Citations, 2017, p. 1).
3. Precedent or *stare decisis*—The doctrine that rules or principles of law on which a court rested a previous decision are authoritative in all future cases in which the facts are substantially the same. *Stare decisis* is Latin for "to stand by things decided." In short, it is the doctrine of precedent. According to the Supreme Court, *stare decisis* "promotes the evenhanded, predictable and consistent development of legal principles, fosters reliance on judicial decisions, and contributes to the actual and perceived integrity of the judicial process." In practice, the Supreme Court will usually defer to its previous decisions even if the soundness of the decision is in doubt (*Stare Decisis*, 2017, p. 1).

Procedures and organization of dissertation

The remainder of this dissertation is constructed and organized in the following manner:

Chapter 2 will provide an overview of assisted suicide from the perspective of legal adjudication and its constitutional foundation. It includes a discussion of federal, state, and constitutional regulations as well as Supreme Court rulings. The legal lens of study approach allows not only for a comparison of these state rulings, policies and laws, but also for a detailed analysis of the differences and commonalities. Data collected by the Center for Disease Control (CDC), by the American Foundation for Suicide Prevention and by states that allow assisted suicide have been reviewed. Theories as to why assisted suicide is currently at the top of many agendas are proposed. The significance of *stare decisis* in proposing any regulations is discussed in detail. The chapter concludes with the theories and teachings of prominent public administrators renowned for their expertise in the legal arena. Even though the issue of assisted suicide was never evaluated or written about by them, their writings and theories add an important theoretical underpinning to the topic of this policy evaluation study.

Chapter 3 discusses and explains the qualitative methodology used in this dissertation relative to research and data collection. The methodology chapter identifies the long-standing and academically accepted descriptive and evaluative research approach followed in order to establish the five research questions and answer them as completely as possible. The chapter presents the academic requirements followed in order to undertake the kind of legal evaluative research in this dissertation.

Chapter 3 details the necessary steps taken to develop a complete and academically acceptable research methodology for this dissertation. Four of the steps to describe the rationale of the procedures used to identify, select and analyze the research

information in order to fully develop the public policy healthcare model detailed herein are as follows:

- The first step is to gather all the applicable and pertinent federal and state law concerning assisted suicide from the 19 states and the District of Columbia.
- The second step compares and discusses the differences between these laws and policies and analyze why these differences exist, using techniques found in the legal lens of study approach.
- The third step is to gather information from the writings of legal and public policy experts about the most persuasive arguments affecting judges, jurists, politicians, lawmakers, healthcare providers and public administrators.
- The fourth step is to uncover important directional trends which will contribute to formulating and proposing a legal, rational and workable public policy healthcare model for dealing with assisted suicide using a dignified, compassionate and common sense approach.

This type of methodological approach to research, with an emphasis on description and exploration, allows for a firm understanding of the reasons, motivations and opinions that have generated the diametrically opposed points-of-view concerning assisted suicide.

Chapter 3 also reiterates the definition of the "legal lens of study approach" as stated above. Articles from academicians were researched and studied in order to support the significance and importance of the legal lens of study approach for a policy evaluation study dissertation. Secondary methodological considerations were followed in

order to complete the accepted substantive doctrinal research approach for this dissertation.

In Chapter 4, the Findings Chapter, the information and data are presented in a well-organized strategy that is clear, explanatory and comprehensive. The legal lens of study approach followed, presents the information and data covering the laws in the states of the United States of America and the District of Columbia that allow for assisted suicide in the most logical and precise manner. The laws and policies of each state and the District of Columbia share several commonalities, but as importantly they contain differences that after a thorough study and review help structure a public policy healthcare model for dealing with assisted suicide.

In addition, the laws and public policies of Belgium, Canada, Germany, Luxembourg, Switzerland and The Netherlands are included in the collaborative results-oriented discussion in order to better understand assisted suicide from different cultural approaches.

The information and data compiled, analyzed, discussed and explained in Chapters 2 through 4 provide an uncomplicated segue into a conclusion in Chapter 5, which will propound a public policy healthcare model for dealing with assisted suicide.

In Chapter 5, the author evaluates and interprets the results of the study in order to structure a public policy healthcare model for dealing with assisted suicide. The principal implications of all findings in this dissertation are concisely summarized in this chapter.

Significance of study

The issue of assisted suicide is of critical importance especially to the peace of mind and well-being of the entire "baby-boomer generation" (those born in 1945 to 1964). Dealing with the issue of assisted suicide now, before a new wave of prosecutions, protests and rallies, and more wasteful civil litigation begins, will not only benefit society as a whole, but could offer a more dignified and caring path for millions of individuals who suffer needlessly at the end of their lives.

Chapter II

LITERATURE REVIEW

An important national concern

Currently, the controversy over whether to permit assisted suicide and allow individuals more autonomy over this end-of-life decision is a major public policy dilemma and, from a legal perspective, very contentious and litigious. As public discussions and activism about assisted suicide increase, the legal and political arenas become filled with lawsuits and referendums advocating for changes to be made so individuals and those who assist individuals in ending their lives will have a more perspicuous direction to follow.

This chapter identifies the research material undertaken for this paper, presents and reviews the research material and then clearly delineates how the legal lens of study approach was used to discover, examine, analyze, explain, clarify and update said research in order to propose a public policy healthcare model dealing with assisted suicide. Research material compiled is examined from different perspectives and schools of thought. The main stakeholder perspective examined originates from the individual patient. However, the research material provides the perspectives of spouses of patients, family members and loved ones, physicians, nurses and other medical personnel, hospitals, hospice workers and public administrators who have either chosen or been forced to weigh in on the controversies surrounding assisted suicide.

Evaluating the public policy programs that have been utilized over the past two decades and understanding the history of the motives that have led to certain changes and modifications assisted in the promulgation of a more contemporary public policy healthcare model dealing with this extremely important issue. Among many factors, any new public policy healthcare model should respect an individual's right of autonomy and self-determination, consider mandated consent restrictions, examine any states' rights issues, deal with the issue of any type of residency requirement, contemplate a mandatory "expected death" period and, in general, look to simplify guidelines and compliance protocols.

Suicide and assisted suicide statistics

Suicide rates vary considerably among different groups of people. The Centers for Disease Control (CDC) and the American Foundation for Suicide Prevention (AFSP) both publish statistical reports on suicide rates. The CDC uses four key demographic variables: age, sex, race/ethnicity, and geographic region/state (Curtin, Warner & Hedegaard, 2016). The AFSP uses four key variables as well, albeit slightly different: age, race/ethnicity, methods, and attempts (*Suicide Statistics*, 2016). Males take their own lives at nearly four times the rate of females and represent 77.9% of all suicides. In 2016, firearms were the most commonly used suicide method among males. Poisoning by intentional overdose is the most common method for suicide for females (34.8%). In 2016, suicide was the tenth leading cause of death and one of just three leading causes that are on the rise among the U.S population (*Suicide rates rising across the U.S.,* 2018).

In addition to the emotional toll that suicide and attempted suicide have on family and friends of those who died, there is an economic toll ($58.4 billion based on reported numbers alone), which includes many direct costs such as medical care, ambulance transport, investigations by medical examiners, nursing home care and general and specialty physician care. There are also indirect monetary cost factors, lost productivity from premature death or lost time from injuries being the largest (97.1% of all in-direct costs). Adjustments for under-reporting are also an indirect monetary factor representing an additional $93.5 billion annually ($298 per capita) for a total in excess of $151 billion per year (Shepard, Gurewich, Lwin, Reed & Silverman, 2016, pp. 352-353).

These statistics on suicide and attempted suicide are not only overwhelming, but heart-breaking as well. Although the topic and dilemma of assisted suicide is different from the general topic of suicide and accounts for fewer than 1% of all suicide deaths, it is just as important and emotionally charged (Warnes, 2014, p. 2).

Reporting, state laws and laws of other countries

Statistically speaking, the process of reporting deaths from assisted suicides varies by state. Only those states where physician-assisted suicide is permitted by law {California, Colorado, Hawaii (as of 1-1-2019), Oregon, Vermont and Washington} have a reporting process, which is primarily based on applications filed with the proper state authorities by individuals wanting to end their lives (CNN, 2018, p. 1).

In general terms, the vast majority of states have laws against individuals ending their lives via suicide, either on their own or through the aid of a doctor. However, in 1990 the U.S. Supreme Court did rule that patients or their designated health care agents may refuse life-preserving medical treatment, including feeding tubes (*Cruzan v.*

Director, 1990, p. 261). A *health care agent* is an individual named by the patient to make health care decisions on his/her behalf, usually through a durable power of attorney. Health care agents typically follow a patient's wishes laid out in a living will or a properly executed "do not resuscitate" medical form *("Death with Dignity" Laws by State*, 2017, p. 1).

In the few states that allow physicians to take an active role in assisting a patient in his or her death, a review of these laws indicates that most require the patient to:

- Have a reasonable expectation of dying within a certain period of time (normally six months)
- Be a resident of the state and be a certain age (18 years of age)
- Have the ability to make and communicate health care decisions
- Receive counseling and understand what is discussed
- Follow other multiple written consent guidelines

("*Death with Dignity" Laws by State*, 2017, p. 2).

Since 1997 in Oregon, according to the latest published statistics, prescriptions were written by physicians for self-administered lethal doses of medications for 1,967 terminally-ill adults, and 1,275 patients died from ingesting the drugs that were legally prescribed (*Oregon Death with Dignity Act 2017 Data Summary*, 2017, p. 5). The highest percentage of patients taking the prescription written by a physician was in 1999 (81.8%). The lowest percentage was in 2001 (47.7%). In 2017, 65.6% of the patients requesting medications took the drugs. Most patients were aged 65 years or older (80.4%) and had cancer (76.9%). The median age at death was 74 years (*Oregon Death with Dignity Act 2017 Data Summary*, 2017, p. 12). In 2017, the three most frequently

mentioned end-of-life concerns were decreasing ability to participate in activities that made life enjoyable (88.1%), loss of autonomy (87.4%), and loss of dignity (67.1%) *(Oregon Death with Dignity Act 2017 Data Summary*, 2017, p. 6).

In Washington, since 2009, prescriptions were written for 1,401 terminally-ill adults and 1,364 patients died from ingesting the drugs (*Washington State Death with Dignity Act Report*, 2018, p. 5). The highest percentages of patients taking the medication were in 2010 and 2012 (100%). The lowest percentage was in 2017 (92.5%). Of the 196 participants in 2017 who died, the youngest was 33 years and the oldest was 98 years. Most patients had cancer (72%). In 2017, the three most frequently mentioned end-of-life concerns were loss of autonomy (90%), decreasing ability to participate in activities that made life enjoyable (87%), and loss of dignity (73%) (*Washington State Death with Dignity Act Report*, 2017, p. 8).

Depending on the length of time that assisted suicide statutes have been in place, the states of California, Colorado, Hawaii (as of 1-1-2019), Vermont and Montana, as well as the District of Columbia, also statistically track assisted suicide and report the findings to a designated public administration department or agency. Those reports are then disseminated to the public. A comparison of these statistical findings and the mechanisms used to generate said statistics helps with understanding the issue of assisted suicide from a public policy perspective.

After dividing the United States of America into six geographical divisions and selecting twelve states at random (Alabama, Arizona, Florida, Georgia, Illinois, Maryland, Mississippi, Missouri, New Jersey, New York, Texas and Utah—see Chapter 3 for an in-depth discussion as to how these states were chosen), the laws of those states

or the "common law" approach used in each state for assisted suicide are compared and contrasted not only among those states, but also with the states where assisted suicide laws are already in place. In addition, the laws and public policies of the countries of Belgium, Canada, Germany, Luxembourg, Switzerland and The Netherlands are examined, compared and contrasted in order to better understand assisted suicide from different legal and cultural approaches in other parts of the world (Emanuel, Onwuteaka-Philipsen, Urwin & Cohen, 2016, p. 79). These six countries were selected because they have laws in place allowing for physician-assisted suicide, or PAS, as they refer to it. In his latest study, Emanuel examined the attitudes and practices of physician-assisted suicide (and euthanasia) in the United States, Canada and Europe, specifically the six countries listed above (Emanuel et al., 2016). His main conclusion was that "physician-assisted suicide (and euthanasia) are increasingly being legalized, remain relatively rare, and primarily involve patients with cancer" (Emanuel et al., 2016, p. 79).

Five critical events concerning assisted suicide

From 1990 to early 2000, five events brought assisted suicide to the forefront of the thoughts and actions of America's mainstream. First was the most publicized event, which took place in 1990 when Dr. Jack Kevorkian assisted Janet Atkins in "killing herself" (*People v. Kevorkian*, 1994, p. 172). The second event occurred in 1991 when The Netherlands passed legislation in favor of physician-assisted suicide (*Holland's Euthanasia Law*, 2016, p. 1). Next came a published article, also in 1991, by Dr. Timothy Quill in the *New England Journal of Medicine* "discussing and defending his decision to prescribe barbiturates to a cancer patient, even though she admitted that she might use them at some indefinite time in the future to kill herself" (Quill, 1991, p. 691).

The fourth event was the publication of an article in the *Journal of the American Medical Association* entitled, "A piece of my mind. It's Over Debbie" by an anonymous writer. The article described how the physician-author administered a lethal injection to a terminal cancer patient after her plea "to get this over with" (Anonymous, 1988, p. 272). Lastly, the President of the Hemlock Society, Derek Humphry, published a book entitled *Final Exit* providing step-by-step instructions on various methods of "self-deliverance" (Humphry, 1991, p. 109).

These five events, and the discussions, debates and arguments surrounding them, gave rise to multiple attempts over the next 15 years by assisted suicide proponents, legal activists and sympathetic state lawmakers to legalize assisted suicide (Gorsuch, 2006). However, as little progress was made by activists or through state legislative efforts, federal lawsuits were filed in Washington and New York seeking to have any statutes disallowing or banning assisted suicide declared unconstitutional (Gorsuch, 2006).

According to Professor Brown Lewis, the Plevin Professor of Law and Director, Center for Health Law and Policy at Cleveland-Marshall College of Law, the majority of terminally-ill patients who choose physician-assisted suicide do so because their illnesses prevent them from engaging in activities that they enjoy, cause them to lose their independence, and take away their dignity. "Those patients are comforted by knowing that they control the time and place of their deaths" (Lewis, 2017, p. 3). However, the reasons listed above by Lewis are sometimes overlooked, as both proponents and opponents of assisted-suicide use emotionally charged arguments meant to persuade lawmakers, public administrators and judges to accept or agree with their positions.

Before further discussing the term "assisted suicide" from a legal perspective, it is important to note that according to Teresa Yao, program coordinator for the Department of Life Issues, Archdiocese of Washington D.C., some proponents for assisted suicide base their main argument on the avoidance of suffering and the exercise of individual autonomy, both non-legal reasons. She states that a merciful society should allow patients in great pain—specifically, uncontrollable physical pain caused by advanced illness—to end their lives when that is the only way to end their suffering. She adds that since physical anguish is not limited to the last six months of life, the importance and sanctity of individual autonomy should take precedent (Yao, 2016, p. 385).

"Whether to permit assistance in suicide (and euthanasia) is among the most contentious legal and public policy questions in America today" (Gorsuch, 2006, p. 1). Although the following statement by now Supreme Court Justice Neil Gorsuch is simplistic in its content, the following descriptive and definitional misnomer is worth mentioning before further discussing some of the findings of the research into the statutes, cases, state constitutions, federal constitutional law and public policies that were examined and evaluated for this paper.

There is no crime called "assisted suicide" and therefore no legal penalty exists for the patient who seeks help in dying. Beginning with Dr. Kevorkian, the crime at issue was *assisting* in a suicide and the law targeted only those who helped another commit suicide. The legal right sought by early activists and sympathetic state lawmakers was the right to receive *assistance* in killing oneself without the *assistant* suffering adverse legal consequences (Gorsuch, 2006, p. 5).

United States Constitution–Fourteenth Amendment Summary

When viewing assisted suicide through the legal lens of study, the point of beginning must be the Constitution of the United States of America. The text of Section 1 of the Fourteenth Amendment to the United States Constitution reads as follows:

> All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

There are four basic principles asserted in the text of the Fourteenth Amendment. Those principles include:

1. State and federal citizenship for all persons, regardless of race, either born or naturalized in the United States was reaffirmed.
2. No state would be allowed to abridge the "privileges and immunities" of any of its citizens.
3. No person was allowed to be deprived of life, liberty, or property without "due process of law."
4. No person could be denied "equal protection of the laws."

(Kelly, 2017, p. 1).

(See Appendix A for complete text of the Fourteenth Amendment).

Supreme Court of the United States Fourteenth Amendment cases–1990 to 2018

Beginning in the early 1900s, the Supreme Court of the United States first expanded the use of the Fourteenth Amendment to issues in addition to freedom, equality, equal protection, and due process for slaves (LaMance, 2017). Over the past 115 years, the Supreme Court has issued rulings and set the course of legal history by using the Fourteenth Amendment to decide cases in education, criminal law, abortion, voting rights, assisted suicide, same-sex marriage and immigration, and should tackle the subject of gender identity (via a transgender rights case) within the next year (LaMance, 2017).

The equal protection and substantive due process arguments used by proponents and opponents within these different categories of cases in front of the Supreme Court and other courts in the 19 states in this study are examined, analyzed, studied, compared and contrasted. The main purpose is to understand the essential reasoning used by the courts to see why the subject matter being litigated was the primary factor for the ruling and what other secondary or tertiary factors were present to help determine the outcome of each case. Understanding these factors help in developing a public policy that would likely be acceptable to the courts and the public.

Foundational litigation and case law from 1990 to 2018

Federal trial court–state of Washington–1994

In 1994, using the Fourteenth Amendment as the primary legal foundation, Judge Barbara Rothstein from the U.S. District Court for the Western District of Washington became the first judge to hold assisted suicide to be a right guaranteed by the U. S. Constitution. Her reasoning was based on the precedent that for many years the Supreme

Court, in case after case, has held that due process contains a "substantive" component – one that imposes a nearly absolute bar on certain governmental actions "regardless of the fairness of the procedures used to implement them" (Gorsuch, 2006, p. 8). She observed that many of the substantive rights adduced by the court pertained to "personal decisions relating to marriage, procreation, contraception, family relationships, childrearing and education" that were constitutionally protected (*Compassion in Dying v. State of Washington*, 1994, p. 1459).

Judge Rothstein relied extensively on the United States Supreme Court's language from what was then the most recent substantive due process case, *Planned Parenthood v. Casey* (1992). Even though the court was ruling on the right to abortion almost twenty years post *Roe v. Wade* (1973), the majority based its opinion on two of the liberties protected by the Fourteenth Amendment: personal dignity and autonomy. "At the heart of these liberties are the rights to define one's own concept of existences, of meaning, of the universe, and of the mystery of life" (*Planned Parenthood v. Casey*, 1992, p. 851).

Judge Rothstein also expanded the minority view found in *Cruzan v. Director, Missouri Department of Health* wherein the U. S. Supreme Court addressed the issue of the right of a seriously ill person to terminate any life-sustaining medical treatment (*Cruzan v. Director, Missouri Department of Health*, 1990). The minority opinion contained strong *dicta* that clearly favored the right of a seriously ill person not only to terminate life-sustaining medical treatment, but to refuse medical intervention and be allowed to die (*Cruzan v. Director, Missouri Department of Health*, 1990). Justice Rehnquist stated in the majority opinion of the Court that:

> No right is held more sacred, or is more carefully guarded by common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law. Every human being of adult years and sound mind has a right to determine what shall be done with his own body. (*Cruzan v. Director, Missouri Department of Health*, 1990, p. 268)

A majority of the justices separately declared that a competent person has a constitutionally protected right to refuse life-saving hydration and nutrition. The case primarily dealt with the standard of evidentiary proof required by the state of Missouri to allow co-guardians to order the withdrawal of life-sustaining treatments based on the "wishes" of an incompetent individual who was in a non-reversible coma. The Supreme Court stated that a person has a right to privacy and that privacy includes the right to terminate treatment as afforded by the fourteenth amendment of the United States Constitution (*Cruzan v. Director, Missouri Department of Health*, 1990). Relying on and agreeing with this right, Judge Rothstein found no difference between "finding a Fourteenth Amendment liberty interest in refusing unwanted treatment which would result in death and committing assisted-suicide in the final stages of life" (Gorsuch, 2006, p. 9).

Even though the United States Court of Appeals, Ninth Circuit in March of 1996 eventually overturned the decision of Judge Rothstein by using the reasoning in the majority opinion espoused in *Cruzan* (*Compassion in Dying v. State of Washington,* 1996, p. 586), the concurring opinions of Justice Sandra Day O'Connor and the late Justice Antonin G. Scalia from 1990 bear further mention. In her opinion, Justice

O'Connor expressed the view that "the liberty guaranteed by the due process clause protected an individual's personal decision to refuse medical treatment, including the artificial delivery of food and water" (*Cruzan v. Director, Missouri Department of Health*, 1990, p. 278). Justice Scalia expressed the view "that it would be preferable for the United States Supreme Court to announce that the federal courts have no business in the field of preserving life, insofar as the American law had always accorded states the power to prevent suicide–including suicide by refusing to take appropriate measures necessary to preserve one's life–by force if necessary, and the Federal Constitution had nothing to say about the subject" (*Cruzan v. Director, Missouri Department of Health*, 1990, p. 279).

It is also worth noting that Justice William J. Brennan, Jr., who was joined by Justice Thurgood Marshall and Justice Harry Blackmun in a dissenting opinion, expressed the view that "the evidentiary standard neither enhanced the accuracy of a determination of the woman's wishes nor was consistent with an accurate determination. The woman had a fundamental right, under the due process clause, to be free of unwanted artificial nutrition and hydration and that right was not outweighed by the State of Missouri's asserted interest in the preservation of life and which standard of evidence should apply" (*Cruzan v. Director, Missouri Department of Health*, 1990, p. 280).

Justice John Paul Stevens was even more adamant in his dissenting opinion when he expressed the view that "the failure of Missouri's policy to heed the woman's interest with respect to private matters was ample evidence of the policy's illegitimacy and the court's deference to such policy was patently unconstitutional, insofar as it seemed to derive from the premise that chronically incompetent persons had no constitutional

cognizable interests at all, and so were not persons within the meaning of the Constitution" (*Cruzan v. Director, Missouri Department of Health*, 1990, p. 290).

It is important to focus on the fact that the Supreme Court in *Cruzan* ruled that the state of Missouri could use the "clear and convincing evidentiary standard" relative to the testimony involving whether or not the feeding tubes could be removed from a comatose patient (a competent individual before coming to the hospital, 21 years or older). But even more important is the fact that six of the justices in concurring or dissenting opinions repeatedly stated three beliefs:

1. The liberty guaranteed by the due process clause protected an individual's personal decision to refuse medical treatment.
2. The United States Supreme Court should announce that federal courts have no business in the field of preserving life, insofar as the American law had always accorded states the power to prevent suicide and the Federal Constitution had nothing to say about the subject.
3. Nancy Cruzan had a fundamental right, under the due process clause, to be free of unwanted artificial nutrition and hydration, and that right was not outweighed by the state of Missouri's asserted interest in the preservation of life and which standard of evidence should apply.

   (*Cruzan v. Director, Missouri Department of Health*, 1990, pp. 285-292).

From a cumulative perspective, the concurring opinions and the dicta in the minority opinions in *Cruzan* support a very strong argument for the right of every individual to have possession and control of his or her own person, free from all restraint or interference of others and the right of every human being of adult years and sound

mind to determine what shall be done with his/her own body, even the planning and fulfillment of an assisted suicide (*Cruzan v. Director, Missouri Department of Health*, 1990, p. 282).

At about the same time that the federal courts in the State of Washington (and eventually the United States Supreme Court) were ruling on the issue of assisted suicide, physicians in New York were challenging a New York state law prohibiting the intentional assistance of suicide in the federal court system using a moderately different approach.

Federal trial court–state of New York 1994

Litigation continued post *Cruzan* (1990). In 1994, Dr. Timothy Quill challenged the state of New York's law prohibiting the intentional assistance or promotion of suicide, contending that it violated the substantive component of the 14th Amendment's due process clause (Gorsuch, 2006). The trial judge in the case of *Quill v. Koppell*, 870 F. Supp. 78 (1994), denied Dr. Quill's motion for a preliminary injunction against the enforcement of the relevant statutes, §§ 125.15(3) and 120.30 of the New York Penal Law, to the extent they apply to physicians who give assistance to those who wish to commit suicide. The defendants (three officials in their governmental capacities representing the State of New York) opposed the plaintiff's motion and cross-moved for judgment on the pleadings dismissing the action (*Quill v. Koppell*, 1994, p. 78).

Chief Judge Thomas Griesa of the Southern District of New York denied Dr. Quill's motion for preliminary injunction and granted the defendants' cross-motion to dismiss the action. The motion to dismiss was treated as one for summary judgment since the court had considered matters outside the pleadings (*Quill v. Koppell*, 1994, p.

78). Judge Griesa rejected the plaintiff's attempt to rely on the reasoning of the Supreme Court in *Planned Parenthood v. Casey* (1992). Judge Griesa stated that the issue of personal autonomy being applied to assisted suicide cases was "too broad" since "the Supreme Court has been careful to explain that the abortion cases [*Roe v. Wade* (1973) and *Planned Parenthood v. Casey* (1992)], and other related decisions on procreation and child rearing, are not intended to lead automatically to the recognition of fundamental rights on different subjects" (*Quill v. Koppell*, 1994).

The Second Circuit Court of Appeals reversed Judge Griesa's ruling. The appellate court did not address the due process theory advanced by Dr. Quill, but instead adopted his equal protection theory because it could not agree with the "natural-artificial" distinction between refusing care and assisting suicide reasoned by Judge Griesa since it could not find anything "natural" about causing death by removing feeding tubes or ventilators (Gorsuch, 2006, p. 12).

The appellate court ruled that "The New York statutes criminalizing assisted suicide violate the Equal Protection Clause because, to the extent that they prohibit a physician from prescribing medications to be self-administered by a mentally competent, terminally-ill person in the final stages of his terminal illness, they are not rationally related to any legitimate state interest" (*Quill v. Vacco,* 1996, p. 731). This case would eventually be consolidated with another case (*Washington v. Glucksberg*) and be heard by the Supreme Court in 1997.

It would take three years for these two landmark cases to come before the nine justices of the United States Supreme Court. Each justice, in his/her own unique way, had something to say about assisted suicide.

Washington and *Vacco*–Journey to the Supreme Court–1997–All nine justices weigh in on assisted suicide

The case of *Washington v. Glucksberg* began its journey to the U. S. Supreme Court in January of 1994 in the U.S. District Court for the Western District of Washington under the name *Compassion in Dying v. Washington*. Four Washington physicians, three gravely ill patients, and a nonprofit organization that counsels people considering doctor-assisted suicide filed a lawsuit challenging the constitutionality of Washington Revised Code Section 9A.36.060, which makes it a crime to knowingly assist, aid, or cause the suicide of another person. The district court ruled the statute unconstitutional on the ground that it violated the liberty interest protected by the due process clause of the Fifth and Fourteenth Amendments to the U.S. Constitution (*Compassion in Dying v. Washington*, 1994, p. 1454).

The case was then appealed to the U.S. Court of Appeals for the Ninth Circuit, where a panel of judges reversed the district court's ruling and reinstated the Washington statute. In a 2–1 decision, the court of appeals emphasized that no right to assisted suicide has ever been recognized by a court of final jurisdiction anywhere in the United States (*Compassion in Dying v. Washington*, 1995, p. 586). Agreeing to rehear the case en banc (before all 11 judges on the Ninth Circuit), the court of appeals reversed the panel's decision and affirmed the district court's ruling, which had invalidated the Washington statute. In an 8–3 decision, the appellate court said that "the Constitution encompasses a due process liberty interest in controlling the time and manner of one's death," including the liberty interest of certain patients to hasten their deaths by taking

deadly amounts of medication prescribed by their physicians (*Compassion in Dying v. Washington*, 1996, p. 790).

The decisions in both the cases of *Washington v. Glucksberg* and *Vacco v. Quill* were announced the same day by the U.S. Supreme Court (June 27, 1997). In both cases the Supreme Court decisions were unanimous in reversing the appellate court decision, but based on different reasoning. In *Washington v. Glucksberg*, Chief Justice William H. Rehnquist wrote that the case turned on whether the Due Process Clause protects the right to commit suicide with another's assistance. The unanimous decision rejected such a constitutional claim for three reasons (*Washington v. Glucksberg*, 1997, p. 717). First, the Court observed that suicide and assisted suicide have been disapproved by Anglo-Saxon law for more than seven hundred years. From thirteenth-century England through nineteenth-century America, the Court said, the "common law" has consistently authorized the punishment of those who have attempted to kill themselves or assisted others in doing so (*Washington v. Glucksberg*, 1997, p. 710). Second, the Court pointed to the overwhelming majority of states that currently prohibit physician-assisted suicide. Only Oregon expressly allows doctors to help their patients hasten their demise through lethal doses of prescribed medication, and the law that allows this practice is constantly being challenged in court (*Washington v. Glucksberg*, 1997, p. 713). Third, the Court found that the history of the Due Process Clause does not support the asserted right to assisted suicide (*Washington v. Glucksberg*, 1997, p. 719).

The third reason demands a discussion in greater detail. The Court wrote that although the Due Process Clause protects certain "fundamental rights," the asserted right to physician-assisted suicide does not rise to "this level of importance" (*Washington v.*

Glucksberg, 1997, p. 719). Before a right may be deemed "fundamental" in nature, it must be deeply rooted in the nation's legal history. The Court found the asserted right to physician-assisted suicide to be contrary to U.S. history, tradition, and practice; therefore, it concluded that it was not a "fundamental right" (*Washington v. Glucksberg*, 1997, p. 729). When legislation affects a highly valued liberty or freedom, the Court must apply the "strict scrutiny" standard of "judicial review." Since the Court ruled that this was not the case, they applied "a minimal standard of judicial scrutiny" (*Washington v. Glucksberg*, 2017, p. 730). This standard of judicial scrutiny, known as the rational relationship test, requires courts to uphold laws that are "reasonably related to some legitimate government interest" (*Washington v. Glucksberg*, 2017, p. 730). In this case the Court said that the state of Washington had a legitimate interest in preserving life, preventing suicide, protecting the integrity and ethics of the medical profession, and safeguarding vulnerable members of society, such as the poor, elderly, and disabled, from friends and relatives who see physician-assisted suicide as a way to end the heartache and burden that often accompany the protracted illness of a loved one (*Washington v. Glucksberg*, 1997, p. 731).

As previously stated, on the same day that the Court released its decision in *Washington v. Glucksberg* (1997), it announced its decision in the companion case of *Vacco v. Quill*, 521 U.S. 793 (1997). *Vacco v. Quill* (1997) differed from *Washington v. Glucksberg* (1997) in that the plaintiffs in *Vacco* (three doctors and three terminally ill patients) challenged a New York law prohibiting physician-assisted suicide on the ground that it violated the Equal Protection Clause of the Fourteenth Amendment to the U.S. Constitution. New York Penal Law Section 125.15 makes it a crime to intentionally help

another person commit suicide. However, pursuant to the Supreme Court's decision in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990), New York permits competent adult patients to terminate life-sustaining treatment, such as artificial hydration, nutrition, and respiration (*Vacco v. Quill*, 1997, p. 794).

The Equal Protection Clause requires the government to provide equal treatment to all similarly situated people. The Fourteenth Amendment prohibits the government from denying legal rights to one group of persons when those same rights are afforded to another group confronted by indistinguishable circumstances. The plaintiffs argued that the withdrawal of life-sustaining treatment is tantamount to suicide, because by definition its withdrawal typically ends life by ceasing to sustain it. The plaintiffs in *Vacco* contended that, in allowing some patients to hasten their death by terminating life-sustaining measures but not allowing other patients to hasten their deaths by taking lethal doses of prescribed medication, New York had denied patients equal protection of the laws (*Vacco v. Quill*, 1997, p. 799).

The Supreme Court ruled that a fundamental distinction exists between letting a patient die and killing her. Chief Justice Rehnquist wrote in the unanimous opinion that in one instance, the patient is allowed to die by natural causes when life-sustaining treatment is withdrawn. The patient's cause of death in that instance is the underlying illness. In the other instance, death is intentionally inflicted by the joint effort of doctor and patient. The cause of death in that instance is not the underlying illness, but human action (*Vacco v. Quill*, 1997, p. 808).

The Court in *Vacco* also noted that a right to physician-assisted suicide has never been approved by the common law but has been historically discouraged by both

common-law and statutory schemes throughout the United States. Thus, the Court concluded that physician-assisted suicide is not substantially similar to refusing medical treatment and that the legal systems of New York and other states may treat each practice differently without running afoul of the Equal Protection Clause (*Vacco v. Quill*, 1997, p. 801).

Although the decisions in *Glucksberg* and *Vacco* were both unanimous, it is very interesting to note that several of the justices wrote concurring opinions that were not only purposely designed to be applicable to both cases, but put forth different reasons and directions for why laws about assisted suicide may be changing in the future. It is important to note that a concurring opinion filed by a judge or judges agrees with the majority decision, but it expresses his or her different reasons for the decision, or a different view of the facts of the case, or of the law (*Concurring opinion*, 2017, p.1).

In a concurring opinion by Justice O'Connor in *Glucksberg*, which was joined by Justice Ruth Bader Ginsburg, O'Connor stressed that the states remain free to establish a right to physician-assisted suicide or to otherwise strike a proper balance between the interests of terminally ill patients and the interests of society. State legislatures, O'Connor suggested, are a more appropriate forum for making such difficult decisions because their members are accountable to the electorate at the ballot box. By contrast, the federal judiciary is often insulated from public opinion because its members are appointed to the bench for life. Relying on several studies undertaken by the states to evaluate the problem of physician-assisted suicide, O'Connor said that the right to die must first be grappled with at the local level before entangling federal courts in the controversy (*Washington v. Glucksberg*, 1997, p. 736). This opinion by Justice

O'Conner read very much like Justice Antonin G. Scalia's concurring opinion in the *Cruzan* case some seven years before (*Cruzan v. Director, Missouri Department of Health*, 1990, p. 279).

Justice John Paul Stevens' concurring opinion in *Washington v. Glucksberg* (1997) also underscored the need for further national debate on the propriety of physician-assisted suicide, but in a different vein. Although the states' interests may have been adequately served in *Glucksberg* and *Vacco*, Stevens cautioned that the Court's holding in these two cases does not foreclose the possibility that other circumstances might arise in which such statutes would infringe on a constitutionally protected area. "There will be times when a patient's interests in hastening his death will outweigh the state's countervailing interests in preserving his life. This reasoning also applies to the *Vacco* case" (*Washington v. Glucksberg*, 1997, p. 739).

In both the *Glucksberg* and *Vacco* cases, Justice Stephen G. Breyer suggested that the right to die should be renamed "the right-to-die with dignity." Once recognized by the Court, Breyer said, "the right to die with dignity" would include a competent patient's right to control the manner of his/her death, the quality and degree of professional care and intervention, and the amount of physical pain and suffering one is willing to tolerate. According to Breyer, a statute that would prevent patients from obtaining access to certain palliative care aimed at reducing pain and suffering might infringe on the right to die with dignity. Competent, terminally ill adult patients, Breyer intimated, may enjoy a constitutional right to prescription medication that will minimize the agony that often tortures the final days of their existence (*Washington v. Glucksberg*, 1997).

Justice David H. Souter articulated a different method of analysis for evaluating right-to-die cases in a very lengthy concurring opinion (37 pages) that he applied to both cases. Souter argued that the so-called right to die is a species of "substantive due process." Substantive due process, Souter reminded the Court, is a doctrine under which a judge evaluates the substantive merits of a statute, as opposed to the procedure by which it is implemented or administered. Under the rubric of substantive due process, the Court has recognized an individual's interest in dignity, autonomy, and privacy, among other things, over the course of the last century. The right to refuse unwanted medical treatment recognized by the Court in *Cruzan*, for example, was designed in part to serve these three interests (*Washington v. Glucksberg*, 1997).

Souter further contended that the doctrine of substantive due process protects individuals from "arbitrary impositions" and "purposeless restraints" created by the government. Souter advocated viewing substantive due process claims on a continuum of liberty in which the level of judicial scrutiny would increase in direct proportion to the level of government restraint or imposition. First enunciated by Justice John Marshall Harlan in his dissenting opinion in *Poe v. Ullman*, 367 U.S. 497 (1961), this approach to substantive due process would require courts to carefully balance the competing interests presented by the litigants in each right-to-die case (*Washington v. Glucksberg*, 1997).

Souter finalized his remarks by contrasting his "simpler" approach with the more complicated analysis presently employed by the Court, an analysis that involves multiple tiers of judicial scrutiny, ranging from strict to minimal scrutiny, different categories of constitutional rights, ranging from fundamental to non-fundamental rights, and different classes of protected status into which a plaintiff may fall, ranging from suspect to non-

suspect classes. A balancing approach like the one articulated in *Poe*, Souter maintained, would allow for the gradual evolution of a constitutional right to die, instead of the complicated all-or-nothing approach that the Court has effectively adopted (*Washington v. Glucksberg*, 1997).

The case law and legal rulings discussed in this foundational litigation and case law section, which includes the myriad of contradictory decisions pronounced by the judges and jurists, presents us with the following important summarized points:

- The decisions and rulings of the trial court judges, the appellate court judges and the justices of the Supreme Court are conflicting as to the issue of assisted suicide.
- Beginning with Judge Barbara Rothstein in the state of Washington in 1994, the use of selected parts of previous case decisions (selective precedent) to make a ruling began in earnest.
- The most publicized and important trial court rulings always favored the individual making the request to terminate their own life.
- Trial court rulings, whether in the state or federal system allowing for assisted suicide based on the Fourteenth Amendment rights of equal protection and substantive due process were always overturned by the higher courts.
- The minority opinions of the justices of the Supreme Court consistently favored the right of a seriously ill person to end his/her own life.
- The concurring opinions of the majority of judges and the minority opinions of the justices supported a very strong argument for the right of every individual to have possession and control of his or her person, free from all restraint or

interference of others as well as the right of every human being of adult years and sound mind to determine what shall be done with his/her own body, even the planning and fulfillment of an assisted suicide.

As the next decade unfolded, important Fourteenth Amendment cases dealing with issues other than assisted suicide would be heard by the Supreme Court. These cases signaled an expansive shift in protected "individual rights" under the Fourteenth Amendment. Could this "new reasoning" based on equal protection and substantive due process be used in shaping assisted suicide laws?

A decade+ of expanding "individual rights" under the 14th Amendment–1997-2018

Between 1997 and 2018, there were no cases involving assisted suicide heard by the Supreme Court. However, in 2003, the Supreme Court in the case of *Lawrence v. Texas* expanded its approach to substantive due process by using the Fourteenth Amendment to strike down a Texas sodomy statute by stating the "liberty presumes an autonomy of self that includes freedom of thought, belief, expression, and certain intimate conduct" (such as sex between two men or sex between same-sex couples) (*Lawrence v. Texas*, 2003, p.563). The Court concluded that the case should be resolved by determining whether the petitioners were free as adults to engage in the private conduct in the exercise of their liberty under the Due Process Clause of the Fourteenth Amendment to the Constitution (*Lawrence v. Texas*, 2003). The Court held that the Texas statute banning same-sex sodomy was unconstitutional relying on both the substantive component of the Fourteenth Amendment's Due Process Clause and the fourteenth amendment's Equal Protection Clause (*Lawrence v. Texas*, 2003). In a dissenting opinion, Justice Antonin G. Scalia stated that "the majority's position requires

it to effectively overrule *Glucksberg*, the leading modern case setting the bounds of substantive due process" (by a unanimous ruling in *Glucksberg,* the Court ruled against any fourteenth amendment right to assisted suicide) (*Lawrence v. Texas*, 2003).

In 2014, in a federal case at the trial court level in New Mexico, Judge Nan G. Nash, temporarily placed the state of New Mexico into the realm of allowing assisted suicide under the guise of a constitutional right. "This court cannot envision a right more fundamental, more private or more integral to the liberty, safety and happiness of a New Mexican than the right of a competent, terminally ill patient to choose aid in dying," wrote Judge Nan G. Nash of the Second District Court in Albuquerque (*Morris v. Brandenberg*, 2014, p. 12 & Eckholm, 2014, p. 1). The state trial court had ruled that "terminally ill residents have a constitutional right to obtain 'aid in dying'" (Eckholm, 2014, p. 1). At the time, the court ruling made New Mexico the fifth state to allow doctors to prescribe fatal drug doses that suffering patients can use to end their lives (Eckholm, 2014). "The State argued that such an action by a doctor was covered by the law and that banning doctor-assisted suicide was consistent with individual rights under the State Constitution. Judge Nash agreed that the law applied, but said that 'the liberty, safety and happiness interest of a competent, terminally ill patient to choose aid in dying is a fundamental right under the New Mexico Constitution'" (Eckholm, 2014, p. 3). This case, in which the competent adult patient asked the physician for medication that would end her life instead of using a gun to terminate her existence, appears to move us closer to accepting the act of assisted suicide when a terminally ill and competent patient "does not want to suffer needlessly at the end" (Eckholm, 2014, p. 3). However, in 2016, the Supreme Court of New Mexico in a unanimous decision "declined to hold that there is an

absolute and fundamental constitutional right to a physician's aid in dying," thus overturning Judge Nash's decision (*Morris v. Brandenberg*, 2016, p. 6).

The issues of history and tradition, the backgrounds and personal beliefs of judges and jurists, and cultural trends may have a significant impact in the near future on the issue of assisted suicide (Myers, 2016). In 2015, in the case of *Obergefell v. Hodges* supporting same-sex marriage, as both the Fourteenth Amendment doctrines of due process and equal protection were expanded once again, the Supreme Court reversed its historical approach to substantive due process and relied rather on its own understanding of the nature of liberty (Myers, 2016, p. 397). This "understanding" emphasizes respect for individual autonomy, self-determination and choice. The Court's analysis was unconstrained by history or a careful description of the right to substantive due process or even an assessment of emerging trends. The Court's focus was more on its own reflections on the nature of liberty and its own discernment of new insights and societal understandings about "what freedom is and must become" (Myers, 2016, p. 398). In a dissenting opinion, Chief Justice John Roberts stated, as had Justice Antonin Scalia in the *Lawrence* case, that the majority ruling in *Obergefell* effectively overruled *Glucksberg* which had previously "set the bounds of substantive due process" (*Obergefell v. Hodges, 2015*, p. 587).

Could the Supreme Court extend its reasoning based on the Fourteenth Amendment in the *Lawrence* and *Obergefell* cases to the issue of assisted suicide? In doing so, the Court would be emphasizing the "autonomy of life" philosophy by concluding that ending one's life is the ultimate act of liberty, freedom, belief and self-determination (Myers, 2016, p. 399).

State legislation from 1994 to 2018

In 1994, Oregon was the first state to enact a *"Death with Dignity"* law that "allows terminally-ill Oregonians to end their lives through the voluntary self-administration of lethal medications, expressly prescribed by a physician for that purpose" (Oregon Health Authority, 1997, p. 1). The statute is entitled, *"Chapter 127– Powers of Attorney; Advance Directives for Health Care; Physician Orders for Life Sustaining Treatment Registry; Declarations for Mental Health Treatment; Death with Dignity"* (Death with Dignity Act, 1997, p. 2). The statute was revised in 2016 by the Oregon legislature. However, no substantive changes were made.

The Oregon statute has five requirements that the patient must meet. The five requirements are:

- The patient must be an adult (18 years or older).
- The patient must be a resident of the state of Oregon (Factors demonstrating residency include, but are not limited to a state-issued driver's license, a lease agreement or property ownership document showing that the individual rents or owns property in the state, a state voter registration or a recent state tax return).
- The patient must be mentally competent (defined as being capable of making health care decisions and being able to communicate those decisions with his or her physician).
- The patient must be diagnosed with a terminal illness that will lead to death within six months.
- The patient must be able to self-administer and ingest the prescribed medication without assistance.

Two physicians must determine whether these criteria have been met. The process entails two oral requests, one written request and certain waiting periods.

The attending physician must comply with six responsibilities/requirements. The six responsibilities/requirements are:

- The physician must be licensed by the state and certified to prescribe medication.
- The physician's diagnosis must include a terminal illness, with six or fewer months to live.
- The physician's diagnosis must be certified by a consulting physician, who must also certify that the patient is mentally competent to make and communicate health care decisions.
- If either physician determines that the patient's judgment is impaired, the patient must be referred for a psychological examination.
- The attending physician must inform the patient of alternatives, including palliative care, hospice and pain management options.
- The attending physician must request that the patient notify the next of kin of the prescription request.

Both the patient and the attending physician must send certain documentation to the State Registrar for Vital Records at the time the prescription is written (Oregon Health Authority, 1997, p. 1). (See Appendix B for complete text of Oregon's original statute with revisions).

Beginning in 2008 and over the next ten years, the states of Washington, Montana, Vermont, California, Colorado, Hawaii and the District of Columbia, in chronological order, enacted statutes similar to Oregon's. These laws came into

existence either by the citizens of the state voting for enactment of an assisted suicide law, by enactment of legislation by the state government without a vote by its citizens or by a state Supreme Court case ruling. All of the laws included patient and physician responsibilities and requirements similar to Oregon's. Included in the laws of all six states and the District of Columbia under patient responsibilities and requirements were the age requirement of 18, citizenship in the state or district, diagnosis of a terminal illness with less than six months to live and capability of making and communicating health care decisions by oneself. The physician responsibilities and requirements in all six states and the District of Columbia were inclusive of those in the Oregon statute (Oregon Health Authority, 1997). Colorado's law added a requirement that the physician must inform the patient that the medication should be taken in a private place with another person present, and the Supreme Court of Montana's ruling found no indication in Montana law that physician aid in dying provided to terminally ill, mentally competent adult patients is against public policy; therefore, the physician who assists is shielded from criminal liability by the patient's consent. Chapter 4 of this qualitative policy evaluation study dissertation herein contains Table 1 showing the similarities and differences among all six state statutes, the District of Columbia and the state of Montana via the Supreme Court of Montana case, *Baxter v. Montana* (2009). (See Plural Appendices B through I for complete text of each state statute, the District of Columbia statute and the Supreme Court of Montana ruling of *Baxter v. Montana*).

In the additional 12 states selected for this study (Alabama, Arizona, Florida, Georgia, Illinois, Maryland, Mississippi, Missouri, New Jersey, New York, Texas and Utah), assisted suicide is illegal. Each of the 12 states, other than Alabama and Utah, has

a specific statute against assisted suicide. Alabama has accepted the "common law" approach to assisted suicide without promulgating a state statute, and Utah's position is unclear since it does not recognize the "common law" approach, nor does it have a state statute concerning assisted suicide (*State-by-State*, 2017). Chapter IV of this dissertation contains Table 2 showing the criminal laws/statutes and punishment guidelines for each of the 12 states.

The federal government does not have any assisted suicide laws.

Precedent (stare decisis)

The bridge between the content of this literature review to this point and the theoretical underpinnings section below is grounded in a discussion of the importance and significance of historical legal precedent, and of how judges and justices explain, regard and align their own legal reasoning with said precedent. "Since the ramifications of a legal proceeding extend beyond that one proceeding, legal research is grounded in the past (precedent), as well as the present, in order to suggest what future rulings may be. Precedent is a pillar of the American legal system, and this principle is known as 'stare decisis'" (*Stare decisis*, 2017, p. 1).

Providing an example of the importance of legal precedent (stare decisis) is the polarizing paradigm of opinions between Justices on the United States Supreme Court. Justice Lewis F. Powell, Jr., believed that "the history test" offers "a comparatively objective approach to due process litigation" (Gorsuch, 2006, p. 19). Powell stated in the case of *Moore v. City of East Cleveland* (1977) that "an approach grounded in history imposes limits on the judiciary that are more meaningful than any based on the abstract formula suggested as an alternative" (Gorsuch, 2006, p. 19). On the opposite end of the

spectrum, Justice David Souter believes that the analysis of historical legal rules and rights relative to substantive due process issues "bears little or no relevance to current substantive due process analysis" (Gorsuch, 2006, p. 19).

It is important to understand that in the United States courts seek to follow precedent whenever possible, pursuing the maintenance of stability and continuity in the law. Devotion to "stare decisis" is considered a mark of judicial restraint, limiting a judge's ability to determine the outcome of a case in a way that he or she might choose if it were a matter of first impression (*Stare decisis*, 2017, p. 2). An example of stare decisis (precedent) and its importance can be seen in the following two famous United States Supreme Court cases. In the 1973 case of *Roe v. Wade* (*Roe v. Wade*, 1973, 113), the Supreme Court defined a woman's right to choose abortion as a fundamental constitutional right. Despite the controversy engendered by the decision, and calls for its repudiation, a majority of the justices, including some conservatives who might have decided Roe differently, invoked stare decisis in all succeeding abortion cases including the 1992 case of *Planned Parenthood v. Casey* (*Planned Parenthood v. Casey*, 1992, 844).

The principle of "stare decisis" has always been tempered with a conviction that prior decisions must comport with notions of good reason, or they can be overruled by the highest court in the jurisdiction (*Stare decisis*, 2017, p. 2). The United States Supreme Court rarely overturns one of its precedents, but when it does, the ruling usually signifies a new way of looking at an important legal issue. For example, in the landmark case *Brown v. Board of Education* (1954), the Supreme Court repudiated the separate-but-equal doctrine it endorsed in *Plessey v. Ferguson* (1896). The Court ignored stare

decisis, renouncing a legal precedent that had legitimated racial segregation for almost 60 years (*Stare decisis*, 2017). This judicial principle of *stare decisis* is the single most important defining characteristic of the "rule of law" and therefore must be considered in any literature review involving legal research about assisted suicide.

Final consideration from a legal perspective–an individual's ability to manipulate information rationally

The final and most stringent category (of legal debate) to consider when dealing with assisted suicide is whether a patient has the "ability to manipulate information rationally," which is regarded as the toughest competency standard to meet and considers a patient's "reasoning capacity or ability to employ logical thought processes to compare the risks and benefits of treatment options" (Stillman, 2016, 293).

A patient who can understand, appreciate and communicate a decision may still be impaired because she is unable to process information logically, in accordance with her preferences. "The appreciation piece takes place when the subject (patient) can acknowledge the conditions of his or her illness and the value of possible treatments. This standard has been further defined to consider whether a patient is able to knowingly and intelligently evaluate the information at hand and otherwise participate in the treatment decision by means of rational thought processes" (Stillman, 2016, p. 295). This additional "ability to manipulate information rationally" maxim appears to be an extra legal psychological layer used by some to help determine the true desires and wishes of the patient who is choosing to terminate his or her own life.

The different individual judicial views and approaches to assisted suicide as expressed in the majority, concurring and dissenting opinions of the cases discussed

herein, as well as changing public sentiment over the past 20 years towards assisted suicide, may signal an opportunity to proponents, activists, advocates and public administrators to begin developing a universal public policy healthcare model concerning the topic of assisted suicide, using a dignified, compassionate and common-sense approach.

Theoretical underpinnings–1801 to 2018

As the literature review for this policy evaluation paper progressed, it became obvious, as well as imperative, to look through the legal lens of study at two public administrators who were and are renowned experts in the combined areas of law, ethics, the U.S. Constitution, the administrative state and the United States Supreme Court. This part of the research added the foundational theoretical underpinnings to the topic of assisted suicide, even though the topic of assisted suicide was never directly addressed by either of them. This, in turn, helped structure part of the methodology used herein and facilitated the process of being able to propose a public policy healthcare model dealing with assisted suicide. The two public administrators chosen were the late John A. Rohr, the nationally renowned American political scientist who was Professor Emeritus at the Center for Public Administration & Policy at Virginia Tech for over 25 years, and Jeffrey A. Toobin, the Harvard-educated lawyer, author, public administrator, legal analyst and expert on the U.S. Supreme Court and many of its justices, both past and present.

Professor John A. Rohr (1934–2011)

Professor John A. Rohr was internationally acknowledged as an expert on the U.S. Constitution as it related to civil servants and public administrators. He was an expert on "constitutionalism," which refers to the "role of written constitutions and of

unwritten but constitution-like conventions or political agreements in promoting good government" (Uhr, 2016, p. 142). The main theme of constitutionalist theorists such as Rohr has been the legitimacy of public administration within the American political order (Overeem, 2008, p. 48). In this regard, Rohr resuscitated normative concepts like "public interest" and "responsibility" and argued that the American administrative state is compatible with the constitutional republic envisaged by the Founders (Rohr, 1986, p. 37). Rohr elevated public administration to the central position of constitutional "guardian," thus playing a role comparable to that of the original Senate (Rohr, 1986, p. 39). Rohr used this approach and the elevation of public administration (and thereby public administrators) to "guardian" status to present his concept of "regime values" in his first book, *Ethics for Bureaucrats* (Rohr, 1978). Rohr's basic argument was that an orientation on regime values can help bureaucrats to choose their path when the law gives them no guidance and they have to make use of their discretion (Overeem, 2013, p. 51).

Rohr spoke of regime values as the "values of the people" or the "values of the American people" or simply "American values" (Overeem, 2013, 52). Most importantly (to Rohr), was that these democratic responsibilities of public administrators were symbolized by their oath of office: "The oath to uphold the Constitution is the moral foundation of ethics for bureaucrats" (Rohr, 1978, p. 70). Rohr's basic regime values were defined as "freedom, equality, and property" (Overeem, 2013, 53). These "values" Rohr refers to are discovered in the public law, in the Declaration of Independence, the Constitution, statutes and in court decisions by the Supreme Court and other important lower tribunals (Rohr, 1978, pp. 49-56). More specifically, Rohr says that the most suitable source to study regime values is Supreme Court opinions. His main reasoning on

this point is that the Supreme Court is the principal interpreter of the Constitution, and its opinions have four characteristics that make them particularly instructive for public administrators (Overeem, 2013, p. 53).

It is important to note the four characteristics espoused by Rohr, not only for clarity's sake, but to segue into the writings of Jeffrey R. Toobin. The four characteristics are:

1. Regime values are institutional in the sense that they have a certain grounding in the past which gives them stability [see precedent or stare decisis as explained by Toobin (Overeem, 2013)].
2. They are dialectic, consisting of concurring and dissenting opinions that can both sharpen the administrative mind.
3. They are concrete and "disciplined by reality" and thus especially useful for administrative practice.
4. They are pertinent, i.e., "useful for reflection on fundamental values" rather than trivialities.

   (Overeem, 2013, p. 53).

Rohr received criticism from postmodernist scholars of public administration relative to his work and writings on constitutionalism, regime values and the importance of the opinions of the Supreme Court. However, many academicians continued to agree with Rohr on a certain level by saying that the constitutional approach to public administration has merit, but the approach could not provide universal standards as suggested by Rohr. In 2007, Michael W. Spicer from Cleveland State University argued that:

> Constitutionalism encourages the resolution of conflict among cultural conceptions of the good by practices of adversarial argument and procedural justice rather than simply by force and in doing so, it makes possible the protection of a broader range of such conceptions of good than would otherwise be the case. (Spicer, 2007, p. 3)

Spicer further stated that the constitutional approach to public administration has merit in directing our attention towards constitutional practices, but any attempt to legitimize public administration in terms of these practices is always potentially problematic since the practices are always contestable (Spicer, 2007, p. 3).

In 2017, Sheila Kennedy, Professor of Law and Policy in the School of Public and Environmental Affairs (SPEA) at Indiana University-Purdue University Indianapolis, agreed with Rohr as she discussed and reiterated his belief that "one of the most fundamental problems with the public management movement is its failure to emphasize that the job of public manager is to implement the Constitution" (Kennedy, 2017, p.4). Kennedy claims that public administrators lack understanding in basic civic (including professional and ethical behavior) and constitutional knowledge because of a lack of teaching and training (Kennedy, 2017). In re-emphasizing the importance of the constitutional roots of public management and agreeing with scholars Robert Christenson, David Rosenbloom and Michael Spicer on the proposition that the Constitution is "the normative base for our scholarship, and it demands that we reemphasize and reestablish a greater commitment to how the rule of law pervades public administrative management in its entirety," she echoes Rohr's conviction that the

"legitimacy of the administrative state requires fidelity to the Constitution" (Kennedy, 2017, p. 6).

In his writings, Jeffrey R. Toobin was not one of the public administrators who criticized Rohr's work. However, as described by Toobin in the next section of this paper, the ideology-driven opinions of the justices of the Supreme Court may have changed or unwoven some of the benchmark constitutionally-driven beliefs supporting Rohr's main concepts (Toobin, 2007).

Jeffrey R. Toobin

For more than 200 years, the United States Supreme Court has confronted the same political issues as the other branches of government. During his long tenure (1801 to 1835) as chief justice, John Marshall did as much as the framers of the Constitution themselves to shape an enduring structure for the government of the United States (Toobin, 2007, p. 2). As the leading Federalist of the day, he solidified the position of the American judiciary as an independent and influential branch of government (Toobin, 2007, p. 2).

However, during the period of territorial and economic expansion before World War I, the Court shrank from a position of leadership to one of "accommodating business interests and their political allies who dominated the other branches of government" (Toobin, 2007, p. 2). It was not until the 1950s and 1960s, under the tenure (1953 to 1969) of Chief Justice Earl Warren, that the Court began to consistently re-assert itself as an independent and aggressive guarantor of constitutional rights. Over the next 40 years, even though the Court was "divided" on the most pressing issues before it, the Court

continued its main leadership quality of being "constitutionally directed" (Toobin, 2007, p. 2).

Like all their predecessors, the justices during this time period belonged to a fundamentally antidemocratic institution. They were not elected; they were not accountable to the public in any meaningful way; their life tenure gave them no reason to cater to the will of the people (Toobin, 2007, p. 2). But according to Toobin, from 1992 to 2005, the decisions of the Supreme Court reflected public opinion with great precision. "The opinions were issued in the Court's customary language of legal certainty, announced as if the constitutional text and precedents alone mandated their conclusions, but the decisions in these cases probably would have been the same if they had simply been put to a popular vote" (Toobin, 2007, p. 2).

Over many years, as the writings of Toobin developed, it is interesting to note the expanse and timing of his public administration experience. Toobin served in the arena of public administration on three separate occasions, first as a law clerk to a federal judge (1987) and then as an associate counsel to Edward Walsh, the independent counsel during the Iran-Contra affair and the criminal trial of Oliver North (1989). He then served as an Assistant U. S. Attorney in Brooklyn (1991). He took the oath to uphold the U.S. Constitution as an associate counsel and an Assistant U.S. Attorney (Harvard Law Today, 2013, p. 1). The "taking the oath to uphold the U.S. Constitution" portion of Toobin's resume would have been of particular interest to John Rohr.

One particular event in history helped initially shape Toobin's approach and guided his thinking to the conclusion that "the identity of the justices and therefore their

individual ideologies trump precedent, which in turn drives their opinions" (Toobin, 2007, p. 339).

That one particular event was the construction of the original Supreme Court building. Legal historians have discussed and debated the significance of the processional approaches to the Capitol, the Washington Monument and the Lincoln Memorial since these landmarks were designed and built. When Cass Gilbert, the architect who designed the Supreme Court building (or "home" of the Supreme Court as he referred to it), was commissioned to design the building, his main thought was to "convey to visitors the magnitude and importance of the judicial process taking place within the Court's walls" (Toobin, 2007, p. 1). Gilbert decided that the most important feature of the building's exterior should be the steps.

> The public face of the building would be a portico with a massive and imposing stairway. Visitors would not have to walk a long distance to enter, but few would forget the experience of mounting those forty-four steps to the double row of eight massive columns supporting the roof. The walk up the stairs would be the central symbolic experience of the Supreme Court, a physical manifestation of the American march to justice. The stairs separated the Court from the everyday world–and especially from the earthly concerns of the politicians in the Capitol–and announced that the justices would operate, literally, on a higher plane. (Toobin. 2007, p. 1)

According to Toobin, as of 2007, the main leadership quality of the Supreme Court was that of being "constitutionally directed." However, at the same time, the "constitutionally directed decisions of the Court reflected public opinion with great

precision" (Toobin, 2007, p. 2). Toobin claims that this "constitutionally directed" process of decision-making (and therefore the outcomes of most cases) from a historically antidemocratic institution was about to undergo a revolution.

Justice William Rehnquist passed away in late 2005, and Justice Sandra Day O'Conner retired in early 2006. According to Toobin, from these two events, plus a "conservative ideological offensive" being led by some elite law schools, evangelical churches and the White House, the upcoming general election in 2008 and lip service being given to retirement by Justices David H. Souter and John Paul Stevens, the "decisions being made by the Court equaling the public opinion of the people" paradigm was about to change (Toobin, 2007, p. 3).

How did this revolution occur? Has Toobin's educated prediction come to pass? How do Toobin's thinking and future predictions compare or conflict with Professor Rohr's teachings of "ethics in public service involving an intense sensitivity to appropriate forms of constitutional practice where the bureaucratic code of conduct should be based on each government employee's understanding of constitutional principles" (Rohr, 1998, p. 4)? According to Rohr, "a government employee's understanding of constitutional principles provides him or her with an instinctive sense of correct conduct in every situation they find themselves" (Rohr, 1978, p. 5). Does Toobin's predictive shift by the justices of the Court change the "benchmark of understanding" for these government employees?

When John G. Roberts, Jr., was nominated to the Supreme Court at age 55 (2005), he reflected upon the great symbol at the heart of architect Cass Gilbert's design–the steps (Toobin, 2007, p. 337). "I always got a lump in my throat whenever I walked up

those marble steps to argue a case before the Court and I don't think it was just from the nerves" (Toobin, 2007, p. 337). Due to renovations in 2009, the steps were closed to the public and a new entrance to the building was built. Visitors to the Supreme Court building are still allowed to depart down the original steps, but only to watch Gilbert's vision recede behind them (Toobin, 2007, p. 337). Is the closing of the steps (and the original intended architectural meaning of them that the Supreme Court Justices would be operating on a higher plane) a metaphor for a deeper change in the Court's approach as was predicted (Toobin, 2017, p. 337)?

More than any other influence, the Court has always reflected the political currents driving the broader society (Toobin, 2007). But as Toobin noted in 2007, the fundamental divisions in American society are not regional or religious, but ideological. "When it comes to the core of the Court's work, determining the contemporary meaning of the Constitution, it is ideology, not craft or skill that controls the outcome of the case" (Toobin, 2007, p. 338). Toobin is an admirer of the recently retired conservative appellate judge (United States Court of Appeals for the Seventh Circuit), economist and law professor, Richard A. Posner. Posner said, "It is rarely possible to say with a straight face of a Supreme Court constitutional decision that it was decided correctly or incorrectly. Constitutional cases can be decided only on political judgment, and a political judgment cannot be called right or wrong by reference to legal norms" (Toobin, 2007, p. 339).

One needs to look no further than the case of *Lawrence v. Texas* (p. 21, supra) as an example of ideology trumping precedent or stare decisis. As previously stated, in *Lawrence*, the Supreme Court held that the Texas statute banning same-sex sodomy was

unconstitutional relying on both the substantive component of the 14th Amendment's Due Process Clause and the 14th Amendment's Equal Protection Clause (*Lawrence v. Texas*, 2003, p. 579). This 2003 decision overturned the Court's barely 17-year-old decision in *Bowers v. Hardwick* (1986) that had upheld the constitutionality of a Georgia sodomy law criminalizing oral and anal sex in private between consenting adults, in this case with respect to homosexual sodomy, though the law did not differentiate between homosexual sodomy and heterosexual sodomy (Toobin, 2007, p. 339).

A second example of ideology trumping precedent is the 2015 case of *Obergefell v. Hodges* (2015). In the case of *Obergefell v. Hodges* (2015), both the Fourteenth Amendment doctrines of due process and equal protection were expanded to support same-sex marriage, as the Supreme Court reversed its historical approach to substantive due process and relied rather on its own understanding of the nature of liberty (Myers, 2016, p. 397).

Some experts may not agree with Toobin and cite specific Supreme Court rulings since 2008 in order to validate their points of view. Some may point to the *National Federation of Independent Business v. Sebelius* case in 2012 as an example. In a 5-4 ruling, the Supreme Court upheld the 2010 Patient Protection and Affordable Care Act. The Court held that the requirement that certain individuals pay a financial penalty for not obtaining health insurance was constitutional under the Commerce Clause. More specifically, in writing the majority opinion, Chief Justice John G. Roberts, Jr., found the mandate constitutional by characterizing the mandate as a tax. Roberts reasoned that since the penalty is to be paid to the IRS, along with the individual's income taxes, "it is not our role to forbid it, or to pass upon its wisdom or fairness" (*National Federation of*

Independent Business v. Sebelius, 2012, p. 520). However, Roberts did not find the law valid under the Commerce Clause as did the four other justices (Ginsburg, Breyer, Sotomayor and Kagan) voting in the majority. Roberts upheld the mandate citing the Congress's power under the Taxing Clause. But ideologically speaking, all but Roberts' fit into Toobin's theory. However, this case is very different from the other cases discussed herein. The *NFIB* case deals with the Commerce Clause and the taxing authority of Congress. The rights, tenets and mandates of the Fourteenth Amendment are not mentioned anywhere in the entire opinion. Perhaps for some justices, the "ideologically-directed thinking" applies to all cases, but for others, it only applies to equal protection and substantive due process cases. Until the Supreme Court rules on the next major Fourteenth Amendment case (possibly on assisted suicide), Toobin's prognostication will remain untested.

To date, Toobin's "ideological-directed thinking" conceptual prognostication based on political appointments has not been disputed. Unlike Rohr, whose ideas, writings and teachings have been around since the early 1960s, Toobin's theory is very recent (2007) as far as judicial history is concerned. His reputation as a writer, public administrator and legal analyst has been lauded by some as being esteemed, insightful, well-respected and balanced (Kakutani, 2007).

Toobin's main theory of "a new directional, politically-motivated revolution of individualized ideological-directed thinking by the Justices" coupled with his pronouncement (paraphrased) that "justices use their own individual ideologies when determining the meaning of the Constitution and when it comes to the core of the Court's work, it is ideology, not craft or skill that controls the outcome of the case," has support

from other authors.

In 2010, in the Journal of Politics, Professor Christopher Zorn from Pennsylvania State University and Assistant Professor Jennifer Bowie from George Mason University "found robust support for the contention that ideological and policy-related influence on federal judges' decision are larger at the higher levels of the judicial hierarchy" (Zorn & Bowie, 2010. p. 1212). Also in 2010, Professor Corey Yung from the University of Kansas School of Law agreed that the theory of ideological-directed thinking (and thus how a judge would rule) was extremely important, but that the measuring techniques currently used were too limited, thus inadequate and should be expanded in order to help predict how a judge would rule (Yung, 2010, p. 2).

Benjamin Oliphant, lawyer and adjunct Professor of Law at the UBC Allard School of Law in Vancouver, states that "judicial ideology is based on what a judge believes to be his or her role within the legal system, which in turn informs a set of principles and the interpretive methods they employ in going about their job" (Oliphant, 2015, p. 2). Oliphant further explains:

> In very broad terms, a judicial ideology with respect to constitutional law may require deference to elected bodies, or require adherence to past precedent and the intentions of lawmakers, or the original meaning of a law as passed, or it may seek to ensure the proper operation of robust democratic institutions or it may counsel making pragmatic decisions in the context of specific cases. It is this form of ideology that I think is particularly important for principled constitutional decision-making.
>
> (Oliphant, 2015, p. 2).

As to the issue of assisted suicide, any future decision by the Supreme Court may be weighed on the new scale of "ideologically-directed thinking based on politics and which jurists are appointed as Justices to the Supreme Court" and not on the historic precedent-based "scale of justice" (stare decisis) and the public opinion of the majority of Americans.

Do the precedent-setting assisted suicide cases of *Glucksberg* and *Vacco* face the same fate as the *Bowers* case due to this shift and intertwinement of the collective ideologies of the current nine justices of the Supreme Court? Do the writings of Toobin compromise a part of Rohr's conception of regime values that emphasize the centrality of the U.S. Constitution in the decisions of the Supreme Court? Have we unknowingly witnessed a decade (2007 to present day) where Rohr's fundamental approach to public administrative ethics known as "constitutionalism" has been modified, abated or completely perished?

If Toobin is correct and the future opinions issued by the Supreme Court are guided by the ideologically-directed thinking of nine justices, then said opinions may not reflect public sentiment. They will simply be motivated by political judgment and will not therefore be constitutionally directed. If so, what effect will this have on assisted suicide laws?

Synopsis

Using the legal lens of study approach allowed for the broad examination and assimilation of the most important and pertinent research data about assisted suicide. The legal lens of study approach provided not only the latest federal and state case rulings and updates, but insight into how jurists have been influenced in arriving at their decisions.

The subject matter of this dissertation is emotional and polarizing. Judges are not immune from the "emotional influence" of this type of subject matter. Therefore, in addition to following a path of legal reasoning that is objective, based on precedent, dispassionate, detached and constitutionally-directed, judges and justices apparently add their own personal experiences and ideologies to the legal decision-making process. According to Toobin (2006, p. 33), justices on the Supreme Court make their decisions based more on their own ideologies and not on the Constitution, at least when dealing with Fourteenth Amendment cases based on substantive due process and equal protection. If he is correct, Toobin's theory could change the entire landscape for laws concerning assisted suicide and possibly disrupt Rohr's regime value theory.

In the practice of law, there is an old legal aphorism that states, "If the facts of the case are against you, argue the law. If the law is against you, argue the facts. If the facts and the law are against you, just argue (some say, 'pound the table and yell like hell')" (Sandburg, 2009, p. 1). Perhaps more importantly, the ideologies of the judges and justices need to be examined and understood and then argued as well. The legal lens of study approach exposed the tenets of this aphorism as the facts of each case, each position and the legal arguments concerning assisted suicide were explored.

This study is impacted on a major level by several pieces of research literature including Associate Supreme Court Justice Neil Gorsuch's book from 2006, *The Future of Assisted Suicide and Euthanasia.* The book introduces and examines the primary legal arguments deployed by those in favor of assisted suicide. It also sets forth legal arguments for retaining existing laws against assisted suicide. The book also debates

several ethical issues that are almost inseparable and inextricably linked to many of the legal issues involving assisted suicide (Gorsuch, 2006).

Also impacting this study on a major level is Jeffrey R. Toobin's book from 2007, *The Nine.* This writing predicts a dramatic shift in the approach of the justices of the Supreme Court away from being constitutionally-centric to being ideologically-driven. If Toobin is correct, the topic of assisted suicide should reappear before the Supreme Court in the near future, and a very different opinion may come forth than the opinions in the cases from the 1990s (*Glucksberg* and *Vacco*).

Four of Professor John Rohr's writings (as cited herein) impacted this policy evaluation study because of their importance to public administrators, public law and the Constitution. Rohr's approach using the Constitution as the foundational document for guidance, decision making and protection for citizens is tantamount to any public policy proposal concerning assisted suicide.

The assisted suicide statute in the state of Oregon and the assisted suicide/euthanasia laws of The Netherlands form the basis for all of the other statutes and laws studied, within both the United States and the other five countries included in the study. This fact alone makes the Oregon statute and The Netherlands law of extreme importance when attempting to propose a compassionate and common sense public policy healthcare model dealing with assisted suicide.

Research literature dealing with the 1803 Supreme Court case of *Marbury v. Madison* and Justice Antonin G. Scalia's dissent in the *Cruzan* case both are of vital importance. Scalia announced in his dissent that "federal courts have no business in the field of preserving life, insofar as the American law had always accorded states the power

to prevent suicide—including suicide by refusing to take appropriate measures necessary to preserve one's life—by force if necessary, and the Federal Constitution had nothing to say about the subject." Both the *Marbury* case and Scalia's dissent will be the antithetical lynchpins as to how a public policy healthcare model for assisted suicide should be approached on a federal level.

The research literature surrounding the latest U.S. Supreme Court case of *Obergefell v. Hodges* (2015) and Richard S. Myers' study "The Constitutionality of Laws Banning Physician Assisted Suicide" are examples of the Court expanding the use and understanding of substantive due process. This importance of both these pieces of research literature, coupled with other Fourteenth Amendment cases involving education, criminal law, abortion, voting rights, assisted suicide, same-sex marriage and immigration, served as a directional compass for proposing a public policy healthcare model for assisted suicide that would withstand both legal and ethical assaults.

Chapter III

METHODOLOGY

Research and data collection

The current qualitative policy evaluation study looks at assisted suicide using a legal lens of study approach. The purpose of the current study is to develop a public policy healthcare model for dealing with assisted suicide using a dignified, compassionate, and common-sense approach.

Methodology overview

From a methodological standpoint, the term "legal lens of study approach" must be carefully and constructively defined in order to give the term clear meaning and show academic evidence that appropriate and proper qualitative research rules exist for this approach and that they were adhered to in this dissertation. But first, the long-standing and academically accepted descriptive and evaluative research approach followed herein must be identified in order to determine the research questions. After determining the research questions, the methodology to accomplish this determination herein must be explained and adopted. "All good legal research should begin by identifying the specific goal or goals which the researcher wishes to achieve" (Dobinson & Johns, 2007, p. 33). According to Arlene Fink**,** Professor of Medicine and Public Health at the University of California, Los Angeles, there are some general requirements to follow when undertaking this kind of research, regardless of whether the research is descriptive or evaluative or both (Dobinson & Johns, 2007, p. 33).

Professor Fink specifies five requirements:

1. Specific research questions

2. Defined and justified sample

3. Valid data collection

4. Appropriate analytic methods

5. Interpretation based on the data (Dobinson & Johns, 2007, p. 33)

In addition to Dr. Fink's five requirements, Professors Epstein and King suggest four rules "that are, regardless of whether the research is qualitative or quantitative, essential to reaching valid inferences" (Dobinson & Johns, 2007, p. 33). Their four rules essential to reaching valid inferences are:

1. Identify the population of interest

2. Collect as much data as is feasible

3. Record the process by which data come to be observed

4. Collect data in a manner that avoids selection bias

The general requirements of Dr. Fink are discussed in separate paragraphs below. The four rules of Professors Epstein and King relative to reaching valid inferences are examined as a unit in a separate paragraph. The five requirements and four rules mentioned above were adhered to in this program evaluation study dissertation on assisted suicide.

Requirement number one is that the researcher identifies specific research questions. In this dissertation, after stating the general objective for this program evaluation study, the following five research questions were proposed in Chapter 2:

Question 1. What major similarities and differences are there in the current assisted suicide laws and statutes in effect in the 20 jurisdictions selected for this study?

Question 2. What major similarities and differences are there in the current assisted suicide laws in the six countries other than the United States selected for this study?

Question 3. Are there universal language elements in the assisted suicide laws of the 20 jurisdictions and in the six countries other than the United States selected for this study?

Question 4. Over the past 45 years, how do the rulings of the United States Supreme Court in Fourteenth Amendment cases using the doctrines of equal protection and substantive due process as applied to assisted suicide laws reflect public opinion of the citizenry of the United States as reported in opinion polls?

Question 5. A. Does evidence in case law support Rohr's "regime value/constitutionally-directed" theory or Toobin's more recently formulated theory that justices of the Supreme Court are increasingly motivated not by the Constitution but by politics and personal ideology when deciding 14th Amendment cases? Can both theories co-exist and not totally conflict?

Question 5. B. What does the answer to part A suggest about the future of assisted suicide laws in the United States?

The accepted methodology followed and used herein was established in order to answer as completely as possible the research questions proposed above (and in Chapter 2). The first step was to start with a comprehensive literature review of all laws covering assisted suicide in the states which allow for assisted suicide, and laws in other states randomly selected for this study that do not allow for assisted suicide or have chosen not

to promulgate any laws for or against the issue. The second step taken in the comprehensive literature review was to look at six countries from other parts of the world and see how these countries have dealt with the issue of assisted suicide. The comprehensive literature review consisted of a thorough and complete reading of all statutes and laws in order to uncover each pertinent element of the statutory laws promulgated. The comprehensive review detailed the most important similarities and differences of each law and also detailed the historical placement from a chronological perspective. The third step was to research general statistics about assisted suicide including the reporting systems used by states that allow for assisted suicide.

Five additional research steps were taken in order to ensure that a substantial, complete and accepted research methodology was followed in this dissertation. The topic of assisted suicide was researched, and the five most critical events as stated by experts on the subject matter, which brought the issue to the forefront of the thoughts and actions of America's mainstream, were uncovered. All United States Supreme Court cases on assisted suicide issues were researched, analyzed and shepardized. When cases are "shepardized" (using the term to define the in-depth use of *Shepard's Citations*, the main legal citation source which is widely recognized by academicians such as McConville and Chui (see McConville and Chui, 2007), the process provided a list of all courts and judicial authorities citing a particular case or statutory authority from the date of the ruling of the case to present day. This type of doctrinal legal research revealed if a case has been reaffirmed, followed, applied, questioned, modified, distinguished, overturned or generally cited in later cases, thus upholding, modifying or adding some additional parameters to the ruling of the case (Shepard's Citations, 2017, p. 1). The analysis of the

cases entailed an in-depth look into the chronology of the cases, the legal reasoning of the majority, how many justices voted in the majority, the main tenets of any dissenting opinions, different views expressed by any concurring opinions, main precedents followed (or not), and more.

The research into the Supreme Court cases dealing with assisted suicide led to research centered around the Fourteenth Amendment of the United States Constitution and other cases in the past 45 years relying on equal protection and substantive due process arguments before the Supreme Court, the same arguments used by proponents and opponents in the assisted suicide cases. Cases concerning assisted suicide in other state and federal jurisdictions were researched, analyzed and shepardized to uncover how these cases were argued and resolved at the trial court and appellate court levels. Finally, research was conducted into the history of "constitutionalism" and, in addition, how the justices of the Supreme Court have dealt with precedent in major Fourteenth Amendment cases over the past 45 years and how their directional reasoning has changed.

In the strictest sense, most of Professor Fink's second requirement does not apply to this qualitative study. There were no interviews conducted, nor were there any surveys or questionnaires sent to a defined audience (sample). Since this author has chosen a legal studies approach, as in one of the studies examined under this requirement heading by Professors Dobinson and Johns, the scope and depth of the research conducted for this study was exhaustive, "thus giving the conclusions drawn a much better chance of being valid" (Dobinson & Johns, 2007, p.35).

Requirements number three, valid data collection, and number four, appropriate analytical method, were followed in the sense that all laws, statutes and cases were

researched, shepardized and analyzed in order to make certain that no data remained uncollected. In addition, even though the analysis of all the data collected could be labelled as subjective, the experience and expertise of the individual doing the research for this study was skillful, proficient and competent.

Requirement number five, interpretations based on the data, "is where most legal research falls down" (Dobinson & Johns, 2007, p.37). The main general explanation is that "many conclusions are not justified by the data collected" (Dobinson & Johns, 2007). Dobinson and Johns' comment refers to Fink's requirement number five, interpretation based on data collected from surveys, interviews and questionnaires, not empirical qualitative legal research. In this study, there are no methodological limitations due to survey sample. The research questions herein are objective and avoid bias. For this dissertation, how the data (research) was collected and how it was analyzed followed the appropriate and accepted "methodology along the lines of a social science literature review" (Dobinson & Johns, 2007, p.41).

As part of the methodology for this study, Epstein and King's four rules essential to reaching valid inferences regardless of whether the research is qualitative or quantitative were also followed. The population (herein the subject) was identified, as much data as possible was collected, the process by which the data was observed (recorded) was explained and the manner in which the data was collected in order to avoid selection bias was observed and followed.

Legal lens of study approach defined

The "legal lens of study approach" is defined as being the best and most studious qualitative research method that allows for locating, reading and understanding the investigative road map that will insure the discovery of the best primary sources of legal materials (cases, statutes and laws) and other secondary sources covering the topic being evaluated and analyzed. In order to move forward under this approach, the fundamentals of the topic first need to be identified. In this dissertation, the approach to the topic of assisted suicide falls into the category of doctrinal as opposed to non-doctrinal. "Doctrinal or theoretical research can be defined in simple terms as research which asks what the law is in a particular area. The researcher seeks to collect and then analyze a body of case law, together with any relevant legislation (so-called primary sources)" (Epstein & King, 2002, p. 19). Secondary sources such as journal articles, annotated statute books, black-letter law works, legal encyclopedias and law digests were researched as well.

The qualitative legal research approach (legal lens of study approach) used herein is also non-numerical, in contrast to quantitative (numerical) research (Epstein & King, 2002, p. 17). The research approach to the subject matter of assisted suicide is of an academic nature as opposed to legal research for professional purposes or research by government agencies (Epstein & King, 2002, p. 17).

Secondary methodology considerations

Since at least 2002, there has been a debate between social scientists and law professors concerning empirical legal research and empirical legal analysis. A primary example of this "debate" was described by Professor Richard L. Revesz in an article

published in the University of Chicago Law Review entitled *"*Empirical Research and the Goals of Legal Scholarship: A Defense of Empirical Legal Scholarship*"* (Revesz, 2002, p. 169). In a previous article published in the University of Chicago Law Review, two social scientists had criticized a law review article written by Revesz (one of many law review articles criticized that were written by multiple authors) claiming that he had "breached the basic rules of empirical research by being wholly unconcerned with questions of methodology and his article did not concern itself with understanding, explicating, or adapting the rules of inference" (Epstein & King, 2002, p.1).

The afore-mentioned debate was primarily aimed at the issue of how legal research is being undertaken in law schools by graduate students and academics. This dissertation will not address the debate. However, it will use the main points of argument in the debate as a springboard to assist in explaining the following:

1. Explaining the historical and accepted academic methodology followed in this dissertation;
2. Acknowledging and explaining the type of research used in this dissertation;
3. Explaining how the research was structured in order to insure that the most widely accepted doctrinal empirical approach was followed

In the paragraphs and sections that follow the segment immediately below discussing "the importance of legal research in informing policy, law reform and in academia," the doctrinal approach to determining the existing law for assisted suicide was followed. Then in the appropriate sections, problems currently affecting the existing law(s) were considered. Existing laws were also studied within a historical context in

order to uncover the stanchion-like strategy that was followed to develop these laws, including any flaws in the basic and secondary principles.

Using the legal lens of study approach as defined herein, primary sources including state statutes and state laws covering assisted suicide, federal and state cases addressing assisted suicide, and other federal cases involving the Fourteenth Amendment of the United States Constitution as it has been applied to socially relevant issues and causes and laws from six other countries dealing with assisted suicide were researched and examined. Secondary sources were used when necessary to elaborate or provide clarifications on these rulings. When appropriate, the following resources were used: journal articles, annotated statute books, black-letter law works, legal encyclopedias, recorded expert legal reasoning, statistics, papers by academicians and experts, stances and positions promoted and published by opponents and proponents of assisted suicide, documented theoretical underpinnings and medical and psychological opinions. As to these secondary sources, journal articles, recorded expert legal reasoning and papers by academicians and experts were the most useful (Law Library of Congress, 2018).

As previously stated, the comprehensive literature review in Chapter 2 gave rise to five research questions that are addressed in the sections that follow, using the research and data collection methodological processes described in this chapter, as well as the sections below. However, as a precursor to moving forward, the importance of qualitative legal research in informing policy and law reform and in academia must be emphasized.

The importance of legal research in informing policy, in academia and in qualitative policy evaluation dissertation studies in public administration

Legal research is both an art and a science. The significance and importance of using the legal lens of study approach as defined above cannot be overstated for several reasons. One of the most important reasons was stated by Professors Christina L. Kunz, Deborah A. Schmedemann, Ann L. Bateson, Matthew P. Downs & C. Peter Erlinder in their 1992 textbook *The Process of Legal Research: Successful Strategies.* Kunz stated, "Discerning what the law is requires gathering bits and pieces from a variety of sources, sorting them according to their relative weight and relevance to the problem (or issue), and combining them into as cohesive an analysis as possible." Another important reason is offered by Professor Ralph D. Mawdsley from Cleveland State University. He stated, "What is most important to remember is that legal inquiry is a systematic investigation to interpret and explain the law on a particular topic" (Mawdsley & Permuth, 2006, p. 22). This systematic investigation of interpretation and explanation can lead to uncovering and understanding the articulated will of the people, as inferred by Jeffrey Toobin when discussing the "uncanny ear for American opinion" of Supreme Court Justice Sandra Day O'Connor and how "she kept her rulings closely tethered to what most people wanted or at least would accept" (Toobin, 2007, p. 7).

Academic legal research and efforts to discover the "rule of law" and how it should be applied to public administration and used by public administrators have been under contentious discussion for many years. Laurence E. Lynn, Jr., the Sid Richardson Research Professor at the Lyndon B. Johnson School of Public Affairs, University of Texas at Austin, when speaking from a historical perspective about this topic, described a

pendulum-like swing about how it has been perceived. Lynn begins with Frank J. Goodnow's emphasis on the need for the intimacy of law to be intertwined with public administration and be a substantial part of the fundamental principle of democratic governance, then moves to Leonard White's "managerialism approach," which describes the rule of law as a constraint on administrative direction and then back to the need to accept the rule of law as being indispensable to constitutional governance (Lynn, 2009, p. 803). Lynn stated that the main purpose of his essay was "to argue, as a matter of urgency, for assigning the rule of law the central place in public administration scholarship, teaching, and practice envisioned by Frank J. Goodnow" (Lynn, 2009, p. 804).

Expanding Lynn's position of the rule of law being the indispensable centerpiece to constitutional governance, Professor Michael W. Spicer, Professor Emeritus of Public Administration and Urban Affairs at Cleveland State University, in his article "Value Conflict and Legal Reasoning in Public Administration," explored how "legal reasoning" as a form of practical reasoning could help public administrators deal with problems and issues that arise because of "value pluralism" (Spicer, 2009, p. 537). He argued that legal reasoning is valuable because "it is rooted in a process of adversary argument and analogical reasoning that promotes the consideration of conflicting values and conceptions of the good" (Spicer, 2009, p. 537). Since the concept of value pluralism is rooted in "the conflict between equally good moral conceptions that are incompatible and at odds," public administrators need a process that is rational, practical, reasonable, reasoned, analytical, and pluralistic to help them (public administrators) make the best

decisions. That "process" is provided by legal reasoning and the rule of law (Spicer, 2009, pp. 547, 551, & 555).

States and countries selected

The first states selected for this policy evaluation study were the six states that have current statutes allowing for assisted suicide (California, Colorado, Hawaii, Oregon, Vermont and Washington) and the one state that allows assisted suicide based on case law from its Supreme Court (Montana), plus the District of Columbia, which statutorily allows for assisted suicide as well. The laws (and case rulings) were examined using the legal research methods described herein. These laws and case rulings were analyzed and compared for similarities and differences based on such components as time restrictions, residency requirements, counseling prerequisites, consent mandates, age requirements, what documentation must be in writing, expectation of death period requirements, historical policy underpinnings and other factors. It was anticipated that the components of residency requirements, consent mandates and expectation of death period requirements will be the most conducive to comparison. A table showing and explaining this comparative data is contained in Chapter 4.

Twelve other states that do not currently have assisted suicide laws were selected. The states were "randomly" selected after placing the remaining 43 states into five geographical regions. The random selection process used did not follow a "pure" random selection process. In addition, the random selection process followed was not a "pure modified random assignment" approach (Lani, 2018, p.1). The five geographical regions selected were Mid-America, Northeast, Northwest, Southeast and Southwest. These regions and the states assigned to each of them were selected after researching and

finding the most widely-accepted definitions of geographical positioning in the United States. The 12 states selected at random (by assigning each of the states a number and then using a blind-selection process) were Alabama, Arizona, Florida, Georgia, Illinois, Maryland, Mississippi, Missouri, New Jersey, New York, Texas and Utah.

Since six of the seven states that allow for assisted suicide are in the Northwest and Southwest regions (all states except Vermont), only one state was chosen from the Northwest (Utah) and only one state was chosen from the Southwest (Arizona). For the remaining states and geographical regions, four were chosen from the Southeast (Alabama, Florida, Georgia and Mississippi), three were chosen from the Northeast (Maryland, New Jersey and New York) and three were chosen from the Mid-American region (Illinois, Missouri and Texas). This type of hybrid random selection process, which took into account the geographic locations of the states that have assisted suicide laws, allowed for a more representative sample of states from the entire country.

The states were selected in this manner for two additional important reasons. The first reason is extremely obvious and pertains to the inclusion of the seven states and the District of Columbia that allow for assisted suicide. The historical and current approach to dealing with assisted suicide of these states and the District of Columbia will be the practical foundational nexus for ascertaining how support for assisted suicide came into being in the United States. The second reason pertains to the 12 states selected at random. It was the best academic approach to randomly select the states used for this dissertation. This process allowed for research to be commenced in order to gather the data, information, laws against assisted suicide, statutory legal directives, case law, public policies and current trends about assisted suicide from states throughout the United States

that have not promulgated statutes or directives allowing for assisted suicide. A second table in Chapter 4 compares and contrasts the legal approaches and directives taken by these 12 states as to assisted suicide. The comparison discussed in the table includes whether the state has accepted the "common law" approach to assisted suicide or whether there are specific statues against assisted suicide and more.

In addition, the laws and public policies of the countries of Belgium, Canada, Germany, Luxembourg, Switzerland and The Netherlands concerning assisted suicide were researched, identified and then compared and contrasted not only to each other, but to the laws of the states selected in order to better understand assisted suicide from different cultural perspectives in other parts of the world. The laws and public policies of these countries were researched and analyzed following the detailed methodology explained on Chapter 3 herein.

Accepted and proper standards and protocols of legal research were adhered to as these laws and public policies were researched and analyzed. Reading, studying and comparing these laws and policies allowed for the ascertainment of similarities and differences and provided key issues and words to be compared and contrasted. This type of legal research conducted by a thorough reading of each law and the use of the "common word" study application available in Microsoft Word allowed for the discovery of commonalities and differences in the laws. Such rules as residency time restrictions or edicts, counseling prerequisites, written consent mandates, age requirements, physician authorization or approval and "expectation of death" period directives were compared and contrasted. It was expected that the rules pertaining to residency time restrictions or edits, written consent mandates and expectation of death period directives would be the

most ascertainable and significance. A third table in Chapter 4 contains this comparative data and information.

The information obtained from the research and accepted methodological data processes used in this study was the cornerstone for answering the first three research questions from Chapter 2 as listed below:

1. What major similarities and differences are there in the current assisted suicide laws and statutes in effect in the 20 jurisdictions selected for this study?
2. What major similarities and differences are there in the current assisted suicide laws in the six countries other than the United States selected for this study?
3. Are there universal language elements in the assisted suicide laws of the 20 jurisdictions and in the six countries other than the United States selected for this study?

Statistics, state laws and statutes, U.S. Constitution, case law and legal precedent

Statistics concerning suicide and assisted suicide were obtained from published reports from the Centers for Disease Control (CDC) and the American Foundation for Suicide Prevention (AFSP). These statistics not only underscored the importance of this major national concern, but helped frame some of the primary issues of this topic which clearly portray the ongoing debate of this emotional, contentious, polarizing and litigious subject.

The process of reporting deaths from assisted suicides varies by state. Only those states where physician-assisted suicide is permitted by law (California, Colorado, Hawaii, Oregon, Vermont and Washington) have a reporting process, which is primarily based on applications filed with the proper state authorities by individuals wanting to end their

lives (CNN, 2016). The statistics from these reports were gathered and analyzed in order to have the latest information concerning trends, preferences and reasoning of those individuals choosing to follow assisted suicide protocols. These statistics were compared in a table in Chapter 4 by analyzing them for common reporting principles such as frequency of reporting mandates, ages of those who died, number of attempts per person, success rate, number of physicians used, types of drugs administered (if available), history of the reporting process and other principles.

The state of Oregon was used as the starting reference point for researching state statutes dealing with assisted suicide since Oregon was the first State to enact a "*Death with Dignity*" statute, which "allows terminally-ill Oregonians to end their lives through the voluntary self-administration of lethal medications, expressly prescribed by a physician for that purpose" (Oregon Health Authority, 1997, p. 1). The history of how the Oregon state statute came into being was researched and studied in order to understand from a historical perspective the views, stances and arguments of both proponents and opponents of assisted suicide.

Statutes allowing for assisted suicide in the states of California, Colorado, Hawaii Vermont, and Washington and the District of Columbia were researched and studied following the same primary reasoning listed in the previous paragraph and using the methodological structured approach stated on pages 2 and 3 herein. However, an additional reason for researching and studying the statutes of these states is that all five states and the District of Columbia based most of their laws on the Oregon statute. Also, for the reasons espoused herein, the ruling of the Supreme Court of Montana in the case

of *Baxter v. Montana* (2009) was studied since much of the language from the Oregon state statute was used in this opinion allowing for assisted suicide (Knaplund, 2009).

The federal cases and state cases from the 19 states selected were identified, researched, analyzed and shepardized in order to uncover the current state of the law. As previously stated, the process of "shepardizing" a case [using Shepard's Citations as the main citation source, which is widely recognized by academicians such as McConville and Chui (2007)] provided a list of all courts and judicial authorities citing a particular case or statutory authority from the date of the ruling of the case to present day. This type of doctrinal legal research revealed if a case has been reaffirmed, followed, applied, questioned, modified, distinguished, overturned or generally cited in later cases, thus upholding, modifying or adding some additional parameters to the ruling of the case (Shepard's Citations, 2017, p. 1).

The 12 cases listed immediately below were used as a broad foundational base for the study of the federal and state cases (from the selected states) concerning assisted suicide. The cases were chosen after research revealed that they were the most important cases regarding assisted suicide (and other Fourteenth Amendment issues) decided by the United States Supreme Court, supreme courts of the states chosen, appellate courts in the federal judicial system and some federal trial courts. The first case studied is from 1990 (Cruzan), and the last case studied is dated 2016 (Morris), covering over a quarter of a century of cases heard by these courts on the issue of assisted suicide:

1. *Cruzan v. Director, Missouri Department of Health* (1990)
2. *Planned Parenthood v. Casey* (1992)
3. *Compassion in Dying et al v. Washington et al* (W.D. Wash. 1994)

4. *People v. Kevorkian*, 517 N.W. 2d 293 (Mich. Ct. App. 1994)
5. *Quill v. Koppell*, 870 F. Supp. 78 (S.D.N.Y. 1994)
6. *Washington v. Glucksberg*, 521 U.S. 702 (1997)
7. *Quill v. Vacco*, 521 U.S. 793 (1997)
8. *Baxter v. Montana* (2009 MT 449)
9. *Lawrence v. Texas*, 539 U.S. 538 (2003)
10. *Morris v. Brandenberg*, Second District Court, New Mexico (No. D-202-CV-2012-02909) 2014
11. *Obergefell v. Hodges*, 135 S. Ct. 2584 (2015)
12. *Morris v. Brandenberg,* 376 P. 3d 836 (2016)

(Full citations for all twelve cases are located in the Table of Cases)

As the legal history of judicial precedent unfolded for this policy evaluation study, the 1803 United States Supreme Court case of *Marbury v. Madison* (1803) was examined and analyzed. The main reason for examining and analyzing the case of *Marbury v. Madison* is that in the *Marbury* case, the United States Supreme Court held that "federal courts have the power under Article III of the Constitution to declare statutory law enacted by elected legislatures null and void if it violates the supreme law of the land" (p. 176). This landmark Supreme Court decision, which is still the "law of the land" today, will be of utmost importance to the legal, practical and functional formation of the proposed public policy healthcare model dealing with assisted suicide to be enunciated in Chapter 5.

As additional methodological justification for legal research into the importance and significance of historical legal precedent, and of how judges and justices explain,

regard and align their own legal reasoning with said precedent, was a look into and an analysis of how this foundational pillar-like concept matters to the issue of assisted suicide. "Since the ramifications of a legal proceeding extends beyond that one proceeding, legal research is grounded in the past (precedent), as well as the present, in order to suggest what future rulings may be. Precedent is a pillar of the American legal system, and this principle is known as 'stare decisis'" (*Stare decisis*, 2017, p. 1).

Included in the view into the precedent/stare decisis landscape was a glimpse into ancient Roman law and English Common Law. This judicial principle of *stare decisis* is the single most important defining characteristic of the "rule of law" and therefore is one of the foundational bases of all legal research as per the accepted methodology followed herein.

It was also necessary to research, uncover and analyze some critical events in recent history that spearheaded the interest in assisted suicide. It was imperative that these events be analyzed in order to properly determine the beginning of the modern-day timeline for the subject of this policy evaluation study dissertation.

For this dissertation, researching and understanding the public policy programs that have been utilized over the past two decades, and understanding the history of the motives that have led to certain changes and modifications in those policies, were foundational necessities for being able to propose a more contemporary public policy healthcare model dealing with assisted suicide.

This section of the doctrinal legal research and methodological data collection process provided extremely important information with which to help answer research questions 1, 2, & 3 (as previously stated herein) and also provide the information

necessary to answer research question number 4 as listed in Chapter 2 and immediately below:

4. Over the past 45 years, how do the rulings of the United States Supreme Court in Fourteenth Amendment cases using the doctrines of equal protection and substantive due process as applied to assisted suicide laws reflect public opinion of the citizenry of the United States as reported in opinion polls?

Following the methodology elaborated herein and adhering to the promulgated mandates of doctrinal legal research, the information researched and studied covering the topics listed below provided an articulate and intelligent set of guidelines explaining how the issue of assisted suicide should be dealt with in the future:

1. Selection of the 19 states and the District of Columbia, and the research and examination of the laws on assisted suicide in those jurisdictions;

2. Researching reported information and statistics on assisted suicide from the states with assisted suicide laws;

3. Researching and examining the federal and state case from the 19 states selected for this study;

4. Researching, studying and explaining the 13 foundational assisted suicide cases;

5. “Shepardizing” the federal and state cases;

6. Researching, analyzing and applying the concept of legal precedent (stare decisis) to assisted suicide and other Fourteenth Amendment cases;

7. Researching and analyzing the Fourteenth Amendment of the U.S Constitution and the inclusive rights of equal protection and substantive due process

to assisted suicide cases and other socially relevant issue cases; and

8. Researching and analyzing the works of Rohr and Toobin to uncover and determine the correctness and therefore applicability of their theories to the issue of assisted suicide.

Theoretical underpinnings

Researching and examining what is referred to as the legal and somewhat ethical "theoretical underpinnings" to the topic of assisted suicide from the perspectives of renowned public administrators helped answer research question number 5 in Chapter 2 and also listed in this chapter.

The methodology used herein for this portion of the dissertation, began with research into the iconic writings of Professor John A. Rohr. An in-depth look into Rohr's "constitutionalism" concept provided an excellent comparative starting point in which to study the normative concepts of "public interest" and "responsibility" in public administration and how they helped frame the approaches taken by different states in dealing with assisted suicide.

Since Rohr was the first to elevate public administration to the central position of constitutional guardian, it was discoverable just how this stepping stone of "guardian status" enabled Rohr's concept of "regime values" to become the "guiding-light" for bureaucrats when the law failed to fulfill that role (Rohr, 1986, pp. 37–39). If, or how, Rohr's principles were considered and followed by the states that promulgated statutes dealing with assisted suicide as the courts were interpreting the Constitution was important relative to discovering, understanding and comparing the actions of the states with the court rulings.

Following the accepted methodological doctrinal research path as defined at the beginning of the chapter for updating Rohr's writings on "constitutionalism" and "regime values," as well as those of his distractors, enabled this public policy evaluation study to uncover the most recent authoritative writings that may have unwoven or at least modified some of Rohr's (1986) benchmark constitutionally-driven beliefs.

The work of legal expert, writer and public administrator Jeffrey R. Toobin (2007) was analyzed and explained using the methodological approach delineated herein in order to see if his "ideology motivated decision-making" theory about the justices of the Supreme Court will have an impact on the laws dealing with assisted suicide. The analysis and explanation of Toobin's work in an academic context also allowed for a determination as to whether it is in conflict with Rohr's teachings or the two theories can co-exist relative to the topic of assisted suicide.

As the legal and somewhat ethical "theoretical underpinnings" to the topic of assisted suicide were uncovered and examined, it became clear that other Fourteenth Amendment cases dealing with such issues as education, criminal law, abortion, voting rights, same-sex marriage, immigration and transgender/gender identity rights were of value in giving other researchers an understanding as to how the Supreme Court's approach, position and rulings have changed over the past quarter century and, as to this dissertation study, how they related to future arguments for and against assisted suicide. This approach lead to a more predictive understanding of how the Supreme Court may rule on the next assisted suicide case, if the justices choose to approach the topic of assisted suicide as they have in the past 45 years when dealing with the other "rights" issues mentioned herein. The information and data collected and analyzed using the

approach in this section of the study helped provide an answer to research question number 5 in Chapter 2, which is also stated immediately below:

5. A. Does evidence in case law support Rohr's "regime value/constitutionally-directed" theory or Toobin's more recently formulated theory that justices of the Supreme Court are increasingly motivated not by the Constitution but by politics and personal ideology when deciding Fourteenth Amendment cases? Can both theories co-exist and not totally conflict?

   B. What does the answer to part A suggest about the future of assisted suicide laws in the United States?

Synopsis

By using the "legal lens of study" approach (as defined herein, infra, p. 7) in this dissertation, the most important and pertinent data concerning assisted suicide was gathered, studied and examined using accepted and proven academic methodology in order to propose a public policy healthcare model using a dignified, compassionate, and common sense approach. Even though the legal lens of study approach is the most objective and dispassionate approach (as opposed to ethical, moral or religious approaches), the subject matter itself remains emotional, fervent and polarizing. It was imperative that the five research questions generated herein be objective, relational, comparative, functional and revealing. However, these research questions also needed to be enlightening and thought provoking in order to be able to create and propose a public policy healthcare model for the extremely important issue of assisted suicide.

The roadmap of methodological direction used herein and explained throughout Chapter 3 has many important steps covering many essential and significant parts, all

dealing with the topic of assisted suicide. If analogizing methodology to a roadmap which contains a designated destination point, there are not only a primary expressway to follow, but also many secondary and tertiary throughways to traverse. As the goal of a methodology chapter in any dissertation is to provide a clear and complete description of the specific steps taken to address the research questions propounded therein, the journey, inclusive of explaining all tributaries taken, is as important as arriving at the destination.

In addition to being comprehensive and informative, the methodological rationale used for identifying, selecting and analyzing the information and data herein was inductive, emphatic, contextual, analytical and non-manipulative by design. But this type of rationale also revealed the political views, emotions, sentiments and ideological approaches of the judges and justices as they explained their reasoning, how they came to their decisions concerning assisted suicide (and other Fourteenth Amendment based issues), and where they may be taking us in the future.

Finally, proper academic protocol was followed in requesting at the appropriate time and receiving an exemption report from the IRB (see Appendix J).

Chapter IV

FINDINGS

Overview

This chapter presents the findings and results of this qualitative policy evaluation study concerning assisted suicide. The main avenue of methodology used throughout this dissertation is a legal lens of study approach. The findings and results are meant to be descriptive and therefore are arranged in a logical sequence and presented in an analytical and objective manner following the methodology described in the previous chapter. The academic approach taken in this chapter is non-manipulative and without bias.

As to the flow of this Chapter, since the Supreme Court has not ruled on a case involving assisted suicide since 1997 (*Washington* and *Vacco*), it was important to structure the contents in a distinct thematic and chronological order, not only centered around the five research questions, but by discussing other socially relevant issue cases.

The first several pages of the chapter cover the history of assisted suicide from 1938 to the present. This overview leads to the first research question and a discussion concerning the seven states and the District of Columbia which allow for assisted suicide. It continues with an examination of definitional similarities in the statutes and ends with information regarding the main "takeaways" from the case of *Baxter v. Montana* (2009), which is the basis for the state of Montana allowing for assisted suicide.

The next section examines the twelve states selected at random for this study without laws allowing for assisted suicide. The section contains Table 2 which shows the

diversity of the approach to assisted suicide of the twelve states. Informational statistics from the seven states and the District of Columbia allowing for assisted suicide are contained in the next section. Table 3 categorizes and breaks down the data from each state using six columns of information.

Research question number 2 is in the next section along with Table 4 which contains information from the six countries other than the United States chosen for this study with laws allowing for assisted suicide. The next section contains research question number 3, the methodology followed to answer the question and a breakdown of the ten major foundational universal language elements found in the statutes and laws.

The next section answers research question number 4 by looking at the socially relevant case of *Roe v. Wade* (1973). The section also contains information about Supreme Court Justices O'Connor and Powell and their "uncanny ear for American public opinion." Polling data about abortion from 1973 to 2013 is also contained in this section, along with a discussion of how it pertains to assisted suicide.

The next three sections discuss the further expansion by the Supreme Court of the Fourteenth Amendment rights of equal protection and substantive due process by its rulings in cases involving socially relevant issues other than assisted suicide. These cases include the latest decisions of the first Supreme Court through its first session in 2018, which ended in June. The cases are then compared to the assisted suicide cases of *Washington* (1997) and *Vacco* (1997). This part of the chapter ends with a discussion of *stare decisis* (precedent) and what it means to the issue of assisted suicide.

The last section of the chapter answers research question number 5 concerning Rohr's (1978) "regime value/constitutional-directed" theory and Toobin's (2007) theory,

which propounds the idea that beginning in 2008, the political and personal ideology of the Supreme Court Justices will be the main reasoning behind their decisions, and how both theories pertain to assisted suicide.

Introduction

The topic of assisted suicide is one of the most important issues facing society today. But as with many issues dealing with death, assisted suicide has taken a backseat, at least temporarily, to other important societal issues in part because many people psychologically avoid end-of-life decisions (Elliot & Thrash, 2002).

In 1938, the "right to die" movement (later to become known as the "death with dignity" movement) started with the founding of the Euthanasia Society of America (ESA) in New York. In Florida, State Representative Walter S. Sackett, a physician, introduced unsuccessful "right to die" legislation in 1967. It was the first legislation of its kind to be introduced in any state legislature (Humphry, 2018).

Next came the historic United States Supreme Court case of *Roe v. Wade* decided in 1973. The Supreme Court of the United States held that all state and federal laws against abortion violated a "constitutional right to privacy" even though nowhere is such a right written in the Constitution of the United States. The *Roe* (1973) case dealt with a woman's right to have an abortion and did not contain any mention of the topic of assisted suicide. However, the case set the legal tone and directional compass for using the Fourteenth Amendment to decide important social issues (*Roe v. Wade*, 1973).

In 1976, California's "Natural Death Act" became law, making Living Wills (the first Advance Directives for Health Care) legal. The original Living Will was a directive by which the signer refused medical treatment in the event he or she had a "terminal

condition" and was deemed incapable of making decisions. An unintended consequence of the Act was that the Living Will blurred the distinction between allowing a person to die naturally and intentionally causing death (Towers, 1978). Once a physician had ordered a life-sustaining procedure for the patient and/or had prescribed medication that is keeping the patient alive (albeit temporarily), this document sets up a situation when the actions of the physician could be said to be intentionally causing the patient's death if he/she orders the procedure stopped or terminates the medication. The conundrum of the physician as proposed in this question is how the distinction between allowing a person to die naturally and intentionally causing death became blurred (Towers, 1978).

That same year, the New Jersey Supreme Court decided the first "right to die" case. Karen Ann Quinlan, a young woman with brain damage, was on a ventilator for several months. Her parents wanted the ventilator removed so that Quinlan would be allowed to die, but the hospital refused to do so. The court ruled in favor of her parents based on a constitutional right of privacy, arguing that this unwritten right "is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances, in much the same way it is broad enough to encompass a woman's decision to terminate pregnancy under certain conditions" (*In Re Quinlan*, 1976). The case set three important precedents. The Supreme Court of New Jersey was the first court ever to recognize a "right to die." Secondly, the court held that the decision of another person to refuse treatment for an incompetent patient was the same as "a patient's decision" (*In Re Quinlan*, 1976). Thirdly, the patient's right to privacy can be exercised and "vindicated" by a legal guardian (*In Re Quinlan*, 1976).

Then in 1987, 32-year-old Nancy Ellen Jobes died from dehydration after the

New Jersey Supreme Court upheld a lower court decision that family members could refuse medical care, including tube-feeding, without clear evidence of a patient's wishes even though two neurologists had found Nancy to be "aware, responsive and purposeful" (*In The Matter of Nancy Ellen Jobes*, 1987, p. 420). The Hemlock Society and the Americans Against Human Suffering organizations were founded in the 1980s and in 1990. These organizations were founded to promote death-on-demand without restrictions (*History of Suicide Laws and Development*, 2014, p. 5).

Next, in 1990, in Michigan, Dr. Jack Kevorkian assisted Janet Adkins in committing suicide. Adkins was a 54-year-old Oregon woman in the early stages of Alzheimer's disease. Criminal charges against Kevorkian were dropped, but a judge ordered him not to use his "self-execution machine" again (Meehan, 1990).

Also in 1990, Congress enacted the "Patient Self-Determination Act" that forced all health care facilities and programs to provide education about Advance Directives for Health Care. Non-compliance would be penalized by loss of federal funds such as Medicare reimbursements (*History of Suicide laws and development*, 2014).

The U. S. Supreme Court decided its first "right to die" case in 1990. The case of *Cruzan v. Missouri* (1996) held that "a State may apply a clear and convincing evidence standard in proceedings where a guardian seeks to discontinue nutrition and hydration of a person diagnosed to be in a persistent vegetative state" (*Cruzan v. Missouri*, 1996, p. 261).

In 1991, the President of the Hemlock Society, Derek Humphry, published a book entitled *Final Exit* providing step-by-step instructions on various methods of "self-deliverance" or "how-to-commit suicide." It topped the USA bestseller list (Humphry,

1991, p. 109).

The state of Oregon became the first state to enact a "Death with Dignity" statute in 1994 by voter referendum. Because of legal battles that ensued, brought by opponents of assisted suicide, the statute did not take effect until 1997 (Oregon Health Authority, *Death with Dignity Act,* 1997).

In 1998, the state of Michigan passed a law making assisted suicide a crime (*History of Suicide laws and development*, 2014).

In 2008, the state of Washington became the second state in which residents voted in favor of a "Death with Dignity" law which legalized doctor-assisted suicide (Washington Death with Dignity Act, 2008).

By way of the *Baxter v. Montana* case (2009), the Supreme Court of Montana ruled that "physician-assisted suicide is not against public policy," thus making the state of Montana the third state to allow assisted suicide (*Baxter v. Montana*, 2009, p. 449).

In 2012, the Georgia Supreme Court struck down a state law that restricted assisted suicides, siding with four members of a suicide group who said the law violated their free speech rights. The Georgia Supreme Court unanimously ruled that the law violated the free speech clauses of the U.S. and Georgia Constitutions. Georgia's law did not expressly forbid assisted suicide. In 1994, lawmakers had adopted a law that bans people from publicly advertising suicide assistance. The law made it a felony for anyone who "publicly advertises offers or holds himself out as offering that he or she will intentionally and actively assist another person in the commission of suicide and commits any overt act to further that purpose" (Fox News, 2012). As per Table 4 herein, the state of Georgia still has a law against assisting anyone in committing suicide.

In 2013, Vermont became the fourth state with a "Death with Dignity" law allowing for physician assisted suicide (*History of Suicide laws and development*, 2014). In 2014, Brittany Maynard died by her own hand after moving from California to Oregon where her "right to die" was protected by law. She had terminal brain cancer and was 29 years old. In the last six months of her life, she became a spokesperson for national "Death with Dignity" organizations promoting physician-assisted suicide (*History of Suicide laws and development*, 2014).

In 2016, California became the fifth state to permit assisted suicide as an end of life option. It joined Oregon, Washington, Montana and Vermont (Alifiers, 2016). Also in 2016, Colorado became the sixth state with an "End-of-Life" option for assisted suicide. The measure allows Colorado residents over 18 to request assistance to die if they are ill and have less than six months to live. They must also be judged competent enough to make their own choices and must voluntarily ask for the medicine that would cause their death. Before this measure, helping someone end his or her life was a crime. The referendum was passed in 2016 and became law in 2017 (Chen, 2016).

The District of Columbia (Washington, D.C.) became the seventh jurisdiction (sixth by referendum and/or law) in the United States to enact an assisted suicide dying statute. The D.C. Death with Dignity Act went into effect on February 18, 2017, and implementation started on June 6, 2017 (Richardson, 2017).

On April 5, 2018, the state of Hawaii legislature passed HB 2739, *Hawai'i Our Care, Our Choice Act*, which allows "qualified patients in the State with a medically confirmed terminal illness with less than six months to live and possessing decisional capacity to determine their own medical care at the end of their lives" (Hawaii HB 2739,

p. 1). The law will take effect on January 1, 2019, thus making Hawaii the seventh state and eighth jurisdiction in the United States to enact an assisted suicide statute.

As in *Roe v. Wade* (1973), in two cases, the first in 2003 and the second in 2015, the U.S. Supreme Court used the equal protection and the substantive due process clauses of the Fourteenth Amendment to expand its approach to protecting and allowing certain actions or conduct under the banner of "liberty presuming an autonomy of self that includes freedom of thought, belief, expression and certain conduct" (Myers, 2016). In the cases of *Lawrence v. Texas* (2003) (a criminal case based on a sodomy statute) and *Obergefell v. Hodges* (2015) (a same-sex marriage case), the Supreme Court expanded and affirmed its rulings concerning the right to autonomy and the Fourteenth Amendment. These two cases are purposely placed out of chronological order as to the "history" of assisted suicide to emphasize the most current legal perspective and the latest rulings of the Supreme Court relative to Fourteenth Amendment issues. The rulings in these two cases [*Lawrence* (2003) and *Obergefell* (2015)], as well as the other historical information contained herein, provide an important foundational segue into answering each of the five research questions.

Research Question 1

What major similarities and differences are there in the current assisted suicide laws and statutes in effect in the 20 jurisdictions selected for this study?

1. Seven States and the District of Columbia with assisted suicide laws

The state of Oregon was the first state to enact a "Death with Dignity" statute allowing for physician assisted suicide. By way of a voter referendum, the citizenry of the state voted in favor of the proposed statute in 1994. However, because of multiple

lawsuits filed by opponents of assisted suicide, the referendum did not become law until 1997. Since Oregon was the first state to enact a statue allowing for assisted suicide, the states that followed Oregon's lead based most of their laws on the Oregon statute.

Four more western states followed in Oregon's footsteps by passing legislation allowing for assisted suicide. Washington (2008), California (2015), Colorado (2016) and Hawaii (effective January 1, 2019) all passed legislation allowing for assisted suicide, basing most of their laws on the Oregon statute. These states used the same residency requirement, minimum age specification and life expectancy based on a matter of months terminology, except Washington and California used "terminal illness diagnosis" language instead of the "less than six months to live" directive. Vermont and the District of Columbia used the Oregon statute as the basis for their statutes, but Vermont placed the decision for determining whether an individual was a resident of the state on the physician. Both Vermont and the District of Columbia followed the prerequisite of the California and Colorado laws of having an individual make a total of three requests to the physician for the medication to terminate their lives, instead of two requests as in the Oregon statute.

The Supreme Court of Montana's decision in *Baxter v. Montana* (2009) allowing for assisted suicide uses many of the tenets of the Oregon statute in its ruling. Table 1 on the next page, entitled "7 States and DC with Legal Physician Assisted Suicide" includes a listing of all seven states and the District of Columbia and shows the effective date of each jurisdiction's law, the residency requirement, the minimum age required, the number of months expected until death or use of a different mandate, and the number of physician interactions required and whether the interaction must be in writing. Table 1

also contains Figure 1, which is a map of the United States showing the geographical location of the jurisdictions that allow for assisted suicide.

Figure 1
Map of Jurisdictions in U.S. That Allow Assisted Suicide
(Map from ProCon.org. at https://euthanasia.procon.org/view.resource.php?resourceID=000132)

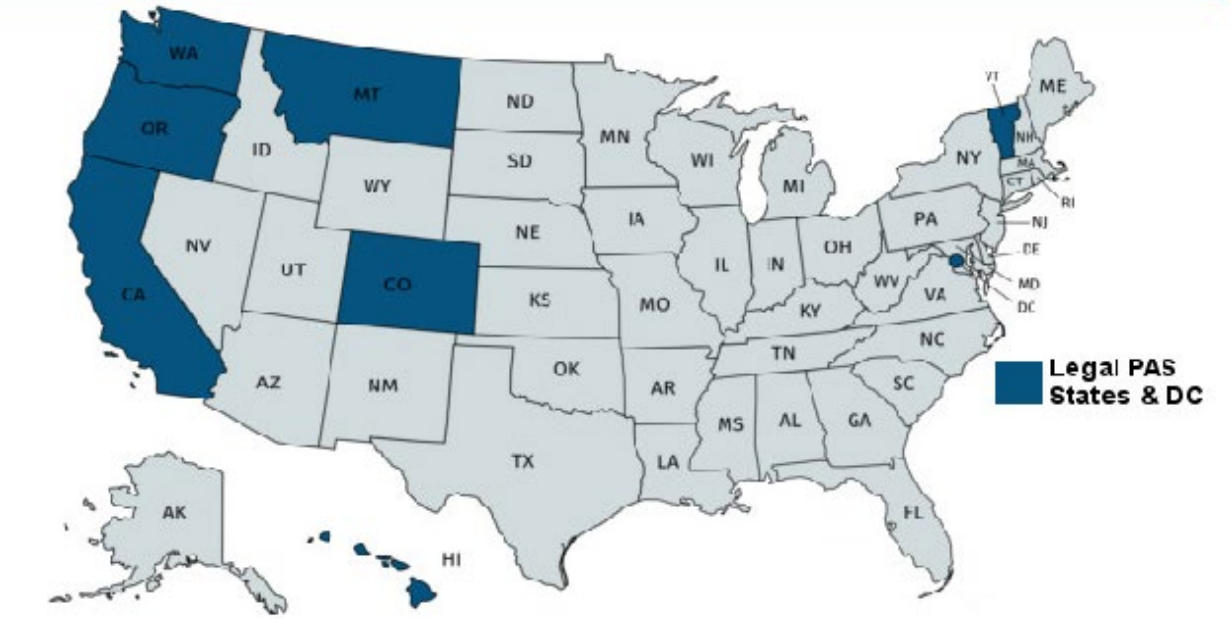

Table 1
7 States and DC with Legal Physician Assisted Suicide

	Effective date-Year	Residency Required	Age	# of months until expected death	# of requests to Physicians
Oregon	1997	Yes*	18	6	Two - one oral & one in writing
Washington	2008	Yes*	18	Terminal illness diagnosis	Two – one oral & one in writing
Montana	2009	Yes	18	Terminal illness	One – oral or written?
Vermont	2013	Yes**	18	6	Three – two oral & one in writing
California	2015	Yes*	18	Terminal illness diagnosis	Three – two oral & one in writing
DC	2016	Yes*	18	6	Three – two oral & one in writing
Colorado	2016	Yes*	18	6	Three – two oral & one in writing
Hawaii	2019	Yes*	18	6	Three – two oral & one in writing

*Proof of State driver's license, registered to vote, owns or leases property, tax return filing
**Physician's responsibility to determine if individual is a resident

Any state moving in the direction of allowing for assisted suicide would be well-served by replicating what the state of Oregon has done statutorily. The mandates of the Oregon statute have been for the most part replicated by the other six states and the District of Columbia. The laws in all jurisdictions have the same residency requirement mandates, minimum age specification (18 years old) and the same life-expectancy language of "less than six months to live." However, two states, Washington and California, use the words "terminal illness diagnosis" instead of "less than six months to live." In all jurisdictions, the patient must make either two or three requests to the physician to terminate his or her life, one of which needs to be in writing. In every jurisdiction, proof of residency is a prerequisite. Residency can be proven by showing a valid State driver's license, being registered to vote, owning or leasing property or filing a state tax return. However, there is one major difference in the Vermont statute. The Vermont statute requires that the physician determine if the patient is a resident.

Important information to mention, not specifically contained in Table 1 on the previous page, is that each of the state statutes begins with a "Definition" section. To find the most common words defined in each statute, the common word element of Microsoft Word was utilized to discover how many repetitions of certain words were contained in the definitional sections of the statutes. The definitional common words were also analyzed in a contextual manner to make sure that the words were being used in same definitional sense. This comparative process known as comparative extrapolation has been used in legal research for many years (Van Hoecke, 2015, p. 2). Examples of some of the words used most often were; residency, written, time,

counseling, age, physician, death expectation, competent, consulting, medication, citizenship, suffering and incurable.

Each of the statutes use this definition section to define the following common words, phrases and terms and they do so by using very similar language:

a. Adult—an individual 18 years of age or older.

b. Attending physician—the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal illness.

c. Capable—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.

d. Consulting physician—a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.

e. Counseling—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.

f. Health care provider—a person licensed, certified or otherwise authorized or permitted by the law of the state to administer health care or dispense medication in the ordinary course of business or practice of a profession, and includes a health care facility.

g. Informed decision—a decision by a qualified patient, to request and obtain a

prescription to end his or her life in a humane and dignified manner, which is based on an appreciation of the relevant facts after being fully informed by the attending physician on all important matters about his or her disease and prognosis.

h. Medically confirmed—the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.

i. Patient and qualified patient—a person who is under the care of a physician, is an adult and who is a resident of the state and has satisfied other requirements in order to obtain a prescription for medication to end his or her life in a humane and dignified manner.

j. Terminal illness—an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.

k. Self-administer—any patient requesting a prescription for medication for the purpose of ending his or her life must be able to be primarily responsible for taking the medication.

The exact list of common words, phrases and terms is not contained in each statute, but all statutes are similar to and in conformity with the definitional section of the original Oregon statutory provision. Each of the six state statutes, the District of Columbia law and the case of *Baxter v. Montana* (2009) are contained in their entirety in Appendices lettered B through I at the end of this dissertation as previously noted in Chapter 2.

The Supreme Court ruling in the Montana case of *Baxter v. Montana* (2009) does not define the provisions for assisted suicide with the same specificity as the statutes from the states or the District of Columbia. But a careful reading of the case reveals that the Supreme Court of Montana, in affirming the appellate court's decision "that a competent, terminally ill patient has a right to die with dignity under Article II, Sections 4 and 10 of the Montana Constitution, which includes protection of the patient's physician from prosecution under the homicide statute," rephrased the issues on appeal, thus covering many of the parameters mandated in the state statutes. The court ruled that there was "no indication in Montana law that physician aid in dying to terminally ill, mentally competent patients is against public policy" (*Baxter v. Montana*, 2009, p. 457). However, the court reversed the District Court of Appeals' decision granting attorney's fees to Baxter, but that fact is irrelevant to the issue of assisted suicide and is only mentioned to fully detail the entire ruling.

The key issue for the Supreme Court of Montana was the fact that in physician aid in dying scenarios, the patient – not the physician – commits the final death-causing act by self-administering a lethal dose of medicine. Through dicta in his concurring opinion, Justice John Warner summarized exactly the ruling of the court when he stated, "Is it, as a matter of law, against the public policy of Montana for a physician to assist a mentally competent, terminally ill person to end their life? The answer is: No, it is not, as a matter of law" (*Baxter v. Montana*, 2009, p. 470).

The main take-away(s) from the court's decision are that a patient must be an adult (18 in the state of Montana), mentally competent, a resident of the state, have a terminal illness, and the one to request aid in dying from a physician and self-administer

the lethal dose of medicine provided, thus making the ruling an almost exact replication of the Oregon statute. Since the *Baxter* ruling in 2009, there has not been any state court litigation that has changed, modified or reversed this Supreme Court of Montana ruling (Compassion & Choices.org, 2017). Also, since the court's ruling, all legislation introduced by state lawmakers to change the ruling or any parts therein has been defeated (Compassion & Choices.org, 2017).

2. Twelve States selected at random without laws allowing for assisted suicide

The twelve states selected at random for this study were Alabama, Arizona, Florida, Georgia, Illinois, Maryland, Mississippi, Missouri, New Jersey, New York, Texas and Utah. The laws of these states dealing with assisted suicide are compared in Table 2 on page 17. As the information in Table 2 reveals, none of the twelve states has laws allowing for assisted suicide. Table 2 shows that assisted suicide is illegal in all twelve states by way of specific statutes and by adoption of common law (Alabama), except possibly for the state of Utah. Utah does not have a specific statute making assisted suicide illegal, nor does it recognize "common law" under which assisted suicide was illegal.

Common law, also known as judicial precedent, judge-made law or case law, is one of the two major legal systems of the modern Western world (the other is civil law). It originated in the United Kingdom and is now followed in most English-speaking countries. Initially, common law was founded on common sense as reflected in social customs. Over the centuries, it was supplanted by statute law (rules enacted by a legislative body such as a Parliament, Congress or State Legislatures) and clarified by the judgments of the higher courts (that set a precedent for all courts to follow in similar

cases). These precedents are recognized, affirmed, and enforced by subsequent court decisions, thus continually expanding the common law. In contrast to civil law (which is based on a rigid Code of rules), common law is based on broad principles (Common Law, 2010).

Seven of the states have made assisted suicide a felony of one class or another and do not differentiate with any further specificity. Three of the states (Illinois, New Jersey and Texas) further divide their assisted suicide laws into categories of "class" for felonies and, depending on the specific circumstances of the individual and his/her death, Illinois and Texas downgrade the crime to a misdemeanor.

Providing further clarification, Table 2 shows that assisted suicide is a felony in all the states except Utah and sometimes in Illinois and Texas. The status of the law in Utah has been explained. In Texas, assisted suicide is a "Class C misdemeanor if no suicide or bodily injury results; a state jail felony if suicide or attempted suicide with serious bodily injury occurs." The statute in Illinois is an example of a state that divides its law on assisted suicide into four different categories based on how the level of assistance was provided. "Assistance" is defined in terms of operative words such as "direct, coercion, inducement, resulting and compulsion" (Illinois Law on Assisted Suicide, 2012, p. 1).

Normally, the two major differences between a felony and a misdemeanor, regardless of which "Class" it falls into, is the length of imprisonment allowed under the charging statute and where the incarceration time will be spent: county jail or a state/federal penitentiary. A felony is a much more serious crime than a misdemeanor and carries much higher penalties, such as long-term jail sentencing. For example,

murder and armed robberies are felonies, while shoplifting, which typically is a nonviolent crime, is a misdemeanor. The penalty for misdemeanors often involves only a fine and no jail sentence. If jail time is ordered, it is for no more than one year (Misdemeanor v. Felony, 2015. pp.1-3).

The information in Table 2 demonstrates that the approaches of the states chosen for this study that don't have laws allowing for assisted suicide are extremely diverse.

Table 2

Twelve States Randomly Selected for the Study Without Laws Allowing for Assisted Suicide

States	Criminal Statute	Type of Crime
Alabama	Common law	Class A felony
Arizona	13-1103	Manslaughter
Florida	782.08	Second Degree Felony
Georgia	16-5-5	One to ten years imprisonment
Illinois	12.34.5	Class 2, 3 or 4 felony or class A misdemeanor
Maryland	3-102	Felony
Mississippi	97-3-49	Felony
Missouri	565.023.1	Voluntary manslaughter (class B felony)
New Jersey	2C:11-6	Second or fourth degree crime
New York	125.15	Second degree manslaughter
Texas	22.08	Class C misdemeanor or state jail felony
Utah	Unclear	Utah does not recognize common law and has no specific statute for assisted suicide

3. Informational statistics from the seven States and the District of Columbia allowing for assisted suicide

Table 3 on page 107 contains assisted suicide information from the latest reports filed by the seven states and the District of Columbia that allow for physician assisted suicide. The state of Hawaii has not yet experienced a mandatory reporting year since its law does not take effect until January 1, 2019. The District of Columbia has yet to publish its latest annual report. The state of Montana does not have a mandatory reporting system in place since it allows for assisted suicide based on case law and not a state statute.

Reporting deaths by assisted suicide is mandatory in each state or jurisdiction that has a statute allowing for assisted suicide. Each state statute and the District of Columbia law contain the following common elements relative to mandatory reporting:

1. There is an administrative department designated that is tasked with reviewing a sample of the records on an annual basis.
2. The administrative department must make rules to facilitate collection of the information.
3. The information collected shall not be a public record and is not available for inspection by the public.
4. The administrative department must generate and make available to the public an annual statistical report of information.
5. Any healthcare provider dispensing medication meant to terminate a patient's life must file a copy of the dispensing record with the administrative department so designated.

The information contained in Table 3 as reported by the jurisdictions allowing for assisted suicide shows the year each law was enacted and the State's latest reporting year. As discussed previously herein, the state of Oregon was the first state to enact a physician assisted suicide statute in 1997. Hawaii will be the latest state to enact a physician assisted suicide statute when (of if, depending on litigation) its law goes into effect on January 1, 2019. Each state has a mandatory report process it must adhere to. The most recent year for reporting by each state is 2017, with the exception of Montana and Hawaii. The reason for this is that Montana's law is case-law-based with no mandated provision for reporting, and Hawaii's law is yet to take effect.

One important reporting provision in each statute are statistics about the "percentage of patients over the age of 65" and the "median age at death" of the individuals who choose physician assisted suicide. Earlier the point was made that assisted suicide is a very important and immediate societal issue which needs to be addressed. "Baby Boomers" (those individuals born between 1946 and 1964) currently represent 22 percent of the population in the United States (Newcomb & Iriondo, 2017). Add the 25 million individuals in the U.S. who comprise the "Silent Generation" (those born between 1925 and 1945), representing approximately 8 percent of the population, and you have approximately 30 percent of the U.S. population currently facing the potential of the issues of terminal illness, pain and long-term suffering from these illnesses, loss of independence, poor quality of life, loss of autonomy, the fear of not being able to take care of themselves, loss of dignity and not being able to participate in the activities that made life enjoyable (Missouri.edu., Generations, 2010).

There is no stated reason in any of the statutes as to why the "main type of illness" is tracked. A reasonable inference would be that in tracking this category insight may be gained into the type of illness most dominant relative to terminality, pain and long-term suffering and quality of life (Lannon v. Hogan, 1983, p. 521).

Table 3

Assisted Suicide Statistics from the 7 States and the District of Columbia

State	Year law enacted – latest reporting year	Number of patients requesting medication	Number of patients taking medication	Percentage of patients over the age of 65	Median age at death	Main type of illness
Oregon	1997 2017	218	143	80.4%	74	Cancer 76.9%
Washington	2008 2017	212	164	74.5%	72	Cancer 68.9%
Montana	2009	0	0	0	0	No reporting on assisted suicide**
Vermont	2013 2017 (4-year report)	52	29	Not reported	Not reported	Cancer 83%
California	2015 2017	191	111	76.7%	78	Cancer 58.6%
District of Columbia	2016 2017	0	0	0	0	Not reported
Colorado	2016 2017	69	50	78.6%	75	Cancer 63.8%
Hawaii	2019 Annual reporting is mandated in statute	N/A*	N/A*	N/A*	N/A*	N/A*

*N/A - not applicable

**Montana does not have a reporting system in place for physician assisted suicide. However, according to the state's own statistical reporting department, Montana is one of the top 3 states in suicides in the nation.

Research Question 2

What major similarities and differences are there in the current assisted suicide laws in the six countries other than the United States selected for this study?

On page 111, Table 4 contains a listing of the laws/policy referendums of the six countries allowing for assisted suicide, other than the United States that were chosen for this dissertation. The countries of Belgium, Canada, Germany, Luxembourg, Switzerland and The Netherlands are compared to better understand assisted suicide from different legal and cultural approaches in other parts of the world with the intent of garnering information that might be helpful in crafting a nationwide policy for the U.S.

There are several unique differences between the laws of the countries listed in Table 4 and the laws in the seven states and the District of Columbia allowing for physician assisted suicide. Examples of some of the most unique and differential are:

a. In Belgium, Luxembourg, Switzerland and The Netherlands there is no requirement that the individual be under an "expectation of death" in terms of months/time left to live. In the United States jurisdictions allowing for assisted suicide, a patient must be either terminally ill or have six months or less to live.

b. There is no residency requirement in Switzerland or Belgium, but in Belgium there is a comprehensive registration process. In each United States jurisdiction there is a residency requirement which must be proven.

c. In Luxembourg, a minor the age of 16 or above may make a request to terminate his or her life with his parent's permission. In the Netherlands, a minor the age of 12 or older may make a request to terminate his or her life

with the permission of a parent or a guardian. In the United States, the age of 18 is the minimum age for each jurisdiction.

d. Only Germany allows a pharmacist to be involved in its process and provide the medication instead of a physician. In all other countries and in the United States jurisdictions, a physician must be involved. In several of the jurisdictions in the United States, the involvement of more than one physician is required.

e. Likewise only in Germany, there is a written mandate that the patient must be able to take the medication by himself or herself with no assistance whatsoever. The laws and statutes in the other countries and the jurisdictions in the United States make provisions for those that are incapable of taking the medication alone, such as an oral request for help.

f. Each of the laws in the six countries and the United States jurisdictions specifically mandate that the individual requesting assistance in dying must be "medically or mentally" competent" except for Belgium and Canada. However, the lengthy registration process in Belgium and the preamble to the law in Canada speak to mental competence.

Only the country of Switzerland has allowed for assisted suicide longer than the state of Oregon, due primarily to an omission in the country's euthanasia law in 1940. The countries of Canada and Germany had to use their court systems, much like the state of Wyoming, to eventually have a law allowing for assisted suicide.

As the information in Table 4 reveals, the laws of these six countries are significantly more open and less restrictive than the assisted suicide laws in the

jurisdictions within the United States. The law/referendum in Switzerland is by far the most liberal and uniquely different. The Canadian law addressing assisted suicide most resembles the laws in the U.S.

Table 4

6 Countries other than the United States with Laws Allowing for Assisted Suicide

Countries	Year provision established	Residency Restrictions	Consent mandates	Age	Expectation of death	Physician Involvement
Belgium	2002	No; but must complete a lengthy registration form	Yes; in writing plus physician registration	18 or an emanci-pated minor	No	One or two; depending on expectation of death
Canada	2016 (by Supreme Court)	Yes; residency or waiting period	Yes; multiple consents in writing	18	Yes; grievous and irremediable medical condition	One; with oversight from the Minister of Health
Germany	2017 (by a Federal Admin. Court)	Yes; medically competent citizen of Germany	Written request to pharmacy by patient or physician	18	Yes; seriously & incurably ill	No; plus the individual must take medication by themselves
Luxembourg	2009	Yes; competent citizen of Luxembourg	Yes; written request to physician	18, but 16 with parent's permis-sion	Incurable condition	Multiple meetings with physician
Switzerland	1940 & in 2011 by referendum	No; but must be mentally competent	No; based on conversations with physician	Unclear	Suffering intolerably	One; also must document diagnosis
The Netherlands	2002	Yes; must be a mentally competent citizen	Yes; written request to physician after several meetings & second physician report	16*	No; but physician must hold conviction that P's suffering is lasting & unbearable	Two; physicians must consult and agree

*In the Netherlands, a minor between the ages of 12 and 16 may request to terminate his/her life but must have the permission of a parent or guardian.

Research Question 3

Are there universal language elements in the assisted suicide laws of the 20 jurisdictions and in the six countries other than the United States selected for this study?

There are ten major foundational universal language elements in the assisted suicide laws examined as part of this study. Following the methodology described in detail in Chapter III, the first priority in answering research question number 3 was to "identify the specific goal which the researcher wishes to achieve," said goal being to define the term "universal language element" (Dobinson & Johns, 2007, p. 33). In order to answer research question 3 properly and ascertain the universal language elements contained in the laws, a broad and sufficient amount of data was collected, read and studied. This collection and study process avoided any selection bias because of the thoroughness of the process and the experience of the legal researcher.

A step-by-step methodological approach was followed, the main tenets of which are explained in detail in Chapter 3, to ascertain the universal language elements in the assisted suicide laws studied herein. The chronological steps followed were:

1. First, a detailed, studious and comprehensive reading of all laws was performed. This type of reading brought some common key elements and provisions of the laws into focus.

2. Second, the common word element of Microsoft Word was utilized to discover the repetitions of certain common words contained in the laws, as well as in the definitional sections of the statutes. This approach provided an analysis of the entire contents of the statutes by identifying common words which were repeated most often. Examples of some of the words used most often were: residency,

written, time, counseling, age, physician, death expectation, competent, consulting, medication, capable, provider, citizenship, suffering, terminal and incurable. However, a second step of comparison was necessary to ensure that these oft-used common words were being used in the same context. The sentence containing the common word, as well as the sentence before and the sentence after the one containing the common word were analyzed. This allowed for the comparative process known as comparative extrapolation to be used to verify that the common words were being used in the same contextual sense and with the same definitional meaning (Guala, 2010, p. 1070).

3. As the "universal language elements" started coming into focus, a search was performed for a common and proper definition of the term. The definition of the term most applicable from a legal lens perspective and settled upon is as follows: "Recurring or oft-repeated words, phrases or concepts used as building blocks or mandatory components in all the laws, regardless of the language of the text" (Lockwood & Katrin, 2016, p. 2).

4. The data collected was then recorded in a manner which was not only unbiased but used as a precursor to the formation of Table 4 on page 23 (Dobinson & Johns, 2007, p. 33).

5. The final step was to make sure that the data collection process and the analytical techniques used followed the appropriate and accepted methodology for a social science qualitative literature review study as described by in Chapter 3 (Dobinson & Johns, 2007, p. 41).

This five-step approach was used to ensure that an academic pathway to answering the question was followed, instead of the approach used for professional purposes or by government agencies (Epstein & King, 2002, p. 17). This approach also provided some of the information necessary to formulate and propose the public policy healthcare model for allowing assisted suicide decisions to be found in Chapter 5.

The ten major foundational universal language elements found were:

1. The adult (varying ages in statutes) and/or the child (with parental permission) must be "mentally capable" to make the important decision relative to terminating his/her own life.
2. At some point in the overall process, some type of "healthcare provider" must be involved, including an option for professional counseling.
3. The procedure to terminate one's life as dictated in all the laws must be humane and dignified.
4. The only acceptable form of assisted suicide is by prescribed medication and the procedure and death should be painless.
5. The probable result of taking the prescribed medication must be explained orally or in writing to the individual making the request to die.
6. A written record of the process must be kept in order to provide statistical data to the appropriate reporting agency or department.
7. The autonomy and privacy of a person's right to control his/her individual end-of-life circumstances must be respected.
8. Death must be reasonably foreseeable, regardless of the terminology used to define "reasonably foreseeable" (six months to live, intolerable suffering,

suffering that is lasting and unbearable, enduring suffering, suffering that will continue, an incurable condition, serious and incurably ill, a terminal illness or irremediable medical condition).

9. "Interested persons" (spouses, family, friends, co-workers, neighbors, acquaintances) can be contacted, but only with the direct and unforced permission of the individual going through the process.
10. The individual may rescind the written or oral request for the medication or continuing the process regardless of his/her mental state.

These ten major foundational universal language elements serve as a transitional intersection in this chapter. The chapter now moves from describing and understanding the contents and mandates of all the laws and answering the first three research questions, to the findings and discussion centered around the cases concerning assisted suicide and other socially relevant 14th Amendment cases and answering research questions 4 and 5.

Research Question 4

Over the past 45 years, how do the rulings of the United States Supreme Court in Fourteenth Amendment cases using the doctrines of equal protection and substantive due process as applied to assisted suicide laws reflect public opinion of the citizenry of the United States as reported in opinion polls?

There have not been any assisted suicide cases heard by the Supreme Court since 1997 (*Washington* and *Vacco*). When conducting legal research for an academic study, if there are no cases covering the issue (assisted suicide), an important historical legal axiom dictates that research should be conducted into cases which either contain subject matter of like-kind or into cases which have been decided by using the same legal

arguments and principles of the older cases (14th Amendment rights or other applicable constitutional rights).

Also, as the contemporary cases are heard by the Supreme Court with a different makeup in terms of "new" Justices, a study of these cases allows for an in-depth comparison of the rulings in terms of the backgrounds, ideological beliefs, avenue of appointment, ages, previous written opinions, party affiliations and other important personal information about the Justices.

1. Expanding the use of the doctrines of equal protection and substantive due process in the 14th Amendment by the Supreme Court beginning in 1973 with the case of *Roe v. Wade* (1973).

Since 1973, beginning with the "abortion rights" case of *Roe v. Wade*, the Supreme Court has used the Fourteenth Amendment doctrines of equal protection and substantive due process to rule on cases dealing with education, criminal law, voting rights and other socially relevant issues such as gay rights, same-sex marriage, immigration, privacy rights and illegal search and seizure issues in the criminal law area.

Legal scholar and analyst, public administrator and author Jeffrey Toobin, in his bestselling book, *The Nine*, claimed that in most socially relevant issue cases, "Justices Sandra Day O'Connor and Lewis F. Powell steered the Court in line with their own cautious instincts, which were remarkably similar to those of the American people" (Toobin, 2007, p. 2).

Justice Powell served on the Supreme Court from 1971 to 1987 (Biography, 1999, p. 1). In the case of *Roe v. Wade*, Justice Powell was part of the 7 to 2 majority allowing for abortion (*Roe v. Wade*, 1973, p. 113). Justice O'Connor served on the Supreme Court

from 1981 to 2006, including six years on the Court with Justice Powell.

Toobin honed in on the touchstone years of 1992 to 2005 and claimed that the Supreme Court decisions "reflected public opinion with great precision" (Toobin, 2009, p. 2). He said that "the decisions in these cases probably would have been the same if they simply had been put to a popular vote" (Toobin, p. 3). "She [Justice O'Connor] had an uncanny ear for American public opinion, and she kept her rulings closely tethered to what most people wanted or at least would accept" (Toobin, p. 7). Justice Powell used his years as a practicing attorney (34 years), being the chair of a city school board for over a decade and his service in the military as an intelligence officer as the foundational basis for a desire to stay aware of the public's opinion (Biography, 1999, p. 2).

In 1973, 54% of Americans believed that abortion should be legal "under certain circumstances" (Saad, 2002, p. 1). The Supreme Court ruled in 1973 that abortion was legal "but a woman's right to choose to have an abortion was not considered an absolute right" (*Roe v. Wade*, 1973, p. 113). In its opinion, the Court set up a framework for the definition of the term "under what circumstances" (*Roe v. Wade*, 1973, p. 114). The Court defined the framework as to the first trimester of a pregnancy as follows:

> In the first trimester (the first three months of the pregnancy), a woman's right to privacy surrounding the choice to have an abortion outweighed a state's interests in regulating this decision. The state's interests are not yet compelling; it cannot interfere with a woman's right to privacy by regulating or prohibiting her from having an abortion during the first trimester. (*Roe v. Wade*, 1973, p. 115).

The Court went on to define the term "under what circumstances" and the word "framework" as to the second and third trimesters of a woman's pregnancy and how a State could or could not regulate abortions during those two trimesters (*Roe v. Wade*, 1972, p. 116).

From 1975 to 2013, Gallup asked the same question more than 50 times in its nationwide polls of Americans: "Should abortion be legal in certain circumstances?" In 1975, 54% said "yes" and in May 2013, 54% said "yes" (Bowman & Marsico, 2014). During that same period (1975–2013), the lowest percentage answering "yes" was 48% in 1993 and the highest percentage was 61% in 1998 (Gallup.com., 2018). The ruling by the Supreme Court in 1973 in *Roe v. Wade* granting women the right to have an abortion (under certain circumstances) and the view of the majority of the public on the issue of abortion were very similar and aligned.

2. The Supreme Court moves forward from the historic ruling on abortion in 1973 to rulings on other socially relevant issues by further expanding the equal protection and substantive due process clauses of the Fourteenth Amendment

The Supreme Court of the United States did not issue an opinion concerning assisted suicide in either *Lawrence v. Texas* (2003) or *Obergefell v. Hodges* (2015). However, what the Court did do, much like in the 1973 case of *Roe v. Wade*, was to use the equal protection and the substantive due process clauses of the Fourteenth Amendment to grant an endorsement to the "autonomy of self" approach to liberty concerning social issues (Myers, 2016, p. 398).

In the case of *Lawrence v. Texas*, a 2003 criminal case involving a Texas sodomy statute, the Supreme Court held that the Texas statute banning same-sex sodomy was

unconstitutional relying on both the substantive component of the Fourteenth Amendment's Due Process Clause and the Fourteenth Amendment's Equal Protection Clause (*Lawrence v. Texas*, 2003, p. 579).

In 2015, the Supreme Court expanded its approach to the doctrines of due process and equal protection in the 14th Amendment and emphasized the right to "autonomy, self-determination and choice" in the same-sex marriage case of *Obergefell v. Hodges* (Myers, 2016, p. 397). The Court's analysis and ruling in the *Obergefell* case was "unconstrained by history [precedent/*stare decisis*] or a careful description/examination of the right to substantive due process and equal protection" (Myers, 2016, p. 398). In the *Obergefell* ruling, the Supreme Court emphasized an individual's right to "autonomy, self-determination, privacy and choice" (Myers, 2016, p. 397). The majority ruling by Justice Kennedy (joined by Justices Ginsburg, Breyer, Sotomayor and Kagan) held that:

> The Fourteenth Amendment requires States to recognize same-sex marriages validly performed out of State. Since same-sex couples may now exercise the fundamental right to marry in all States, there is no lawful basis for a State to refuse to recognize a lawful same-sex marriage performed in another State on the ground of its same-sex character. (*Obergefell v. Hodges*, 2015, p. 2589)

In 2007, Americans opposed legalizing same-sex marriage by a margin of 54% to 37% (Masci, Brown & Kiley, 2017). The polling centers of Pew Research and Gallup did not conduct a major poll specifically concerning same-sex marriage until 2007. However, it is almost a certainty that the majority of Americans opposed legalizing same-sex marriage in 2003, the year in which the Court handed down its ruling in *Lawrence v.*

Texas. In 2015, when the court ruled in favor of same-sex marriage in the *Obergefell* case, 55% of Americans favored same-sex marriage (Masci et al, 2017).

Justice O'Connor ruled with the majority in the *Lawrence* case in 2003 (6 to 3). In her concurring opinion in *Lawrence*, Justice O'Connor argued that because the law prohibited homosexual sodomy and not heterosexual sodomy, it was a violation of the Equal Protection Clause of the Fourteenth Amendment. However, the majority did not join her extension of Equal Protection rights to gays (*Lawrence v. Texas*, 2003, p. 578). Even though Justice O'Connor's ruling was not in line with the opinion of the majority of Americans in 2003, two important facts must be remembered. The first is that the *Lawrence* case was a criminal case involving a sodomy statute, not a same-sex marriage case. Polling data using questions with exact information concerning adults "consenting to sex in the privacy of their own homes" is not available for 2003. But in several Gallup polls covering the period from 1978 through 2017, the following similar question was asked: "Do you think gay and lesbian relations between consenting adults should or should not be legal?" In 2003, 60% of Americans polled said that gay and lesbian relations between consenting adults should be legal. In 2015, the percentage in favor [should be legal] was 70% (Gallup staff, 2017).

Secondly, since Justice O'Connor's concurring opinion extended equal protection for gay rights, her ruling was a precursor to the *Obergefell* case [same-sex marriage] in 2015, when the majority of Americans favored same-sex marriages [57% in favor].

The second part of Toobin's analysis of Supreme Court cases dealing with the Fourteenth Amendment and the decisions in these cases equaling the majority view of the public ("the rulings in these cases probably would have been the same if they simply had

been put to a popular vote") was that this phenomenon would change beginning in 2008 (Toobin, 2007, pp. 2, 8). However, the decision in the *Obergefell* same-sex marriage case (2015) and the fact that 55% of Americans favored same-sex marriage in 2015 seems to contradict the second part of Toobin's theory that the Court would move away from and not be aligned with the public's majority opinion.

3. The issue of assisted suicide and the Fourteenth Amendment; comparing assisted suicide cases to other socially relevant issue cases

In the 1997 cases of *Washington* and *Vacco*, the Supreme Court rejected the idea that there is a fundamental right to assisted suicide, thus preserving the line between withdrawal-of-treatment cases like *Cruzan* (1990) and active measures to terminate life cases. But since "there is a very thin line between many of the withdrawal-of-treatment cases and the right to assisted suicide, the distinctions the Court has drawn in those cases may be more practical than logical" (Myers, 2016, p. 396). Since the 1997 rulings in *Washington* and *Vacco*, there have not been any cases dealing with assisted suicide heard by the Supreme Court.

In one of the most important historical approaches followed in the legal world of reasoning, when there has not been a case dealing with the subject matter of discussion (assisted suicide), other cases dealing with like-kind socially relevant issues and how the Supreme Court approached these Fourteenth Amendment cases becomes of primary importance.

In *Obergefell* (2015), the dissenting opinions of Justices Roberts, Scalia and Thomas were twice as voluminous as the majority opinion in the length of pages. When this has occurred in the past, it usually signals an extremely high level of disagreement

and dissatisfaction by the dissenters with the majority opinion. The main relevance of these capacious dissenting opinions is that the "*dicta*" contained therein sometimes turns into the majority opinions in future cases. All three Justices concurred in their dissenting opinions that "recognizing same-sex marriage should not be mandated by the Supreme Court." Justice Roberts wrote on page 2 of his dissenting opinion:

> Although the policy arguments for extending marriage to same-sex couples may be compelling, the legal arguments for requiring such an extension are not. The fundamental right to marry does not include a right to make a State change its definition of marriage. And a State's decision to maintain the meaning of marriage that has persisted in every culture throughout human history can hardly be called irrational. In short, our Constitution does not enact any one theory of marriage. The people of a State are free to expand marriage to include same-sex couples, or to retain the historic definition. (*Obergefell v. Hodges*, 2015, p. 2620)

Of equal importance to the dissenting opinion of Chief Justice Roberts in *Obergefell* (2015) is Justice Antonin Scalia's dissenting opinion in *Lawrence* (2003). Justice Scalia stated that "the majority's position (in *Lawrence*) requires it to effectively overrule *Washington v. Glucksberg* (1997), the leading modern case setting the bounds of substantive due process" (in ruling against any 14th Amendment right to assisted suicide) (*Lawrence v. Texas*, 2003, p. 587).

After hearing oral arguments in February 2018, the Supreme Court ruled in the case of *Masterpiece Cakeshop, LTD., et al v. Colorado Civil Rights Commission* on June 4, 2018. Although the case was primarily brought under the guise of a First Amendment argument–"Whether applying Colorado's public accommodations law to compel the petitioner to create expression that violates his sincerely held religious beliefs about

marriage violates the free speech or free exercise clauses of the First Amendment" – many of the oral arguments expounded before the Court were based on the substantive due process and equal protection clauses of the Fourteenth Amendment (*Masterpiece Cakeshop, LTD., et al v. Colorado Civil Rights Commission,* 2018, p. 1).

Justice Kennedy delivered the majority opinion of the Court in which Justices Roberts, Breyer, Alito, Kagan and Gorsuch joined. There were several concurring opinions written, one by Justice Thomas in which he concurred in part and concurred in the judgment, thus making the decision a 7 to 2 ruling. The Court held for the Masterpiece Cakeshop owner (Jack Phillips), ruling that the Colorado Civil Rights Commission violated his right to free speech and his right to free exercise of religion when the Commission ruled that his refusing to create a cake for the wedding of a same-sex couple discriminated against them based on their sexual orientation (*Masterpiece Cakeshop, LTD., et al v. Colorado Civil Rights Commission,* 2018, p. 1).

There were four main reasons given by the Supreme Court in the 56-page opinion (including the dissenting opinion of Justice Ginsburg, who was joined by Justice Sotomayor), for ruling in favor of Phillips.

- The Court relied on the precedent it set in the *Obergefell* case saying that the laws and the Constitution do protect gay persons and gay couples in the exercise of their civil rights, but religious and philosophical objections to gay marriage are protected views and, in some instances, protected forms of expression.
- The crux of the ruling was that at the time, Colorado state law afforded some latitude in declining to create specific messages they (in this case,

bakers) deemed offensive. While this case was pending, the States Civil Rights Division concluded in at least three cases that a baker acted lawfully in declining to create cakes with decorations that demeaned gay persons or gay marriages. "Phillips too was entitled to a neutral and respectful consideration of his claims in all circumstances of the case."

- The commission showed elements of a clear and impermissible hostility toward the sincere beliefs motivating Phillips' objection. The record showed that the Commission "disparaged Phillips' faith as despicable and characterized it as merely rhetorical, and compared his invocation of his sincerely held religious beliefs to defenses of slavery and the Holocaust." These comments cast doubt on the fairness and impartiality of the adjudication of Phillips' case.
- The Commission's treatment of Phillips' case violated the State's duty under the First Amendment not to base laws or regulations on hostility to a religion or religious viewpoint. The official expressions of hostility to religion in some of the commissioners' comments were inconsistent with that requirement, and the Commission's disparate consideration of Phillips' case compared to the cases of the other bakers suggests the same.

(*Masterpiece Cakeshop, LTD., et al v. Colorado Civil Rights Commission,* 2018, pp. 1-6).

The *Masterpiece Cakeshop* case rebuked a state government for its overt hostility to religion. The Court simply ruled that "tolerance" is a two-way street (Farris, 2018, p. 1). If the Court uses this type of "balanced reasoning" in dealing with the issue of

assisted suicide, state laws against assisted suicide could be banned for being intolerable of the right to privacy and the liberty of choice that individuals possess. "The Court refused to strip the First Amendment of its enduring promise of freedom, reminding us once again that the government exists to protect our liberty, not take it away" (Farris, 2018, p. 3). The Court's position in the *Masterpiece Cakeshop* case could bolster the proponent's view of assisted suicide being the ultimate right of freedom to choose one's own end-of-life experience.

The United States Court of Appeals for the Fourth Circuit issued a ruling on August 2, 2017, in a lawsuit filed by Gavin Grimm, a sixteen-year-old transgender boy, against the Gloucester County School Board in the U.S. District Court for the Eastern District of Virginia. Grimm, represented by the national and Virginia ACLU, proceeded under Title IX and 42 U.S.C. § 1983. He sought a preliminary and permanent injunction allowing him to use the boys' restroom at school, claiming that the school board's policy of requiring transgender students to use a private restroom facility violated his rights under Title IX. "The big question is whether transgender rights are protected by the Constitution as well as Title IX, the 1972 federal law that bans discrimination 'on the basis of sex' in schools that receive federal money" (Barnes, 2017, p. 3).

Specifically, the plaintiff alleged that after he had used the boys' restroom with the school's permission for seven weeks without incident, the school board released a policy stating that students' access to restrooms was restricted based on their "biological gender" and that students who were unable to use the corresponding restroom because of "gender identity issues" were to use an alternative private facility. At the time, the plaintiff was the only student at the school required to use the private facility. However,

as in the *Masterpiece Cakeshop, LTD* case, secondary arguments in many of the *amicus curie* briefs filed by "interested parties" were based on the substantive due process and equal protection clauses of the Fourteenth Amendment (*Grimm v. Gloucester County School Board*, 2017, p. 1). The Supreme Court originally agreed to hear the case, but then decided against it saying that "the issue involved (transgender rights and the applicability of Title IX) had not been fully explored in the lower courts" (Barnes, 2017, p. 2).

In a poll conducted by Vox-Morning Consulting in May 2016, respondents were asked to choose between two options: "We should have laws and regulations in place to ensure that transgender people do not face discrimination because of their gender identity" or "We do not need laws or regulations to ensure that transgender people do not face discrimination because of which gender they say they identify with." While 48% of Americans favored having laws and regulations in place, 35% of Americans said they were not needed (Lopez, 2016). The *Grimm* case is mentioned here as an example of another socially relevant issue type case which will eventually be heard by the Supreme Court. When the Supreme Court does hear a "transgender rights" case, additional facts and insights should become available to see if the Court's ruling is aligned with the public's opinion on the issue.

On May 14, 2018, the Supreme Court, in the case of *Murphy v. NCAA, et al,* struck down a 25-year old federal law known as the Professional and Amateur Sports Protection Act (PASPA) that largely outlawed sports betting outside Nevada (*Murphy v. National Collegiate Athletic Association*, 2018). The court's 6-3 decision overruled the Third Circuit Court of Appeals, saying PASPA violates the state's Tenth Amendment

rights, thereby creating a path for New Jersey and other states to offer sports betting (*Murphy v. NCAA et al*, 2018). The case was decided based on the Supreme Court's interpretation and application of the 10th Amendment, known as the "Reserved Powers" Amendment (Legal Information Institute, 1992), not the 14th Amendment issues of equal protection and substantive due process. The *Murphy* case is mentioned and addressed at this point to illustrate that the Court could use this type of contemporary precedent to decide that the issue of "a right to assisted suicide" should be left to each individual State to decide. Instead of dealing with the issue of assisted suicide on a federal level, the Court could choose this Tenth Amendment path (as it did in *Murphy*), thus leaving it up to each State and the proponents and opponents of assisted suicide in each state to continue in the time-consuming, expensive and litigation-laden battle over this issue.

The crux of the matter in research question number 4 and, the issue of assisted suicide, bears repeating. The Supreme Court has not ruled on an assisted suicide case since 1997, over 21 years ago. If an assisted suicide case is heard by the Supreme Court and ruled upon in favor of allowing for assisted suicide, the majority of the justices will have to use the expansive Fourteenth Amendment approach it has taken in the other socially relevant issue cases in the past several years as discussed herein, and not its own precedent as discussed further on the following pages. The Court will also need to veer away from the Tenth Amendment path it has recently taken in the *Murphy* case in order to reach a decision that allows for the option of assisted suicide on a national level.

In a Gallup poll in May 2017, 73% of Americans said that doctors should be allowed to assist a terminally ill patient in severe pain "to commit suicide if the patient requests it" (Wood & McCarthy, 2017, p. 1). "Consistent majorities have expressed

support for doctor-assisted suicide in Gallup's trend polls since the question was first asked in 1997. Before this latest poll, the high point in favor was in 2015 (70%) and the low point in favor was in 2013 (51%)" (Wood & McCarthy, 2017, p. 2).

Support for assisted suicide has nearly doubled since Gallup first polled on the question in 1947, when 37% said it should be allowed by law (assisted suicide was referred to as euthanasia in 1947) (Wood & McCarthy, 2017, p. 2). Views on the issue of assisted suicide often differ based on an individual's religious and political persuasions. "A slim majority of weekly churchgoers (55%) support allowing a doctor to end a terminally ill patient's life through a painless means upon request, whereas nearly nine in 10 adults who rarely if ever go to church say this should be allowed (87%)" (Wood, 2017, p. 3). The issue is somewhat less divisive among party and ideological groups. "About nine in 10 liberals (89%) support assisted suicide, compared with 79% of moderates and 60% of conservatives" (Wood & McCarthy, 2017, p. 3).

Even though the majority of Americans believe that physician-assisted suicide should be legal, it is still against the law in almost every U.S state (43), not to mention almost every country in the world (CNN Library, 2018). "The tension between current policy and the climate of public opinion will soon force the question: Which is the correct path–to provide the most compassionate care possible short of offering physician assisted suicide–or to offer compassionate care *with* the option of physician-assisted suicide as a last resort" (Blizzard, 2002). Rick Blizzard, the healthcare editor of Gallup at the time, made the comment in this article in 2002. His definition of "soon" has gone on to be almost 16 years.

In 2016, LifeWay Research, a division of LifeWay Ministries, conducted a survey using the web-enabled Knowledge Panel®, a probability-based panel designed to be a representation of the U.S. population to conduct a study on physician assisted suicide. The title of the survey was "American Views on Assisted Suicide." The sample stratification and weights used in the survey were different from those of Gallup or Pew in that it divided the responses by gender, age, race/ethnicity, region, metro/non-metro, education and income (LifeWay Research, 2016, p. 2). Of those Americans responding to the survey, 67% agreed that it is morally acceptable for a person to ask for a physician's aid in taking his or her own life (LifeWay Research, 2016, p. 4). Seven out of 10 agreed that physicians should be allowed to assist terminally ill patients in ending their lives (LifeWay Research, 2016, p. 5). Males from the northeast between the ages of 18 to 24, who are white/non-Hispanic, have a college degree or graduate degree, are non-religious or without evangelical beliefs and attend a religious service less than once a month, were the group most supportive and agreed with both previous questions (82%).

All the cases mentioned in this section, including the Grimm case, even though it was sent back to a lower court in Virginia, as well as the information contained in the public opinion polls, answer Research Question 4. This data confirms that the rulings of the United States Supreme Court in Fourteenth Amendment cases using the doctrines of equal protection and substantive due process in dealing with important societal issues are aligned with the opinion of the majority of Americans.

The rulings in these relevant social issue cases may be signaling that the legal landscape has changed, and the Supreme Court may be willing to further expand its

Fourteenth Amendment "autonomy rationale" to allow for and protect physician assisted suicide and once again align itself with the public's majority opinion on the issue.

If another assisted suicide case makes it to the Supreme Court, this will probably afford an opportunity to determine if public opinion and the Fourteenth Amendment are more persuasive than the Court's latest Tenth Amendment directive in the *Murphy* case.

4. The concept of precedent (*stare decisis*) and what it means regarding the issue of assisted suicide

In 2018, the key "legal rights" question that must be asked concerning assisted suicide is, "Does the Constitution of the United States encompass a due process liberty interest in controlling the time and manner of one's death?" (*Compassion in Dying v. Washington*, 1996, p. 790). As of today, according to the Supreme Court of the United States, the answer is no (*Washington v. Glucksberg*, 1997, and *Vacco v. Quill*, 1997).

What legal path did the issue of assisted suicide travel in order to arrive at the Supreme Court? In 1994, Judge Barbara Rothstein from the U.S. District Court for the Western District of Washington began the march to the Supreme Court for assisted suicide when she ruled that since "personal decisions relating to marriage, procreation, contraception, family relationships, child-rearing and education were constitutionally protected under the Fourteenth Amendment, assisted suicide should be as well" (*Compassion for Dying v. State of Washington*, 1994, p. 1459). Citing precedent and dicta from the Supreme Court's ruling in *Planned Parenthood v. Casey* (1992) (precedent) and the minority view of the Supreme Court in *Cruzan v. Missouri Department of Health* (1990) (dicta), Judge Rothstein ruled that a competent adult has the right to terminate his/her own life because of two of the liberties protected by the

Fourteenth Amendment: personal dignity and autonomy.

Judge Rothstein's ruling and the concurring opinions in *Cruzan* (1990), along with other federal court cases (see below), eventually placed the issue of assisted suicide before the Supreme Court. Their basis lay on the cumulative legal perspective that "every individual has the right to the possession and control of his or her own person, free from all restraint or interference of others and the right of every human being of adult years and sound mind to determine what shall be done with his/her own body, even the planning and fulfillment of an assisted suicide" (*Compassion in Dying v. State of Washington*, 1996, p. 586).

At the same time the case of *Compassion in Dying v. State of Washington* (1996) was making its way to the Supreme Court under the name of *Washington v. Glucksberg* (1997), the case of *Quill v. Koppell* (1996), eventually named *Vacco v. Quill* (1997), began its journey to the Supreme Court originating from the Southern District of New York. (The name of a lawsuit/case may change as it moves through the federal court system due to the fact that some parties are dropped from the lawsuit, the successful party at the appellate court level changes from the trial court level due to a ruling that is reversed or modified, a court modifies the name for reporting purposes or other reasons). Both the *Washington* case and the *Quill* case arrived at the Supreme Court with appellate court rulings that invalidated the state's criminal statutes that prohibited physician assisted suicide.

The decisions in both cases were announced by the U.S. Supreme Court on June 27, 1997. Both Supreme Court decisions were unanimous in reversing the appellate court decisions based on the following abbreviated five reasons:

1. In *Washington*, the Court observed that suicide and assisted suicide have been disapproved by Anglo-Saxon law for more than seven hundred years. From thirteenth-century England through nineteenth-century America, the Court said, the "common law" has consistently authorized the punishment of those who have attempted to kill themselves or assisted others in doing so (*Washington v. Glucksberg*, 1997, p. 710).

2. The Court pointed to the overwhelming majority of states that currently prohibit physician-assisted suicide. At this time, only Oregon expressly allows doctors to help their patients hasten their demise through lethal doses of prescribed medication, and the law that allows this practice is constantly being challenged in court (*Washington v. Glucksberg*, 1997, p. 713).

3. The Court found that the history of the Due Process Clause does not support the asserted right to assisted suicide (*Washington v. Glucksberg*, 1997, p. 719). The Court wrote that although the Due Process Clause protects certain "fundamental rights," the asserted right to physician-assisted suicide does not rise to "this level of importance" (*Washington v. Glucksberg*, 1997, p. 719). Before a right may be deemed "fundamental" in nature, it must be deeply rooted in the nation's legal history. The Court found the asserted right to physician-assisted suicide to be contrary to U.S. history, tradition, and practice; therefore, it concluded that it was not a "fundamental right" (*Washington v. Glucksberg*, 1997, p. 729).

4. In *Vacco*, the Supreme Court ruled that a fundamental distinction exists between letting a patient die and killing him/her. Chief Justice Rehnquist wrote in the unanimous opinion that in one instance, the patient is allowed to die by natural

causes when life-sustaining treatment is withdrawn. The patient's cause of death in that instance is the underlying illness. In the other instance, death is intentionally inflicted by the joint effort of doctor and patient. The cause of death in that instance is not the underlying illness, but human action (*Vacco v. Quill*, 1997, p. 808).

5. The Court in *Vacco* noted that a right to physician-assisted suicide has never been approved by the common law but has been historically discouraged by both common-law and statutory schemes throughout the United States. Thus, the Court concluded that physician-assisted suicide is not substantially similar to refusing medical treatment and that the legal systems of New York and other states may treat each practice differently without running afoul of the Equal Protection Clause (*Vacco v. Quill*, 1997, p. 801).

The Supreme Court of the United States has not decided any cases concerning assisted suicide since 1997, except for the case of *Gonzales v. Oregon* in which the Court removed an obstacle to state (Oregon) efforts to authorize physician-assisted suicide (*Gonzales v. Oregon*, 2006, p. 243). In a 6 to 3 ruling, the court stated that John Ashcroft, the former attorney general of the United States, acted without legal authority in 2001 when he "threw the federal government's weight against Oregon's Death with Dignity Act" (Greenhouse, 2006, p.1). Justice Kennedy wrote, "The authority claimed by the attorney general (Ashcroft) is both beyond his expertise and incongruous with the statutory purposes and design of the Controlled Substances Act (CSA)" (Greenhouse, 2006, p. 2). Ashcroft was trying to invoke the tenets of the 1970 federal law that helped

establish the framework of a federal drug policy for regulating physicians as they wrote prescriptions for controlled substances. Ashcroft claimed that the CSA could be used to take away the license of any physician that prescribed lethal doses of drugs for the purpose of assisting a suicide. Justice Kennedy went out of his way to emphasize the unilateral nature of Ashcroft's action. Kennedy stated that his (Ashcroft) position was an executive branch attempt to declare as criminal actions that which Congress had not designated as crimes (Greenhouse, 2006, p. 3). Regardless of the rebuke of the Attorney General and his position, the ruling in the *Gonzales* case did not modify, change or reverse the Court's decisions in *Washington* (1997) and *Vacco* (1997). Therefore, the rulings in *Washington* and *Vacco* represent the current state of the "law of the land" in the federal court system in the United States relative to assisted suicide.

If the Supreme Court is to change its collective mind or modify its current position to allow for assisted suicide, it will have to choose to follow the more expansive and contemporary application of the Fourteenth Amendment it has espoused in other socially relevant cases instead of its own precedent which was set in *Washington* and *Vacco*. Also, as previously noted, the Court will need to choose the expansive Fourteenth Amendment approach over its own strict Tenth Amendment State's rights precedent found in the *Murphy* case.

Research Question 5

A. Does evidence in case law support Rohr's (1986) "regime value/constitutionally-directed" theory or Toobin's (2007) more recently formulated theory that justices of the Supreme Court are increasingly motivated not by the Constitution but by politics and

personal ideology when deciding Fourteenth Amendment cases? Can both theories co-exist and not be in conflict?

B. What does the answer to part A suggest about the future of assisted suicide laws in the United States?

The latest research did not uncover any papers written or opinions expressed on the issue of assisted suicide by either the late Professor John A. Rohr or by Jeffrey R. Toobin, attorney, Supreme Court expert and public administrator. But their individual work on the Constitution, in public administration and on the Supreme Court supplies an expectation of direction for how public administrators should be guided to deal with the issue of assisted suicide (Rohr) and where the Supreme Court may be going and how they may get there on this very important social issue (Toobin).

In June of 2018, Justice Anthony M. Kennedy announced his retirement from the Supreme Court. After being nominated by President Ronald Reagan in 1987, Justice Kennedy was sworn in on February 18, 1988.

"Justice Kennedy, 81, has been a critical 'swing vote' on the sharply polarized court for nearly three decades as he embraced liberal views on gay rights, abortion and the death penalty but helped conservatives trim voting rights, block gun control measures and unleash campaign spending by corporations" (Shear, 2018).

One month later, President Donald J. Trump nominated U.S. Court of Appeals jurist Brett Kavanaugh to replace Justice Anthony M. Kennedy on the Supreme Court. If history provides any precedent, the political games of the confirmation process will begin, most likely laced by scare tactics and semantical chess games of wordsmanship by members of Congress.

In choosing Judge Kavanaugh as his Supreme Court Justice nomination, the President conferred with the same individual he relied on when he nominated Justice Neil Gorsuch to the Supreme Court in 2017. Leonard Leo, an attorney and executive vice president of the Federalist Society, is President Trump's main adviser concerning selection of Supreme Court Justice nominees.

As Toobin suggested in 2007 and as previously discussed herein, when making decisions, Supreme Court Justices "use their own individual ideologies when determining the meaning of the Constitution. When it comes to the core of the Court's work, it is ideology, not craft or skill that controls the outcome of the case" (Toobin, 2007, p. 338).

Leonard Leo agrees with Toobin concerning Supreme Court Justices and ideology but believes the issue is more important during the nomination and selection process. Leo's focus on ideology is more compartmentalized and narrower than Toobin's (Michaelson, 2018). He uses an "ideological test" that covers four primary items of major consequence. Those four primary items are:

1. The prospective justice understands the limits on government power in the Constitution (commonly referred to as being a constitutionalist).
2. The prospective justice interprets the law (statutes, codes, bills, regulations) as written (textualism).
3. The prospective justice is an originalist.

   Originalists attempt to discern the original meaning of the Constitution. An originalist jurist believes that the meaning of the Constitution does not change or evolve over time, but rather the meaning of the text is both fixed and knowable. An originalist believes that the fixed meaning of the text should be

the sole guide for a judge when applying or interpreting a constitutional provision. Originalism and textualism are different, albeit subtly. Textualism is based on a reading of the statute to see how the text would have been understood to mean by an ordinary person at the time it was written. A textualist is an originalist who gives primary weight to the text and structure of the Constitution. However, textualists often are skeptical of the ability of judges to determine collective "intent" (Exploring the Constitution, 2016).

4. The prospective justice should also have a strong belief in "natural law" and how it was emphasized in the Constitution.

It is also important to Leo that the prospective justice not be a "judicial activist" meaning that he or she does not try to change the original meaning of the Constitution in order to move in a new judicial direction (decision) that was never intended by the framers. (Bravin, 2018)

Judge Brett Kavanaugh was confirmed by the Senate and sworn in on October 6, 2018, becoming the 114th Supreme Court justice, creating a conservative majority on the nation's highest court by a margin of 5 to 4. The five "conservatives" on the Court, which will represent a majority, will be Alito, Gorsuch, Kavanaugh, Roberts and Thomas. The four "liberals" on the Court are Breyer, Ginsburg, Kagan, and Sotomayor.

Based on the foregoing, the five conservative justices could easily rule that there is no "right to assisted suicide" in the Constitution. On the other hand, the liberal justices, after convincing one of the conservative justices to vote with them, could create a new "right to assisted suicide" from the situational or relational context of the Constitution as has been the case with other important socially relevant issues. Of

course, this will only be of major consequence if an assisted suicide case makes it to the Supreme Court.

As to Rohr's mandate of the need for public administrators to be "constitutionally-directed" ultimately by the Supreme Court, there have not been any articles that claim his directive should not be followed. The better unasked and therefore unanswered question is, "If the basis of the court's ruling is ideologically misguided and therefore incorrect or erroneous, should administrators still follow the rulings?" This conundrum, if ever raised, is for another paper at another time.

If a federal statute such as the one proposed in Chapter 5 is implemented, it would certainly marginalize the arguments over the structure of the Court and the "war of words" about judicial activism versus strict constitutional originalist interpretation and precedent, at least as far as assisted suicide is concerned.

Conclusion

As previously stated in Chapter 2, Rohr elevated public administration to the central position of constitutional "guardian," thus playing a role comparable to that of the original Senate (Rohr, 1986, p. 39). To Rohr, the main democratic responsibilities of public administrators were symbolized by their oath of office: "The oath to uphold the Constitution is the moral foundation of ethics for bureaucrats" (Rohr, 1978, p. 70). Rohr believed that the most suitable way to understand the Constitution was through the interpretation of Supreme Court decisions (Overeem, 2013, p. 53). So how does the Supreme Court interpret the Constitution in matters involving assisted suicide? To date, the Supreme Court says that assisted suicide is prohibited, unless an individual is in total compliance with the state laws in one of the seven states or the District of Columbia that

allow for physician assisted suicide (*Washington v. Glucksberg* and *Vacco v. Quill*). Therefore, depending on the state in which a public administrator is practicing, he or she will need to follow the constitutional mandate of the Supreme Court as to the issue of assisted suicide, regardless of whether the constitutional mandate is extremely diverse in its application from state to state.

According to Toobin, the Supreme Court has traveled one long road of ideological change and a much shorter road of being in sync with public opinion dogma with great precision. Between 1801 and 1992, the Supreme Court went from establishing itself as an independent and influential branch of government to "accommodating business interests and their political allies" and back to consistently asserting itself as an independent guarantor of constitutional rights, with its main leadership quality being that it was "constitutionally directed." From 1992 to 2005, the decisions of the Supreme Court reflected public opinion with great precision (Toobin, 2007, p. 2).

Toobin believes that both paradigms mentioned above are about to be disrupted and supplanted by a new directional, politically-motivated revolution of individualized ideological-directed thinking by the justices (Toobin, 2017, p. 3). This "new direction" based on the individual ideological-directed thinking of each justice may well be in conflict and contrary to the mandate of interpreting the Constitution by its content and the precedents set by rulings in previous cases. If Toobin's prognostication comes to pass, what constitutional direction will be afforded to public administrators as they attempt to follow their own oath of office (as espoused by Rohr)?

As to the issue of assisted suicide, any future decision by the Supreme Court may be weighed on the new scale of "ideologically-directed thinking based on politics and

which jurists are appointed as Justices to the Supreme Court" and not on the historic precedent-based "scale of justice" (stare decisis) and the public opinion of the majority of Americans.

The research and information in this chapter underscore a new social directional trend and more contemporary legal-minded thoughts concerning physician assisted suicide that have come to the forefront. Since the legal and cultural situations have changed dramatically, it now seems that the majority of justices on the Supreme Court could be willing to extend the autonomy rational relied on in the *Obergefell* case and further described herein to allow for and protect physician assisted suicide (*Obergefell v. Hodges*, 2015, p. 2584). Toobin's theory may still be correct, but applicable only to certain kinds of cases. He said the Court's new individual ideological-thinking would be in conflict with public opinion. But the *Obergefell* case, despite the close 5 to 4 decision, seems to disprove this part of his overall theory. As reflected in public opinion polls and as mirrored in the Court's decision, opinions favoring gay rights and gay marriage are almost at an all-time eye high (Masci et al, 2017).

Chapter 5 proposes a public policy healthcare model for allowing assisted suicide decisions to be made without fear of prosecution and/or the exhaustive use of protracted civil litigation, using a dignified, compassionate and common-sense approach. The social and legal landscapes within the United States may be ready for such an approach to this important social issue, as they have been over the past several years relative to abortion, education rights, same-sex marriage, immigration, political elections, gerrymandering and transgender rights.

Chapter V

CONCLUSION

Introduction

The myriad of reasons given by individuals requesting assistance to terminate their own lives is wide-ranging. For example, in the fall of 2013, Tim Bowers, an Indiana man, was paralyzed in a hunting accident. Bowers was heavily sedated as multiple tests were performed, and the diagnosis of total paralysis (from the shoulders down) and life on a ventilator was explained to his parents and sister. His parents asked if Bowers could be brought out of sedation, so he could hear the diagnosis and decide his own fate. Bowers was informed of the diagnosis and decided to end his own life by asking his doctors to remove the breathing tube they had inserted when he arrived at the emergency room (Sabalow & Guerro, 2013).

The Bowers case was unique in many ways. First and foremost, in accident cases it is normally the family members, spouses or surrogates–not the patient–who make end-of-life decisions, as the patient is normally comatose and incapable of making any decisions, let alone the one to end his/her life. Second, the patient did not have a terminal disease and a reasonable expectation of dying within six months, a requirement of all state laws that allow for assisted suicide. Although he did have the ability to make and communicate health decisions, it was not reported if he received the requisite counseling mandated by the state laws that allow assisted suicide and complied with other written consent guidelines under those laws. Bowers decided for himself to end his life within 48

hours of his accident, which is very rare, according to medical ethicists (Sabalow & Guerro, 2013, p. 2).

Each person deals with death in his or her own individual way. A person's "own individual way" is defined and determined by many factors including but not limited to the individual's health, belief system, ethics, morals, personality, pain and psychological distress levels and personal living conditions.

On the other end of the spectrum from the Tim Bowers' accident case decision is the growing trend to hasten death by self-starvation and dehydration. Approximately 10 years ago, geriatric practitioners and other experts started to notice that many terminally ill patients wished to hasten their deaths by forgoing all food and water. In the past several years, this trend started to include non-terminally ill patients who knew their health was failing them and were simply tired of the pain, discomfort and immobility of "growing old" (Kaplan & Mestel, 2005, p. 1).

In 2011, at the ages of 92 and 90, Armond and Dorothy Rudolph's bodies were failing them. He suffered from severe pain from spinal stenosis, and she was almost entirely immobile. Both suffered from early dementia, but according to their son, they both possessed the requisite mental faculties to make both simple and important decisions (Span, 2011, p. 1). The Rudolphs, who had been married for 69 years, decided to refuse food and water in order to end their lives. At the time they made this decision, they were living in an assisted living facility in Albuquerque, New Mexico. Three days into the fast, the couple told their plans to the staff at the facility. The head administrator immediately called 911, citing an attempted suicide. The assisted living facility evicted the Rudolphs. They moved into a private home where they again stopped eating and

drinking. Ten days after their fast began, Armond Rudolph died. Dorothy Rudolph died the following day (Span, 2011, p. 2).

Armond and Dorothy Rudolph did not ask anyone to assist them in dying. The opposite was true. Other than informing some of the staff at the assisted living facility where they lived of their intentions, no outside help or actions were requested. The Rudolphs simply refused to eat or drink any of the food or beverages which they were given. They apparently could communicate health decisions and did so by informing certain individuals about those decisions, instead of asking for permission or assistance of any kind.

Both the Bowers' and Rudolphs' stories are disturbing, mournful, sad, tragic and heart-breaking. Neither situation fits the exact parameters of the terminally-ill competent adult patient with less than six months to live asking for assistance in ending his or her life. However, these two examples do underscore the highly emotional, over-reactionary and dramatically impassioned approach most people take concerning assisted suicide. Instead of putting the individual's needs and desires first, most people insert their own fervent sentiments and feelings into the equation. These types of reactions are normal perhaps, but not very helpful in addressing the issue or to the individual who desires assistance in terminating his or her own life.

The most helpful and progressive approach to the issue of assisted suicide is the legal lens of study approach for reasons of objectivity, the contextual nature of a historical legal perspective, the allowance for minority opinions and ideas, positions based on solid facts, fewer emotional characteristics and procedures based on problem-solving reasoning.

This qualitative study evaluation dissertation began with five research questions using the legal lens of study approach. The five research questions are as follows:

1. What major similarities and differences are there in the current assisted suicide laws and statutes in effect in the 20 jurisdictions selected for this study?
2. What major similarities and differences are there in the current assisted suicide laws in the six countries other than the United States selected for this study?
3. Are there universal language elements in the assisted suicide laws of the 20 jurisdictions and in the six countries other than the United States selected for this study?
4. Over the past 45 years, how do the rulings of the United States Supreme Court in Fourteenth Amendment cases using the doctrines of equal protection and substantive due process as applied to assisted suicide laws reflect public opinion of the citizenry of the United States as reported in opinion polls?
5. A. Does evidence in case law support Rohr's "regime value/constitutionally-directed" theory or Toobin's more recently formulated theory that justices of the Supreme Court are increasingly motivated not by the Constitution but by politics and personal ideology when deciding Fourteenth Amendment cases? Can both theories co-exist and not be in conflict?

   B. What does the answer to part A suggest about the future of assisted suicide laws in the United States?

Research Questions, Findings and Implications

By following accepted qualitative research techniques and by using a legal lens of study approach, this dissertation revealed three foundational approaches to the issue of assisted suicide that have been followed in the past. As this chapter re-examines the five research questions and analyzes their substance and implicational importance, the approaches followed in the past will be discussed as the five research questions are answered. In order to best explain and support the answers to the five research questions, this chapter was divided into five separate parts. The three previous approaches to the issue of assisted suicide are discussed in Parts A, B and C and the first 4 research questions are answered therein. Specifically as to Parts A, B and C:

1. Part A of this chapter discusses and explains the first approach taken, that being the promulgation of individual state legislation. Within the context of this approach, the first 3 research question are answered.
2. Part B of this chapter discusses and explains the second approach taken, that being the federal and state court litigation approach. This approach answers research question 4.
3. Part C deals with the third approach taken, that being the "status quo" method of resolving an issue. The information revealed and explained in this part of the chapter shows that this approach, which includes an under-lying desire to not deal with the issue of assisted suicide in a progressive manner, helps answer research questions 1 through 4 by promoting the basic belief that the issue is a non-issue.

The remaining two major parts of the chapter, Parts D and E, examine and discuss the "current state of affairs" of the issue of assisted suicide and makes a specific recommendation as to how the issue could be approached on a national level, and answers research question 5.

Specifically as to Parts D and E:

4. Part D will re-examine and discuss how the current "state of affairs" as to the issue of assisted suicide, the directions ignored and the paths not taken, and where we may be going relative to the issue as research question 5 is answered.
5. Part E contains a specific recommendation as to how the issue of assisted suicide could be approached on a national level based upon what some refer to as an "informal amendment to the Constitution."

This chapter also describes and explains the overall findings in terms of expectations and surprises. As stated above, the three courses of action that have not been successful in the past 25 years are examined within the context of the five research questions. The new federal statutory approach proposed to address the issue of assisted suicide on a national basis respects the Constitution and may be the best remedy for this extremely important socially relevant issue.

Part A—Individual State Legislation—Research Questions 1, 2 and 3

(A very long road to travel)

The first three research questions focused on the similarities and differences between the 19 states, the District of Columbia, and the six countries other than the United States selected for this study, as well as universal language elements contained in

those laws and statutes dealing with assisted suicide.

The answers to research questions 1, 2 and 3 revealed the first major foundational directional approach to the assisted suicide issue. This directional approach taken over the past 25 years left each state to deal with the issue of assisted suicide on their own. This approach has not been very successful for the citizenry of the nation and has created a hodge-podge of multi-directional rules and regulations for those wanting assistance in ending their own lives.

Research Question 1

What major similarities and differences are there in the current assisted suicide laws and statutes in effect in the 20 jurisdictions selected for this study?

To answer research question 1, seven states that currently allow assisted suicide were used (California, Colorado, Hawaii, Montana, Oregon, Vermont and Washington), as well as the District of Columbia. These were compared with 12 randomly selected states that do not allow assisted suicide: Alabama, Arizona, Florida, Georgia, Illinois, Maryland, Mississippi, Missouri, New Jersey, New York, Texas and Utah.

The most important link of compatibility between the seven states currently allowing for assisted suicide as well as the District of Columbia was that the mandates and tenets contained in the state of Oregon's law were replicated and used as the foundational basis of the laws in each jurisdiction. This does not come as a surprise since Oregon was the first state to pass a law allowing for physician assisted suicide in 1997 and the Oregon statute has withstood several lawsuits by opponents to invalidate the statute.

The importance of research question 1 and its answer is that it lays the main

foundational predicate for the entire section of this dissertation concerning a state's right to promulgate a statute covering the issue of assisted suicide, but at the same time showing how long and difficult the process can be. It was expected that each statute would be very comprehensive in nature, but it was surprising how similar the statutes were and how each government in the seven jurisdictions other than Oregon chose not to "re-invent the wheel" as far as the substance of their own statutes.

However, a major surprise discovered in answering research question number 1 was that in the states that do not allow for assisted suicide, although all 12 states list the topic as a crime either statutorily or by common law, an extreme diversity of punishment exists for violating the laws in the different jurisdictions. As Table 2 on page 103 describes, some states view the act as the lowest category of a misdemeanor, while other states treat it as a Class A felony with prison time of well over ten years.

The laws in each of the eight jurisdictions allowing for physician-assisted suicide contain a provision to gather and report certain statistical information concerning the issue. Table 3 in Chapter 4 details the most important categorical statistics reported by each state. It was not surprising that cancer was the main type of illness reported. The percentage of patients over 65 and the median age at the time of death of the patients who requested assistance in dying was also not a surprise. These two statistical facts support the importance of the issue of assisted suicide to the three generations which make up almost 30% of the United States population: the "Baby Boomer" generation, those individuals born between 1946 and 1964; the "Silent" generation, those individuals born between 1928 and 1945; and the "Greatest" generation, those individuals born between 1901 and 1927 (CNN Library, 2018).

The latest example of how a state becomes part of the select group that has a law allowing for assisted suicide follows.

The story of the state of Hawaii's history in finally passing legislation to allow its citizens an alternative to end of life suffering is extremely complicated. Coupled with the length of time other states have had to invest in the death with dignity movement, this process demonstrates that the solution to the important and necessary social reform issue of assisted suicide for all citizens must not be left up to the individual states.

Efforts to pass physician-assisted suicide legislation in Hawaii began in 1998 (Stutsman & Foster, 2018). At that time, 72% of Hawaii residents supported right to die legislation. The first bill introduced into the state legislature closely modeled Oregon's law, which was passed the year before (Stutsman & Foster, 2018). From 1999 to 2018, no fewer than fourteen bills supporting physician assisted suicide were sponsored and introduced into the state legislature of Hawaii (Stutsman & Foster, 2018). The public support for this type of legislature never fell below 71% of Hawaii residents. The journey toward policy reform in Hawaii for physician assisted suicide paralleled the efforts in Vermont (12 years), Washington (17 years) and California (25 years) (The Inside Story of Hawaii's Long Road to Victory, 108, p. 1).

Over the course of twenty years, advocates for the cause in Hawaii replicated Oregon's campaign playbook, which provided for funding and marketing expertise, media training, strategic planning and grassroots organizing by local and state leaders, to pass legislation allowing for physician assisted suicide (The Inside Story of Hawaii's Long Road to Victory, 108, p. 2). The herculean effort made by the organizers and proponents of physician assisted suicide legislation and the time and money spent on the

effort dwarfed the movement in any other state.

Governor David Ige signed the "Our Care, Our Choice Act" into law on April 5, 2018, twenty years after the first physician-assisted suicide legislation was introduced in the Hawaii legislature. "Hawaii's citizens will now have the same compassionate end-of-life option that residents of Oregon, Washington, Vermont, California, Colorado and Washington, D.C. enjoy" (The Inside Story of Hawaii's Long Road to Victory, 108, p. 8).

To address the issue of assisted suicide by continuing with a process where each state must invest between 12 and 25 years in a legislative undertaking which culminates with the passing of virtually the same laws of the other states, if in fact the legislative process is successful, seems to be a waste of time, effort and money. To those state citizens wishing to add this option to their end-of-life choices, this arduous process seems nonsensical, uncompassionate and inhumane.

To state the obvious, for any state to go through the process of passing a law allowing for assisted suicide is a very long and arduous process. This entire process would be simplified, and the time invested would be shortened considerably if a federal statute dealing with assisted suicide as proposed in Part E herein were promulgated.

Research Question 2

What major similarities and differences are there in the current assisted suicide laws in the six countries other than the United States selected for this study?

This question was proposed in order to discover how other countries in the world that allow for assisted suicide have dealt with the issue and how their laws compare to those in existence in the jurisdictions of the United States. Table 4 in Chapter 4 lists six countries (Belgium, Canada, Germany, Luxembourg, Switzerland and The Netherlands)

other than the United States with laws allowing for assisted suicide.

There was an expectation that these laws would be less restrictive than the laws in the jurisdictions of the United States, and they were, but there were also a few surprises found in the contents of these laws even with the afore-mentioned expectation. The first surprise was that in two of the countries there is no residency requirement (Belgium and Switzerland). Secondly, in three of the countries there is no requirement of an "expectation of death" (Belgium, Switzerland and The Netherlands). The third surprise dealt with the "age" of those who may request assistance in dying. In Luxembourg and The Netherlands it is permissible for a 16- year-old to request assistance in dying and in Switzerland, there is not set age, which leaves the distinct possibility for those younger than 16 to request assistance in dying as long as they are "suffering intolerably."

Research Question 3

Are there universal language elements in the assisted suicide laws of the 20 jurisdictions and in the six countries other than the United States selected for this study?

Chapter 4 details not only the qualitative methodology followed to discover the universal language elements in the assisted suicide laws, but thoroughly examines ten universal language elements found as well. This research question was proposed in order to complete the first major part of this dissertation, which covers the laws in existence in United States jurisdictions and the six other countries selected for this study that allow for assisted suicide.

The most important and significant reason for discovering, analyzing and understanding the common elements of the laws in the jurisdictions that allow for assisted suicide is to provide some of the important information necessary to formulate

and propose a public policy healthcare model allowing for assisted suicide on a national level. These common elements explain and provide the basic groundwork for laws that have been successful, not only in being passed, but in withstanding litigation by opponents to assisted suicide.

The discovery and analysis of these common elements also places the laws in a historical societal context as far as any political or geopolitical movements. The acceptance of these common elements by the citizenry and by the authorities in different jurisdictions over time and at certain flash-points in history allowed for an understanding of what has been a successful constant as to the issue of assisted suicide.

In addition, this common element discovery approach allowed for the discovery and an understanding of why there were some customary differences between the laws in the United States jurisdictions and the six countries other than the United States. A specific finding and an uncommon element discovered was the approach taken by the jurisdictions in the United States relative to age (18) versus the qualifier mandated in the six countries (in some countries, emancipated or as young as 12).

This analysis was tantamount to preparing the most appropriate tenets that should be included in the federal statute proposed herein, which may be the best national approach for dealing with the issue of assisted suicide.

Part B—Research Question 4

Litigation—the necessity of a "perfect storm" case in the Supreme Court

Over the past 45 years, how do the rulings of the United States Supreme Court in Fourteenth Amendment cases using the doctrines of equal protection and substantive due

process as applied to assisted suicide laws reflect public opinion of the citizenry of the United States as reported in opinion polls?

Court cases from several states and from the federal court system were researched and discussed at length in Chapters 2 and 4. Since there has not been a case heard by the Supreme Court of the United States concerning the issue of assisted suicide since 1997, it was very important to identify and examine how the courts have dealt with other socially relevant issues over the past 45 years by using the doctrines of equal protection and substantive due process in the Fourteenth Amendment and looking at the public's opinion on these issues.

The answer to this question uncovered, among other important discoveries, the ever-present historical ebb and flow of important societal issues such as assisted suicide that are constants in our diverse society. Looking at these Supreme Court rulings and analyzing the recorded public opinion to these issues produced a confluent connectivity that shows how certain important societal issues are pushed to the fore-front and often ruled upon by the highest court in the land.

Another significant reason for using this question and discovering the answer was to try to ascertain whether the Supreme Court, with its current make-up of justices, is ready to hear the issue and how they might rule. Predicting and forecasting judicial opinions can be described as being foolish. However, the height of "foolishness" in this case would be an attempt to predict what the Court will do without being aware of societal opinions on the issue and showing a lack of respect for the voiced societal norms on the subject matter. The answer to this question also sets a directional tone for moving forward with a recommendation that is in line with the current societal majority opinion

on the issue of assisted suicide.

This question also laid the foundation to formulate an in-depth answer to the second major directional approach followed over the past 25 years dealing with the issue of assisted suicide, state and federal litigation. The litigation approach used to deal with the issue of assisted suicide has not solved this highly relevant social issue, but instead has done nothing but further confuse the citizenry of the country, complicate the issue with multi-dimensional legal opinions, half of which have been overturned, and provided little if any relief for those individuals who would like some assistance in dying.

The fact that the Supreme Court has not heard an assisted suicide case since 1997 (*Washington* and *Vacco*), as afore-stated, is a testament to the fact that the "perfect storm" case has not evolved and been presented to the Court with sufficient factual content and an acceptable jurisdictional base. Not having the opportunity to present a case dealing with an important social issue such as assisted suicide is the same as ruling against the issue simply by this form of avoidance. To say that this course of action has not been successful in providing realistic and humane guidance for the citizenry of the nation is an understatement.

As explained in Chapters 2 and 4, the historical litigation approach to the issue of assisted suicide has created a labyrinth-like conundrum that is as complicated and convoluted as any other socially-relevant issue addressed by the courts in the past 45 years. However, some of the main points explained in those two chapters bear repeating.

In 1973, the Supreme Court of the United States in the case of *Roe v. Wade* ruled that a woman's choice to an abortion was protected by the privacy rights guaranteed by the Fourteenth Amendment to the U.S. Constitution (*Roe v. Wade*, 1973, p. 113). The

purpose of this dissertation is not to debate the issue of abortion. But understanding how the Supreme Court approached the issue of abortion in 1973 from a Fourteenth Amendment perspective is tantamount to understanding one of the primary judicial issues underlying physician-assisted suicide as revealed by the legal lens of study approach.

It is important to note some specific facts from the case, as well as part of the Court's interpretation of applicable legal principles on which the case turned. Also of significance is the fact that the Court relied heavily on the precedent setting case of *Griswold v. Connecticut*, a 1965 Supreme Court case ruling that held, "A right to privacy can be inferred from several amendments in the Bill of Rights and this prevents states from making the use of contraception by married couples illegal" (*Griswold v. Connecticut*, 1965, p. 479). In *Roe v. Wade*, after looking at the law's historical lack of recognition of the rights of a fetus (*stare decisis*), the Court concluded that the word "person," as used in the Ninth and Fourteenth Amendments, did not include the unborn (*Roe v. Wade*, 1973, p. 115).

In 1973, most Americans preferred that women be able to have abortions in the early stages of pregnancy, free of government interference, which is how the Court ruled in *Roe v. Wade* (History.com Staff, 2009, p. 1). But to rule in this manner, the Court needed to further expand the Fourteenth Amendment "right to privacy" to include a right to abortion (during the first trimester of pregnancy) that did not exist prior to 1973, except as narrowly defined and applied in the contraception case of *Griswold v. Connecticut*. The majority ruling of the Court was made by seven justices. Only two justices dissented and filed such opinions, Justices White and Rehnquist. Justice Rehnquist argued that the framers of the 14th Amendment did not intend for it to protect

a right to privacy, a right which they (the framers) did not recognize, and that they definitely did not intend for it to protect a woman's decision to have an abortion. Justice Rehnquist further argued that the original right to privacy is that which is protected by the 4th Amendment's prohibition of unreasonable search and seizures (*Roe v. Wade*, 1973, p. 134).

Perhaps the past 45 years has moved us closer to a *Roe v. Wade* "perfect storm" case relative to assisted suicide. But the question is, "How many more years of litigation will it take for an assisted suicide case to make it to the Supreme Court thus giving the majority of the Justices the opportunity to expand and apply the 14th Amendment rights discussed herein to this extremely important social issue?" Since 1973, the Supreme Court has taken these rights and applied them to other abortion cases, criminal law, education, busing, student assignment to schools, employment, civil rights, "do not resuscitate" requests, withdrawal of medication in certain medical situations, requests made in Living Wills, medical school admissions, age discrimination, same-sex marriage, gay rights, immigration, and very soon, freedom of expression & religion (*Masterpiece Cakeshop, LTD*) and possibly transgender rights (*Grimm*).

An additional point must be made when explaining the intricacies within the judicial arena when waiting for some form of finality from the highest court in the land. Many times, litigants continue to plead their cases in other jurisdictions. In May 2018, the California law permitting physicians to prescribe life-ending drugs to terminally ill patients was overturned by a judge who ruled that the law was passed unconstitutionally (Neuman, 2018). Judge Daniel Ottolia of the Riverside Superior Court did not challenge the legality of the nearly three-year-old law but said California lawmakers should not

have passed it during a special session on health care funding (Neuman, 2018). Stephen G. Larson, lead counsel for a group of doctors who sued in 2016 to stop the law, said, "The act itself was rushed through the special session of the Legislature and does not have any of the safeguards one would expect to see in a law like this" (Neuman, 2018). Even though the judge's ruling dealt with "how the law was passed," opponents once again were provided a forum to argue that the law could lead to coercion and abuse of terminally ill patients. Proponents were able to reiterate their argument that the law "provides dignity to terminally ill patients by affording them more control over the end of their lives" (Neuman, 2018).

Legal experts say that this means the California law has been overturned–for now (Symons, 2018). Experts also say that it is unlikely that the decision will affect assisted suicide in California in the long term. Even if the appeals court upholds Ottolia's decision, the state Legislature could pass a similar law, perhaps with additional safeguards. The law has strong support in the Legislature and among the public. A 2015 survey conducted by UC Berkeley found that 76% of Californians supported allowing terminally patients to take their own lives (Symons, 2018). But the main point which should be taken from this example is that the legal maneuvering will continue until the Supreme Court finalizes the issue on a national level.

On July 9, 1868, Louisiana and South Carolina voted to ratify the Fourteenth amendment, after they had rejected it a year earlier (Rojas, 2011, p. 1). The votes made the 14th Amendment officially part of the Constitution. This July 9th (2018) will be the 150th anniversary of this occasion. Could this be the year that a "perfect storm" case involving assisted suicide reaches the Supreme Court? Could the ruling in this "perfect

storm" case allow an individual living in any state the right to add assisted suicide to their end-of-life options list, and chose this option without fear of prosecution or having to go through exhaustive and protracted civil litigation?

The answer, as explained in the previous chapters, illustrates that the Supreme Court's decisions in Fourteenth Amendment cases involving the rights of equal protection, privacy and substantive due process are in lock-step with the opinions of the majority of Americans. The opinion polls claim that the majority of Americans believe in an allowance for physician-assisted suicide. Since assisted suicide is an issue of upmost societal importance, why should an inordinate amount of time have to pass for the Court to recognize that the majority of Americans favor assisted suicide being an end-of-life option choice?

Part C—Status Quo

There are also those lawmakers, so-called experts and medical pundits who deal with the issue of assisted suicide by ignoring it and hoping it will go away or at least run out of steam (Ubel, 2013). This approach represents the third major foundational direction to the assisted suicide issue that was discovered in this study, maintaining the status quo. This approach has not helped in any way, but in fact has hindered the movement in dealing with the issue.

The reasons for this attitude or the desire not to deal with the issue are many, but the assistance given through Hospice programs and "comfort care" initiatives seem to be sufficient for the purveyors of the status quo. An example of "how death with dignity should work" via comfort care follows.

Barbara Bush, the wife of former President George H.W. Bush, died on April 17, 2018. Even though it was not her intention, her announcement that she was seeking "comfort care" shined a new light and stirred an old debate on what it means to stop trying to fight a terminal illness (Bailey & Aleccia, 2018, p. 1).

"Comfort care" usually refers to palliative care, which focuses on managing a patient's symptoms by keeping them comfortable and retaining their dignity (Radulovic, 2018, p. 1). For heart patients (Mrs. Bush suffered from congestive heart failure and chronic obstructive pulmonary disease), "comfort care" usually means opting not to use a breathing machine or CPR (cardiopulmonary resuscitation). However, patients do continue to receive medical treatment, including morphine to ease shortness of breath and diuretics to remove excess fluid from the lungs (Radulovic, 2018, p. 2).

Opponents of assisted suicide use Mrs. Bush's approach to dying (her personal form of comfort care) as an example of why nothing needs to be done about making provisions for assisted suicide on a national basis as an end-of-life option because the status quo is working just fine. The fallacy in this line of thinking is that Mrs. Bush's high level of "comfort care" is only available to a minute percentage of the entire population. Her resources, insurance, money, living arrangements, medical assistance and family support for this type of comfort care are available to so few that this choice is not a viable option.

Hospice care is available to all Medicare Part A and Medicaid recipients (How is Hospice Care Paid For?, 2018). However, the level of care under these two programs cannot compare to the level of "comfort care" provided to Mrs. Bush because of her station in life. This is not meant as a criticism to Mrs. Bush or her family. It is simply

the reality of living in the upper strata of society. The same opponents of assisted suicide claiming that her "comfort care" approach to dying is why the status quo works use the established Hospice program approach as an example of why no changes are necessary.

However, the main point concerning Mrs. Bush's end-of-life option is that it was her choice, not the government's. Choosing the end-of-life option of assisted suicide should be an alternative for all terminally/seriously ill competent adults, just as "comfort care" was for Mrs. Bush.

Part D—Research Question 5

Current state of affairs, directional paths ignored and not taken, and where we may be going relative to the issue of assisted suicide

A. Does evidence in case law support Rohr's "regime value/constitutionally-directed" theory or Toobin's more recently formulated theory that justices of the Supreme Court are increasingly motivated not by the Constitution but by politics and personal ideology when deciding Fourteenth Amendment cases? Can both theories co-exist and not be in conflict?

B. What does the answer to part A suggest about the future of assisted suicide laws in the United Sates?

Chapters 2 and 4 detail the past 45 years of state and federal litigation concerning the assisted suicide issue and other important socially relevant issues. In doing so, it was not surprising that the various court opinions offered were as different as the judges and justices who wrote them. However, some main points of contention bear not only repeating, but further explanation in order to place in proper context where the assisted suicide issue stands, where the issue may be going, how public administrators will be

directed on dealing with the issue and how the highest court in the land will have a final say in the matter and what may be motivating the justices to take a certain directional approach.

An extremely important issue, which has remained under the judicial radar as far as the issue of assisted suicide is concerned, was raised by the late Justice Antonin G. Scalia in the 1990 Supreme Court case of *Cruzan v. Director, Missouri Department of Health.* His concurring opinion clearly stated that "the federal courts have no business in this field (assisted suicide)" (*Cruzan v. Director, Missouri Department of Health*, 1990, p. 293). A critical snippet from his opinion follows:

> While I agree with the Court's analysis today, and therefore join in its opinion, I would have preferred that we announce, clearly and promptly, that the federal courts have no business in this field; that American law has always accorded the State the power to prevent, by force if necessary, suicide – including suicide by refusing to take appropriate measures necessary to preserve one's life; that the point at which life becomes "worthless," and the point at which the means necessary to preserve it become "extraordinary" or "inappropriate," are neither set forth in the Constitution nor known to the nine Justices of this Court any better than they are known to nine people picked at random from the Kansas City telephone directory; and hence, that even when it is demonstrated by clear and convincing evidence that a patient no longer wishes certain measures to be taken to preserve her life, it is up to the citizens of Missouri to decide, through their elected representatives, whether that wish will be honored.
>
> (*Cruzan v. Director, Missouri Department of Health*, 1990, p. 294)

Besides the states' rights issue expounded upon by Scalia, there are three additional main points to his argument that should be re-emphasized:

a. Instead of relying on precedent (*stare decisis*), the Supreme Court has been confusing the enterprise of legislating with the enterprise of ruling on the law.
b. The Justices, as ordinary human beings, are incapable of deciding the point at which an individual's life becomes "worthless" and the point at which the means necessary to preserve it become "extraordinary" or "inappropriate."
c. The Due Process Clause of the Fourteenth Amendment is not an unconditional protection against all deprivations of liberty, including substantive restrictions. Justice Scalia's reasoning in his concurring opinion in the *Cruzan* case has been reinforced by the majority opinion in the *Murphy v. NCAA et al* case. Even though the *Murphy* case was a Tenth Amendment state's rights case and not a Fourteenth Amendment rights case, the Court's decision in the case followed Scalia's thinking that the federal government has no business in mandating how states should deal with the issue of gambling. The Court's 6-3 decision overruled the Third Circuit Court of Appeals, saying a 1995 federal law violated the state's (New Jersey) Tenth Amendment right to allow gambling on sports.

The *Murphy* case and Justice Scalia's concurring opinion in *Cruzan* are presented to emphasize the fact that the current Supreme Court may use this type of contemporary precedent to decide that the issue of "a right to assisted suicide" should be left to each individual state to decide. To put it another way, this directional approach by the court to the issue of gambling provides a legal opportunity and platform for the Court to not deal with the issue of assisted suicide. Since the 10th Amendment to the Constitution helps

define the concept of federalism (the constitutional division of power between U.S. state governments and the federal government of the United States), the Supreme Court could easily rule that the issue of assisted suicide should be reserved to each state (and therefore to its citizenry). Instead of dealing with the issue of assisted suicide on a federal level, as the Court has done with so many socially relevant issue cases, the justices could choose this Tenth Amendment path (as it did in *Murphy*), thus leaving it up to each state, and the proponents and opponents of assisted suicide in each state, to continue the time-consuming, expensive and litigation laden battle over assisted suicide.

In many of its rulings on socially relevant issues, the Supreme Court has extended the Fourteenth Amendment rights of equal protection and substantive due process beyond what the framers originally intended. However, if a majority of the Justices on the current Supreme Court adopt Scalia's approach from his concurring opinion in Cruzan and/or apply the Tenth Amendment argument in *Murphy,* the issue of assisted suicide will be relegated back to the slow, expensive and exasperating approach of each individual state dealing with assisted suicide.

On the state side of the ledger, in 2009, Justice James C. Nelson of the Supreme Court of Montana in the case of *Baxter v. Montana*, wrote an opinion that perhaps stated the best legal and practical reasoning for allowing individuals the right to physician aid in dying. Unfortunately, his opinion was never adopted by most of the judges and justices in the federal court system.

Justice Nelson stated in his twenty four-page concurring opinion that "physician aid in dying" is protected by the Montana Constitution "as a matter of privacy and as a matter of individual dignity" (*Baxter v. Montana*, 2009, p. 477). The first part of Justice

Nelson's analysis dealt with the issue of "public policy" and whether physician aid in dying is against it. He opined that physician aid in dying was not against public policy, as the majority opinion in the case stated.

But the most important part of Justice Nelson's opinion was based both on constitutional and practical grounds. He started by saying that the *Baxter* case (aid in dying so as to die with dignity) was "most fundamentally and quintessentially a matter of human dignity" (*Baxter v. Montana*, 2009, p. 480). His position was that the *Baxter* case was not about the "right to die." "The notion that there is such a 'right' is patently absurd, if not downright silly. No constitution, no statute, no legislation, and no court can grant an individual the 'right to die.' Nor can they take such a right away" (*Baxter v. Montana*, 2009, p. 481). Justice Nelson also stated, "The only "right" guaranteed to him in any of these decisions is the right to preserve his personal autonomy and his individual dignity, as he sees fit, in face of an ultimate destiny that no power on earth can prevent" (*Baxter v. Montana*, 2009, p. 481).

Justice Nelson listed seven "nonexclusive reasons" for his approach to the issue of assisted suicide and why he uses certain terminology in explaining his legal opinion (*Baxter v. Montana*, 2009, p. 481). Each reason is important, but the first two especially bear mentioning;

> First, the amount of physical, emotional, spiritual and mental suffering that one is willing or able to endure is uniquely and solely a matter of individual constitution, conscience and personal autonomy. Second, "suffering" in this expansive sense may implicate a person's uniquely personal perception of his "quality of life." This perception may be informed by, among other things, one's level of suffering,

> one's loss of personal autonomy, one's ability to make choices about his situation, one's ability to communicate, one's perceived loss of value to self and others, one's ability to care for his personal needs and hygiene, one's loss of dignity, one's financial situation and concern over the economic burdens of prolonged illness, and one's level of tolerance for the invasion of personal privacy and individual dignity that palliative treatment necessarily involves.
>
> (*Baxter v. Montana*, 2009, p. 488)

Justice Nelson's concurring opinion provides a portion of the answer to research question 5 as to the legal concept of precedent, but it also supports the new paradigm of individualized ideological-thinking pronounced by Toobin (2007). In addition, it gives Rohr's legion of public administrators appropriate guidance in looking at a state constitution to interpret and explain the precedents set in previous cases and why the ruling (opinion) should be followed. This way, public administrators will be following the "constitutional direction" as mandated in their oaths of office and as directed by Rohr (1986).

Also, if there is a new directional, politically-motivated revolution of individualized ideological-directed thinking paradigm to follow, Justice Nelson's concurring opinion could represent the approach of the new paradigm if adopted by the Supreme Court. But if the Supreme Court follows its own precedent as to the issue of assisted suicide, chooses to follow the Tenth Amendment thinking espoused in *Murphy* and/or opts not to include the issue of assisted suicide in its expansive approach to the Fourteenth Amendment, this extremely important current social issue will remain unresolved and in conflict on a national level.

As far back as 1986, an appellate court judge in California seemed to look far into the future through some type of legal looking glass relative to the issue of assisted suicide. Justice J. Compton of the Court of Appeals of California, Second Appellate District, in the case of *Bouvia v. Superior Court (Glenchur)* wrote a concurring opinion that reads as if it is written to solve the conundrum of assisted suicide in 2018.

Petitioner Elizabeth Bouvia was a patient in a public hospital and sought the removal from her body of a nasogastric tube inserted and maintained against her will and without her consent by physicians who so placed it for the purpose of keeping her alive through involuntary forced feeding. Elizabeth was a 28-year-old woman who since her birth had been afflicted with and suffered from severe cerebral palsy. She was quadriplegic (*Bouvia v. Superior Court of California*, 1986, p. 1128).

Justice Compton wrote a lengthy concurring opinion which held that all tubes should be removed from the patient (Bouvia), thus allowing her to end her life. The main focus in his opinion was the "integral part of our right to control our own destinies and freedom of choice."

> Elizabeth apparently has made a conscious and informed choice that she prefers death to continued existence in her helpless and, to her, intolerable condition. I believe she has an absolute right to effectuate that decision. The right to die is an integral part of our right to control our own destinies so long as the rights of others are not affected. That right should, in my opinion, include the ability to enlist assistance from others, including the medical profession, in making death as painless and quick as possible.

> If there is ever a time when we ought to be able to get the "government off our backs" it is when we face death–either by choice or otherwise.
>
> (*Bouvia v. Superior Court of California*, 1986, p. 1147)

The court in which Justice Compton presided was an appellate court in the state of California court system, not a circuit court of appeals in the federal system. As previously stated, the trial court in California had originally ruled against the Petitioner (Elizabeth Bouvia); therefore, she filed a writ of mandamus (a prayer for an order commanding an inferior tribunal or individual to perform, or refrain from performing, a particular act, the performance or omission of which is required by law) in the state appellate court seeking the relief from the trial court's ruling. The Respondents in the case, the Superior Court of Los Angeles County (the trial court) and Harry Glenchur (Hospital Administrator), did not appear and were unrepresented at the court hearing. This fact demonstrates the position of the defendants, in that they did not want to object on the appellate court record or stand in the way of the relief being sought by the Petitioner. The precedent (stare decisis) set by this appellate court decision only had to be followed by state trial courts under the jurisdiction of the second appellate division in California. No other trial court or appellate court in the state of California, nor any federal court in California or any other state had to follow this decision.

If Justice Compton's ruling had been in the federal court system and had become the law (because of precedent/stare decisis) on a national basis, it could have saved many individuals countless hours of pain and agony in facing their own choice about dying. It could have also saved untold millions of dollars in litigation costs and expenses relative to this most important private and personal decision about dying.

Before moving on to Part E of Chapter 5, which expounds upon the proposed new public policy law for dealing with the issue of assisted suicide, three more findings from Chapters II and IV need to be recapitulated for the purposes of answering research question number 5.

In Supreme Court Justice Neil Gorsuch's 2006 book, *The Future of Assisted Suicide and Euthanasia,* and as previously stated in Chapter 2 herein, he forewarned his readers in the first sentence on page 1 that "Whether or not to permit assistance in suicide and euthanasia is among the most contentious legal and public policy questions in America today" (Gorsuch, 2006, p. 1). His stance and opinion as to the issue of assisted suicide is clearly expressed in Chapters 9 and 10, where he outlines "the second purpose of the book, that being an extensive argument for retaining current laws banning assisted suicide and euthanasia based on the idea that all human beings are intrinsically valuable and the intentional taking of human life by private persons is always wrong" (Gorsuch, 2006, pp. 4-5).

Justice Gorsuch first gives a complete and thorough examination of the issues of assisted suicide and euthanasia in the first eight chapters of his book using mostly a legal lens of study approach as he expounds upon, among other broad topics, the history of the issues going back to the days of Socrates and Plato (400 BC), the legal history of the issues in the United States beginning with the Supreme Court case of *Marbury v. Madison* in 1803 and continuing with case rulings dealing with assisted suicide and the Fourteenth Amendment up to 2005, the principles of autonomy, the law of unintended consequences, the utilitarian case for assisted suicide and the libertarian case for assisted suicide. Justice Gorsuch, in what he describes as a march "toward a consistent end-of-life

ethic," leaves only a very slight crack in the door of his "taking of human life by private persons is always wrong" position (as espoused on page 5) as he discusses what to do when a competent individual or a parent or guardian of a minor asks that either medical treatment be terminated or medical treatment be refused (Gorsuch 2006, p. 181). That slight crack in the door is based upon his examination of 15 medical cases (including *Bouvia*, see above) and then concluding with the directive that the medical profession and the States should continue to approach these cases on an individual basis.

Justice Gorsuch's stance and opinion help answer both parts of research question 5. Case law is present and will continue to direct public administrators in their principles of policy when dealing with the issue of assisted suicide. His foundational legal constitutional directive to public administrators on this very important public policy issue is that "taking of human life by private persons is always wrong." As to cases dealing with competent individuals and parents or guardians of minors as described herein above, the public administrator must follow the mandates, whatever they may be, on a case by case basis.

Gorsuch's personal ideology, as espoused in Chapters 9 and 10, apparently provides his most important motivation in dealing with the issue of assisted suicide and shows that his position on the future of assisted suicide laws in the United States is that the issue should be left up to the states, and the states should not allow assisted suicide other than in extremely narrowly defined individual cases.

The second finding to be re-emphasized from Chapters 2 and 4 centers directly around Toobin's theory that justices of the Supreme Court are increasingly motivated not by the Constitution but by politics and personal ideology. Seven key legal opinions

already discussed at length in the previous mentioned chapters were *Roe v. Wade* (1973), *Compassion in Dying v. State of Washington* 1996), *Planned Parenthood v. Casey* (1992)*, Cruzan v. Director, Missouri Department of Health* (1990)*, Vacco v. Quill* (1997)*, Lawrence v. Texas* (2003) *and Obergefell v. Hodges* (2015)*. Roe v. Wade* was decided in 1973 by the Supreme Court and dealt with the issue of abortion. It is a freedom of choice case which the justices neatly fit into their Fourteenth Amendment reasoning. It is an outlier, both as to date (1973) and subject matter as far as the issue of assisted suicide is concerned, but not as to public opinion as previously discussed. However, as to the ideologically-directed thinking of judges and justices, it signaled the beginning not of Toobin's theory per se, but as a decisive directional shift in the legal paradigm as to his theory.

Beginning in 1990, in the case of *Cruzan v. Director, Missouri Department of Health*, a majority of the justices separately declared that a competent person has a constitutionally protected right to refuse life-saving hydration and nutrition. This type of reasoning was a precursor to Judge Barbara Rothstein's decision in *Compassion in Dying v. State of Washington* in 1994. Judge Rothstein clearly and unabashedly opined and therefore began the drumbeat for the diatribes which would follow by using personal ideology (and the precedent of *Planned Parenthood v. Casey* in her decision) in saying that "assisted suicide is a right guaranteed by the Constitution because there is a liberty to define one's own concept of existences, of meaning, of the universe and the mystery of life" even though none of those words can be found in the document itself (*Compassion in Dying v. State of Washington*, 1994, p. 1450).

Even though the justices voted unanimously in *Vacco v. Quill* not to allow assisted suicide, several of them wrote concurring opinions putting forth reasons and directions for why laws about assisted suicide may be changing in the future. For example, Justice Sandra Day O'Connor suggested that "states should remain free to balance the interests of terminally ill patients and the interests of society," much as Justice Scalia had stated in *Cruzan* (*Vacco v. Quill*, 1997, p. 736).

Although the cases of *Lawrence v. Texas* (2003) and *Obergefell v. Hodges* (2015) were not assisted suicide cases, the Justices reversed precedent and the Court's own historical approach to substantive due process under the Fourteenth Amendment in overturning a sodomy conviction (Lawrence) and granting the right to same-sex marriage (Obergefell) by "relying on its own understanding of the nature of liberty" (Myers, 2016, p. 397). The rulings were also in line with the majority of the public's opinion as to the actions of consenting adults and same-sex marriage.

Toobin's theory was propounded in 2007 in his book *The Nine* as stated in Chapters 2 and 4. Since 2007, Toobin's theory that Justices of the Supreme Court are increasingly motivated not by the Constitution but by politics and personal ideology when deciding 14th Amendment cases seems to be coming into full realization right before our very eyes. However, in looking back to 1973 and *Roe v. Wade* or at the very least to 1990 and *Cruzan* or 1994 and *Compassion in Dying*, it does seem that Toobin's theory has been in the making for a while.

The third finding from Chapters 2 and 4 which needs to be briefly re-stated is that the research and information contained in Chapters 2 and 4 show ample evidence that the theories of Rohr and Toobin propounded in research question 5 can co-exist.

The future conundrum for Rohr's theory has already been stated. What happens if public administrators choose not to follow the edicts of the various courts (especially the Supreme Court) and decline to follow the decades old mandate of Rohr that their regime values (principles of policy) should be constitutionally-directed because they disagree with the ruling or the politician they work for tells them to disregard it? What immediately comes to mind is the conflict currently playing out within the realm of the issue of immigration: federal policy and federal law on one side and the adversarial directions taken by "sanctuary cities" on the other. Could the same happen concerning the issue of assisted suicide if and when the Supreme Court decides to rule on the matter?

In answering research question 5, two surprising issues were discovered. The first issue is that no one had put forth Toobin's theory before 2006. The important cases researched and analyzed show that judges and Justices have been "creating" law for years from their own personal ideology. The second surprise is that no one has put forth the latest conundrum that may be facing some public administrators, that being a directive from their superiors not to follow certain judicial opinions and therefore not be constitutionally-directed in their principles of policy by the "rule of case law." The "sanctuary cities" example in the previous paragraph immediately comes to mind, as do some of the choices made by "street level bureaucrats" (police, teachers, case workers) not to enforce common marijuana possession laws because these laws are not a priority to their own individual goals, caseloads or positions.

The direction the courts will go in concerning the future of assisted suicide laws in the United States, as well as what impact the personal ideology of the judges and justices will have, is anyone's guess. The inability of individuals to choose assisted

suicide as an end-of-life option is sufficient reasoning for advocates to support the idea of a federal statute supporting this proposal.

Part E—A proposed federal law following constitutional principles and based on common sense, compassion and dignity

Making states face the issue of assisted suicide on an individual basis, waiting for the "perfect storm" case to land in front of the Supreme Court, or allowing the status quo to prevail will do nothing but waste more money and time relative to the issue of assisted suicide. The best approach to this issue on a national basis is the promulgation of a federal law that allows for assisted suicide for those wishing to choose this end-of -life option. The law would include an option by the states to add parameters to the statutory law, as long as they are not too restrictive or constricting.

Others may suggest taking the constitutional amendment route in order to deal with the issue of assisted suicide. This route would likely be unsuccessful since there have been 11,539 proposals for constitutional amendments made since 1789 (currently about 100 per legislative session) and a major part of the amendment procedure calls for the proposal to be ratified by three-fourths of the states (in this case, 38 of 50 states) and only 27 have been ratified (Rifkin, 2017, p. 3).

A federal statute similar to the following example would allow for healthcare professionals to assist individuals who request aid-in-dying in any state and also grant the states the ability to add mandates to the process, as long as the mandates are not too restrictive upon the individual requesting the aid-in-dying or the process.

Proposed Federal Statute

Section: Title 42 – The Public Health and Welfare

Formal Number: Chapter 117A - 2018-3446489-263-2667277466

Name of Statute: Assisted Right-to-Die with Aid from a Healthcare Professional

Section 1 - Findings and purpose:

(a) Findings

Congress finds the following:

(1) The Federal Government provides financial support for the provision of and payment for health care services, including those for futile medical procedures at end-of-life, as well as for advocacy activities to protect the rights of individuals.

(2) It has become lawful in areas of the United States to furnish assistance and services in support of aid-in-dying, known as assisted suicide support, when an individual has been determined to be terminally ill with limited life expectancy.

(b) Purpose

(1) It is, therefore, the principal purpose of the chapter to provide a pathway to create a uniform policy that will allow any citizen of the United States to have control over end of life decisions, as long as those decisions are made in counsel with a physician, who will state in writing that the person is terminally ill or irreparably injured with no hope for recovery.

Section 2 – Allowance for assisted suicide

(a) Allowance

(1) Any and all citizens of the United States, residing in any State in the United States, and who have been determined by a two physicians to be terminally ill

with a life expectancy of six months or less, may voluntarily choose to end their own lives by way of assisted suicide using medication prescribed by a healthcare professional.

(2) This federal law shall nullify and/or override any State law disallowing assisted suicide and/or punishing any healthcare individual who assists in ending an individual's life.

Section 3 – Allowance for States to add compliance policies to end-of-life procedure:

(1) Any State may add mandates or compliance policies to this law and create regulatory policy, but said mandates and compliance policies may not be in conflict with other federal health care laws or policies (such as Medicare and Medicaid), and said mandates, policies and regulations must not interfere with the individual's right to request and receive aid in dying.

(2) Recommendations for mandates or compliance policies may include the following:

(a) A minimum age for the person making the request

(b) Definition of illness (such as severe, terminal, unbearable, irremediable or incurable)

(c) Definition for the physician assisting in the end-of-life process and procedure

(d) Type and number of requests (oral or written)

(e) Number of meetings with healthcare professional

(f) Counseling requirement

(g) Record keeping (before and after procedure)

Section 4 – Effective Date

(1) The provisions of this Act take effect upon its enactment (October 1, 2018).

END OF PROPOSED FEDERAL STATUTE

It is understood that this approach of using a federal statute to deal with the issue of assisted suicide on a national level will not be an easy legal road to travel. It is also understood that any statute and the terminology contained therein will be bombarded with lawsuits, suggestions, changes, suggested revisions and the like.

However, there is legal precedent for this approach. This statutory process is referred to by many as an "informal amendment" to the Constitution (Constitutional Amendments, 2010. p. 1). Sometimes the U. S. Constitution changes because society, judges and lawmakers reinterpret it over time. An older example is the circumstantial societal change which took place when the movement to expand voting rights in federal elections from "only land-holding white males" to all males in the burgeoning middle class at the peak of the Industrial Revolution in the 1800s. Society as a whole became very focused on expanding rights for the middle and working classes. This eventually led to the right to vote being extended to more and more of the middle and working class males because of the societal focus on universal male suffrage, causing the Constitution to informally change (Amending the Constitution, 2012, p. 5).

A second method is judicial review. When the Supreme Court decides if a law is constitutional, this somewhat controversial process creates another "informal amendment" to the Constitution (*Marbury v. Madison*, 1803, p. 137). "Informal amendment" means that the Constitution does not specifically list these forms of

amending the Constitution, but because of a change in society or because of judicial review, the rule of law changes "de facto" (in fact, or in effect, whether by right or not). These methods depend on interpretations of what the Constitution says and on interpretive understanding of the underlying intent (Amending the Constitution, 2012, p. 6).

The federal statute approach would propel the issue immediately to the Supreme Court if any state filed a lawsuit trying to nullify the proposed law since the Supreme Court has original jurisdiction over cases involving states and the federal government (Federal Judicial Center, 2010, p. 1).

This recommendation may be the legal path with the best chance of success to end the confusion and extremely negative discord over the issue of assisted suicide. This policy simply proposes a dignified, compassionate and common sense approach to a public policy healthcare model allowing assisted suicide decisions to be made voluntarily by competent adults without fear of prosecution and/or the exhaustive use of protracted litigation.

Thomas Paine, political activist & theorist, philosopher and revolutionary, was quoted as saying, "Nothing, they say is more certain than death, and nothing more uncertain than the time of dying" (Thomas Paine-Quotes, 2012). We do not have a choice as to whether we are going to die. But as so eloquently opined by Justice Compton in 1986, by Justice Nelson in 2009, and by several other jurists over the past 30 plus years, shouldn't we have a choice in selecting the time and the place to die?

Limitations of study

Although past knowledge and discernible legal facts clearly emphasized "the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law" (Union Pacific Railway Company, 1891), the diametrically opposite points of view and opinions of legal experts were underestimated at the beginning of this dissertation. This fact per se did not limit the study, but it is a fact that should be recognized when conducting comprehensive research for any socially relevant issue such as assisted suicide.

Challenges in any policy evaluation study include the constantly shifting sands of public opinion, continual movements of lawmakers and public administrators, and state and federal court rulings. These are not true limitations of the study, but significant issues that need to be considered and updated before completion.

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APPENDICES LIST

APPENDIX A
Fourteenth Amendment to the United States Constitution

APPENDIX A

Fourteenth Amendment to the United States Constitution

Section 1

All persons born or naturalized in the United States and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

Section 2

Representatives shall be apportioned among the several States according to their respective numbers, counting the whole number of persons in each State, excluding Indians not taxed. But when the right to vote at any election for the choice of electors for President and Vice President of the United States,

Representatives in Congress, the Executive and Judicial officers of a State, or the members of the Legislature thereof, is denied to any of the male inhabitants of such State, being twenty-one years of age, and citizens of the United States, or in any way abridged, except for participation in rebellion, or other crime, the basis of representation therein shall be reduced in the proportion which the number of male citizens shall bear to the whole number of male citizens twenty-one years of age in such State.

Section 3

No person shall be a Senator or Representative in Congress, or elector of President and Vice President, or hold any office, civil or military, under the United States, or under any State, who, having previously taken an oath, as a member of Congress, or as an officer of the United States, or as a member of any State legislature, or as an executive or judicial officer of any State, to support the Constitution of the United States, shall have engaged in insurrection or rebellion against the same, or given aid or comfort to the enemies thereof. But Congress may by a vote of two-thirds of each House, remove such disability.

Section 4

The validity of the public debt of the United States, authorized by law, including debts incurred for payment of pensions and bounties for services in suppressing insurrection or rebellion, shall not be questioned. But neither the United States nor any State shall assume or pay any debt or obligation incurred in aid of insurrection or rebellion against the United States, or any claim for the loss or emancipation of any slave; but all such debts, obligations and claims shall be held illegal and void.

Section 5

The Congress shall have the power to enforce, by appropriate legislation, the provisions of this article.

APPENDIX B
State of Oregon Statute

APPENDIX B
State of Oregon Statute
THE OREGON DEATH WITH DIGNITY ACT
OREGON REVISED STATUTES

(General Provisions)

(Section 1)

Note: The division headings, subdivision headings and lead-lines for 127.800 to 127.890, 127.895 and 127.897 were enacted as part of Ballot Measure 16 (1994) and were not provided by Legislative Counsel.

127.800 §1.01. Definitions. The following words and phrases, whenever used in ORS 127.800 to 127.897, have the following meanings:

(1) "Adult" means an individual who is 18 years of age or older.

(2) "Attending physician" means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.

(3) "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.

(4) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.

(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.

(6) "Health care provider" means a person licensed, certified or otherwise authorized or permitted by the law of this state to administer health care or dispense medication in the ordinary course of business or practice of a profession, and includes a health care facility.

(7) "Informed decision" means a decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an

appreciation of the relevant facts and after being fully informed by the attending physician of:

(a) His or her medical diagnosis;

(b) His or her prognosis;

(c) The potential risks associated with taking the medication to be prescribed;

(d) The probable result of taking the medication to be prescribed; and

(e) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

(8) “Medically confirmed” means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the patient and the patient’s relevant medical records.

(9) “Patient” means a person who is under the care of a physician.

(10) “Physician” means a doctor of medicine or osteopathy licensed to practice medicine by the Board of Medical Examiners for the State of Oregon.

(11) “Qualified patient” means a capable adult who is a resident of Oregon and has satisfied the requirements of ORS 127.800 to 127.897 in order to obtain a prescription for medication to end his or her life in a humane and dignified manner.

(12) ""terminal disease” means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months. [1995 c.3 §1.01; 1999 c.423 §1]

(Written Request for Medication to End One’s Life in a Humane and Dignified Manner)

(Section 2)

127.805 §2.01. Who may initiate a written request for medication.

(1) An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with ORS 127.800 to 127.897.

(2) No person shall qualify under the provisions of ORS 127.800 to 127.897 solely because of age or disability. [1995 c.3 §2.01; 1999 c.423 §2]

127.810 §2.02. Form of the written request. (1) A valid request for medication under ORS 127.800 to 127.897 shall be in substantially the form described in ORS 127.897, signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, 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.

(2) One of the witnesses shall be a person who is not:

(a) A relative of the patient by blood, marriage or adoption;

(b) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or

(c) An owner, operator or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.

(3) The patient's attending physician at the time the request is signed shall not be a witness.

(4) If the patient is a patient in a long term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility and having the qualifications specified by the Department of Human Services by rule. [1995 c.3 §2.02] (Safeguards)

(Section 3)

127.815 §3.01. Attending physician responsibilities.

(1) The attending physician shall:

(a) Make the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily;

(b) Request that the patient demonstrate Oregon residency pursuant to ORS 127.860;

(c) To ensure that the patient is making an informed decision, inform the patient of:

(A) His or her medical diagnosis;

(B) His or her prognosis;

(C) The potential risks associated with taking the medication to be prescribed;

(D) The probable result of taking the medication to be prescribed; and

(E) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control;

(d) Refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily;
(e) Refer the patient for counseling if appropriate pursuant to ORS 127.825;
(f) Recommend that the patient notify next of kin;
(g) Counsel the patient about the importance of having another person present when the patient takes the medication prescribed pursuant to ORS 127.800 to 127.897 and of not taking the medication in a public place;
(h) 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 at the end of the 15 day waiting period pursuant to ORS 127.840;
(i) Verify, immediately prior to writing the prescription for medication under ORS 127.800 to 127.897, that the patient is making an informed decision;
(j) Fulfill the medical record documentation requirements of ORS 127.855;
(k) Ensure that all appropriate steps are carried out in accordance with ORS 127.800 to 127.897 prior to writing a prescription for medication to enable a qualified patient to end his or her life in a humane and dignified manner; and
(L)(A) Dispense medications directly, including ancillary medications intended to facilitate the desired effect to minimize the patient's discomfort, provided the attending physician is registered as a dispensing physician with the Board of Medical Examiners, has a current Drug Enforcement Administration certificate and complies with any applicable administrative rule; or
(B) With the patient's written consent:
(i) Contact a pharmacist and inform the pharmacist of the prescription; and
(ii) Deliver the written prescription personally or by mail to the pharmacist, who will dispense the medications to either the patient, the attending physician or an expressly identified agent of the patient.
(2) Notwithstanding any other provision of law, the attending physician may sign the patient's death certificate. [1995 c.3 §3.01; 1999 c.423 §3]
127.820 §3.02. Consulting physician confirmation.
Before a patient is qualified under ORS 127.800 to 127.897, a consulting physician shall examine the patient and his or her relevant medical records and confirm, in writing, the

attending physician's diagnosis that the patient is suffering from a terminal disease, and verify that the patient is capable, is acting voluntarily and has made an informed decision. [1995 c.3 §3.02]

127.825 §3.03. Counseling referral. If in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient for counseling. No medication to end a patient's life in a humane and dignified manner shall be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment. [1995 c.3 §3.03; 1999 c.423 §4]

127.830 §3.04. Informed decision.

No person shall receive a prescription for medication to end his or her life in a humane and dignified manner unless he or she has made an informed decision as defined in ORS 127.800 (7). Immediately prior to writing a prescription for medication under ORS 127.800 to 127.897, the attending physician shall verify that the patient is making an informed decision. [1995 c.3 §3.04]

127.835 §3.05. Family notification.

The attending physician shall recommend that the patient notify the next of kin of his or her request for medication pursuant to ORS 127.800 to 127.897. A patient who declines or is unable to notify next of kin shall not have his or her request denied for that reason. [1995 c.3 §3.05; 1999 c.423 §6]

127.840 §3.06. Written and oral requests.

In order to receive a prescription for medication to end his or her life in a humane and dignified manner, a qualified patient shall have made an oral request and a written request, and reiterate the oral request to his or her attending physician no less than fifteen (15) days after making the initial oral request. At the time the qualified patient makes his or her second oral request, the attending physician shall offer the patient an opportunity to rescind the request. [1995 c.3 §3.06]

127.845 §3.07. Right to rescind request.

A patient may rescind his or her request at any time and in any manner without regard to his or her mental state. No prescription for medication under ORS 127.800 to 127.897 may

be written without the attending physician offering the qualified patient an opportunity to rescind the request. [1995 c.3 §3.07]

127.850 §3.08. Waiting periods.

No less than fifteen (15) days shall elapse between the patient's initial oral request and the writing of a prescription under ORS 127.800 to 127.897. No less than 48 hours shall elapse between the patient's written request and the writing of a prescription under ORS 127.800 to 127.897. [1995 c.3 §3.08]

127.855 §3.09. Medical record documentation requirements.

The following shall be documented or filed in the patient's medical record:

(1) All oral requests by a patient for medication to end his or her life in a humane and dignified manner;

(2) All written requests by a patient for medication to end his or her life in a humane and dignified manner;

(3) The attending physician's diagnosis and prognosis, determination that the patient is capable, acting voluntarily and has made an informed decision;

(4) The consulting physician's diagnosis and prognosis, and verification that the patient is capable, acting voluntarily and has made an informed decision;

(5) A report of the outcome and determinations made during counseling, if performed;

(6) The attending physician's offer to the patient to rescind his or her request at the time of the patient's second oral request pursuant to ORS 127.840; and

(7) A note by the attending physician indicating that all requirements under ORS 127.800 to 127.897 have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed. [1995 c.3 §3.09]

127.860 §3.10. Residency requirement.

Only requests made by Oregon residents under ORS 127.800 to 127.897 shall be granted. Factors demonstrating Oregon residency include but are not limited to:

(1) Possession of an Oregon driver license;

(2) Registration to vote in Oregon;

(3) Evidence that the person owns or leases property in Oregon; or

(4) Filing of an Oregon tax return for the most recent tax year. [1995 c.3 §3.10; 1999 c.423 §8]

127.865 §3.11. Reporting requirements.

(1)(a) The Department of Human Services shall annually review a sample of records maintained pursuant to ORS 127.800 to 127.897.

(b) The department shall require any health care provider upon dispensing medication pursuant to ORS 127.800 to 127.897 to file a copy of the dispensing record with the department.

(2) The department shall make rules to facilitate the collection of information regarding compliance with ORS 127.800 to 127.897. Except as otherwise required by law, the information collected shall not be a public record and may not be made available for inspection by the public.

(3) The department shall generate and make available to the public an annual statistical report of information collected under subsection (2) of this section. [1995 c.3 §3.11; 1999 c.423 §9; 2001 c.104 §40]

127.870 §3.12. Effect on construction of wills, contracts and statutes.

(1) No provision in a contract, will or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end his or her life in a humane and dignified manner, shall be valid.

(2) No obligation owing under any currently existing contract shall be conditioned or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. [1995 c.3 §3.12]

127.875 §3.13. Insurance or annuity policies.

The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. Neither shall a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner have an effect upon a life, health, or accident insurance or annuity policy. [1995 c.3 §3.13]

127.880 §3.14. Construction of Act.

Nothing in ORS 127.800 to 127.897 shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with ORS 127.800 to 127.897 shall not, for any purpose,

constitute suicide, assisted suicide, mercy killing or homicide, under the law. [1995 c.3 §3.14]

(Immunities and Liabilities)

(Section 4)

127.885 §4.01.

Immunities; basis for prohibiting health care provider from participation; notification; permissible sanctions. Except as provided in ORS 127.890:

(1) No person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with ORS 127.800 to 127.897. This includes being present when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner.

(2) No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith compliance with ORS 127.800 to 127.897.

(3) No request by a patient for or provision by an attending physician of medication in good faith compliance with the provisions of ORS 127.800 to 127.897 shall constitute neglect for any purpose of law or provide the sole basis for the appointment of a guardian or conservator.

(4) No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's request under ORS 127.800 to 127.897, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.

(5)(a) Notwithstanding any other provision of law, a health care provider may prohibit another health care provider from participating in ORS 127.800 to 127.897 on the premises of the prohibiting provider if the prohibiting provider has notified the health care provider of the prohibiting provider's policy regarding participating in ORS 127.800 to 127.897.

Nothing in this paragraph prevents a health care provider from providing health care services to a patient that do not constitute participation in ORS 127.800 to 127.897.

(b) Notwithstanding the provisions of subsections (1) to (4) of this section, a health care provider may subject another health care provider to the sanctions stated in this paragraph if the sanctioning health care provider has notified the sanctioned provider prior to participation in ORS 127.800 to 127.897 that it prohibits participation in ORS 127.800 to 127.897:

(A) Loss of privileges, loss of membership or other sanction provided pursuant to the medical staff bylaws, policies and procedures of the sanctioning health care provider if the sanctioned provider is a member of the sanctioning provider's medical staff and participates in ORS 127.800 to 127.897 while on the health care facility premises, as defined in ORS 442.015, of the sanctioning health care provider, but not including the private medical office of a physician or other provider;

(B) Termination of lease or other property contract or other nonmonetary remedies provided by lease contract, not including loss or restriction of medical staff privileges or exclusion from a provider panel, if the sanctioned provider participates in ORS 127.800 to 127.897 while on the premises of the sanctioning health care provider or on property that is owned by or under the direct control of the sanctioning health care provider; or

(C) Termination of contract or other nonmonetary remedies provided by contract if the sanctioned provider participates in ORS 127.800 to 127.897 while acting in the course and scope of the sanctioned provider's capacity as an employee or independent contractor of the sanctioning health care provider. Nothing in this subparagraph shall be construed to prevent:

(i) A health care provider from participating in ORS 127.800 to 127.897 while acting outside the course and scope of the provider's capacity as an employee or independent contractor; or

(ii) A patient from contracting with his or her attending physician and consulting physician to act outside the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(c) A health care provider that imposes sanctions pursuant to paragraph (b) of this subsection must follow all due process and other procedures the sanctioning health care

provider may have that are related to the imposition of sanctions on another health care provider.

(d) For purposes of this subsection:

(A) "Notify" means a separate statement in writing to the health care provider specifically informing the health care provider prior to the provider's participation in ORS 127.800 to 127.897 of the sanctioning health care provider's policy about participation in activities covered by ORS 127.800 to 127.897.

(B) "Participate in ORS 127.800 to 127.897" means to perform the duties of an attending physician pursuant to ORS 127.815, the consulting physician function pursuant to ORS 127.820 or the counseling function pursuant to ORS 127.825. "Participate in ORS 127.800 to 127.897" does not include:

(i) Making an initial determination that a patient has a terminal disease and informing the patient of the medical prognosis;

(ii) Providing information about the Oregon Death with Dignity Act to a patient upon the request of the patient;

(iii) Providing a patient, upon the request of the patient, with a referral to another physician; or

(iv) A patient contracting with his or her attending physician and consulting physician to act outside of the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(6) Suspension or termination of staff membership or privileges under subsection (5) of this section is not reportable under ORS 441.820. Action taken pursuant to ORS 127.810, 127.815, 127.820 or 127.825 shall not be the sole basis for a report of unprofessional or dishonorable conduct under ORS 677.415 (2) or (3).

(7) No provision of ORS 127.800 to 127.897 shall be construed to allow a lower standard of care for patients in the community where the patient is treated or a similar community.

[1995 c.3 §4.01; 1999 c.423 §10]

Note: As originally enacted by the people, the lead line to section 4.01 read "Immunities." The remainder of the lead line was added by editorial action.

127.890 §4.02. Liabilities.

(1) A person who without authorization of the patient willfully alters or forges a request for medication or conceals or destroys a rescission of that request with the intent or effect of causing the patient's death shall be guilty of a Class A felony.
(2) A person who coerces or exerts undue influence on a patient to request medication for the purpose of ending the patient's life, or to destroy a rescission of such a request, shall be guilty of a Class A felony.
(3) Nothing in ORS 127.800 to 127.897 limits further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person.
(4) The penalties in ORS 127.800 to 127.897 do not preclude criminal penalties applicable under other law for conduct which is inconsistent with the provisions of ORS 127.800 to 127.897. [1995 c.3 §4.02]
127.892 Claims by governmental entity for costs incurred. Any governmental entity that incurs costs resulting from a person terminating his or her life pursuant to the provisions of ORS 127.800 to 127.897 in a public place shall have a claim against the estate of the person to recover such costs and reasonable attorney fees related to enforcing the claim. [1999 c.423 §5a]
(Severability)

(Section 5)
127.895 §5.01. Severability.
Any section of ORS 127.800 to 127.897 being held invalid as to any person or circumstance shall not affect the application of any other section of ORS 127.800 to 127.897 which can be given full effect without the invalid section or application. [1995 c.3 §5.01]

(Form of the Request)
(Section 6)
127.897 §6.01. Form of the request.
A request for a medication as authorized by ORS 127.800 to 127.897 shall be in substantially the following form:
REQUEST FOR MEDICATION

TO END MY LIFE IN A HUMANE
AND DIGNIFIED MANNER

I, _____, am an adult of sound mind.

I am suffering from _____, which my attending physician has determined is a terminal disease and which has been medically confirmed by a consulting physician.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care and pain control.

I request that my attending physician prescribe medication that will end my life in a humane and dignified manner.

INITIAL ONE:

_____ I have informed my family of my decision and taken their opinions into consideration.

_____ I have decided not to inform my family of my decision.

_____ I have no family to inform of my decision.

I understand that I have the right to rescind this request at any time.

I understand the full import of this request and I expect to die when I take the medication to be prescribed. I further understand that although most deaths occur within three hours, my death may take longer and my physician has counseled me about this possibility.

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

Signed: _____

Dated: _____

DECLARATION OF WITNESSES

We declare that the person signing this request:

(a) Is personally known to us or has provided proof of identity;

(b) Signed this request in our presence;

(c) Appears to be of sound mind and not under duress, fraud or undue influence;

(d) Is not a patient for whom either of us is attending physician.

_____Witness 1/Date

_____Witness 2/Date

NOTE: One witness shall not be a relative (by blood, marriage or adoption) of the person signing this request, shall not be entitled to any portion of the person's estate upon death and shall not own, operate or be employed at a health care facility where the person is a patient or resident. If the patient is an inpatient at a health care facility, one of the witnesses shall be an individual designated by the facility.

[1995 c.3 §6.01; 1999 c.423 §11]

PENALTIES

127.990: [Formerly part of 97.990; repealed by 1993 c.767 §29]

127.995 Penalties. (1) It shall be a Class A felony for a person without authorization of the principal to willfully alter, forge, conceal or destroy an instrument, the reinstatement or revocation of an instrument or any other evidence or document reflecting the principal's desires and interests, with the intent and effect of causing a withholding or withdrawal of life-sustaining procedures or of artificially administered nutrition and hydration which hastens the death of the principal.

(2) Except as provided in subsection (1) of this section, it shall be a Class A misdemeanor for a person without authorization of the principal to willfully alter, forge, conceal or destroy an instrument, the reinstatement or revocation of an instrument, or any other evidence or document reflecting the principal's desires and interests with the intent or effect of affecting a health care decision. [Formerly 127.585]

APPENDIX C
State of California Statute

APPENDIX C
State of California Statute

Assembly Bill No. 15

CHAPTER 1
An act to add and repeal Part 1.85 (commencing with Section 443) of Division 1 of the Health and Safety Code, relating to end of life.
[Approved by Governor October 5, 2015. Filed with Secretary of State October 5, 2015.]

AB 15, End of life.

Existing law authorizes an adult to give an individual health care instruction and to appoint an attorney to make health care decisions for that individual in the event of his or her incapacity pursuant to a power of attorney for health care.

This bill, until January 1, 2026, would enact the End of Life Option Act authorizing an adult who meets certain qualifications, and who has been determined by his or her attending physician to be suffering from a terminal disease, as defined, to make a request for a drug prescribed pursuant to these provisions for the purpose of ending his or her life. The bill would establish the procedures for making these requests. The bill would also establish specified forms to request an aid-in-dying drug, under specified circumstances, an interpreter declaration to be signed subject to penalty of perjury, thereby creating a crime and imposing a state-mandated local program, and a final attestation for an aid-in-dying drug. This bill would require specified information to be documented in the individual's medical record, including, among other things, all oral and written requests for an aid-in-dying drug.

This bill would prohibit a provision in a contract, will, or other agreement from being conditioned upon, or affected by, a person making or rescinding a request for the above-described drug. The bill would prohibit the sale, procurement, or issuance of any life, health, or annuity policy, health care service plan contract, or health benefit plan, or the rate charged for any policy or plan contract, from being conditioned upon or affected by the request. The bill would prohibit an insurance carrier from providing any information in communications made to an individual about the availability of an aid-in-dying drug absent a request by the individual or his or her attending physician at the behest of the individual. The bill would also prohibit any communication from containing both the denial of treatment and information as to the availability of aid-in-dying drug coverage.

This bill would provide a person, except as provided, immunity from civil or criminal liability solely because the person was present when the qualified individual self-administered the drug, or the person assisted the qualified individual by preparing the aid-in-dying drug so long as the person did not

assist with the ingestion of the drug, and would specify that the immunities and prohibitions on sanctions of a health care provider are solely reserved for conduct of a health care provider provided for by the bill. The bill would make participation in activities authorized pursuant to its provisions voluntary, and would make health care providers immune from liability for refusing to engage in activities authorized pursuant to its provisions. The bill would also authorize a health care provider to prohibit its employees, independent contractors, or other persons or entities, including other health care providers, from participating in activities under the act while on the premises owned or under the management or direct control of that prohibiting health care provider, or while acting within the course and scope of any employment by, or contract with, the prohibiting health care provider.

This bill would make it a felony to knowingly alter or forge a request for drugs to end an individual's life without his or her authorization or to conceal or destroy a withdrawal or rescission of a request for a drug, if it is done with the intent or effect of causing the individual's death. The bill would make it a felony to knowingly coerce or exert undue influence on an individual to request a drug for the purpose of ending his or her life, to destroy a withdrawal or rescission of a request, or to administer an aid-in-dying drug to an individual without their knowledge or consent. By creating a new crime, the bill would impose a state-mandated local program. The bill would provide that nothing in its provisions is to be construed to authorize ending a patient's life by lethal injection, mercy killing, or active euthanasia, and would provide that action taken in accordance with the act shall not constitute, among other things, suicide or homicide.

This bill would require physicians to submit specified forms and information to the State Department of Public Health after writing a prescription for an aid-in-dying drug and after the death of an individual who requested an aid-in-dying drug. The bill would authorize the Medical Board of California to update those forms and would require the State Department of Public Health to publish the forms on its Internet Web site. The bill would require the department to annually review a sample of certain information and records, make a statistical report of the information collected, and post that report to its Internet Web site.
Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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The people of the State of California do enact as follows:
SECTION 1. Part 1.85 (commencing with Section 443) is added to

Division 1 of the Health and Safety Code, to read:
PART 1.85. END OF LIFE OPTION ACT
443. This part shall be known and may be cited as the End of Life Option Act.
443.1. As used in this part, the following definitions shall apply:
(a) “Adult” means an individual 18 years of age or older.
(b) “Aid-in-dying drug” means a drug determined and prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about his or her death due to a terminal disease.
(c) “Attending physician” means the physician who has primary responsibility for the health care of an individual and treatment of the individual’s terminal disease.
(d) “Attending physician checklist and compliance form” means a form, as described in Section 443.22, identifying each and every requirement that must be fulfilled by an attending physician to be in good faith compliance with this part should the attending physician choose to participate.
(e) “Capacity to make medical decisions” means that, in the opinion of an individual’s attending physician, consulting physician, psychiatrist, or psychologist, pursuant to Section 4609 of the Probate Code, the individual has the ability to understand the nature and consequences of a health care decision, the ability to understand its significant benefits, risks, and alternatives, and the ability to make and communicate an informed decision to health care providers.
(f) “Consulting physician” means a physician who is independent from the attending physician and who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding an individual’s terminal disease.
(g) “Department” means the State Department of Public Health.
(h) “Health care provider” or “provider of health care” means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code; any person licensed pursuant to the Osteopathic Initiative Act or the Chiropractic Initiative Act; any person certified pursuant to Division 2.5 (commencing with Section 1797) of this code; and any clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200) of this code.
(i) “Informed decision” means a decision by an individual with a terminal disease to request and obtain a prescription for a drug that the individual may self-administer to end the individual’s life, that is based on an understanding and acknowledgment of the relevant facts, and that is made after being fully informed by the attending physician of all of the following:

(1) The individual’s medical diagnosis and prognosis.
(2) The potential risks associated with taking the drug to be prescribed.
(3) The probable result of taking the drug to be prescribed.
(4) The possibility that the individual may choose not to obtain the drug or may obtain the drug but may decide not to ingest it.
(5) The feasible alternatives or additional treatment opportunities, including, but not limited to, comfort care, hospice care, palliative care, and pain control.
(j) “Medically confirmed” means the medical diagnosis and prognosis of the attending physician has been confirmed by a consulting physician

who has examined the individual and the individual's relevant medical records.
(k) "Mental health specialist assessment" means one or more consultations between an individual and a mental health specialist for the purpose of determining that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.
(*l*) "Mental health specialist" means a psychiatrist or a licensed psychologist.
(m) "Physician" means a doctor of medicine or osteopathy currently licensed to practice medicine in this state.
(n) "Public place" means any street, alley, park, public building, any place of business or assembly open to or frequented by the public, and any other place that is open to the public view, or to which the public has access.
(o) "Qualified individual" means an adult who has the capacity to make medical decisions, is a resident of California, and has satisfied the requirements of this part in order to obtain a prescription for a drug to end his or her life.
(p) "Self-administer" means a qualified individual's affirmative, conscious, and physical act of administering and ingesting the aid-in-dying drug to bring about his or her own death.
(q) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months.
443.2. (a) An individual who is an adult with the capacity to make medical decisions and with a terminal disease may make a request to receive a prescription for an aid-in-dying drug if all of the following conditions are satisfied:
(1) The individual's attending physician has diagnosed the individual with a terminal disease.
(2) The individual has voluntarily expressed the wish to receive a prescription for an aid-in-dying drug.
(3) The individual is a resident of California and is able to establish residency through any of the following means:
(A) Possession of a California driver license or other identification issued by the State of California.
(B) Registration to vote in California.
(C) Evidence that the person owns or leases property in California.

(D) Filing of a California tax return for the most recent tax year.
(4) The individual documents his or her request pursuant to the requirements set forth in Section 443.3.
(5) The individual has the physical and mental ability to self-administer the aid-in-dying drug.
(b) A person shall not be considered a "qualified individual" under the provisions of this part solely because of age or disability.
(c) A request for a prescription for an aid-in-dying drug under this part shall be made solely and directly by the individual diagnosed with the terminal disease and shall not be made on behalf of the patient, including, but not limited to, through a power of attorney, an advance health care directive, a conservator, health care agent, surrogate, or any other legally recognized health care decisionmaker.
443.3. (a) An individual seeking to obtain a prescription for an

aid-in-dying drug pursuant to this part shall submit two oral requests, a minimum of 15 days apart, and a written request to his or her attending physician. The attending physician shall directly, and not through a designee, receive all three requests required pursuant to this section.
(b) A valid written request for an aid-in-dying drug under subdivision (a) shall meet all of the following conditions:
(1) The request shall be in the form described in Section 443.11.
(2) The request shall be signed and dated, in the presence of two witnesses, by the individual seeking the aid-in-dying drug.
(3) The request shall be witnessed by at least two other adult persons who, in the presence of the individual, shall attest that to the best of their knowledge and belief the individual is all of the following:
(A) An individual who is personally known to them or has provided proof of identity.
(B) An individual who voluntarily signed this request in their presence.
(C) An individual whom they believe to be of sound mind and not under duress, fraud, or undue influence.
(D) Not an individual for whom either of them is the attending physician, consulting physician, or mental health specialist.
(c) Only one of the two witnesses at the time the written request is signed may:
(1) Be related to the qualified individual by blood, marriage, registered domestic partnership, or adoption or be entitled to a portion of the individual's estate upon death.
(2) Own, operate, or be employed at a health care facility where the individual is receiving medical treatment or resides.
(d) The attending physician, consulting physician, or mental health specialist of the individual shall not be one of the witnesses required pursuant to paragraph (3) of subdivision (b).
443.4. (a) An individual may at any time withdraw or rescind his or her request for an aid-in-dying drug, or decide not to ingest an aid-in-dying drug, without regard to the individual's mental state.

(b) A prescription for an aid-in-dying drug provided under this part may not be written without the attending physician directly, and not through a designee, offering the individual an opportunity to withdraw or rescind the request.
443.5. (a) Before prescribing an aid-in-dying drug, the attending physician shall do all of the following:
(1) Make the initial determination of all of the following:
(A) (i) Whether the requesting adult has the capacity to make medical decisions.
(ii) If there are indications of a mental disorder, the physician shall refer the individual for a mental health specialist assessment.
(iii) If a mental health specialist assessment referral is made, no aid-in-dying drugs shall be prescribed until the mental health specialist determines that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.
(B) Whether the requesting adult has a terminal disease.
(C) Whether the requesting adult has voluntarily made the request for an aid-in-dying drug pursuant to Sections 443.2 and 443.3.
(D) Whether the requesting adult is a qualified individual pursuant to

subdivision (o) of Section 443.1.
(2) Confirm that the individual is making an informed decision by discussing with him or her all of the following:
(A) His or her medical diagnosis and prognosis.
(B) The potential risks associated with ingesting the requested aid-in-dying drug.
(C) The probable result of ingesting the aid-in-dying drug.
(D) The possibility that he or she may choose to obtain the aid-in-dying drug but not take it.
(E) The feasible alternatives or additional treatment options, including, but not limited to, comfort care, hospice care, palliative care, and pain control.
(3) Refer the individual to a consulting physician for medical confirmation of the diagnosis and prognosis, and for a determination that the individual has the capacity to make medical decisions and has complied with the provisions of this part.
(4) Confirm that the qualified individual's request does not arise from coercion or undue influence by another person by discussing with the qualified individual, outside of the presence of any other persons, except for an interpreter as required pursuant to this part, whether or not the qualified individual is feeling coerced or unduly influenced by another person.
(5) Counsel the qualified individual about the importance of all of the following:
(A) Having another person present when he or she ingests the aid-in-dying drug prescribed pursuant to this part.
(B) Not ingesting the aid-in-dying drug in a public place.

(C) Notifying the next of kin of his or her request for an aid-in-dying drug. A qualified individual who declines or is unable to notify next of kin shall not have his or her request denied for that reason.
(D) Participating in a hospice program.
(E) Maintaining the aid-in-dying drug in a safe and secure location until the time that the qualified individual will ingest it.
(6) Inform the individual that he or she may withdraw or rescind the request for an aid-in-dying drug at any time and in any manner.
(7) Offer the individual an opportunity to withdraw or rescind the request for an aid-in-dying drug before prescribing the aid-in-dying drug.
(8) Verify, immediately before writing the prescription for an aid-in-dying drug, that the qualified individual is making an informed decision.
(9) Confirm that all requirements are met and all appropriate steps are carried out in accordance with this part before writing a prescription for an aid-in-dying drug.
(10) Fulfill the record documentation required under Sections 443.8 and 443.19.
(11) Complete the attending physician checklist and compliance form, as described in Section 443.22, include it and the consulting physician compliance form in the individual's medical record, and submit both forms to the State Department of Public Health.
(12) Give the qualified individual the final attestation form, with the instruction that the form be filled out and executed by the qualified individual within 48 hours prior to the qualified individual choosing to self-administer

the aid-in-dying drug.
(b) If the conditions set forth in subdivision (a) are satisfied, the attending physician may deliver the aid-in-dying drug in any of the following ways:
(1) Dispensing the aid-in-dying drug directly, including ancillary medication intended to minimize the qualified individual's discomfort, if the attending physician meets all of the following criteria:
(A) Is authorized to dispense medicine under California law.
(B) Has a current United States Drug Enforcement Administration (USDEA) certificate.
(C) Complies with any applicable administrative rule or regulation.
(2) With the qualified individual's written consent, contacting a pharmacist, informing the pharmacist of the prescriptions, and delivering the written prescriptions personally, by mail, or electronically to the pharmacist, who may dispense the drug to the qualified individual, the attending physician, or a person expressly designated by the qualified individual and with the designation delivered to the pharmacist in writing or verbally.
(c) Delivery of the dispensed drug to the qualified individual, the attending physician, or a person expressly designated by the qualified individual may be made by personal delivery, or, with a signature required on delivery, by United Parcel Service, United States Postal Service, Federal Express, or by messenger service.

443.6. Before a qualified individual obtains an aid-in-dying drug from the attending physician, the consulting physician shall perform all of the following:
(a) Examine the individual and his or her relevant medical records.
(b) Confirm in writing the attending physician's diagnosis and prognosis.
(c) Determine that the individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision.
(d) If there are indications of a mental disorder, refer the individual for a mental health specialist assessment.
(e) Fulfill the record documentation required under this part.
(f) Submit the compliance form to the attending physician.
443.7. Upon referral from the attending or consulting physician pursuant to this part, the mental health specialist shall:
(a) Examine the qualified individual and his or her relevant medical records.
(b) Determine that the individual has the mental capacity to make medical decisions, act voluntarily, and make an informed decision.
(c) Determine that the individual is not suffering from impaired judgment due to a mental disorder.
(d) Fulfill the record documentation requirements of this part.
443.8. All of the following shall be documented in the individual's medical record:
(a) All oral requests for aid-in-dying drugs.
(b) All written requests for aid-in-dying drugs.
(c) The attending physician's diagnosis and prognosis, and the determination that a qualified individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision, or that the attending physician has determined that the individual is not a qualified individual.

(d) The consulting physician's diagnosis and prognosis, and verification that the qualified individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision, or that the consulting physician has determined that the individual is not a qualified individual.
(e) A report of the outcome and determinations made during a mental health specialist's assessment, if performed.
(f) The attending physician's offer to the qualified individual to withdraw or rescind his or her request at the time of the individual's second oral request.
(g) A note by the attending physician indicating that all requirements under Sections 443.5 and 443.6 have been met and indicating the steps taken to carry out the request, including a notation of the aid-in-dying drug prescribed.
443.9. (a) Within 30 calendar days of writing a prescription for an aid-in-dying drug, the attending physician shall submit to the State Department of Public Health a copy of the qualifying patient's written request, the attending physician checklist and compliance form, and the consulting physician compliance form.

(b) Within 30 calendar days following the qualified individual's death from ingesting the aid-in-dying drug, or any other cause, the attending physician shall submit the attending physician followup form to the State Department of Public Health.
443.10. A qualified individual may not receive a prescription for an aid-in-dying drug pursuant to this part unless he or she has made an informed decision. Immediately before writing a prescription for an aid-in-dying drug under this part, the attending physician shall verify that the individual is making an informed decision.
443.11. (a) A request for an aid-in-dying drug as authorized by this part shall be in the following form:

REQUEST FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER I, ..., am an adult of sound mind and a resident of the State of California.
I am suffering from ....., which my attending physician has determined is in its terminal phase and which has been medically confirmed.
I have been fully informed of my diagnosis and prognosis, the nature of the aid-in-dying drug to be prescribed and potential associated risks, the expected result, and the feasible alternatives or additional treatment options, including comfort care, hospice care, palliative care, and pain control.
I request that my attending physician prescribe an aid-in-dying drug that will end my life in a humane and dignified manner if I choose to take it, and I authorize my attending physician to contact any pharmacist about my request.
INITIAL ONE:
..... I have informed one or more members of my family of my decision and taken their opinions into consideration.
..... I have decided not to inform my family of my decision.
..... I have no family to inform of my decision.
I understand that I have the right to withdraw or rescind this request at any time.
I understand the full import of this request and I expect to die if I take the aid-in-dying drug to be prescribed. My attending physician has counseled me about the possibility that my death may not be immediately upon the consumption of the drug.

I make this request voluntarily, without reservation, and without being coerced.
Signed:.....
Dated:.....

DECLARATION OF WITNESSES
We declare that the person signing this request:
(a) is personally known to us or has provided proof of identity;
(b) voluntarily signed this request in our presence;
(c) is an individual whom we believe to be of sound mind and not under duress, fraud, or undue influence; and

(d) is not an individual for whom either of us is the attending physician, consulting physician, or mental health specialist.
.....Witness 1/Date
.....Witness 2/Date

NOTE: Only one of the two witnesses may be a relative (by blood, marriage, registered domestic partnership, or adoption) of the person signing this request or be entitled to a portion of the person's estate upon death. Only one of the two witnesses may own, operate, or be employed at a health care facility where the person is a patient or resident.
(b) (1) The written language of the request shall be written in the same translated language as any conversations, consultations, or interpreted conversations or consultations between a patient and his or her attending or consulting physicians.
(2) Notwithstanding paragraph (1), the written request may be prepared in English even when the conversations or consultations or interpreted conversations or consultations were conducted in a language other than English if the English language form includes an attached interpreter's declaration that is signed under penalty of perjury. The interpreter's declaration shall state words to the effect that:

I, (INSERT NAME OF INTERPRETER), am fluent in English and (INSERT TARGET LANGUAGE).
On (insert date) at approximately (insert time), I read the "Request for an Aid-In-Dying Drug to End My Life" to (insert name of individual/patient) in (insert target language).
Mr./Ms. (insert name of patient/qualified individual) affirmed to me that he/she understood the content of this form and affirmed his/her desire to sign this form under his/her own power and volition and that the request to sign the form followed consultations with an attending and consulting physician.
I declare that I am fluent in English and (insert target language) and further declare under penalty of perjury that the foregoing is true and correct.
Executed at (insert city, county, and state) on this (insert day of month) of (insert month), (insert year).
X_____Interpreter signature
X_____Interpreter printed name
X_____Interpreter address
(3) An interpreter whose services are provided pursuant to paragraph (2) shall not be related to the qualified individual by blood, marriage, registered domestic partnership, or adoption or be entitled to a portion of the person's estate upon death. An interpreter whose services are provided pursuant to paragraph (2) shall meet the standards promulgated by the California Healthcare Interpreting Association or the National Council on Interpreting

in Health Care or other standards deemed acceptable by the department for health care providers in California.

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(c) The final attestation form given by the attending physician to the qualified individual at the time the attending physician writes the prescription shall appear in the following form:

FINAL ATTESTATION FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER I,

....., am an adult of sound mind and a resident of the State of California.

I am suffering from ....., which my attending physician has determined is in its terminal phase and which has been medically confirmed.

I have been fully informed of my diagnosis and prognosis, the nature of the aid-in-dying drug to be prescribed and potential associated risks, the expected result, and the feasible alternatives or additional treatment options, including comfort care, hospice care, palliative care, and pain control.

I have received the aid-in-dying drug and am fully aware that this aid-in-dying drug will end my life in a humane and dignified manner.

INITIAL ONE:

..... I have informed one or more members of my family of my decision and taken their opinions into consideration.

..... I have decided not to inform my family of my decision.

..... I have no family to inform of my decision.

My attending physician has counseled me about the possibility that my death may not be immediately upon the consumption of the drug.

I make this decision to ingest the aid-in-dying drug to end my life in a humane and dignified manner. I understand I still may choose not to ingest the drug and by signing this form I am under no obligation to ingest the drug. I understand I may rescind this request at any time.

Signed:.....

Dated:.....

Time:.....

(1) Within 48 hours prior to the individual self-administering the aid-in-dying drug, the individual shall complete the final attestation form. If aid-in-dying medication is not returned or relinquished upon the patient's death as required in Section 443.20, the completed form shall be delivered by the individual's health care provider, family member, or other representative to the attending physician to be included in the patient's medical record.

(2) Upon receiving the final attestation form the attending physician shall add this form to the medical records of the qualified individual.

443.12. (a) A provision in a contract, will, or other agreement executed on or after January 1, 2016, whether written or oral, to the extent the provision would affect whether a person may make, withdraw, or rescind a request for an aid-in-dying drug is not valid.

(b) An obligation owing under any contract executed on or after January 1, 2016, may not be conditioned or affected by a qualified individual making, withdrawing, or rescinding a request for an aid-in-dying drug.

443.13. (a) (1) The sale, procurement, or issuance of a life, health, or annuity policy, health care service plan contract, or health benefit plan, or the rate charged for a policy or plan contract may not be conditioned upon or affected by a person making or rescinding a request for an aid-in-dying drug.

(2) Pursuant to Section 443.18, death resulting from the

self-administration of an aid-in-dying drug is not suicide, and therefore health and insurance coverage shall not be exempted on that basis.
(b) Notwithstanding any other law, a qualified individual's act of self-administering an aid-in-dying drug shall not have an effect upon a life, health, or annuity policy other than that of a natural death from the underlying disease.
(c) An insurance carrier shall not provide any information in communications made to an individual about the availability of an aid-in-dying drug absent a request by the individual or his or her attending physician at the behest of the individual. Any communication shall not include both the denial of treatment and information as to the availability of aid-in-dying drug coverage. For the purposes of this subdivision, "insurance carrier" means a health care service plan as defined in Section 1345 of this code or a carrier of health insurance as defined in Section 106 of the Insurance Code.
443.14. (a) Notwithstanding any other law, a person shall not be subject to civil or criminal liability solely because the person was present when the qualified individual self-administers the prescribed aid-in-dying drug. A person who is present may, without civil or criminal liability, assist the qualified individual by preparing the aid-in-dying drug so long as the person does not assist the qualified person in ingesting the aid-in-dying drug.
(b) A health care provider or professional organization or association shall not subject an individual to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for participating in good faith compliance with this part or for refusing to participate in accordance with subdivision (e).
(c) Notwithstanding any other law, a health care provider shall not be subject to civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff

action, sanction, or penalty or other liability for participating in this part, including, but not limited to, determining the diagnosis or prognosis of an individual, determining the capacity of an individual for purposes of qualifying for the act, providing information to an individual regarding this part, and providing a referral to a physician who participates in this part. Nothing in this subdivision shall be construed to limit the application of, or provide immunity from, Section 443.16 or 443.17.
(d) (1) A request by a qualified individual to an attending physician to provide an aid-in-dying drug in good faith compliance with the provisions of this part shall not provide the sole basis for the appointment of a guardian or conservator.
(2) No actions taken in compliance with the provisions of this part shall constitute or provide the basis for any claim of neglect or elder abuse for any purpose of law.
(e) (1) Participation in activities authorized pursuant to this part shall be voluntary. Notwithstanding Sections 442 to 442.7, inclusive, a person or entity that elects, for reasons of conscience, morality, or ethics, not to engage in activities authorized pursuant to this part is not required to take any action in support of an individual's decision under this part.
(2) Notwithstanding any other law, a health care provider is not subject to civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action, sanction,

or penalty or other liability for refusing to participate in activities authorized under this part, including, but not limited to, refusing to inform a patient regarding his or her rights under this part, and not referring an individual to a physician who participates in activities authorized under this part.
(3) If a health care provider is unable or unwilling to carry out a qualified individual's request under this part and the qualified individual transfers care to a new health care provider, the individual may request a copy of his or her medical records pursuant to law.
443.15. (a) Subject to subdivision (b), notwithstanding any other law, a health care provider may prohibit its employees, independent contractors, or other persons or entities, including other health care providers, from participating in activities under this part while on premises owned or under the management or direct control of that prohibiting health care provider or while acting within the course and scope of any employment by, or contract with, the prohibiting health care provider.
(b) A health care provider that elects to prohibit its employees, independent contractors, or other persons or entities, including health care providers, from participating in activities under this part, as described in subdivision (a), shall first give notice of the policy prohibiting participation under this part to the individual or entity. A health care provider that fails to provide notice to an individual or entity in compliance with this subdivision shall not be entitled to enforce such a policy against that individual or entity.

(c) Subject to compliance with subdivision (b), the prohibiting health care provider may take action, including, but not limited to, the following, as applicable, against any individual or entity that violates this policy:
(1) Loss of privileges, loss of membership, or other action authorized by the bylaws or rules and regulations of the medical staff.
(2) Suspension, loss of employment, or other action authorized by the policies and practices of the prohibiting health care provider.
(3) Termination of any lease or other contract between the prohibiting health care provider and the individual or entity that violates the policy.
(4) Imposition of any other nonmonetary remedy provided for in any lease or contract between the prohibiting health care provider and the individual or entity in violation of the policy.
(d) Nothing in this section shall be construed to prevent, or to allow a prohibiting health care provider to prohibit, any other health care provider, employee, independent contractor, or other person or entity from any of the following:
(1) Participating, or entering into an agreement to participate, in activities under this part, while on premises that are not owned or under the management or direct control of the prohibiting provider or while acting outside the course and scope of the participant's duties as an employee of, or an independent contractor for, the prohibiting health care provider.
(2) Participating, or entering into an agreement to participate, in activities under this part as an attending physician or consulting physician while on premises that are not owned or under the management or direct control of the prohibiting provider.
(e) In taking actions pursuant to subdivision (c), a health care provider shall comply with all procedures required by law, its own policies or procedures, and any contract with the individual or entity in violation of the

policy, as applicable.
(f) For purposes of this section:
(1) “Notice” means a separate statement in writing advising of the prohibiting health care provider policy with respect to participating in activities under this part.
(2) “Participating, or entering into an agreement to participate, in activities under this part” means doing or entering into an agreement to do any one or more of the following:
(A) Performing the duties of an attending physician as specified in Section 443.5.
(B) Performing the duties of a consulting physician as specified in Section 443.6.
(C) Performing the duties of a mental health specialist, in the circumstance that a referral to one is made.
(D) Delivering the prescription for, dispensing, or delivering the dispensed aid-in-dying drug pursuant to paragraph (2) of subdivision (b) of, and subdivision (c) of, Section 443.5.
(E) Being present when the qualified individual takes the aid-in-dying drug prescribed pursuant to this part.

(3) “Participating, or entering into an agreement to participate, in activities under this part” does not include doing, or entering into an agreement to do, any of the following:
(A) Diagnosing whether a patient has a terminal disease, informing the patient of the medical prognosis, or determining whether a patient has the capacity to make decisions.
(B) Providing information to a patient about this part.
(C) Providing a patient, upon the patient’s request, with a referral to another health care provider for the purposes of participating in the activities authorized by this part.
(g) Any action taken by a prohibiting provider pursuant to this section shall not be reportable under Sections 800 to 809.9, inclusive, of the Business and Professions Code. The fact that a health care provider participates in activities under this part shall not be the sole basis for a complaint or report by another health care provider of unprofessional or dishonorable conduct under Sections 800 to 809.9, inclusive, of the Business and Professions Code.
(h) Nothing in this part shall prevent a health care provider from providing an individual with health care services that do not constitute participation in this part.
443.16. (a) A health care provider may not be sanctioned for any of the following:
(1) Making an initial determination pursuant to the standard of care that an individual has a terminal disease and informing him or her of the medical prognosis.
(2) Providing information about the End of Life Option Act to a patient upon the request of the individual.
(3) Providing an individual, upon request, with a referral to another physician.
(b) A health care provider that prohibits activities under this part in accordance with Section 443.15 shall not sanction an individual health care provider for contracting with a qualified individual to engage in activities

authorized by this part if the individual health care provider is acting outside of the course and scope of his or her capacity as an employee or independent contractor of the prohibiting health care provider.
(c) Notwithstanding any contrary provision in this section, the immunities and prohibitions on sanctions of a health care provider are solely reserved for actions of a health care provider taken pursuant to this part. Notwithstanding any contrary provision in this part, health care providers may be sanctioned by their licensing board or agency for conduct and actions constituting unprofessional conduct, including failure to comply in good faith with this part.
443.17. (a) Knowingly altering or forging a request for an aid-in-dying drug to end an individual's life without his or her authorization or concealing or destroying a withdrawal or rescission of a request for an aid-in-dying drug is punishable as a felony if the act is done with the intent or effect of causing the individual's death.

(b) Knowingly coercing or exerting undue influence on an individual to request or ingest an aid-in-dying drug for the purpose of ending his or her life or to destroy a withdrawal or rescission of a request, or to administer an aid-in-dying drug to an individual without his or her knowledge or consent, is punishable as a felony.
(c) For purposes of this section, "knowingly" has the meaning provided in Section 7 of the Penal Code.
(d) The attending physician, consulting physician, or mental health specialist shall not be related to the individual by blood, marriage, registered domestic partnership, or adoption, or be entitled to a portion of the individual's estate upon death.
(e) Nothing in this section shall be construed to limit civil liability.
(f) The penalties in this section do not preclude criminal penalties applicable under any law for conduct inconsistent with the provisions of this section.
443.18. Nothing in this part may be construed to authorize a physician or any other person to end an individual's life by lethal injection, mercy killing, or active euthanasia. Actions taken in accordance with this part shall not, for any purposes, constitute suicide, assisted suicide, homicide, or elder abuse under the law.
443.19. (a) The State Department of Public Health shall collect and review the information submitted pursuant to Section 443.9. The information collected shall be confidential and shall be collected in a manner that protects the privacy of the patient, the patient's family, and any medical provider or pharmacist involved with the patient under the provisions of this part. The information shall not be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding.
(b) On or before July 1, 2017, and each year thereafter, based on the information collected in the previous year, the department shall create a report with the information collected from the attending physician follow-up form and post that report to its Internet Web site. The report shall include, but not be limited to, all of the following based on the information that is provided to the department and on the department's access to vital statistics:
(1) The number of people for whom an aid-in-dying prescription was written.
(2) The number of known individuals who died each year for whom aid-in-dying prescriptions were written, and the cause of death of those

individuals.
(3) For the period commencing January 1, 2016, to and including the previous year, cumulatively, the total number of aid-in-dying prescriptions written, the number of people who died due to use of aid-in-dying drugs, and the number of those people who died who were enrolled in hospice or other palliative care programs at the time of death.
(4) The number of known deaths in California from using aid-in-dying drugs per 10,000 deaths in California.
(5) The number of physicians who wrote prescriptions for aid-in-dying drugs.

(6) Of people who died due to using an aid-in-dying drug, demographic percentages organized by the following characteristics:
(A) Age at death.
(B) Education level.
(C) Race.
(D) Sex.
(E) Type of insurance, including whether or not they had insurance.
(F) Underlying illness.
(c) The State Department of Public Health shall make available the attending physician checklist and compliance form, the consulting physician compliance form, and the attending physician follow-up form, as described in Section 443.22, by posting them on its Internet Web site.
443.20. A person who has custody or control of any unused aid-in-dying drugs prescribed pursuant to this part after the death of the patient shall personally deliver the unused aid-in-dying drugs for disposal by delivering it to the nearest qualified facility that properly disposes of controlled substances, or if none is available, shall dispose of it by lawful means in accordance with guidelines promulgated by the California State Board of Pharmacy or a federal Drug Enforcement Administration approved take-back program.
443.21. Any governmental entity that incurs costs resulting from a qualified individual terminating his or her life pursuant to the provisions of this part in a public place shall have a claim against the estate of the qualified individual to recover those costs and reasonable attorney fees related to enforcing the claim.
443.215. This part shall remain in effect only until January 1, 2026, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2026, deletes or extends that date.
443.22. (a) The Medical Board of California may update the attending physician checklist and compliance form, the consulting physician compliance form, and the attending physician follow-up form, based on those provided in subdivision (b). Upon completion, the State Department of Public Health shall publish the updated forms on its Internet Web site.
(b) Unless and until updated by the Medical Board of California pursuant to this section, the attending physician checklist and compliance form, the consulting physician compliance form, and the attending physician follow-up form shall be in the following form:
(6) Of people who died due to using an aid-in-dying drug, demographic percentages organized by the following characteristics:

(A) Age at death.
(B) Education level.
(C) Race.
(D) Sex.
(E) Type of insurance, including whether or not they had insurance.
(F) Underlying illness.
(c) The State Department of Public Health shall make available the attending physician checklist and compliance form, the consulting physician compliance form, and the attending physician follow-up form, as described in Section 443.22, by posting them on its Internet Web site.
443.20. A person who has custody or control of any unused aid-in-dying drugs prescribed pursuant to this part after the death of the patient shall personally deliver the unused aid-in-dying drugs for disposal by delivering it to the nearest qualified facility that properly disposes of controlled substances, or if none is available, shall dispose of it by lawful means in accordance with guidelines promulgated by the California State Board of Pharmacy or a federal Drug Enforcement Administration approved take-back program.
443.21. Any governmental entity that incurs costs resulting from a qualified individual terminating his or her life pursuant to the provisions of this part in a public place shall have a claim against the estate of the qualified individual to recover those costs and reasonable attorney fees related to enforcing the claim.
443.215. This part shall remain in effect only until January 1, 2026, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2026, deletes or extends that date.
443.22. (a) The Medical Board of California may update the attending physician checklist and compliance form, the consulting physician compliance form, and the attending physician follow-up form, based on those provided in subdivision (b). Upon completion, the State Department of Public Health shall publish the updated forms on its Internet Web site.
(b) Unless and until updated by the Medical Board of California pursuant to this section, the attending physician checklist and compliance form, the consulting physician compliance form, and the attending physician follow-up form shall be in the following form:

ATTENDING PHYSICIAN CHECKLIST & COMPLIANCE FORM

A	PATIENT INFORMATION	
	PATIENT'S NAME (LAST, FIRST, M.I.)	DATE OF BIRTH
	PATIENT RESIDENTIAL ADDRESS (STREET, CITY, ZIP CODE)	

B	ATTENDING PHYSICIAN INFORMATION	
	PHYSICIAN'S NAME (LAST, FIRST, M.I.)	TELEPHONE NUMBER ( ) —
	MAILING ADDRESS (STREET, CITY, ZIP CODE)	
	PHYSICIAN'S LICENSE NUMBER	

C	CONSULTING PHYSICIAN INFORMATION	
	PHYSICIAN'S NAME (LAST, FIRST, M.I.)	TELEPHONE NUMBER ( ) —
	MAILING ADDRESS (STREET, CITY, ZIP CODE)	
	PHYSICIAN'S LICENSE NUMBER	

D	ELIGIBILITY DETERMINATION
	1. TERMINAL DISEASE
	2. CHECK BOXES FOR COMPLIANCE. ☐ 1. Determination that the patient has a terminal disease. ☐ 2. Determination that patient is a resident of California. ☐ 3. Determination that patient has the capacity to make medical decisions** ☐ 4. Determination that patient is acting voluntarily. ☐ 5. Determination of capacity by mental health specialist, if necessary. ☐ 6. Determination that patient has made his/her decision after being fully informed of: ☐ a) His or her medical diagnosis; and ☐ b) His or her prognosis; and ☐ c) The potential risks associated with ingesting the requested aid-in-dying drug; ☐ d) The probable result of ingesting the aid-in-dying drug; ☐ e) The possibility that he or she may choose to obtain the aid-in-dying drug but not take it

ATTENDING PHYSICIAN CHECKLIST &
COMPLIANCE FORM

E ADDITIONAL COMPLIANCE REQUIREMENTS

- ☐ 1. Counseled patient about the importance of all of the following:
- ☐ a) Maintaining the aid-in-dying drug in a safe and secure location until the time the qualified individual will ingest it;
- ☐ b) Having another person present when he or she ingests the aid-in-dying drug;
- ☐ c) Not ingesting the aid-in-dying drug in a public place;
- ☐ d) Notifying the next of kin of his or her request for an aid-in-dying drug. (an individual who declines or is unable to notify next of kin shall not have his or her request denied for that reason); and
- ☐ e) Participating in a hospice program or palliative care program.
- ☐ 2. Informed patient of right to rescind request (1st time)
- ☐ 3. Discussed the feasible alternatives, including, but not limited to, comfort care, hospice care, palliative care and pain control.
- ☐ 4. Met with patient one-on-one, except in the presence of an interpreter, to confirm the request is not coming from coercion
- ☐ 5. First oral request for aid-in-dying: _____/_____/_____ Attending physician initials:_____
- ☐ 6. Second oral request for aid-in-dying:_____/_____/_____ Attending physician initials:_____
- ☐ 7. Written request submitted: _____/_____/_____ Attending physician initials:_____
- ☐ 8. Offered patient right to rescind (2nd time)

F PATIENT'S MENTAL STATUS

Check one of the following **(required)**:

- ☐ I have determined that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.
- ☐ I have referred the patient to the mental health specialist**** listed below for one or more consultations to determine that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.
- ☐ If a referral was made to a mental health specialist, the mental health specialist has determined that the patient is not suffering from impaired judgment due to a mental disorder

Mental health specialist's information, if applicable:

MENTAL HEALTH SPECIALIST NAME

MENTAL HEALTH SPECIALIST TITLE & LICENSE NUMBER

MENTAL HEALTH SPECIALIST ADDRESS (STREET, CITY, ZIP CODE)

ATTENDING PHYSICIAN CHECKLIST & COMPLIANCE FORM

G	MEDICATION PRESCRIBED	
	PHARMACIST NAME	TELEPHONE NUMBER ( ) —

1. Aid-in-dying medication prescribed:
   - ☐ a. Name:_____
   - ☐ b. Dosage:_____
2. Antiemetic medication prescribed:
   - ☐ a. Name:_____
   - ☐ b. Dosage:_____
3. Method prescription was delivered:
   - ☐ a. In person
   - ☐ b. By mail
   - ☐ c. Electronically
4. Date medication was prescribed:_____/_____/_____

	X	PHYSICIAN'S SIGNATURE	DATE
		NAME (PLEASE PRINT)	

** "Capacity to make medical decisions" means that, in the opinion of an individual's attending physician, consulting physician, psychiatrist, or psychologist, pursuant to Section 4609 of the Probate Code, the individual has the ability to understand the nature and consequences of a health care decision, the ability to understand its significant benefits, risks, and alternatives, and the ability to make
****"Mental Health Specialist" means a psychiatrist or a licensed psychologist.

CONSULTING PHYSICIAN COMPLIANCE FORM

A PATIENT INFORMATION

PATIENT'S NAME (LAST, FIRST, M.I.)	DATE OF BIRTH

B ATTENDING PHYSICIAN

ATTENDING PHYSICIAN'S NAME (LAST, FIRST, M.I.)	TELEPHONE NUMBER ( ) —

C CONSULTING PHYSICIAN'S REPORT

1. TERMINAL DISEASE	DATE OF EXAMINATION(S)

2. Check boxes for compliance. *(Both the attending and consulting physicians must make these determinations.)*

- ☐ 1. Determination that the patient has a terminal disease.
- ☐ 2. Determination that patient has the mental capacity to make medical decisions.**
- ☐ 3. Determination that patient is acting voluntarily.
- ☐ 4. Determination that patient has made his/her decision after being fully informed of:
- ☐ a) His or her medical diagnosis; and
- ☐ b) His or her prognosis; and
- ☐ c) The potential risks associated with taking the drug to be prescribed; and
- ☐ d) The potential result of taking the drug to be prescribed; and
- ☐ e) The feasible alternatives, including, but not limited to, comfort care, hospice care, palliative care and pain control.

D PATIENT'S MENTAL STATUS

Check one of the following **(required)**:

- ☐ I have determined that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.
- ☐ I have referred the patient to the mental health specialist**** listed below for one or more consultations to determine that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.
- ☐ If a referral was made to a mental health specialist, the mental health specialist has determined that the patient is not suffering from impaired judgment due to a mental disorder

MENTAL HEALTH SPECIALIST'S NAME	TELEPHONE NUMBER ( ) —	DATE

E CONSULTANT'S INFORMATION

X	PHYSICIAN'S SIGNATURE	DATE
	NAME (PLEASE PRINT)	
	MAILING ADDRESS	
	CITY, STATE AND ZIP CODE	TELEPHONE NUMBER ( ) —

** "Capacity to make medical decisions" means that, in the opinion of an individual's attending physician, consulting physician, psychiatrist, or psychologist, pursuant to Section 4609 of the Probate Code, the individual has the ability to understand the nature and consequences of a health care decision, the ability to understand its significant benefits, risks, and alternatives, and the ability to make

**** "Mental Health Specialist" means a psychiatrist or a licensed psychologist.

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ATTENDING PHYSICIAN FOLLOW-UP FORM

The End of Life Option Act requires physicians who write a prescription for an aid-in-dying drug to complete this follow-up form within **30 calendar days** of a patient's death, whether from ingestion of the aid-in-dying drug obtained under the Act or from any other cause.

For the State Department of Public Health to accept this form, it must be signed by the attending physician, whether or not he or she was present at the patient's time of death.

This form should be mailed or sent electronically to the State Department of Public Health. All information is kept strictly confidential.

Date: _____/_____/_____

Patient name: _____

Attending physician name: _____

Did the patient die from ingesting the aid-in-dying drug, from their underlying illness, or from another cause such as terminal sedation or ceasing to eat or drink?

☐ **Aid-in-dying drug** (lethal dose) → Please sign below and go to page 2.
Attending physician signature:_____

☐ **Underlying illness** → There is no need to complete the rest of the form. Please sign below.
Attending physician signature:_____

☐ **Other** → There is no need to complete the rest of the form. Please specify the circumstances surrounding the patient's death and sign
Please specify:
_____
_____

Attending physician signature:_____

PART A and PART B should only be completed if the patient died from ingesting the lethal dose of the aid-in-dying drug.

Please read carefully the following to determine which situation applies. Check the box that indicates the scenario and complete the remainder of the form accordingly.

☐ The attending physician was present at the time of death.
→ The attending physician must complete this form in its entirety and sign Part A and Part B.

☐ The attending physician was not present at the time of death, but another licensed health care provider was present.
→ The licensed health care provider must complete and sign Part A of this form. The attending physician must complete and sign Part B of the form.

☐ Neither the attending physician nor another licensed health care provider was present at the time of death.
→ Part A may be left blank. The attending physician must complete and sign Part B of the form.

ATTENDING PHYSICIAN FOLLOW-UP FORM

PART A: To be completed and signed by the attending physician or another licensed health care provider present at death:

1. Was the attending physician at the patient's bedside when the patient took the aid-in-dying drug?
   - ☐ Yes
   - ☐ No

If no: Was another physician or trained health care provider present when the patient ingested the aid-in-dying drug?
   - ☐ Yes, another physician
   - ☐ Yes, a trained health-care provider/volunteer
   - ☐ No
   - ☐ Unknown

2. Was the attending physician at the patient's bedside at the time of death?
   - ☐ Yes
   - ☐ No

If no: Was another physician or a licensed health care provider present at the patient's time of death?
   - ☐ Yes, another physician or licensed health care provider
   - ☐ No
   - ☐ Unknown

3. On what day did the patient consume the lethal dose of the aid-in-dying?
_____/_____/_____ (month/day/year) ☐ Unknown

4. On what day did the patient die after consuming the lethal dose of the aid-in-dying drug?
_____/_____/_____ (month/day/year) ☐ Unknown

5. Where did the patient ingest the lethal dose of the aid-in-dying drug?
   - ☐ Private home
   - ☐ Assisted-living residence
   - ☐ Nursing home
   - ☐ Acute care hospital in-patient
   - ☐ In-patient hospice resident
   - ☐ Other (specify)_____
   - ☐ Unknown

6. What was the time between the ingestion of the lethal dose of aid-in-dying drug and unconsciousness?
   Minutes_____ and/or Hours_____ ☐Unknown

7. What was the time between lethal medication ingestion and death?
   Minutes_____ and/or Hours_____ ☐Unknown

ATTENDING PHYSICIAN FOLLOW-UP FORM

8. Were there any complications that occurred after the patient took the lethal dose of the aid-in-dying drug?

- ☐ Yes- vomiting, emesis
- ☐ Yes-regained consciousness
- ☐ No Complications
- ☐ Other- Please describe:_____
- ☐ Unknown

9. Was the Emergency Medical System activated for any reason after ingesting the lethal dose of the aid-in-dying drug?

- ☐ Yes- Please describe:_____
- ☐ No
- ☐ Unknown

10. At the time of ingesting the lethal dose of the aid-in-dying drug, was the patient receiving hospice care?

- ☐ Yes
- ☐ No, refused care
- ☐ No, other (specify) _____

Signature of attending physician present at time of death: _____

Name of Licensed Health Care Provider present at time of death if not attending physician:_____

Signature of Licensed Health Care Provider: _____

ATTENDING PHYSICIAN FOLLOW-UP FORM

PART B: To be completed and signed by the attending physician

12. On what date was the prescription written for the aid-in-dying drug? ____/____/____

13. When the patient initially requested a prescription for the aid-in-dying drug, was the patient receiving hospice care?

- ☐ Yes
- ☐ No, refused care
- ☐ No, other (specify) _____

14. What type of health-care coverage did the patient have for their underlying illness? (*Check all that apply.*)

- ☐ Medicare
- ☐ Medi-cal
- ☐ Covered California
- ☐ V.A.
- ☐ Private Insurance
- ☐ No insurance
- ☐ Had insurance, don't know type

15. Possible concerns that may have contributed to the patient's decision to request a prescription for aid-in-dying drug Please check "yes," "no," or "Don't' know," depending on whether or not you believe that concern contributed to their request (Please check as many boxes as you think may apply)
A concern about…

- **His or her terminal condition representing a steady loss of autonomy**
  - ☐ Yes
  - ☐ No
  - ☐ Don't Know
- **The decreasing ability to participate in activities that made life enjoyable**
  - ☐ Yes
  - ☐ No
  - ☐ Don't Know
- **The loss of control of bodily functions**
  - ☐ Yes
  - ☐ No
  - ☐ Don't Know
- **Persistent and uncontrollable pain and suffering**
  - ☐ Yes
  - ☐ No
  - ☐ Don't Know
- **A loss of Dignity**
  - ☐ Yes
  - ☐ No
  - ☐ Don't Know
- **Other concerns** (specify): _____

Signature of attending physician: _____

SEC. 2. The Legislature finds and declares that Section 1 of this act, which adds Section 443.19 to the Health and Safety Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

(a) Any limitation to public access to personally identifiable patient data collected pursuant to Section 443.19 of the Health and Safety Code as proposed to be added by this act is necessary to protect the privacy rights of the patient and his or her family.

(b) The interests in protecting the privacy rights of the patient and his or her family in this situation strongly outweigh the public interest in having access to personally identifiable data relating to services.

(c) The statistical report to be made available to the public pursuant to subdivision (b) of Section 443.19 of the Health and Safety Code is sufficient to satisfy the public's right to access.

SEC. 3. The provisions of this part are severable. If any provision of this part or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

APPENDIX D
State of Colorado Statute

Final #145

Be it enacted by the people of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, **add** article 48 to title 25 as follows:

ARTICLE 48

End-of-life Options

25-48-101. Short title. THE SHORT TITLE OF THIS ARTICLE IS THE "COLORADO END-OF-LIFE OPTIONS ACT".

25-48-102. Definitions. AS USED IN THIS ARTICLE, UNLESS THE CONTEXT OTHERWISE REQUIRES:
(1) "ADULT" MEANS AN INDIVIDUAL WHO IS EIGHTEEN YEARS OF AGE OR OLDER.
(2) "ATTENDING PHYSICIAN" MEANS A PHYSICIAN WHO HAS PRIMARY RESPONSIBILITY FOR THE CARE OF A TERMINALLY ILL INDIVIDUAL AND THE TREATMENT OF THE INDIVIDUAL'S TERMINAL ILLNESS.
(3) "CONSULTING PHYSICIAN" MEANS A PHYSICIAN WHO IS QUALIFIED BY SPECIALTY OR EXPERIENCE TO MAKE A PROFESSIONAL DIAGNOSIS AND PROGNOSIS REGARDING A TERMINALLY ILL INDIVIDUAL'S ILLNESS.
(4) "HEALTH CARE PROVIDER" OR "PROVIDER" MEANS A PERSON WHO IS LICENSED, CERTIFIED, REGISTERED, OR OTHERWISE AUTHORIZED OR PERMITTED BY LAW TO ADMINISTER HEALTH CARE OR DISPENSE MEDICATION IN THE ORDINARY COURSE OF BUSINESS OR PRACTICE OF A PROFESSION. THE TERM INCLUDES A HEALTH CARE FACILITY, INCLUDING A LONG-TERM CARE FACILITY AS DEFINED IN SECTION 25-3-103.7 (1) (f.3) AND A CONTINUING CARE RETIREMENT COMMUNITY AS DESCRIBED IN SECTION 25.5-6-203 (1)(c)(I), C.R.S.
(5) "INFORMED DECISION" MEANS A DECISION THAT IS:
(a) MADE BY AN INDIVIDUAL TO OBTAIN A PRESCRIPTION FOR MEDICAL AID-IN-DYING MEDICATION THAT THE QUALIFIED INDIVIDUAL MAY DECIDE TO SELF-ADMINISTER TO END HIS OR HER LIFE IN A PEACEFUL MANNER;
(b) BASED ON AN UNDERSTANDING AND ACKNOWLEDGMENT OF THE RELEVANT FACTS; AND
(c) MADE AFTER THE ATTENDING PHYSICIAN FULLY INFORMS THE INDIVIDUAL OF:
(I) HIS OR HER MEDICAL DIAGNOSIS AND PROGNOSIS OF SIX MONTHS OR LESS;
(II) THE POTENTIAL RISKS ASSOCIATED WITH TAKING THE MEDICAL AID-IN DYING MEDICATION TO BE PRESCRIBED;
(III) THE PROBABLE RESULT OF TAKING THE MEDICAL AID-IN-DYING MEDICATION TO BE PRESCRIBED;
(IV) THE CHOICES AVAILABLE TO AN INDIVIDUAL THAT DEMONSTRATE HIS OR HER SELF-DETERMINATION AND INTENT TO END HIS OR HER LIFE IN A PEACEFUL MANNER, INCLUDING THE ABILITY TO CHOOSE WHETHER TO:
(A) REQUEST MEDICAL AID IN DYING;
(B) OBTAIN A PRESCRIPTION FOR MEDICAL AID-IN-DYING MEDICATION TO END HIS OR HER LIFE;

(C) FILL THE PRESCRIPTION AND POSSESS MEDICAL AID-IN-DYING MEDICATION TO END HIS OR HER LIFE; AND

(D) ULTIMATELY SELF-ADMINISTER THE MEDICAL AID-IN-DYING MEDICATION TO BRING ABOUT A PEACEFUL DEATH; AND

(V)ALL FEASIBLE ALTERNATIVES OR ADDITIONAL TREATMENT OPPORTUNITIES, INCLUDING COMFORT CARE, PALLIATIVE CARE, HOSPICE CARE, AND PAIN CONTROL.

(6) "LICENSED MENTAL HEALTH PROFESSIONAL" MEANS A PSYCHIATRIST LICENSED UNDER ARTICLE 36 OF TITLE 12, C.R.S., OR A PSYCHOLOGIST LICENSED UNDER PART 3 OF ARTICLE 43 OF TITLE 12, C.R.S.

(7) "MEDICAL AID IN DYING" MEANS THE MEDICAL PRACTICE OF A PHYSICIAN PRESCRIBING MEDICAL AID-IN-DYING MEDICATION TO A QUALIFIED INDIVIDUAL THAT THE INDIVIDUAL MAY CHOOSE TO SELF-ADMINISTER TO BRING ABOUT A PEACEFUL DEATH.

(8) "MEDICAL AID-IN-DYING MEDICATION" MEANS MEDICATION PRESCRIBED BY A PHYSICIAN PURSUANT TO THIS ARTICLE TO PROVIDE MEDICAL AID IN DYING TO A QUALIFIED INDIVIDUAL.

(9) "MEDICALLY CONFIRMED" MEANS THAT A CONSULTING PHYSICIAN WHO HAS EXAMINED THE TERMINALLY ILL INDIVIDUAL AND THE INDIVIDUAL'S RELEVANT MEDICAL RECORDS HAS CONFIRMED THE MEDICAL OPINION OF THE ATTENDING PHYSICIAN.

(10) "MENTAL CAPACITY" OR "MENTALLY CAPABLE" MEANS THAT IN THE OPINION OF AN INDIVIDUAL'S ATTENDING PHYSICIAN, CONSULTING PHYSICIAN, PSYCHIATRIST OR PSYCHOLOGIST, THE INDIVIDUAL HAS THE ABILITY TO MAKE AND COMMUNICATE AN INFORMED DECISION TO HEALTH CARE PROVIDERS.

(11) "PHYSICIAN" MEANS A DOCTOR OF MEDICINE OR OSTEOPATHY LICENSED TO PRACTICE MEDICINE BY THE COLORADO MEDICAL BOARD.

(12) "PROGNOSIS OF SIX MONTHS OR LESS" MEANS A PROGNOSIS RESULTING FROM A TERMINAL ILLNESS THAT THE ILLNESS WILL, WITHIN REASONABLE MEDICAL JUDGMENT, RESULT IN DEATH WITHIN SIX MONTHS AND WHICH HAS BEEN MEDICALLY CONFIRMED.

(13) "QUALIFIED INDIVIDUAL" MEANS A TERMINALLY ILL ADULT WITH A PROGNOSIS OF SIX MONTHS OR LESS, WHO HAS MENTAL CAPACITY, HAS MADE AN INFORMED DECISION, IS A RESIDENT OF THE STATE, AND HAS SATISFIED THE REQUIREMENTS OF THIS ARTICLE IN ORDER TO OBTAIN A PRESCRIPTION FOR MEDICAL AID-IN-DYING MEDICATION TO END HIS OR HER LIFE IN A PEACEFUL MANNER.

(14) "RESIDENT" MEANS AN INDIVIDUAL WHO IS ABLE TO DEMONSTRATE RESIDENCY IN COLORADO BY PROVIDING ANY OF THE FOLLOWING DOCUMENTATION TO HIS OR HER ATTENDING PHYSICIAN:

(a) A COLORADO DRIVER'S LICENSE OR IDENTIFICATION CARD ISSUED PURSUANT TO ARTICLE 2 OF TITLE 42, C.R.S.;

(b) A COLORADO VOTER REGISTRATION CARD OR OTHER DOCUMENTATION SHOWING THE INDIVIDUAL IS REGISTERED TO VOTE IN COLORADO;

(c) EVIDENCE THAT THE INDIVIDUAL OWNS OR LEASES PROPERTY IN COLORADO; OR
(d) A COLORADO INCOME TAX RETURN FOR THE MOST RECENT TAX YEAR.
(15) "SELF-ADMINISTER" MEANS A QUALIFIED INDIVIDUAL'S AFFIRMATIVE, CONSCIOUS, AND PHYSICAL ACT OF ADMINISTERING THE MEDICAL AID-IN-DYING MEDICATION TO HIMSELF OR HERSELF TO BRING ABOUT HIS OR HER OWN DEATH.
(16) "TERMINAL ILLNESS" MEANS AN INCURABLE AND IRREVERSIBLE ILLNESS THAT WILL, WITHIN REASONABLE MEDICAL JUDGMENT, RESULT IN DEATH.

25-48-103. Right to request medical aid-in-dying medication. (1) AN ADULT RESIDENT OF COLORADO MAY MAKE A REQUEST, IN ACCORDANCE WITH SECTIONS 25-48-104 AND 25-48-112, TO RECEIVE A PRESCRIPTION FOR MEDICAL AID-IN-DYING MEDICATION IF:
(a) THE INDIVIDUAL'S ATTENDING PHYSICIAN HAS DIAGNOSED THE INDIVIDUAL WITH A TERMINAL ILLNESS WITH A PROGNOSIS OF SIX MONTHS OR LESS;
(b) THE INDIVIDUAL'S ATTENDING PHYSICIAN HAS DETERMINED THE INDIVIDUAL HAS MENTAL CAPACITY; AND
(c) THE INDIVIDUAL HAS VOLUNTARILY EXPRESSED THE WISH TO RECEIVE A PRESCRIPTION FOR MEDICAL AID-IN-DYING MEDICATION.
(2) THE RIGHT TO REQUEST MEDICAL AID-IN-DYING MEDICATION DOES NOT EXIST BECAUSE OF AGE OR DISABILITY.

25-48-104. Request process - witness requirements. (1) IN ORDER TO RECEIVE A PRESCRIPTION FOR MEDICAL AID-IN-DYING MEDICATION PURSUANT TO THIS ARTICLE, AN INDIVIDUAL WHO SATISFIES THE REQUIREMENTS IN SECTION 25-48-103 MUST MAKE TWO ORAL REQUESTS, SEPARATED BY AT LEAST FIFTEEN DAYS, AND A VALID WRITTEN REQUEST TO HIS OR HER ATTENDING PHYSICIAN.
(2)(a) TO BE VALID, A WRITTEN REQUEST FOR MEDICAL AID-IN-DYING MEDICATION MUST BE:
(I) SUBSTANTIALLY IN THE SAME FORM AS SET FORTH IN SECTION 25-48-112;
(II) SIGNED AND DATED BY THE INDIVIDUAL SEEKING THE MEDICAL AID-IN-DYING MEDICATION; AND
(III) WITNESSED BY AT LEAST TWO INDIVIDUALS WHO, IN THE PRESENCE OF THE INDIVIDUAL, ATTEST TO THE BEST OF THEIR KNOWLEDGE AND BELIEF THAT THE INDIVIDUAL IS:
(A) MENTALLY CAPABLE;
(B) ACTING VOLUNTARILY; AND
(C) NOT BEING COERCED TO SIGN THE REQUEST.
(b) OF THE TWO WITNESSES TO THE WRITTEN REQUEST, AT LEAST ONE MUST NOT BE:
(I) RELATED TO THE INDIVIDUAL BY BLOOD, MARRIAGE, CIVIL UNION, OR ADOPTION;
(II) AN INDIVIDUAL WHO, AT THE TIME THE REQUEST IS SIGNED, IS ENTITLED, UNDER A WILL OR BY OPERATION OF LAW, TO ANY PORTION OF THE INDIVIDUAL'S ESTATE UPON HIS OR HER DEATH; OR
(III) AN OWNER, OPERATOR, OR EMPLOYEE OF A HEALTH CARE FACILITY WHERE THE INDIVIDUAL IS RECEIVING MEDICAL TREATMENT OR IS A RESIDENT.

(c) NEITHER THE INDIVIDUAL'S ATTENDING PHYSICIAN NOR A PERSON AUTHORIZED AS THE INDIVIDUAL'S QUALIFIED POWER OF ATTORNEY OR DURABLE MEDICAL POWER OF ATTORNEY SHALL SERVE AS A WITNESS TO THE WRITTEN REQUEST.

25-48-105. Right to rescind request - requirement to offer opportunity to rescind. (1) AT ANY TIME, AN INDIVIDUAL MAY RESCIND HIS OR HER REQUEST FOR MEDICAL AID-IN-DYING MEDICATION WITHOUT REGARD TO THE INDIVIDUAL'S MENTAL STATE.
(2) AN ATTENDING PHYSICIAN SHALL NOT WRITE A PRESCRIPTION FOR MEDICAL AID-IN-DYING MEDICATION UNDER THIS ARTICLE UNLESS THE ATTENDING PHYSICIAN OFFERS THE QUALIFIED INDIVIDUAL AN OPPORTUNITY TO RESCIND THE REQUEST FOR THE MEDICAL AID-IN-DYING MEDICATION.

25-48-106. Attending physician responsibilities. (1) THE ATTENDING PHYSICIAN SHALL:
(a) MAKE THE INITIAL DETERMINATION OF WHETHER AN INDIVIDUAL REQUESTING MEDICAL AID-IN-DYING MEDICATION HAS A TERMINAL ILLNESS, HAS A PROGNOSIS OF SIX MONTHS OR LESS, IS MENTALLY CAPABLE, IS MAKING AN INFORMED DECISION, AND HAS MADE THE REQUEST VOLUNTARILY;
(b) REQUEST THAT THE INDIVIDUAL DEMONSTRATE COLORADO RESIDENCY BY PROVIDING DOCUMENTATION AS DESCRIBED IN SECTION 25-48-102 (14);
(c) PROVIDE CARE THAT CONFORMS TO ESTABLISHED MEDICAL STANDARDS AND ACCEPTED MEDICAL GUIDELINES;
(d) REFER THE INDIVIDUAL TO A CONSULTING PHYSICIAN FOR MEDICAL CONFIRMATION OF THE DIAGNOSIS AND PROGNOSIS AND FOR A DETERMINATION OF WHETHER THE INDIVIDUAL IS MENTALLY CAPABLE, IS MAKING AN INFORMED DECISION, AND ACTING VOLUNTARILY;
(e) PROVIDE FULL, INDIVIDUAL-CENTERED DISCLOSURES TO ENSURE THAT THE INDIVIDUAL IS MAKING AN INFORMED DECISION BY DISCUSSING WITH THE INDIVIDUAL:
(I) HIS OR HER MEDICAL DIAGNOSIS AND PROGNOSIS OF SIX MONTHS OR LESS;
(II) THE FEASIBLE ALTERNATIVES OR ADDITIONAL TREATMENT OPPORTUNITIES, INCLUDING COMFORT CARE, PALLIATIVE CARE, HOSPICE CARE, AND PAIN CONTROL;
(III) THE POTENTIAL RISKS ASSOCIATED WITH TAKING THE MEDICAL AID-IN-DYING MEDICATION TO BE PRESCRIBED;
(IV) THE PROBABLE RESULT OF TAKING THE MEDICAL AID-IN-DYING MEDICATION TO BE PRESCRIBED; AND
(V) THE POSSIBILITY THAT THE INDIVIDUAL CAN OBTAIN THE MEDICAL AID-IN-DYING MEDICATION BUT CHOOSE NOT TO USE IT;
(f) REFER THE INDIVIDUAL TO A LICENSED MENTAL HEALTH PROFESSIONAL PURSUANT TO SECTION 25-48-108 IF THE ATTENDING PHYSICIAN BELIEVES THAT THE INDIVIDUAL MAY NOT BE MENTALLY CAPABLE OF MAKING AN INFORMED DECISION;
(g) CONFIRM THAT THE INDIVIDUAL'S REQUEST DOES NOT ARISE FROM COERCION OR UNDUE INFLUENCE BY ANOTHER PERSON BY DISCUSSING WITH THE INDIVIDUAL, OUTSIDE THE PRESENCE OF

OTHER PERSONS, WHETHER THE INDIVIDUAL IS FEELING COERCED OR UNDULY INFLUENCED BY ANOTHER PERSON;

(h) COUNSEL THE INDIVIDUAL ABOUT THE IMPORTANCE OF:

(I) HAVING ANOTHER PERSON PRESENT WHEN THE INDIVIDUAL SELF-ADMINISTERS THE MEDICAL AID-IN-DYING MEDICATION PRESCRIBED PURSUANT TO THIS ARTICLE;

(II) NOT TAKING THE MEDICAL AID-IN-DYING MEDICATION IN A PUBLIC PLACE;

(III) SAFE-KEEPING AND PROPER DISPOSAL OF UNUSED MEDICAL AID-IN-DYING MEDICATION IN ACCORDANCE WITH SECTION 25-48-120; AND

(IV) NOTIFYING HIS OR HER NEXT OF KIN OF THE REQUEST FOR MEDICAL AID-IN-DYING MEDICATION;

(i) INFORM THE INDIVIDUAL THAT HE OR SHE MAY RESCIND THE REQUEST FOR MEDICAL AID-IN-DYING MEDICATION AT ANY TIME AND IN ANY MANNER;

(j) VERIFY, IMMEDIATELY PRIOR TO WRITING THE PRESCRIPTION FOR MEDICAL AID-IN-DYING MEDICATION, THAT THE INDIVIDUAL IS MAKING AN INFORMED DECISION;

(k) ENSURE THAT ALL APPROPRIATE STEPS ARE CARRIED OUT IN ACCORDANCE WITH THIS ARTICLE BEFORE WRITING A PRESCRIPTION FOR MEDICAL AID-IN-DYING MEDICATION; AND

(l) EITHER:

(I) DISPENSE MEDICAL AID-IN-DYING MEDICATIONS DIRECTLY TO THE QUALIFIED INDIVIDUAL, INCLUDING ANCILLARY MEDICATIONS INTENDED TO MINIMIZE THE INDIVIDUAL'S DISCOMFORT, IF THE ATTENDING PHYSICIAN HAS A CURRENT DRUG ENFORCEMENT ADMINISTRATION CERTIFICATE AND COMPLIES WITH ANY APPLICABLE ADMINISTRATIVE RULE; OR

(II) DELIVER THE WRITTEN PRESCRIPTION PERSONALLY, BY MAIL, OR THROUGH AUTHORIZED ELECTRONIC TRANSMISSION IN THE MANNER PERMITTED UNDER ARTICLE 42.5 OF TITLE 12, C.R.S., TO A LICENSED PHARMACIST, WHO SHALL DISPENSE THE MEDICAL AID-IN-DYING MEDICATION TO THE QUALIFIED INDIVIDUAL, THE ATTENDING PHYSICIAN, OR AN INDIVIDUAL EXPRESSLY DESIGNATED BY THE QUALIFIED INDIVIDUAL.

25-48-107. Consulting physician responsibilities. BEFORE AN INDIVIDUAL WHO IS REQUESTING MEDICAL AID-IN-DYING MEDICATION MAY RECEIVE A PRESCRIPTION FOR THE MEDICAL AID-IN-DYING MEDICATION, A CONSULTING PHYSICIAN MUST:

(1) EXAMINE THE INDIVIDUAL AND HIS OR HER RELEVANT MEDICAL RECORDS;

(2) CONFIRM, IN WRITING, TO THE ATTENDING PHYSICIAN:

(a) THAT THE INDIVIDUAL HAS A TERMINAL ILLNESS;

(b) THE INDIVIDUAL HAS A PROGNOSIS OF SIX MONTHS OR LESS;

(c) THAT THE INDIVIDUAL IS MAKING AN INFORMED DECISION; AND

(d) THAT THE INDIVIDUAL IS MENTALLY CAPABLE, OR PROVIDE DOCUMENTATION THAT THE CONSULTING PHYSICIAN HAS REFERRED THE INDIVIDUAL FOR FURTHER EVALUATION IN ACCORDANCE WITH SECTION 25-48-108.

25-48-108. Confirmation that individual is mentally capable - referral to mental health professional. (1) AN ATTENDING PHYSICIAN SHALL NOT PRESCRIBE MEDICAL AID-IN-DYING

MEDICATION UNDER THIS ARTICLE FOR AN INDIVIDUAL WITH A TERMINAL ILLNESS UNTIL THE INDIVIDUAL IS DETERMINED TO BE MENTALLY CAPABLE AND MAKING AN INFORMED DECISION, AND THOSE DETERMINATIONS ARE CONFIRMED IN ACCORDANCE WITH THIS SECTION.

(2) IF THE ATTENDING PHYSICIAN OR THE CONSULTING PHYSICIAN BELIEVES THAT THE INDIVIDUAL MAY NOT BE MENTALLY CAPABLE OF MAKING AN INFORMED DECISION, THE ATTENDING PHYSICIAN OR CONSULTING PHYSICIAN SHALL REFER THE INDIVIDUAL TO A LICENSED MENTAL HEALTH PROFESSIONAL FOR A DETERMINATION OF WHETHER THE INDIVIDUAL IS MENTALLY CAPABLE AND MAKING AN INFORMED DECISION.

(3) A LICENSED MENTAL HEALTH PROFESSIONAL WHO EVALUATES AN INDIVIDUAL UNDER THIS SECTION SHALL COMMUNICATE, IN WRITING, TO THE ATTENDING OR CONSULTING PHYSICIAN WHO REQUESTED THE EVALUATION, HIS OR HER CONCLUSIONS ABOUT WHETHER THE INDIVIDUAL IS MENTALLY CAPABLE AND MAKING INFORMED DECISIONS. IF THE LICENSED MENTAL HEALTH PROFESSIONAL DETERMINES THAT THE INDIVIDUAL IS NOT MENTALLY CAPABLE OF MAKING INFORMED DECISIONS, THE PERSON SHALL NOT BE DEEMED A QUALIFIED INDIVIDUAL UNDER THIS ARTICLE AND THE ATTENDING PHYSICIAN SHALL NOT PRESCRIBE MEDICAL AID-IN-DYING MEDICATION TO THE INDIVIDUAL.

25-48-109. Death certificate. (1) UNLESS OTHERWISE PROHIBITED BY LAW, THE ATTENDING PHYSICIAN OR THE HOSPICE MEDICAL DIRECTOR SHALL SIGN THE DEATH CERTIFICATE OF A QUALIFIED INDIVIDUAL WHO OBTAINED AND SELF-ADMINISTERED AID-IN-DYING MEDICATION.

(2) WHEN A DEATH HAS OCCURRED IN ACCORDANCE WITH THIS ARTICLE, THE CAUSE OF DEATH SHALL BE LISTED AS THE UNDERLYING TERMINAL ILLNESS AND THE DEATH DOES NOT CONSTITUTE GROUNDS FOR POST-MORTEM INQUIRY UNDER SECTION 30-10-606 (1), C.R.S.

25-48-110. Informed decision required. (1) AN INDIVIDUAL WITH A TERMINAL ILLNESS IS NOT A QUALIFIED INDIVIDUAL AND MAY NOT RECEIVE A PRESCRIPTION FOR MEDICAL AID-IN-DYING MEDICATION UNLESS HE OR SHE HAS MADE AN INFORMED DECISION.

(2) IMMEDIATELY BEFORE WRITING A PRESCRIPTION FOR MEDICAL AID-IN-DYING MEDICATION UNDER THIS ARTICLE, THE ATTENDING PHYSICIAN SHALL VERIFY THAT THE INDIVIDUAL WITH A TERMINAL ILLNESS IS MAKING AN INFORMED DECISION.

25-48-111. Medical record documentation requirements - reporting requirements - department compliance reviews - rules. (1) THE ATTENDING PHYSICIAN SHALL DOCUMENT IN THE INDIVIDUAL'S MEDICAL RECORD, THE FOLLOWING INFORMATION:

(a) DATES OF ALL ORAL REQUESTS;

(b) A VALID WRITTEN REQUEST;

(c) THE ATTENDING PHYSICIAN'S DIAGNOSIS AND PROGNOSIS, DETERMINATION OF MENTAL CAPACITY AND THAT THE INDIVIDUAL IS MAKING A VOLUNTARY REQUEST AND AN INFORMED DECISION;

(d) THE CONSULTING PHYSICIAN'S CONFIRMATION OF DIAGNOSIS AND PROGNOSIS, MENTAL CAPACITY AND THAT THE INDIVIDUAL IS MAKING AN INFORMED DECISION;
(e) IF APPLICABLE, WRITTEN CONFIRMATION OF MENTAL CAPACITY FROM A LICENSED MENTAL HEALTH PROFESSIONAL;
(f) A NOTATION OF NOTIFICATION OF THE RIGHT TO RESCIND A REQUEST MADE PURSUANT TO THIS ARTICLE; AND
(g) A NOTATION BY THE ATTENDING PHYSICIAN THAT ALL REQUIREMENTS UNDER THIS ARTICLE HAVE BEEN SATISFIED; INDICATING STEPS TAKEN TO CARRY OUT THE REQUEST, INCLUDING A NOTATION OF THE MEDICAL AID-IN-DYING MEDICATIONS PRESCRIBED AND WHEN.
(2)(a) THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT SHALL ANNUALLY REVIEW A SAMPLE OF RECORDS MAINTAINED PURSUANT TO THIS ARTICLE TO ENSURE COMPLIANCE. THE DEPARTMENT SHALL ADOPT RULES TO FACILITATE THE COLLECTION OF INFORMATION DEFINED IN SUBSECTION (1) OF THIS SECTION. EXCEPT AS OTHERWISE REQUIRED BY LAW, THE INFORMATION COLLECTED BY THE DEPARTMENT IS NOT A PUBLIC RECORD AND IS NOT AVAILABLE FOR PUBLIC INSPECTION. HOWEVER, THE DEPARTMENT SHALL GENERATE AND MAKE AVAILABLE TO THE PUBLIC AN ANNUAL STATISTICAL REPORT OF INFORMATION COLLECTED UNDER THIS SUBSECTION (2).
(b) THE DEPARTMENT SHALL REQUIRE ANY HEALTH CARE PROVIDER, UPON DISPENSING A MEDICAL AID-IN-DYING MEDICATION PURSUANT TO THIS ARTICLE, TO FILE A COPY OF A DISPENSING RECORD WITH THE DEPARTMENT. THE DISPENSING RECORD IS NOT A PUBLIC RECORD AND IS NOT AVAILABLE FOR PUBLIC INSPECTION.

25-48-112. Form of written request. (1) A REQUEST FOR MEDICAL AID-IN-DYING MEDICATION AUTHORIZED BY THIS ARTICLE MUST BE IN SUBSTANTIALLY THE FOLLOWING FORM:

REQUEST FOR MEDICATION TO END MY LIFE
IN A PEACEFUL MANNER

I,_____AM AN ADULT OF SOUND MIND. I AM SUFFERING FROM_____, WHICH MY ATTENDING PHYSICIAN HAS DETERMINED IS A TERMINAL ILLNESS AND WHICH HAS BEEN MEDICALLY CONFIRMED. I HAVE BEEN FULLY INFORMED OF MY DIAGNOSIS AND PROGNOSIS OF SIX MONTHS OR LESS, THE NATURE OF THE MEDICAL AID-IN-DYING MEDICATION TO BE PRESCRIBED AND POTENTIAL ASSOCIATED RISKS, THE EXPECTED RESULT, AND THE FEASIBLE ALTERNATIVES OR ADDITIONAL TREATMENT OPPORTUNITIES, INCLUDING COMFORT CARE, PALLIATIVE CARE, HOSPICE CARE, AND PAIN CONTROL.
I REQUEST THAT MY ATTENDING PHYSICIAN PRESCRIBE MEDICAL AID-IN-DYING MEDICATION THAT WILL END MY LIFE IN A PEACEFUL MANNER IF I CHOOSE TO TAKE IT, AND I AUTHORIZE MY ATTENDING PHYSICIAN TO CONTACT ANY PHARMACIST ABOUT MY REQUEST.
I UNDERSTAND THAT I HAVE THE RIGHT TO RESCIND THIS REQUEST AT ANY TIME.
I UNDERSTAND THE SERIOUSNESS OF THIS REQUEST, AND I EXPECT TO DIE IF I TAKE THE AID-IN-DYING MEDICATION PRESCRIBED.

I FURTHER UNDERSTAND THAT ALTHOUGH MOST DEATHS OCCUR WITHIN THREE HOURS, MY DEATH MAY TAKE LONGER, AND MY ATTENDING PHYSICIAN HAS COUNSELED ME ABOUT THIS POSSIBILITY. I MAKE THIS REQUEST VOLUNTARILY, WITHOUT RESERVATION, AND WITHOUT BEING COERCED, AND I ACCEPT FULL RESPONSIBILITY FOR MY ACTIONS.

SIGNED: _____
DATED: _____

DECLARATION OF WITNESSES

WE DECLARE THAT THE INDIVIDUAL SIGNING THIS REQUEST:

IS PERSONALLY KNOWN TO US OR HAS PROVIDED PROOF OF IDENTITY;
SIGNED THIS REQUEST IN OUR PRESENCE;

APPEARS TO BE OF SOUND MIND AND NOT UNDER DURESS, COERCION, OR UNDUE INFLUENCE; AND

I AM NOT THE ATTENDING PHYSICIAN FOR THE INDIVIDUAL.

_____WITNESS 1/DATE
_____WITNESS 2/DATE

NOTE: OF THE TWO WITNESSES TO THE WRITTEN REQUEST, AT LEAST ONE MUST NOT:
BE A RELATIVE (BY BLOOD, MARRIAGE, CIVIL UNION, OR ADOPTION) OF THE INDIVIDUAL SIGNING THIS REQUEST; BE ENTITLED TO ANY PORTION OF THE INDIVIDUAL'S ESTATE UPON DEATH; OR OWN, OPERATE, OR BE EMPLOYED AT A HEALTH CARE FACILITY WHERE THE INDIVIDUAL IS A PATIENT OR RESIDENT.
AND NEITHER THE INDIVIDUAL'S ATTENDING PHYSICIAN NOR A PERSON AUTHORIZED AS THE INDIVIDUAL'S QUALIFIED POWER OF ATTORNEY OR DURABLE MEDICAL POWER OF ATTORNEY SHALL SERVE AS A WITNESS TO THE WRITTEN REQUEST.

25-48-113. Standard of care. (1) PHYSICIANS AND HEALTH CARE PROVIDERS SHALL PROVIDE MEDICAL SERVICES UNDER THIS ACT THAT MEET OR EXCEED THE STANDARD OF CARE FOR END-OF-LIFE MEDICAL CARE.
(2) IF A HEALTH CARE PROVIDER IS UNABLE OR UNWILLING TO CARRY OUT AN ELIGIBLE INDIVIDUAL'S REQUEST AND THE INDIVIDUAL TRANSFERS CARE TO A NEW HEALTH CARE PROVIDER, THE HEALTH CARE PROVIDER SHALL COORDINATE TRANSFER OF THE INDIVIDUAL'S MEDICAL RECORDS TO A NEW HEALTH CARE PROVIDER.

25-48-114. Effect on wills, contracts, and statutes. (1) A PROVISION IN A CONTRACT, WILL, OR OTHER AGREEMENT, WHETHER WRITTEN OR ORAL, THAT WOULD AFFECT WHETHER AN INDIVIDUAL

MAY MAKE OR RESCIND A REQUEST FOR MEDICAL AID IN DYING PURSUANT TO THIS ARTICLE IS INVALID.

(2) AN OBLIGATION OWING UNDER ANY CURRENTLY EXISTING CONTRACT MUST NOT BE CONDITIONED UPON, OR AFFECTED BY, AN INDIVIDUAL'S ACT OF MAKING OR RESCINDING A REQUEST FOR MEDICAL AID-IN-DYING MEDICATION PURSUANT TO THIS ARTICLE.

25-48-115. Insurance or annuity policies. (1) THE SALE, PROCUREMENT, OR ISSUANCE OF, OR THE RATE CHARGED FOR, ANY LIFE, HEALTH, OR ACCIDENT INSURANCE OR ANNUITY POLICY MUST NOT BE CONDITIONED UPON, OR AFFECTED BY, AN INDIVIDUAL'S ACT OF MAKING OR RESCINDING A REQUEST FOR MEDICAL AID-IN-DYING MEDICATION IN ACCORDANCE WITH THIS ARTICLE.

(2) A QUALIFIED INDIVIDUAL'S ACT OF SELF-ADMINISTERING MEDICAL AID-IN-DYING MEDICATION PURSUANT TO THIS ARTICLE DOES NOT AFFECT A LIFE, HEALTH, OR ACCIDENT INSURANCE OR ANNUITY POLICY.

(3) AN INSURER SHALL NOT DENY OR OTHERWISE ALTER HEALTH CARE BENEFITS AVAILABLE UNDER A POLICY OF SICKNESS AND ACCIDENT INSURANCE TO AN INDIVIDUAL WITH A TERMINAL ILLNESS WHO IS COVERED UNDER THE POLICY, BASED ON WHETHER OR NOT THE INDIVIDUAL MAKES A REQUEST PURSUANT TO THIS ARTICLE.

(4) AN INDIVIDUAL WITH A TERMINAL ILLNESS WHO IS A RECIPIENT OF MEDICAL ASSISTANCE UNDER THE "COLORADO MEDICAL ASSISTANCE ACT", ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S. SHALL NOT BE DENIED BENEFITS UNDER THE MEDICAL ASSISTANCE PROGRAM OR HAVE HIS OR HER BENEFITS UNDER THE PROGRAM OTHERWISE ALTERED BASED ON WHETHER OR NOT THE INDIVIDUAL MAKES A REQUEST PURSUANT TO THIS ARTICLE.

25-48-116. Immunity for actions in good faith - prohibition against reprisals. (1) A PERSON IS NOT SUBJECT TO CIVIL OR CRIMINAL LIABILITY OR PROFESSIONAL DISCIPLINARY ACTION FOR ACTING IN GOOD FAITH UNDER THIS ARTICLE, WHICH INCLUDES BEING PRESENT WHEN A QUALIFIED INDIVIDUAL SELF-ADMINISTERS THE PRESCRIBED MEDICAL AID-IN-DYING MEDICATION.

(2) EXCEPT AS PROVIDED FOR IN SECTION 25-48-118, A HEALTH CARE PROVIDER OR PROFESSIONAL ORGANIZATION OR ASSOCIATION SHALL NOT SUBJECT AN INDIVIDUAL TO ANY OF THE FOLLOWING FOR PARTICIPATING OR REFUSING TO PARTICIPATE IN GOOD-FAITH COMPLIANCE UNDER THIS ARTICLE:

(a) CENSURE;

(b) DISCIPLINE;

(c) SUSPENSION;

(d) LOSS OF LICENSE, PRIVILEGES, OR MEMBERSHIP; OR

(e) ANY OTHER PENALTY.

(3) A REQUEST BY AN INDIVIDUAL FOR, OR THE PROVISION BY AN ATTENDING PHYSICIAN OF, MEDICAL AID-IN-DYING MEDICATION IN GOOD-FAITH COMPLIANCE WITH THIS ARTICLE DOES NOT:

(a) CONSTITUTE NEGLECT OR ELDER ABUSE FOR ANY PURPOSE OF LAW; OR

(b) PROVIDE THE BASIS FOR THE APPOINTMENT OF A GUARDIAN OR CONSERVATOR.

(4) THIS SECTION DOES NOT LIMIT CIVIL OR CRIMINAL LIABILITY FOR NEGLIGENCE, RECKLESSNESS, OR INTENTIONAL MISCONDUCT.

25-48-117. No duty to prescribe or dispense. (1) A HEALTH CARE PROVIDER MAY CHOOSE WHETHER TO PARTICIPATE IN PROVIDING MEDICAL AID-IN-DYING MEDICATION TO AN INDIVIDUAL IN ACCORDANCE WITH THIS ARTICLE.
(2) IF A HEALTH CARE PROVIDER IS UNABLE OR UNWILLING TO CARRY OUT AN INDIVIDUAL'S REQUEST FOR MEDICAL AID-IN-DYING MEDICATION MADE IN ACCORDANCE WITH THIS ARTICLE, AND THE INDIVIDUAL TRANSFERS HIS OR HER CARE TO A NEW HEALTH CARE PROVIDER, THE PRIOR HEALTH CARE PROVIDER SHALL TRANSFER, UPON REQUEST, A COPY OF THE INDIVIDUAL'S RELEVANT MEDICAL RECORDS TO THE NEW HEALTH CARE PROVIDER.

25-48-118. Health care facility permissible prohibitions - sanctions if provider violates policy. (1) A HEALTH CARE FACILITY MAY PROHIBIT A PHYSICIAN EMPLOYED OR UNDER CONTRACT FROM WRITING A PRESCRIPTION FOR MEDICAL AID-IN-DYING MEDICATION FOR A QUALIFIED INDIVIDUAL WHO INTENDS TO USE THE MEDICAL AID-IN-DYING MEDICATION ON THE FACILITY'S PREMISES. THE HEALTH CARE FACILITY MUST NOTIFY THE PHYSICIAN IN WRITING OF ITS POLICY WITH REGARD TO PRESCRIPTIONS FOR MEDICAL AID-IN-DYING MEDICATION. A HEALTH CARE FACILITY THAT FAILS TO PROVIDE ADVANCE NOTICE TO THE PHYSICIAN SHALL NOT BE ENTITLED TO ENFORCE SUCH A POLICY AGAINST THE PHYSICIAN.
(2) A HEALTH CARE FACILITY OR HEALTH CARE PROVIDER SHALL NOT SUBJECT A PHYSICIAN, NURSE, PHARMACIST, OR OTHER PERSON TO DISCIPLINE, SUSPENSION, LOSS OF LICENSE OR PRIVILEGES, OR ANY OTHER PENALTY OR SANCTION FOR ACTIONS TAKEN IN GOOD-FAITH RELIANCE ON THIS ARTICLE OR FOR REFUSING TO ACT UNDER THIS ARTICLE.
(3) A HEALTH CARE FACILITY MUST NOTIFY PATIENTS IN WRITING OF ITS POLICY WITH REGARD TO MEDICAL AID-IN-DYING. A HEALTH CARE FACILITY THAT FAILS TO PROVIDE ADVANCE NOTIFICATION TO PATIENTS SHALL NOT BE ENTITLED TO ENFORCE SUCH A POLICY.

25-48-119. Liabilities. (1) A PERSON COMMITS A CLASS 2 FELONY AND IS SUBJECT TO PUNISHMENT IN ACCORDANCE WITH SECTION 18-1.3-401, C.R.S. IF THE PERSON, KNOWINGLY OR INTENTIONALLY CAUSES AN INDIVIDUAL'S DEATH BY:
(a) FORGING OR ALTERING A REQUEST FOR MEDICAL AID-IN-DYING MEDICATION TO END AN INDIVIDUAL'S LIFE WITHOUT THE INDIVIDUAL'S AUTHORIZATION; OR
(b) CONCEALING OR DESTROYING A RESCISSION OF A REQUEST FOR MEDICAL AID-IN-DYING MEDICATION.
(2) A PERSON COMMITS A CLASS 2 FELONY AND IS SUBJECT TO PUNISHMENT IN ACCORDANCE WITH SECTION 18-1.3-401, C.R.S. IF THE PERSON KNOWINGLY OR INTENTIONALLY COERCES OR EXERTS UNDUE INFLUENCE ON AN INDIVIDUAL WITH A TERMINAL ILLNESS TO:
(a) REQUEST MEDICAL AID-IN-DYING MEDICATION FOR THE PURPOSE OF ENDING THE TERMINALLY ILL INDIVIDUAL'S LIFE; OR
(b) DESTROY A RESCISSION OF A REQUEST FOR MEDICAL AID-IN-DYING MEDICATION.

(3) NOTHING IN THIS ARTICLE LIMITS FURTHER LIABILITY FOR CIVIL DAMAGES RESULTING FROM OTHER NEGLIGENT CONDUCT OR INTENTIONAL MISCONDUCT BY ANY PERSON.
(4) THE PENALTIES SPECIFIED IN THIS ARTICLE DO NOT PRECLUDE CRIMINAL PENALTIES APPLICABLE UNDER THE "COLORADO CRIMINAL CODE", TITLE 18, C.R.S., FOR CONDUCT THAT IS INCONSISTENT WITH THIS ARTICLE.

25-48-120. Safe disposal of unused medical aid-in-dying medications. A PERSON WHO HAS CUSTODY OR CONTROL OF MEDICAL AID-IN-DYING MEDICATION DISPENSED UNDER THIS ARTICLE THAT THE TERMINALLY ILL INDIVIDUAL DECIDES NOT TO USE OR THAT REMAINS UNUSED AFTER THE TERMINALLY ILL INDIVIDUAL'S DEATH SHALL DISPOSE OF THE UNUSED MEDICAL AID-IN-DYING MEDICATION EITHER BY:
(1) RETURNING THE UNUSED MEDICAL AID-IN-DYING MEDICATION TO THE ATTENDING PHYSICIAN WHO PRESCRIBED THE MEDICAL AID-IN-DYING MEDICATION, WHO SHALL DISPOSE OF THE UNUSED MEDICAL AID-IN-DYING MEDICATION IN THE MANNER REQUIRED BY LAW; OR
(2) LAWFUL MEANS IN ACCORDANCE WITH SECTION 25-15-328, C.R.S. OR ANY OTHER STATE OR FEDERALLY APPROVED MEDICATION TAKE-BACK PROGRAM AUTHORIZED UNDER THE FEDERAL "SECURE AND RESPONSIBLE DRUG DISPOSAL ACT OF 2010", PUB.L.111-273, AND REGULATIONS ADOPTED PURSUANT TO THE FEDERAL ACT.

25-48-121. Actions complying with article not a crime. NOTHING IN THIS ARTICLE AUTHORIZES A PHYSICIAN OR ANY OTHER PERSON TO END AN INDIVIDUAL'S LIFE BY LETHAL INJECTION, MERCY KILLING, OR EUTHANASIA. ACTIONS TAKEN IN ACCORDANCE WITH THIS ARTICLE DO NOT, FOR ANY PURPOSE, CONSTITUTE SUICIDE, ASSISTED SUICIDE, MERCY KILLING, HOMICIDE, OR ELDER ABUSE UNDER THE "COLORADO CRIMINAL CODE", AS SET FORTH IN TITLE 18, C.R.S.

25-48-122. Claims by government entity for costs. A GOVERNMENT ENTITY THAT INCURS COSTS RESULTING FROM AN INDIVIDUAL TERMINATING HIS OR HER LIFE PURSUANT TO THIS ARTICLE IN A PUBLIC PLACE HAS A CLAIM AGAINST THE ESTATE OF THE INDIVIDUAL TO RECOVER THE COSTS AND REASONABLE ATTORNEY FEES RELATED TO ENFORCING THE CLAIM.

25-48-123. No effect on advance medical directives. NOTHING IN THIS ARTICLE SHALL CHANGE THE LEGAL EFFECT OF:
(1) A DECLARATION MADE UNDER ARTICLE 18 OF TITLE 15, C.R.S., DIRECTING THAT LIFE-SUSTAINING PROCEDURES BE WITHHELD OR WITHDRAWN;
(2) A CARDIOPULMONARY RESUSCITATION DIRECTIVE EXECUTED UNDER ARTICLE 18.6 OF TITLE 15, C.R.S.; OR
(3) AN ADVANCE MEDICAL DIRECTIVE EXECUTED UNDER ARTICLE 18.7 OF TITLE 15, C.R.S.

APPENDIX E
State of Hawai'i Statute

APPENDIX E
State of Hawai'i Statute
TITLE 19 – HEALTH - Revised Statutes 2017
327E. Uniform Health-Care Decisions Act (Modified)
https://law.justia.com/codes/hawaii/2017/title-19/chapter-327e/

327E-1 Short title.

Universal Citation: HI Rev Stat Section 327E-1 2017

[§327E-1] Short title.

This chapter may be cited as the Uniform Health-Care Decisions Act (Modified). [L 1999, c 169, pt of §1]

327E-2 Definitions.

Universal Citation: HI Rev Stat Section 327E-2 (2017)

§327E-2 Definitions.

Whenever used in this chapter, unless the context otherwise requires:

"Advance health-care directive" means an individual instruction or a power of attorney for health care.

"Agent" means an individual designated in a power of attorney for health care to make a health-care decision for the individual granting the power.

"Best interest" means that the benefits to the individual resulting from a treatment outweigh the burdens to the individual resulting from that treatment and shall include:

(1) The effect of the treatment on the physical, emotional, and cognitive functions of the patient;

(2) The degree of physical pain or discomfort caused to the individual by the treatment or the withholding or withdrawal of the treatment;

(3) The degree to which the individual's medical condition, the treatment, or the withholding or withdrawal of treatment, results in a severe and continuing impairment;

(4) The effect of the treatment on the life expectancy of the patient;

(5) The prognosis of the patient for recovery, with and without the treatment;

(6) The risks, side effects, and benefits of the treatment or the withholding of treatment; and

(7) The religious beliefs and basic values of the individual receiving treatment, to the extent that these may assist the surrogate decision-maker in determining benefits and
“Capacity” means an individual’s ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health-care decision.
“Emancipated minor” means a person under eighteen years of age who is totally self-supporting.
“Guardian” means a judicially appointed guardian having authority to make a health-care decision for an individual.
“Health care” means any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect an individual’s physical or mental condition, including:
(1) Selection and discharge of health-care providers and institutions;
(2) Approval or disapproval of diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; and
(3) Direction to provide, withhold, or withdraw artificial nutrition and hydration; provided that withholding or withdrawing artificial nutrition or hydration is in accord with generally accepted health care standards applicable to health-care providers or institutions.
“Health-care decision”" means a decision made by an individual or the individual’s agent, guardian, or surrogate, regarding the individual’s health care.
“Health-care institution” means an institution, facility, or agency licensed, certified, or otherwise authorized or permitted by law to provide health care in the ordinary course of business.
“Health-care provider” means an individual licensed, certified, or otherwise authorized or permitted by law to provide health care in the ordinary course of business or practice of a profession.
“Individual instruction” means an individual’s direction concerning a health-care decision for the individual.
“Interested persons” means the patient’s spouse, unless legally separated or estranged, a reciprocal beneficiary, any adult child, either parent of the patient, an adult sibling or adult grandchild of the patient, or any adult who has exhibited special care and concern for the patient and who is familiar with the patient’s personal values.

"Person" means an individual, corporation, business trust, estate, trust, partnership, association, joint venture, government, governmental subdivision, agency, or instrumentality, or any other legal or commercial entity.

"Physician" means an individual authorized to practice medicine or osteopathy under chapter 453.

"Power of attorney for health care" means the designation of an agent to make health-care decisions for the individual granting the power.

"Primary physician" means a physician designated by an individual or the individual's agent, guardian, or surrogate, to have primary responsibility for the individual's health care or, in the absence of a designation or if the designated physician is not reasonably available, a physician who undertakes the responsibility.

"Reasonably available" means able to be contacted with a level of diligence appropriate to the seriousness and urgency of a patient's health care needs, and willing and able to act in a timely manner considering the urgency of the patient's health care needs.

"State" means a state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, or a territory or insular possession subject to the jurisdiction of the United States.

"Supervising health-care provider" means the primary physician or the physician's designee, or the health-care provider or the provider's designee who has undertaken primary responsibility for an individual's health care.

"Surrogate" means an individual, other than a patient's agent or guardian, authorized under this chapter to make a health-care decision for the patient. [L 1999, c 169, pt of §1; am L 2004, c 161, §3; am L 2009, c 11, §40]

327E-3 Advance health-care directives.

Universal Citation: HI Rev Stat Section 327E-3 (2017)

§327E-3 Advance health-care directives.

(a) An adult or emancipated minor may give an individual instruction. The instruction may be oral or written. The instruction may be limited to take effect only if a specified condition arises.

(b) An adult or emancipated minor may execute a power of attorney for health care, which may authorize the agent to make any health-care decision the principal could have made while having capacity. The power remains in effect notwithstanding the principal's later incapacity and may include individual instructions. Unless related to the principal by blood, marriage, or adoption, an agent may not be an owner, operator, or employee of the health-care institution at which the principal is receiving care. The power shall be in writing, contain the date of its execution, be signed by the principal, and be witnessed by one of the following methods:

(1) Signed by at least two individuals, each of whom witnessed either the signing of the instrument by the principal or the principal's acknowledgment of the signature of the instrument; or

(2) Acknowledged before a notary public at any place within this State.

(c) A witness for a power of attorney for health care shall not be:

(1) A health-care provider;

(2) An employee of a health-care provider or facility; or

(3) The agent.

(d) At least one of the individuals used as a witness for a power of attorney for health care shall be someone who is neither:

(1) Related to the principal by blood, marriage, or adoption; nor

(2) Entitled to any portion of the estate of the principal upon the principal's death under any will or codicil thereto of the principal existing at the time of execution of the power of attorney for health care or by operation of law then existing.

(e) Unless otherwise specified in a power of attorney for health care, the authority of an agent becomes effective only upon a determination that the principal lacks capacity, and ceases to be effective upon a determination that the principal has recovered capacity.

(f) Unless otherwise specified in a written advance health-care directive, a determination that an individual lacks or has recovered capacity, or that another condition exists that affects an individual instruction or the authority of an agent, shall be made by the primary physician.

(g) An agent shall make a health-care decision in accordance with the principal's individual instructions, if any, and other wishes to the extent known to the agent.

Otherwise, the agent shall make the decision in accordance with the agent's determination of the principal's best interest. In determining the principal's best interest, the agent shall consider the principal's personal values to the extent known to the agent.

(h) A health-care decision made by an agent for a principal shall be effective without judicial approval.

(i) A written advance health-care directive may include the individual's nomination of a guardian.

(j) An advance health-care directive shall be valid for purposes of this chapter if it complies with this chapter, or if it was executed in compliance with the laws of the state where it was executed. [L 1999, c 169, pt of §1; am L 2004, c 161, §36]

327E-4 Revocation of advance health-care directive.

Universal Citation: HI Rev Stat Section 327E-4 2017

[§327E-4] Revocation of advance health-care directive.

(a) An individual may revoke the designation of an agent only by a signed writing or by personally informing the supervising health-care provider.

(b) An individual may revoke all or part of an advance health-care directive, other than the designation of an agent, at any time and in any manner that communicates an intent to revoke.

(c) A health-care provider, agent, guardian, or surrogate who is informed of a revocation shall promptly communicate the fact of the revocation to the supervising health-care provider and to any health-care institution at which the patient is receiving care.

(d) A decree of annulment, divorce, dissolution of marriage, or legal separation revokes a previous designation of a spouse as agent unless otherwise specified in the decree or in a power of attorney for health care.

(e) An advance health-care directive that conflicts with an earlier advance health-care directive revokes the earlier directive to the extent of the conflict. [L 1999, c 169, pt of §1]

327E-5 Health-care decisions; surrogates.

Universal Citation: HI Rev Stat Section 327E-5 (2017)

[§327E-5] Health-care decisions; surrogates.

(a) A patient may designate or disqualify any individual to act as a surrogate by personally informing the supervising health-care provider. In the absence of such a designation, or if the designee is not reasonably available, a surrogate may be appointed to make a health-care decision for the patient.

(b) A surrogate may make a health-care decision for a patient who is an adult or emancipated minor if the patient has been determined by the primary physician to lack capacity and no agent or guardian has been appointed or the agent or guardian is not reasonably available. Upon a determination that a patient lacks decisional capacity to provide informed consent to or refusal of medical treatment, the primary physician or the physician's designee shall make reasonable efforts to notify the patient of the patient's lack of capacity. The primary physician, or the physician's designee, shall make reasonable efforts to locate as many interested persons as practicable, and the primary physician may rely on such individuals to notify other family members or interested persons.

(c) Upon locating interested persons, the primary physician, or the physician's designee, shall inform such persons of the patient's lack of decisional capacity and that a surrogate decision-maker should be selected for the patient.

(d) Interested persons shall make reasonable efforts to reach a consensus as to who among them shall make health-care decisions on behalf of the patient. The person selected to act as the patient's surrogate should be the person who has a close relationship with the patient and who is the most likely to be currently informed of the patient's wishes regarding health-care decisions. If any of the interested persons disagrees with the selection or the decision of the surrogate, or, if after reasonable efforts the interested persons are unable to reach a consensus as to who should act as the surrogate decision-maker, then any of the interested persons may seek guardianship of the patient by initiating guardianship proceedings pursuant to chapter 551. Only interested persons involved in the discussions to choose a surrogate may initiate such proceedings with regard to the patient.

(e) If any interested person, the guardian, or primary physician believes the patient has regained decisional capacity, the primary physician shall reexamine the patient and determine whether or not the patient has regained decisional capacity and shall enter a decision and the basis for such decision into the patient's medical record and shall notify

the patient, the surrogate decision-maker, and the person who initiated the redetermination of decisional capacity.

(f) A surrogate who has been designated by the patient may make health-care decisions for the patient that the patient could make on the patient's own behalf.

(g) A surrogate who has not been designated by the patient may make all health-care decisions for the patient that the patient could make on the patient's own behalf, except that artificial nutrition and hydration may be withheld or withdrawn for a patient upon a decision of the surrogate only when the primary physician and a second independent physician certify in the patient's medical records that the provision or continuation of artificial nutrition or hydration is merely prolonging the act of dying and the patient is highly unlikely to have any neurological response in the future.

The surrogate who has not been designated by the patient shall make health-care decisions for the patient based on the wishes of the patient, or, if the wishes of the patient are unknown or unclear, on the patient's best interest.

The decision of a surrogate who has not been designated by the patient regarding whether life-sustaining procedures should be provided, withheld, or withdrawn shall not be based, in whole or in part, on either a patient's preexisting, long-term mental or physical disability, or a patient's economic status. A surrogate who has not been designated by the patient shall inform the patient, to the extent possible, of the proposed procedure and the fact that someone else is authorized to make a decision regarding that procedure.

(h) A health-care decision made by a surrogate for a patient is effective without judicial approval.

(i) A supervising health-care provider shall require a surrogate to provide a written declaration under the penalty of false swearing stating facts and circumstances reasonably sufficient to establish the claimed authority. [L 1999, c 169, pt of §1]

327E-6 Decisions by guardian.

Universal Citation: HI Rev Stat Section 327E-6 (2017)

§327E-6 Decisions by guardian.

(a) A guardian shall comply with the ward's individual instructions and shall not revoke the ward's pre-incapacity advance health-care directive unless expressly authorized by a court.
(b) Absent a court order to the contrary, a health-care decision of a guardian appointed pursuant to chapter 560 takes precedence over that of an agent.
(c) A health-care decision made by a guardian for the ward is effective without judicial approval. [L 1999, c 169, pt of §1; am L 2004, c 161, §4]

327E-7 Obligations of health-care provider.
Universal Citation: HI Rev Stat Section 327E-7 (2017)
[§327E-7] Obligations of health-care provider.
(a) Before implementing a health-care decision made for a patient, a supervising health-care provider, if possible, shall promptly communicate to the patient the decision made and the identity of the person making the decision.
(b) A supervising health-care provider who knows of the existence of an advance health-care directive, a revocation of an advance health-care directive, or a designation or disqualification of a surrogate, shall promptly record its existence in the patient's health-care record and, if it is in writing, shall request a copy and if one is furnished shall arrange for its maintenance in the health-care record.
(c) A supervising health-care provider who makes or is informed of a determination that a patient lacks or has recovered capacity, or that another condition exists which affects an individual instruction or the authority of an agent, guardian, or surrogate, shall promptly record the determination in the patient's health-care record and communicate the determination to the patient, if possible, and to any person then authorized to make health-care decisions for the patient.
(d) Except as provided in subsections (e) and (f), a health-care provider or institution providing care to a patient shall:
(1) Comply with an individual instruction of the patient and with a reasonable interpretation of that instruction made by a person then authorized to make health-care decisions for the patient; and

(2) Comply with a health-care decision for the patient made by a person then authorized to make health-care decisions for the patient to the same extent as if the decision had been made by the patient while having capacity.

(e) A health-care provider may decline to comply with an individual instruction or health-care decision for reasons of conscience. A health-care institution may decline to comply with an individual instruction or health-care decision if the instruction or decision is contrary to a policy of the institution which is expressly based on reasons of conscience and if the policy was timely communicated to the patient or to a person then authorized to make health-care decisions for the patient.

(f) A health-care provider or institution may decline to comply with an individual instruction or health-care decision that requires medically ineffective health care or health care contrary to generally accepted health-care standards applicable to the health-care provider or institution.

(g) A health-care provider or institution that declines to comply with an individual instruction or health-care decision shall:

(1) Promptly so inform the patient, if possible, and any person then authorized to make health-care decisions for the patient;

(2) Provide continuing care to the patient until a transfer can be effected; and

(3) Unless the patient or person then authorized to make health-care decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health-care provider or institution that is willing to comply with the instruction or decision.

(h) A health-care provider or institution may not require or prohibit the execution or revocation of [an] advance health-care directive as a condition for providing health care. [L 1999, c 169, pt of §1]

327E-8 Health-care information.

Universal Citation: HI Rev Stat Section 327E-8 (2017)

[§327E-8] Health-care information.

Unless otherwise specified in an advance health-care directive, a person then authorized to make health-care decisions for a patient has the same rights as the patient to request,

receive, examine, copy, and consent to the disclosure of medical or any other health-care information. [L 1999, c 169, pt of §1]

327E-9 Immunities.

Universal Citation: HI Rev Stat Section 327E-9 (2017)

[§327E-9] Immunities.

(a) A health-care provider or institution acting in good faith and in accordance with generally accepted health-care standards applicable to the health-care provider or institution shall not be subject to civil or criminal liability or to discipline for unprofessional conduct for:

(1) Complying with a health-care decision of a person apparently having authority to make a health-care decision for a patient, including a decision to withhold or withdraw health care;

(2) Declining to comply with a health-care decision of a person based on a belief that the person then lacked authority; or

(3) Complying with an advance health-care directive and assuming that the directive was valid when made and has not been revoked or terminated.

(b) An individual acting as agent, guardian, or surrogate under this chapter shall not be subject to civil or criminal liability or to discipline for unprofessional conduct for health-care decisions made in good faith. [L 1999, c 169, pt of §1]

327E-10 Statutory damages.

Universal Citation: HI Rev Stat Section 327E-10 (2017)

[§327E-10] Statutory damages.

(a) A health-care provider or institution that intentionally violates this chapter shall be subject to liability to the individual or the individual’s estate for damages of $500 or actual damages resulting from the violation, whichever is greater, plus reasonable attorney's fees.

(b) A person who intentionally falsifies, forges, conceals, defaces, or obliterates an individual's advance health-care directive or a revocation of an advance health-care directive without the individual's consent, or who coerces or fraudulently induces an individual to give, revoke, or not to give an advance health-care directive, shall be subject

to liability to that individual for damages of $2,500 or actual damages resulting from the action, whichever is greater, plus reasonable attorney's fees. [L 1999, c 169, pt of §1]

327E-11 Capacity.

Universal Citation: HI Rev Stat Section E-11 (2017)

[§327E-11] Capacity.

(a) This chapter does not affect the right of an individual to make health-care decisions while having capacity to do so.

(b) An individual is presumed to have capacity to make a health-care decision, to give or revoke an advance health-care directive, and to designate or disqualify a surrogate. [L 1999, c 169, pt of §1]

327E-12 Effect of copy.

Universal Citation: HI Rev State Section 327E-12 (2017)

[§327E-12] Effect of copy.

A copy of a written advance health-care directive, revocation of an advance health-care directive, or designation or disqualification of a surrogate has the same effect as the original. [L 1999, c 169, pt of §1]

327E-13 Effect of this chapter.

Universal Citation: HI Rev Stat Section 327E-13 (2017)

§327E-13 Effect of this chapter.

(a) This chapter shall not create a presumption concerning the intention of an individual who has not made or who has revoked an advance health-care directive.

(b) Death resulting from the withholding or withdrawal of health care in accordance with this chapter shall not for any purpose constitute a suicide or homicide or legally impair or invalidate a policy of insurance or an annuity providing a death benefit, notwithstanding any term of the policy or annuity to the contrary.

(c) This chapter shall not authorize mercy killing, assisted suicide, euthanasia, or the provision, withholding, or withdrawal of health care, to the extent prohibited by other statutes of this State.

(d) This chapter shall not authorize or require a health-care provider or institution to provide health care contrary to generally accepted health-care standards applicable to the health-care provider or institution.
(e) This chapter shall not authorize an agent or surrogate to consent to the admission of an individual to a psychiatric facility as defined in chapter 334, unless the individual's written advance health-care directive expressly so provides.
(f) This chapter shall not affect other statutes of this State governing treatment for mental illness of an individual involuntarily committed to a psychiatric facility. [L 1999, c 169, pt of §1; am L 2000, c 42, §1]

327E-14 Judicial relief.

Universal Citation: HI Rev Stat Section 327E-14 (2017)

[§327E-14] Judicial relief.

On petition of a patient, the patient's agent, guardian, or surrogate, or a health-care provider or institution involved with the patient's care, any court of competent jurisdiction may enjoin or direct a health-care decision or order other equitable relief. A proceeding under this section shall be governed by part 3 of article V of chapter 560. [L 1999, c 169, pt of §1]

327E-15 Uniformity of application and construction.

Universal Citation: HI Rev Stat Section 327E-15 (2017)

[§327E-15] Uniformity of application and construction.

This chapter shall be applied and construed to effectuate its general purpose to make uniform the law with respect to the subject of this chapter among states enacting it. [L 1999, c 169, pt of §1]

327E-16 Optional form.

Universal Citation: HI Rev Stat Section 327E-16 (2017)

§327E-16 Optional form.

The following sample form may be used to create an advance health-care directive. This form may be duplicated. This form may be modified to suit the needs of the person, or a completely different form may be used that contains the substance of the following form.

"ADVANCE HEALTH-CARE DIRECTIVE

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding the designation of your health-care provider. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health-care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator, or employee of a health-care institution where you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all health-care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health-care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

(1) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;

(2) Select or discharge health-care providers and institutions;

(3) Approve or disapprove diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; and

(4) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care.

Part 2 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding,

or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief medication. Space is provided for you to add to the choices you have made or for you to write out any additional wishes.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end and have the form witnessed by one of the two alternative methods listed below. Give a copy of the signed and completed form to your physician, to any other health-care providers you may have, to any health-care institution at which you are receiving care, and to any health-care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health-care directive or replace this form at any time.

PART 1

DURABLE POWER OF ATTORNEY FOR HEALTH-CARE DECISIONS

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health-care decisions for me:

_____

(name of individual you choose as agent)

_____

(address) (city) (state) (zip code)

_____

(home phone) (work phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health-care decision for me, I designate as my first alternate agent:

_____

(name of individual you choose as first alternate agent)

_____

(address) (city) (state) (zip code)

_____

(home phone) (work phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health-care decision for me, I designate as my second alternate agent:

_____

(name of individual you choose as second alternate agent)

_____

(address) (city) (state) (zip code)

_____

(home phone) (work phone)

(2) AGENT'S AUTHORITY: My agent is authorized to make all health-care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive, except as I state here:

_____

_____

_____

(Add additional sheets if needed.)

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health-care decisions unless I mark the following box. If I mark this box [ ], my agent's authority to make health-care decisions for me takes effect immediately.

(4) AGENT'S OBLIGATION: My agent shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) NOMINATION OF GUARDIAN: If a guardian needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or

reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

PART 2

INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want.

(6) END-OF-LIFE DECISIONS: I direct that my health-care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: (Check only one box.)

[ ] (a) Choice Not To Prolong Life

I do not want my life to be prolonged if (i) I have an incurable and irreversible condition that will result in my death within a relatively short time, (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (iii) the likely risks and burdens of treatment would outweigh the expected benefits, OR

[ ] (b) Choice To Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

(7) ARTIFICIAL NUTRITION AND HYDRATION: Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (6) unless I mark the following box. If I mark this box [ ], artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph (6).

(8) RELIEF FROM PAIN: If I mark this box [ ], I direct that treatment to alleviate pain or discomfort should be provided to me even if it hastens my death.

(9) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

_____

_____

(Add additional sheets if needed.)

PART 3

DONATION OF ORGANS AT DEATH

(OPTIONAL)

(10) Upon my death: (mark applicable box)

[ ] (a) I give any needed organs, tissues, or parts,

OR

[ ] (b) I give the following organs, tissues, or parts only

_____

[ ] (c) My gift is for the following purposes (strike any of the following you do not want)

(i) Transplant

(ii) Therapy

(iii) Research

(iv) Education

PART 4

PRIMARY PHYSICIAN

(OPTIONAL)

(11) I designate the following physician as my primary physician:

_____

(name of physician)

_____

(address) (city) (state) (zip code)

_____

(phone)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

_____

(name of physician)

_____

(address) (city) (state) (zip code)

_____

(phone)

(12) EFFECT OF COPY: A copy of this form has the same effect as the original.

(13) SIGNATURES: Sign and date the form here:

_____

(date) (sign your name)

_____

(address) (print your name)

_____

(city) (state)

(14) WITNESSES: This power of attorney will not be valid for making health-care decisions unless it is either (a) signed by two qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or (b) acknowledged before a notary public in the State.

ALTERNATIVE NO. 1

Witness

I declare under penalty of false swearing pursuant to section 710-1062, Hawaii Revised Statutes, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as agent by this document, and that I am not a health-care provider, nor an employee of a health-care provider or facility. I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

_____

(date) (signature of witness)

_____

(address) (printed name of witness)

_____

(city) (state)

Witness

I declare under penalty of false swearing pursuant to section 710-1062, Hawaii Revised Statutes, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as agent by this document, and that I am not a health-care provider, nor an employee of a health-care provider or facility.

_____

(date) (signature of witness)

_____

(address) (printed name of witness)

_____

(city) (state)

ALTERNATIVE NO. 2

State of Hawaii

County of _____

On this _____ day of _____, in the year _____, before me, _____ (insert name of notary public) appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it.

Notary Seal

_____

(Signature of Notary Public)"

[L 1999, c 169, pt of §1; am L 2004, c 161, §36]

Revision Note

Paragraphs re-designated pursuant to §23G-15(1).

APPENDIX F
State of Vermont Statute

APPENDIX F
State of Vermont Statute

Title 18: Health

Chapter 113: Patient Choice at End of Life

§ 5281. Definitions

As used in this chapter:

(1) "Bona fide physician-patient relationship" means a treating or consulting relationship in the course of which a physician has completed a full assessment of the patient's medical history and current medical condition, including a personal physical examination.

(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.

(3) "Health care facility" shall have the same meaning as in section 9432 of this title.

(4) "Health care provider" means a person, partnership, corporation, facility, or institution, licensed or certified or authorized by law to administer health care or dispense medication in the ordinary course of business or practice of a profession.

(5) "Impaired judgment" means that a person does not sufficiently understand or appreciate the relevant facts necessary to make an informed decision.

(6) "Interested person" means:

(A) the patient's physician;

(B) a person who knows that he or she is a relative of the patient by blood, civil marriage, civil union, or adoption;

(C) a person who knows that he or she would be entitled upon the patient's death to any portion of the estate or assets of the patient under any will or trust, by operation of law, or by contract; or

(D) an owner, operator, or employee of a health care facility, nursing home, or residential care facility where the patient is receiving medical treatment or is a resident.

(7) “Palliative care” shall have the same definition as in section 2 of this title.

(8) “Patient” means a person who is 18 years of age or older, a resident of Vermont, and under the care of a physician.

(9) “Physician” means an individual licensed to practice medicine under 26 V.S.A. Chapter 23 or 33.

(10) “Terminal condition” means an incurable and irreversible disease which would, within reasonable medical judgment, result in death within six months. (Added 2013, No. 39, § 1, eff. May 20, 2013.)

§ 5282. Right to information

The rights of a patient under section 1871 of this title to be informed of all available options related to terminal care and under 12 V.S.A. § 1909(d) to receive answers to any specific question about the foreseeable risks and benefits of medication without the physician’s withholding any requested information exist regardless of the purpose of the inquiry or the nature of the information. A physician who engages in discussions with a patient related to such risks and benefits in the circumstances described in this chapter shall not be construed to be assisting in or contributing to a patient's independent decision to self-administer a lethal dose of medication, and such discussions shall not be used to establish civil or criminal liability or professional disciplinary action. (Added 2013, No. 39, § 1, eff. May 20, 2013.)

§ 5283. Requirements for prescription and documentation; immunity

(a) A physician shall not be subject to any civil or criminal liability or professional disciplinary action if the physician prescribes to a patient with a terminal condition medication to be self-administered for the purpose of hastening the patient’s death and the physician affirms by documenting in the patient’s medical record that all of the following occurred:

(1) The patient made an oral request to the physician in the physician’s physical presence for medication to be self-administered for the purpose of hastening the patient’s death.

(2) No fewer than 15 days after the first oral request, the patient made a second oral request to the physician in the physician's physical presence for medication to be self-administered for the purpose of hastening the patient's death.

(3) At the time of the second oral request, the physician offered the patient an opportunity to rescind the request.

(4) The patient made a written request for medication to be self-administered for the purpose of hastening the patient's death that was signed by the patient in the presence of two or more witnesses who were not interested persons, who were at least 18 years of age, and who signed and affirmed that the patient appeared to understand the nature of the document and to be free from duress or undue influence at the time the request was signed.

(5) The physician determined that the patient:

(A) was suffering a terminal condition, based on the physician's physical examination of the patient and review of the patient's relevant medical records;

(B) was capable;

(C) was making an informed decision;

(D) had made a voluntary request for medication to hasten his or her death; and

(E) was a Vermont resident.

(6) The physician informed the patient in person, both verbally and in writing, of all the following:

(A) the patient's medical diagnosis;

(B) the patient's prognosis, including an acknowledgement that the physician's prediction of the patient's life expectancy was an estimate based on the physician's best medical judgment and was not a guarantee of the actual time remaining in the patient's life, and that the patient could live longer than the time predicted;

(C) the range of treatment options appropriate for the patient and the patient's diagnosis;

(D) if the patient was not enrolled in hospice care, all feasible end-of-life services, including palliative care, comfort care, hospice care, and pain control;

(E) the range of possible results, including potential risks associated with taking the medication to be prescribed; and

(F) the probable result of taking the medication to be prescribed.

(7) The physician referred the patient to a second physician for medical confirmation of the diagnosis, prognosis, and a determination that the patient was capable, was acting voluntarily, and had made an informed decision.

(8) The physician either verified that the patient did not have impaired judgment or referred the patient for an evaluation by a psychiatrist, psychologist, or clinical social worker licensed in Vermont for confirmation that the patient was capable and did not have impaired judgment.

(9) If applicable, the physician consulted with the patient's primary care physician with the patient's consent.

(10) The physician informed the patient that the patient may rescind the request at any time and in any manner and offered the patient an opportunity to rescind after the patient's second oral request.

(11) The physician ensured that all required steps were carried out in accordance with this section and confirmed, immediately prior to writing the prescription for medication, that the patient was making an informed decision.

(12) The physician wrote the prescription no fewer than 48 hours after the last to occur of the following events:

(A) the patient's written request for medication to hasten his or her death;

(B) the patient's second oral request; or

(C) the physician's offering the patient an opportunity to rescind the request.

(13) The physician either:

(A) dispensed the medication directly, provided that at the time the physician dispensed the medication, he or she was licensed to dispense medication in Vermont, had a current Drug Enforcement Administration certificate, and complied with any applicable administrative rules; or

(B) with the patient's written consent:

(i) contacted a pharmacist and informed the pharmacist of the prescription; and

(ii) delivered the written prescription personally or by mail or facsimile to the pharmacist, who dispensed the medication to the patient, the physician, or an expressly identified agent of the patient.

(14) The physician recorded and filed the following in the patient's medical record:

(A) the date, time, and wording of all oral requests of the patient for medication to hasten his or her death;

(B) all written requests by the patient for medication to hasten his or her death;

(C) the physician's diagnosis, prognosis, and basis for the determination that the patient was capable, was acting voluntarily, and had made an informed decision;

(D) the second physician's diagnosis, prognosis, and verification that the patient was capable, was acting voluntarily, and had made an informed decision;

(E) the physician's attestation that the patient was enrolled in hospice care at the time of the patient's oral and written requests for medication to hasten his or her death or that the physician informed the patient of all feasible end-of-life services;

(F) the physician's verification that the patient either did not have impaired judgment or that the physician referred the patient for an evaluation and the person conducting the evaluation has determined that the patient did not have impaired judgment;

(G) a report of the outcome and determinations made during any evaluation which the patient may have received;

(H) the date, time, and wording of the physician's offer to the patient to rescind the request for medication at the time of the patient's second oral request; and

(I) a note by the physician indicating that all requirements under this section were satisfied and describing all of the steps taken to carry out the request, including a notation of the medication prescribed.

(15) After writing the prescription, the physician promptly filed a report with the Department of Health documenting completion of all of the requirements under this section.

(b) This section shall not be construed to limit civil or criminal liability for gross negligence, recklessness, or intentional misconduct. (Added 2013, No. 39, § 1, eff. May 20, 2013.)

§ 5284. No duty to aid

A patient with a terminal condition who self-administers a lethal dose of medication shall not be considered to be a person exposed to grave physical harm under 12 V.S.A. § 519, and no person shall be subject to civil or criminal liability solely for being present when a patient with a terminal condition self-administers a lethal dose of medication or for not acting to prevent the patient from self-administering a lethal dose of medication. (Added 2013, No. 39, § 1, eff. May 20, 2013.)

§ 5285. Limitations on actions

(a) A physician, nurse, pharmacist, or other person shall not be under any duty, by law or contract, to participate in the provision of a lethal dose of medication to a patient.

(b) A health care facility or health care provider shall not subject a physician, nurse, pharmacist, or other person to discipline, suspension, loss of license, loss of privileges, or other penalty for actions taken in good faith reliance on the provisions of this chapter or refusals to act under this chapter.

(c) Except as otherwise provided in this section and sections 5283, 5289, and 5290 of this title, nothing in this chapter shall be construed to limit liability for civil damages resulting from negligent conduct or intentional misconduct by any person. (Added 2013, No. 39, § 1, eff. May 20, 2013.)

§ 5286. Health care facility exception

A health care facility may prohibit a physician from writing a prescription for a dose of medication intended to be lethal for a patient who is a resident in its facility and intends to use the medication on the facility's premises, provided the facility has notified the physician in writing of its policy with regard to the prescriptions. Notwithstanding subsection 5285(b) of this title, any physician who violates a policy established by a health care facility under this section may be subject to sanctions otherwise allowable under law or contract. (Added 2013, No. 39, § 1, eff. May 20, 2013.)

§ 5287. Insurance policies; prohibitions

(a) A person and his or her beneficiaries shall not be denied benefits under a life insurance policy, as defined in 8 V.S.A. § 3301, for actions taken in accordance with this chapter.

(b) The sale, procurement, or issue of any medical malpractice insurance policy or the rate charged for the policy shall not be conditioned upon or affected by whether the physician is willing or unwilling to participate in the provisions of this chapter. (Added 2013, No. 39, § 1, eff. May 20, 2013.)

§ 5288. No effect on palliative sedation

This chapter shall not limit or otherwise affect the provision, administration, or receipt of palliative sedation consistent with accepted medical standards. (Added 2013, No. 39, § 1, eff. May 20, 2013.)

§ 5289, 5290. Repealed. 2015, No. 27, § 1, effective May 20, 2015.

§ 5291. Safe disposal of unused medications

The Department of Health shall adopt rules providing for the safe disposal of unused medications prescribed under this chapter. (Added 2013, No. 39, § 1, eff. May 20, 2013.)

§ 5292. Statutory construction

Nothing in this chapter shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing, or active euthanasia. Action taken in accordance with this chapter shall not be construed for any purpose to constitute suicide, assisted suicide, mercy killing, or homicide under the law. This section shall not be construed to conflict with section 1553 of the Patient Protection and Affordable Care Act, Pub.L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub.L. No. 111-152. (Added 2013, No. 39, § 1, eff. May 20, 2013.)

§ 5293. Reporting requirements

(a) The Department of Health shall adopt rules pursuant to 3 V.S.A. chapter 25 to facilitate the collection of information regarding compliance with this chapter, including identifying patients who filled prescriptions written pursuant to this chapter. Except as otherwise required by law, information regarding compliance shall be confidential and shall be exempt from public inspection and copying under the Public Records Act.

(b) Beginning in 2018, the Department of Health shall generate and make available to the public a biennial statistical report of the information collected pursuant to subsection (a) of this section, as long as releasing information complies with the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191. (Added 2015, No. 27, § 2, eff. May 20, 2015.)

APPENDIX G
State of Washington

APPENDIX G
State of Washington Statute

Initiative Measure No. 1000

The Washington Death with Dignity Act

Filed

JAN 24 2008

SECRETARY OF STATE

Section Outline

Immunities and Liabilities

Additional Provisions

Initiative Measure No. 1000

Filed

JAN 24 2008

SECRETARY OF STATE

AN ACT Relating to death with dignity; amending RCW 70.122.100; reenacting and amending RCW 42.56.360 and 42.56.360; adding a new chapter to Title 70 RCW; prescribing penalties; providing an effective date; and providing an expiration date.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF WASHINGTON:

THE WASHINGTON DEATH WITH DIGNITY ACT

General Provisions

NEW SECTION. **Sec. 1.** DEFINITIONS. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Adult" means an individual who is eighteen years of age or older.

(2) "Attending physician" means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.

(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.

(4) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.

(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.

(6) "Health care provider" means a person licensed, certified, or otherwise authorized or permitted by law to administer health care or dispense medication in the ordinary course of business or practice of a profession, and includes a health care facility.

(7) "Informed decision" means a decision by a qualified patient, to request and obtain a prescription for medication that the qualified patient may self-administer to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:

(a) His or her medical diagnosis;

(b) His or her prognosis;

(c) The potential risks associated with taking the medication to be prescribed;

(d) The probable result of taking the medication to be prescribed; and

(e) The feasible alternatives including, but not limited to, comfort care, hospice care, and pain control.

(8) "Medically confirmed" means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.

(9) "Patient" means a person who is under the care of a physician.

(10) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine in the state of Washington.

(11) "Qualified patient" means a competent adult who is a resident of Washington state and has satisfied the requirements of this chapter

in order to obtain a prescription for medication that the qualified patient may self-administer to end his or her life in a humane and dignified manner.

(12) "Self-administer" means a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner.

(13) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.

Written Request for Medication to End Life in a Humane and Dignified Manner

NEW SECTION. **Sec. 2.** WHO MAY INITIATE A WRITTEN REQUEST FOR MEDICATION. (1) An adult who is competent, is a resident of Washington state, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication that the patient may self-administer to end his or her life in a humane and dignified manner in accordance with this chapter.

(2) A person does not qualify under this chapter solely because of age or disability.

NEW SECTION. **Sec. 3.** FORM OF THE WRITTEN REQUEST. (1) A valid request for medication under this chapter shall be in substantially the form described in section 22 of this act, signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is competent, acting voluntarily, and is not being coerced to sign the request.

(2) One of the witnesses shall be a person who is not:

(a) A relative of the patient by blood, marriage, or adoption;

(b) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or

(c) An owner, operator, or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.

(3) The patient's attending physician at the time the request is signed shall not be a witness.

(4) If the patient is a patient in a long-term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility and having the qualifications specified by the department of health by rule.

Safeguards

NEW SECTION. **Sec. 4.** ATTENDING PHYSICIAN RESPONSIBILITIES. (1) The attending physician shall:

(a) Make the initial determination of whether a patient has a terminal disease, is competent, and has made the request voluntarily;

(b) Request that the patient demonstrate Washington state residency under section 13 of this act;

(c) To ensure that the patient is making an informed decision, inform the patient of:

(i) His or her medical diagnosis;

(ii) His or her prognosis;

(iii) The potential risks associated with taking the medication to be prescribed;

(iv) The probable result of taking the medication to be prescribed; and

(v) The feasible alternatives including, but not limited to, comfort care, hospice care, and pain control;

(d) Refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is competent and acting voluntarily;

(e) Refer the patient for counseling if appropriate under section 6 of this act;

(f) Recommend that the patient notify next of kin;

(g) Counsel the patient about the importance of having another person present when the patient takes the medication prescribed under this chapter and of not taking the medication in a public place;

(h) 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 at the end of the fifteen-day waiting period under section 9 of this act;

(i) Verify, immediately before writing the prescription for medication under this chapter, that the patient is making an informed decision;

(j) Fulfill the medical record documentation requirements of section 12 of this act;

(k) Ensure that all appropriate steps are carried out in accordance with this chapter before writing a prescription for medication to enable a qualified patient to end his or her life in a humane and dignified manner; and

(l)(i) Dispense medications directly, including ancillary medications intended to facilitate the desired effect to minimize the patient's discomfort, if the attending physician is authorized under statute and rule to dispense and has a current drug enforcement administration certificate; or

(ii) With the patient's written consent:

(A) Contact a pharmacist and inform the pharmacist of the prescription; and

(B) Deliver the written prescription personally, by mail or facsimile to the pharmacist, who will dispense the medications directly to either the patient, the attending physician, or an expressly identified agent of the patient. Medications dispensed pursuant to this subsection shall not be dispensed by mail or other form of courier.

(2) The attending physician may sign the patient's death certificate which shall list the underlying terminal disease as the cause of death.

NEW SECTION. **Sec. 5.** CONSULTING PHYSICIAN CONFIRMATION. Before a patient is qualified under this chapter, a consulting physician shall examine the patient and his or her relevant medical records and confirm, in writing, the attending physician's diagnosis that the patient is suffering from a terminal disease, and verify that the patient is competent, is acting voluntarily, and has made an informed decision.

NEW SECTION. **Sec. 6.** COUNSELING REFERRAL. If, in the opinion of the attending physician or the consulting physician, a patient may be suffering from a psychiatric or psychological disorder or depression

causing impaired judgment, either physician shall refer the patient for counseling. Medication to end a patient's life in a humane and dignified manner shall not be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

NEW SECTION. **Sec. 7.** INFORMED DECISION. A person shall not receive a prescription for medication to end his or her life in a humane and dignified manner unless he or she has made an informed decision. Immediately before writing a prescription for medication under this chapter, the attending physician shall verify that the qualified patient is making an informed decision.

NEW SECTION. **Sec. 8.** FAMILY NOTIFICATION. The attending physician shall recommend that the patient notify the next of kin of his or her request for medication under this chapter. A patient who declines or is unable to notify next of kin shall not have his or her request denied for that reason.

NEW SECTION. **Sec. 9.** WRITTEN AND ORAL REQUESTS. To receive a prescription for medication that the qualified patient may self-administer to end his or her life in a humane and dignified manner, a qualified patient shall have made an oral request and a written request, and reiterate the oral request to his or her attending physician at least fifteen days after making the initial oral request. At the time the qualified patient makes his or her second oral request, the attending physician shall offer the qualified patient an opportunity to rescind the request.

NEW SECTION. **Sec. 10.** RIGHT TO RESCIND REQUEST. A patient may rescind his or her request at any time and in any manner without regard to his or her mental state. No prescription for medication under this chapter may be written without the attending physician offering the qualified patient an opportunity to rescind the request.

NEW SECTION. **Sec. 11.** WAITING PERIODS. (1) At least fifteen days

shall elapse between the patient's initial oral request and the writing of a prescription under this chapter.

(2) At least forty-eight hours shall elapse between the date the patient signs the written request and the writing of a prescription under this chapter.

NEW SECTION. **Sec. 12.** MEDICAL RECORD DOCUMENTATION REQUIREMENTS. The following shall be documented or filed in the patient's medical record:

(1) All oral requests by a patient for medication to end his or her life in a humane and dignified manner;

(2) All written requests by a patient for medication to end his or her life in a humane and dignified manner;

(3) The attending physician's diagnosis and prognosis, and determination that the patient is competent, is acting voluntarily, and has made an informed decision;

(4) The consulting physician's diagnosis and prognosis, and verification that the patient is competent, is acting voluntarily, and has made an informed decision;

(5) A report of the outcome and determinations made during counseling, if performed;

(6) The attending physician's offer to the patient to rescind his or her request at the time of the patient's second oral request under section 9 of this act; and

(7) A note by the attending physician indicating that all requirements under this chapter have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed.

NEW SECTION. **Sec. 13.** RESIDENCY REQUIREMENT. Only requests made by Washington state residents under this chapter may be granted. Factors demonstrating Washington state residency include but are not limited to:

(1) Possession of a Washington state driver's license;

(2) Registration to vote in Washington state; or

(3) Evidence that the person owns or leases property in Washington state.

NEW SECTION. **Sec. 14.** DISPOSAL OF UNUSED MEDICATIONS. Any medication dispensed under this chapter that was not self-administered shall be disposed of by lawful means.

NEW SECTION. **Sec. 15.** REPORTING REQUIREMENTS. (1)(a) The department of health shall annually review all records maintained under this chapter.

(b) The department of health shall require any health care provider upon writing a prescription or dispensing medication under this chapter to file a copy of the dispensing record and such other administratively required documentation with the department. All administratively required documentation shall be mailed or otherwise transmitted as allowed by department of health rule to the department no later than thirty calendar days after the writing of a prescription and dispensing of medication under this chapter, except that all documents required to be filed with the department by the prescribing physician after the death of the patient shall be mailed no later than thirty calendar days after the date of death of the patient. In the event that anyone required under this chapter to report information to the department of health provides an inadequate or incomplete report, the department shall contact the person to request a complete report.

(2) The department of health shall adopt rules to facilitate the collection of information regarding compliance with this chapter. Except as otherwise required by law, the information collected is not a public record and may not be made available for inspection by the public.

(3) The department of health shall generate and make available to the public an annual statistical report of information collected under subsection (2) of this section.

NEW SECTION. **Sec. 16.** EFFECT ON CONSTRUCTION OF WILLS, CONTRACTS, AND STATUTES. (1) Any provision in a contract, will, or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end his or her life in a humane and dignified manner, is not valid.

(2) Any obligation owing under any currently existing contract shall not be conditioned or affected by the making or rescinding of a

request, by a person, for medication to end his or her life in a humane and dignified manner.

NEW SECTION. **Sec. 17.** INSURANCE OR ANNUITY POLICIES. The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a request, by a person, for medication that the patient may self-administer to end his or her life in a humane and dignified manner. A qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner shall not have an effect upon a life, health, or accident insurance or annuity policy.

NEW SECTION. **Sec. 18.** CONSTRUCTION OF ACT. (1) Nothing in this chapter authorizes a physician or any other person to end a patient's life by lethal injection, mercy killing, or active euthanasia. Actions taken in accordance with this chapter do not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law. State reports shall not refer to practice under this chapter as "suicide" or "assisted suicide." Consistent with sections 1 (7), (11), and (12), 2(1), 4(1)(k), 6, 7, 9, 12 (1) and (2), 16 (1) and (2), 17, 19(1) (a) and (d), and 20(2) of this act, state reports shall refer to practice under this chapter as obtaining and self-administering life-ending medication.

(2) Nothing contained in this chapter shall be interpreted to lower the applicable standard of care for the attending physician, consulting physician, psychiatrist or psychologist, or other health care provider participating under this chapter.

Immunities and Liabilities

NEW SECTION. **Sec. 19.** IMMUNITIES--BASIS FOR PROHIBITING HEALTH CARE PROVIDER FROM PARTICIPATION--NOTIFICATION--PERMISSIBLE SANCTIONS. (1) Except as provided in section 20 of this act and subsection (2) of this section:

(a) A person shall not be subject to civil or criminal liability or professional disciplinary action for participating in good faith

compliance with this chapter. This includes being present when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner;

(b) A professional organization or association, or health care provider, may not subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for participating or refusing to participate in good faith compliance with this chapter;

(c) A patient's request for or provision by an attending physician of medication in good faith compliance with this chapter does not constitute neglect for any purpose of law or provide the sole basis for the appointment of a guardian or conservator; and

(d) Only willing health care providers shall participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's request under this chapter, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.

(2)(a) A health care provider may prohibit another health care provider from participating under this act on the premises of the prohibiting provider if the prohibiting provider has given notice to all health care providers with privileges to practice on the premises and to the general public of the prohibiting provider's policy regarding participating under this act. This subsection does not prevent a health care provider from providing health care services to a patient that do not constitute participation under this act.

(b) A health care provider may subject another health care provider to the sanctions stated in this subsection if the sanctioning health care provider has notified the sanctioned provider before participation in this act that it prohibits participation in this act:

(i) Loss of privileges, loss of membership, or other sanctions provided under the medical staff bylaws, policies, and procedures of the sanctioning health care provider if the sanctioned provider is a member of the sanctioning provider's medical staff and participates in this act while on the health care facility premises of the sanctioning health care provider, but not including the private medical office of a physician or other provider;

(ii) Termination of a lease or other property contract or other nonmonetary remedies provided by a lease contract, not including loss or restriction of medical staff privileges or exclusion from a provider panel, if the sanctioned provider participates in this act while on the premises of the sanctioning health care provider or on property that is owned by or under the direct control of the sanctioning health care provider; or

(iii) Termination of a contract or other nonmonetary remedies provided by contract if the sanctioned provider participates in this act while acting in the course and scope of the sanctioned provider's capacity as an employee or independent contractor of the sanctioning health care provider. Nothing in this subsection (2)(b)(iii) prevents:

(A) A health care provider from participating in this act while acting outside the course and scope of the provider's capacity as an employee or independent contractor; or

(B) A patient from contracting with his or her attending physician and consulting physician to act outside the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(c) A health care provider that imposes sanctions under (b) of this subsection shall follow all due process and other procedures the sanctioning health care provider may have that are related to the imposition of sanctions on another health care provider.

(d) For the purposes of this subsection:

(i) "Notify" means a separate statement in writing to the health care provider specifically informing the health care provider before the provider's participation in this act of the sanctioning health care provider's policy about participation in activities covered by this chapter.

(ii) "Participate in this act" means to perform the duties of an attending physician under section 4 of this act, the consulting physician function under section 5 of this act, or the counseling function under section 6 of this act. "Participate in this act" does not include:

(A) Making an initial determination that a patient has a terminal disease and informing the patient of the medical prognosis;

(B) Providing information about the Washington death with dignity act to a patient upon the request of the patient;

(C) Providing a patient, upon the request of the patient, with a referral to another physician; or

(D) A patient contracting with his or her attending physician and consulting physician to act outside of the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(3) Suspension or termination of staff membership or privileges under subsection (2) of this section is not reportable under RCW 18.130.070. Action taken under section 3, 4, 5, or 6 of this act may not be the sole basis for a report of unprofessional conduct under RCW 18.130.180.

(4) References to "good faith" in subsection (1)(a), (b), and (c) of this section do not allow a lower standard of care for health care providers in the state of Washington.

NEW SECTION. **Sec. 20.** LIABILITIES. (1) A person who without authorization of the patient willfully alters or forges a request for medication or conceals or destroys a rescission of that request with the intent or effect of causing the patient's death is guilty of a class A felony.

(2) A person who coerces or exerts undue influence on a patient to request medication to end the patient's life, or to destroy a rescission of a request, is guilty of a class A felony.

(3) This chapter does not limit further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person.

(4) The penalties in this chapter do not preclude criminal penalties applicable under other law for conduct that is inconsistent with this chapter.

NEW SECTION. **Sec. 21.** CLAIMS BY GOVERNMENTAL ENTITY FOR COSTS INCURRED. Any governmental entity that incurs costs resulting from a person terminating his or her life under this chapter in a public place has a claim against the estate of the person to recover such costs and reasonable attorneys' fees related to enforcing the claim.

Additional Provisions

NEW SECTION. **Sec. 22.** FORM OF THE REQUEST. A request for a medication as authorized by this chapter shall be in substantially the following form:

REQUEST FOR MEDICATION TO END MY LIFE IN A HUMAN AND DIGNIFIED MANNER

I, ..., am an adult of sound mind.

I am suffering from . . . . . ., which my attending physician has determined is a terminal disease and which has been medically confirmed by a consulting physician.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care, and pain control.

I request that my attending physician prescribe medication that I may self-administer to end my life in a humane and dignified manner and to contact any pharmacist to fill the prescription.

INITIAL ONE:

. . . . . I have informed my family of my decision and taken their opinions into consideration.

. . . . . I have decided not to inform my family of my decision.

. . . . . I have no family to inform of my decision.

I understand that I have the right to rescind this request at any time.

I understand the full import of this request and I expect to die when I take the medication to be prescribed. I further understand that although most deaths occur within three hours, my death may take longer and my physician has counseled me about this possibility.

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

Signed: . . . . . .

Dated: . . . . . .

DECLARATION OF WITNESSES

By initialing and signing below on or after the date the person named above signs, we declare that the person making and signing the above request:

Witness 1 Initials	Witness 2 Initials	
.....	.....	1. Is personally known to us or has provided proof of identity;
.....	.....	2. Signed this request in our presence on the date of the person's signature;
.....	.....	3. Appears to be of sound mind and not under duress, fraud, or undue influence;
.....	.....	4. Is not a patient for whom either of us is the attending physician.

Printed Name of Witness 1: .....

Signature of Witness 1/Date: .....

Printed Name of Witness 2: .....

Signature of Witness 2/Date: .....

NOTE: One witness shall not be a relative by blood, marriage, or adoption of the person signing this request, shall not be entitled to any portion of the person's estate upon death, and shall not own, operate, or be employed at a health care facility where the person is a patient or resident. If the patient is an inpatient at a health care facility, one of the witnesses shall be an individual designated by the facility.

Sec. 23. RCW 42.56.360 and 2007 c 261 s 4 and 2007 c 259 s 49 are each reenacted and amended to read as follows:

(1) The following health care information is exempt from disclosure under this chapter:

(a) Information obtained by the board of pharmacy as provided in RCW 69.45.090;

(b) Information obtained by the board of pharmacy or the department of health and its representatives as provided in RCW 69.41.044, 69.41.280, and 18.64.420;

(c) Information and documents created specifically for, and collected and maintained by a quality improvement committee under RCW 43.70.510 or 70.41.200, or by a peer review committee under RCW 4.24.250, or by a quality assurance committee pursuant to RCW 74.42.640 or 18.20.390, or by a hospital, as defined in RCW 43.70.056, for reporting of health care-associated infections under RCW 43.70.056, and

notifications or reports of adverse events or incidents made under RCW 70.56.020 or 70.56.040, regardless of which agency is in possession of the information and documents;

(d)(i) Proprietary financial and commercial information that the submitting entity, with review by the department of health, specifically identifies at the time it is submitted and that is provided to or obtained by the department of health in connection with an application for, or the supervision of, an antitrust exemption sought by the submitting entity under RCW 43.72.310;

(ii) If a request for such information is received, the submitting entity must be notified of the request. Within ten business days of receipt of the notice, the submitting entity shall provide a written statement of the continuing need for confidentiality, which shall be provided to the requester. Upon receipt of such notice, the department of health shall continue to treat information designated under this subsection (1)(d) as exempt from disclosure;

(iii) If the requester initiates an action to compel disclosure under this chapter, the submitting entity must be joined as a party to demonstrate the continuing need for confidentiality;

(e) Records of the entity obtained in an action under RCW 18.71.300 through 18.71.340;

(f) Except for published statistical compilations and reports relating to the infant mortality review studies that do not identify individual cases and sources of information, any records or documents obtained, prepared, or maintained by the local health department for the purposes of an infant mortality review conducted by the department of health under RCW 70.05.170;

(g) Complaints filed under chapter 18.130 RCW after July 27, 1997, to the extent provided in RCW 18.130.095(1); ((~~and~~))

(h) Information obtained by the department of health under chapter 70.225 RCW; and

(i) Information collected by the department of health under chapter 70.-- RCW (sections 1 through 22, 26 through 28, and 30 of this act) except as provided in section 15 of this act.

(2) Chapter 70.02 RCW applies to public inspection and copying of health care information of patients.

Sec. 24. RCW 42.56.360 and 2007 c 273 s 25, 2007 c 261 s 4, and 2007 c 259 s 49 are each reenacted and amended to read as follows:

(1) The following health care information is exempt from disclosure under this chapter:

(a) Information obtained by the board of pharmacy as provided in RCW 69.45.090;

(b) Information obtained by the board of pharmacy or the department of health and its representatives as provided in RCW 69.41.044, 69.41.280, and 18.64.420;

(c) Information and documents created specifically for, and collected and maintained by a quality improvement committee under RCW 43.70.510, 70.230.080, or 70.41.200, or by a peer review committee under RCW 4.24.250, or by a quality assurance committee pursuant to RCW 74.42.640 or 18.20.390, or by a hospital, as defined in RCW 43.70.056, for reporting of health care-associated infections under RCW 43.70.056, and notifications or reports of adverse events or incidents made under RCW 70.56.020 or 70.56.040, regardless of which agency is in possession of the information and documents;

(d)(i) Proprietary financial and commercial information that the submitting entity, with review by the department of health, specifically identifies at the time it is submitted and that is provided to or obtained by the department of health in connection with an application for, or the supervision of, an antitrust exemption sought by the submitting entity under RCW 43.72.310;

(ii) If a request for such information is received, the submitting entity must be notified of the request. Within ten business days of receipt of the notice, the submitting entity shall provide a written statement of the continuing need for confidentiality, which shall be provided to the requester. Upon receipt of such notice, the department of health shall continue to treat information designated under this subsection (1)(d) as exempt from disclosure;

(iii) If the requester initiates an action to compel disclosure under this chapter, the submitting entity must be joined as a party to demonstrate the continuing need for confidentiality;

(e) Records of the entity obtained in an action under RCW 18.71.300 through 18.71.340;

(f) Except for published statistical compilations and reports relating to the infant mortality review studies that do not identify

individual cases and sources of information, any records or documents obtained, prepared, or maintained by the local health department for the purposes of an infant mortality review conducted by the department of health under RCW 70.05.170;

(g) Complaints filed under chapter 18.130 RCW after July 27, 1997, to the extent provided in RCW 18.130.095(1); ((~~and~~))

(h) Information obtained by the department of health under chapter 70.225 RCW; and

(i) Information collected by the department of health under chapter 70.-- RCW (sections 1 through 22, 26 through 28, and 30 of this act) except as provided in section 15 of this act.

(2) Chapter 70.02 RCW applies to public inspection and copying of health care information of patients.

Sec. 25. RCW 70.122.100 and 1992 c 98 s 10 are each amended to read as follows:

Nothing in this chapter shall be construed to condone, authorize, or approve mercy killing ((~~or physician assisted suicide, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying~~)), lethal injection, or active euthanasia.

NEW SECTION. **Sec. 26.** SHORT TITLE. This act may be known and cited as the Washington death with dignity act.

NEW SECTION. **Sec. 27.** SEVERABILITY. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 28.** EFFECTIVE DATE. This act takes effect one hundred twenty days after the election at which it is approved, except for section 24 of this act which takes effect July 1, 2009.

NEW SECTION. **Sec. 29.** Sections 1 through 22, 26 through 28, and 30 of this act constitute a new chapter in Title 70 RCW.

NEW SECTION. **Sec. 30.** CAPTIONS, PART HEADINGS, AND SUBPART HEADINGS NOT LAW. Captions, part headings, and subpart headings used in this act are not any part of the law.

NEW SECTION. **Sec. 31.** Section 23 of this act expires July 1, 2009.

--- **END** ---

APPENDIX H
District of Columbia Act

APPENDIX H
District of Columbia Act

ENROLLED ORIGINAL

AN ACT

D.C. ACT 21-577

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

DECEMEBER 19, 2016

To provide procedures and requirements regarding the request for and dispensation of covered medications to qualified patients seeking to die in a humane and peaceful manner, to define the duties of attending physicians and consulting physicians, to provide for counseling of patients and family notification, to require informed decision-making and waiting periods, to require reporting from the Department of Health, to outline the effect of the act on contracts, wills, insurance, and annuity policies, to provide for immunities, liabilities, and exceptions, to provide an opt-out provision for health care providers, to provide for claims against a qualified patient's estate for costs incurred by the District government when a qualified patient ingests a covered medication in public, and to establish criminal penalties.

BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this act may be cited as the "Death with Dignity Act of 2016".

Sec. 2. Definitions.

For the purposes of this act, the term:

(1) "Attending physician" shall have the same meaning as provided in section 2(1) of the Natural Death Act of 1981, effective February 25, 1982 (D.C. Law 4-69; D.C. Official Code § 7-621(1)); provided, that the attending physician's practice shall not be primarily or solely composed of patients requesting a covered medication.

(2) "Capable" means that, in the opinion of a court or the patient's attending physician, consulting physician, psychiatrist, or psychologist, a patient has the ability to make and communicate health care decisions to health care providers.

(3) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease and who is willing to participate in the provision of a covered medication to a qualified patient in accordance with this act.

(4) "Counseling" means one or more consultations as necessary between a District 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.

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(5) "Covered medication" means a medication prescribed pursuant to this act for the purpose of ending a person's life in a humane and peaceful manner.

(6) "Department" means the Department of Health.

(7) "Health care facility" means a hospital or long-term care facility.

(8) "Health care provider" means a person, partnership, corporation, facility, or institution that is licensed, certified, or authorized under District law to administer health care or dispense medication in the ordinary course of business or practice of a profession.

(9) "Hospital" shall have the same meaning as provided in section 2(1) of the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code § 44-501(1)).

(10) "Informed decision" means a decision by a qualified patient to request and obtain a prescription for a covered medication that is based on an appreciation of the relevant facts and is made after being fully informed by the attending physician of:

(A) His or her medical diagnosis;

(B) His or her prognosis;

(C) The potential risks associated with taking the covered medication;

(D) The probable results of taking the covered medication; and

(E) Feasible alternatives to taking the covered medication, including comfort care, hospice care, and pain control.

(11) "Long-term care facility" means a nursing home or community residence facility, as defined by section 2(3) and (4), respectively, of the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code § 44-501(3) and (4)), or an assisted living residence, as defined by section 201(4) of the Assisted Living Residence Regulatory Act of 2000, effective June 24, 2000 (D.C. Law 13-127; D.C. Official Code § 44-102.01(4)).

(12) "Medically confirmed" means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.

(13) "Patient" means a person who has attained 18 years of age, resides in the District of Columbia, and is under the care of a physician.

(14) "Physician" shall have the same meaning as provided in section 2(4) of the Natural Death Act of 1981, effective February 25, 1982 (D.C. Law 4-69; D.C. Official Code § 7-621(4)).

(15) "Qualified patient" means a patient who:

(A) Has been determined to be capable; and

(B) Satisfies the requirements of this act in order to obtain a prescription for a covered medication.

(16) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within 6 months.

Sec. 3. Requests for a covered medication.

(a) To request a covered medication, a patient shall:

(1) Make 2 oral requests, separated by at least 15 days, to an attending physician.

(2) Submit a written request, signed and dated by the patient, to the attending physician before the patient makes his or her 2nd oral request and at least 48 hours before a covered medication may be prescribed or dispensed.

(b)(1) A written request made pursuant to subsection (a)(2) of this section shall be witnessed by at least 2 individuals who, in the presence of the patient, attest to the best of their knowledge and belief that the patient is capable, acting voluntarily, and is not being unduly influenced to sign the request.

(2) If the patient is a patient in a long-term care facility at the time the written request is made under subsection (a)(2) of this section, one of the witnesses shall be an individual designated by the facility who has met the qualifications specified in the Department's regulations.

(3) One of the witnesses shall be a person who is not:

(A) A relative of the patient by blood, marriage, or adoption;

(B) At the time the request is signed, entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or

(C) An owner, operator, or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.

(4) The patient's attending physician at the time of the request shall not be a witness.

(c) A written request made pursuant to subsection (a)(2) of this section shall be in substantially the following form:

"REQUEST FOR MEDICATION TO END MY LIFE IN A HUMANE AND PEACEFUL MANNER

"I, _____, am an adult of sound mind.

"I am suffering from _____, which my attending physician has determined is a terminal disease and which has been medically confirmed by a consulting physician.

"I have been fully informed of my diagnosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care, and pain control.

"I request that my attending physician prescribe medication that will end my life in a humane and peaceful manner.

"INITIAL ONE:

[ ] I have informed my family of my decision and taken their opinion into consideration.

[ ] I have decided not to inform my family of my decision.

[ ] I have no family to inform of my decision.

"I understand that I have the right to rescind this request as any time.

"I understand the full import of this request, and I expect to die when I take the medication to be prescribed. I further understand that although most deaths occur within 3 hours of taking the medication to be prescribed, my death may take longer, and my physician has counseled me about this possibility.

"I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

"Signed:

"Dated:

"DECLARATION OF WITNESSES:
"We declare that the person signing this request:
(a) Is personally known to us or has provided proof of identity;
(b) Signed this request in our presence;
(c) Appears to be of sound mind and not under duress, fraud, or undue influence;
(d) Is not a patient for whom either of us is the attending physician.
"Date:
"Witness 1:
"Address:
"Witness 1 signature:
"Date:
"Witness 2:
"Address:
"Witness 2 signature:
"NOTE: One witness shall not be a relative (by blood, marriage, or adoption) of the person signing this request, shall not be entitled to any portion of the person's estate upon death, and shall not own, operate, or be employed at the health care facility where the person is a patient or resident. If the patient is a patient at a long-term care facility, one of the witnesses shall be an individual designated by the facility.".

Sec. 4. Responsibilities of the attending physician.

(a) Upon receiving a written request for a covered medication pursuant to section 3(a)(2), the attending physician shall:

(1) Determine that the patient:

(A) Has a terminal disease;

(B) Is capable;

(C) Has made the request voluntarily; and

(D) Is a resident of the District of Columbia;

(2) Inform the patient of:

(A) His or her medical diagnosis;

(B) His or her prognosis;

(C) The potential risks associated with taking a covered medication;

(D) The probable result of taking a covered medication; and

(E) The feasible alternatives to taking a covered medication, including comfort care, hospice care, and pain control;

(3) Refer the patient to a consulting physician;

(4) Refer the patient to counseling if appropriate, pursuant to section 5;

(5) Inform the patient of the availability of supportive counseling to address the range of possible psychological and emotional stress involved with the end stages of life;

(6) Recommend that the patient notify next of kin, friends, and spiritual advisor, if applicable, of his or her decision to request a covered medication;

(7) Counsel the patient about the importance of having another person present when the patient takes a covered medication and of not taking a covered medication in a public place;

(8) Inform the patient that he or she has an opportunity to rescind a request for a covered medication at any time and in any manner;

(9) Verify, immediately before writing the prescription for a covered medication, that the patient is making an informed decision; and

(10) Fulfill the medical record documentation requirements of section 7.

(b) If a consulting physician receives a referral for a patient from an attending physician pursuant to subsection (a)(3) of this section, the consulting physician shall:

(1) Examine the patient and his or her relevant medical records to confirm, in writing, the attending physician's diagnosis that the patient is suffering from a terminal disease;

(2) Verify, in writing, to the attending physician that the patient:

(A) Is capable;

(B) Is acting voluntarily; and

(C) Has made an informed decision; and

(3) Refer the patient to counseling if appropriate, pursuant to section 5.

Sec. 5. Counseling referral.

(a) If, in the opinion of the attending physician or the consulting physician, a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient to counseling.

(b) No covered medication shall be prescribed until the patient receives counseling and the psychiatrist or psychologist performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

Sec. 6. Dispensing a covered medication and reporting requirements.

(a) An attending physician may not prescribe or dispense a covered medication, unless:

(1) The patient has satisfied the requirements of sections 3 and 5, if applicable;

(2) The attending physician has satisfied the requirements of sections 4 and 5, if applicable; and

(3) The attending physician has offered the patient an opportunity to rescind his or her request for a covered medication immediately before prescribing or dispensing the covered medication.

(b) After the attending physician ensures that the requirements provided in subsection (a) of this section have been met, the attending physician may:

(1) Dispense a covered medication, including ancillary medications intended to minimize the patient's discomfort, directly to the qualified patient; provided, that the attending physician is authorized to do so in the District of Columbia pursuant to the District of Columbia Uniform Controlled Substances Act of 1981, effective August 5, 1981 (D.C. Law 4-29; D.C. Official Code § 48-903.02), and has a current Drug Enforcement Administration certificate issued pursuant to 21 C.F.R. § 1301.35; or

(2) After a qualified patient completes the form under section 3(c):

(A) Contact a pharmacist and inform the pharmacist of the prescription for a covered medication; and

(B) Deliver the written prescription for a covered medication personally, or by telephone, facsimile, or electronically to the pharmacist.

(c) Upon receiving a written prescription for a covered medication by an attending physician under subsection (b)(2) of this section, the pharmacist may dispense the covered medication to the following:

(A) The patient;

(B) The attending physician; or

(C) An expressly identified agent designated by the qualified patient, with the designation communicated to the pharmacist by the patient verbally or in writing.

(d) A pharmacist, upon dispensing a covered medication under subsection (c) of this section, shall immediately notify the attending physician that the covered medication was dispensed.

(e) Within 30 days after a health care provider dispenses a covered medication, the attending physician shall file with the Department a copy of the information required by section 7 on a form created by the Department.

(f) Within 30 days after a patient ingests a covered medication, or as soon as practicable after the a health care provider is made aware of a patient's death resulting from ingesting the covered medication, the health care provider shall notify the Department of a patient's death.

(g) Notwithstanding any other provision of law, the attending physician may sign the patient's death certificate.

(h) The cause of death listed on a death certificate shall identify the qualified patient's underlying medical condition consistent with the International Classification of Diseases without reference to the fact that the qualified patient ingested a covered medication.

(i)(1) The Office of the Chief Medical Examiner shall review each death involving a qualified patient who ingests a covered medication and, if warranted by the review, may conduct an investigation.

(2) The review required by paragraph (1) of this subsection shall not constitute an inquiry for the purposes of section 12 of the Vital Records Act of 1981, effective October 8, 1981 (D.C. Law 4-34; D.C. Official Code § 7-211); provided, that an investigation authorized by paragraph (1) of this subsection shall constitute an inquiry for the purposes of the Vital Records Act of 1981, effective October 8, 1981 (D.C. Law 4-34; D.C. Official Code § 7-211).

Sec. 7. Medical record documentation requirements.

(a) The attending physician shall document and file in the medical record of the patient requesting a covered medication:

(1) All oral requests by a patient for a covered medication;

(2) All written requests by a patient for a covered medication;

(3) The attending physician's:

(A) Diagnosis and prognosis of the patient;

(B) Determination that the patient is a District resident and is capable, acting voluntarily, and has made an informed decision when requesting a covered medication;

(C) Offer to the patient to rescind his or her request for a covered medication before the patient makes his or her second oral request;

(D) Notation that all requirements under this act have been met; and

(E) Notation regarding all steps taken to carry out the patient's request for a covered medication, including a notation of the covered medication prescribed;

(4) The consulting physician's:

(A) Diagnosis and prognosis of the patient;

(B) Verification that the patient is capable, acting voluntarily, and has made an informed decision when requesting a covered medication; and

(5) If a patient is referred to counseling pursuant to section 5, a report by the psychiatrist or psychologist of the outcome and determinations made during counseling.

Sec. 8. Reporting requirements.

(a) Beginning one year after the effective date of this act, and on an annual basis thereafter, the Department shall review the records maintained under section 7 for the purpose of gathering data and ensuring compliance with this act.

(b) The Department shall generate and make available to the public an annual statistical report of information collected pursuant to subsection (a) of this section. The report shall include:

(1) The number of qualified patients for whom a prescription for a covered medication was written;

(2) The number of known qualified patients who died each year for whom a prescription for a covered medication was written, and the cause of death of those patients;

(3) The number of known deaths in the District from using a covered medication;

(4) The number of physicians who wrote prescriptions for a covered medication; and

(5) Of the qualified patients who died due to using a covered medication, demographic percentages organized by the following characteristics:

(A) Age at death;

(B) Education level, if known;

(C) Race;

(D) Sex;

(E) Type of insurance, including whether or not they had insurance, if known; and

(F) Terminal disease.

Sec. 9. Effect on construction of wills and contracts.

(a) A provision in a contract, will, or other agreement executed on or after the effective date of this act, whether written or oral, is not valid if the provision would affect whether a person may make or rescind a request for a covered medication.

(b) An obligation owing under any contract, will, or other agreement executed on or after the effective date of this act may not be conditioned or affected by a person making or rescinding a request for a covered medication.

Sec. 10. Insurance and annuity policies.

(a) The sale, procurement, or issuance of any life, health, accident insurance, annuity policy, employment benefits, or the rate charged for any policy may not be conditioned upon or affected by the making or rescinding of a qualified patient's request for a covered medication.

(b) A qualified patient's act of ingesting a covered medication shall not have an effect upon a life, health, accident insurance, annuity policy, or employment benefits.

(c) Nothing in this section shall be construed to limit the ability of an insurance or annuity provider from investigating a claim for benefits for a death.

Sec. 11. Health care provider participation; notification; permissible sanctions.

(a) No health care provider shall be obligated under this act, by contract, or otherwise, to participate in the provision of a covered medication to a qualified patient.

(b) If a health care provider is unable or unwilling to carry out a patient's request for a covered medication under this act and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request of the patient, a copy of the patient's relevant medical records to the new health care provider.

(c) A health care provider may prohibit any other health care provider that it employs or contracts with from providing a covered medication under this act on the prohibiting health care provider's premises; provided, that the prohibiting health care provider has notified the health care provider of this policy before the employee or contractor has provided a covered medication.

(d) Notwithstanding section 12, if, before a covered medication has been provided, the prohibiting health care provider has notified the sanctioned health care provider that it prohibits providing a covered medication under this act, the prohibiting health care provider may impose the following sanctions:

(1) Loss of privileges, loss of membership, or other sanction pursuant to the prohibiting health care provider's medical staff bylaws, policies, and procedures, if the sanctioned health care provider is a member of the prohibiting health care provider's medical staff and participates under this act while on staff on the premises of the prohibiting health care provider's health care facility;

(2) Termination of the lease or other property contract or other nonmonetary remedies provided under the lease or property contract, not including loss or restriction of medical staff privileges or exclusion from a provider panel, if the sanctioned health care provider participates under this act while on the premises of a prohibiting health care provider's health care facility or on the property that is owned by or under the direct control of the prohibiting health care provider;

(3) Termination of an employment contract or other nonmonetary remedies provided by contract if the sanctioned health care provider participates under this act in the course and scope of the sanctioned health care provider's duties as an employee or independent contractor of the prohibiting health care provider; or

(4) Any other sanctions and penalties in accordance with the prohibiting health care provider's policies and practices; provided, that no sanctions or penalties shall be imposed under this paragraph without a procedure for contesting the sections and penalties.

(e) Nothing in this section shall be construed to prevent:

(1) A health care provider from participating under this act while acting outside the course and scope of the health care provider's duties as an employee or independent contractor of the prohibiting health care provider;

(2) A patient from contracting with his or her attending physician and consulting physician to act outside the course and scope of the health care provider's duties as an employee or independent contractor of the prohibiting health care provider;

(3) A health care provider from making an initial determination pursuant to the standard of care that a patient has a terminal disease and informing him or her of the medical prognosis;

(4) A health care provider from providing information about this act upon the request of the patient; or

(5) A health care provider from providing a patient, upon request, with a referral to another health care provider.

(f) Sanctions issued pursuant to subsection (d) of this section are not reportable under section 513(a)(4)(C) of the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1205.13(a)(4)(C)).

Sec. 12. Immunities, liabilities, and exceptions.

(a) Except as provided in section 11, no person shall be subject to civil or criminal liability or professional disciplinary action for:

(1) Participating in good faith compliance with this act;

(2) Refusing to participate in providing a covered medication under this act; or

(3) Being present when a qualified patient takes a covered medication.

(b) Nothing in this act shall be interpreted to lower the applicable standard of care for the attending physician, consulting physician, psychiatrist, psychologist, or other health care provider participating in this act.

(c) No request by a patient for a covered medication made in good-faith compliance with the provisions of this act shall provide the basis for the appointment of a guardian or conservator.

Sec. 13. Claims by District government for costs incurred.

If the District government incurs costs resulting from the death of a qualified patient ingesting a covered medication pursuant to this act in a public place, the District government shall have a claim against the estate of the qualified patient to recover such costs and reasonable attorney fees related to enforcing the claim.

Sec. 14. Penalties.

(a) A person who, without authorization of the patient, willfully alters or forges a request for a covered medication or conceals or destroys a rescission of a request for a covered medication with the intent or effect of causing the patient's death is punishable as a Class A felony.

(b) A person who, without authorization of the patient, willfully coerces or exerts undue influence on a patient to request or ingest a covered medication with the intent or effect of causing the patient's death is punishable as a Class A felony.

Sec. 15. Rules.

(a) The Mayor, pursuant to Title I of the District of Columbia Administrative Procedure Act, approved October 21, 1968 (82 Stat. 1204; D.C. Official Code § 2-501 *et seq.*), shall issue rules to:

(1) Develop the form to collect the medical record information required by section 7;

(2) Facilitate the collection of the medical record information required by section 7; and

(3) Provide for the return of and safe disposal of unused covered medications.

(b) The Mayor, pursuant to Title I of the District of Columbia Administrative Procedure Act, approved October 21, 1968 (82 Stat. 1204; D.C. Official Code § 2-501 *et seq.*), may issue rules to implement the provisions of this act, including rules to:

(1) Specify the recommended methods by which a qualified patient, who so desires, may notify first responders of his or her intent to ingest a covered medication; and

(2) Establish training opportunities for the medical community to learn about the use of covered medications by qualified patients seeking to die in a humane and peaceful manner, including best practices for prescribing the covered medication.

Sec. 16. Construction.

(a) Nothing in this act may be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing, active euthanasia, or any other method or medication not authorized under this act.

(b) Actions taken in accordance with this act do not constitute suicide, assisted suicide, mercy killing, or homicide.

(c) Nothing in this act shall be construed to authorize a qualified patient to ingest a covered medication in a public place.

Sec. 17. Freedom of Information Act exemption.

The information collected by the Department pursuant to this act shall not be a public record and may not be made available for inspection by the public under the Freedom of Information Act of 1976, effective March 25, 1977 (D.C. Law 1-96; D.C. Official Code § 2-531 *et seq.*), or any other law.

Sec. 18. Applicability.

(a) This act shall apply upon the date of inclusion of its fiscal effect in an approved budget and financial plan.

(b) The Chief Financial Officer shall certify the date of the inclusion of the fiscal effect in an approved budget and financial plan, and provide notice to the Budget Director of the Council of the certification.

(c)(1) The Budget Director shall cause the notice of the certification to be published in the District of Columbia Register.

(2) The date of publication of the notice of the certification shall not affect the applicability of this act.

Sec. 18. Fiscal impact statement.

The Council adopts the fiscal impact statement in the committee report as the fiscal impact statement required by section 4a of the General Legislative Procedures Act of 1975, approved October 16, 2006 (120 Stat. 2038; D.C. Official Code § 1-301.47a).

Sec. 19. Effective date.

This act shall take effect following approval by the Mayor (or in the event of veto by the Mayor, action by the Council to override the veto), a 30-day period of congressional review as provided in section 602(c)(1) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(1)), and publication in the District of Columbia Register.

Chairman
Council of the District of Columbia

Mayor
District of Columbia
APPROVED
December 19, 2016

COUNCIL OF THE DISTRICT OF COLUMBIA
WASHINGTON, D.C. 20004

Docket No. **B21-38**

[ ] ITEM ON CONSENT CALENDAR
[X] ACTION & DATE **ADOPTED FIRST READING, 11/01/2016**
[X] VOICE VOTE
RECORDED VOTE ON REQUEST **APPROVED**
ABSENT
[ ] ROLL CALL VOTE – Result ( )

Councilmember	Aye	Nay	NV	AB	Councilmember	Aye	Nay	NV	AB	Councilmember	Aye	Nay	NV	AB
Chmn. Mendelson	X				Evans	X				Silverman	X			
Alexander		X			Grosso	X				Todd	X			
Allen	X				May	X				White	X			
Bonds	X				McDuffie	X								
Cheh	X				Nadeau		X							
X – Indicate Vote					AB – Absent					NV – Present, Not Voting				

CERTIFICATION RECORD

Secretary to the Council — Date: 12.2.16

[ ] ITEM ON CONSENT CALENDAR
[X] ACTION & DATE **ADOPTED FINAL READING, 11/15/2016**
[X] VOICE VOTE
RECORDED VOTE ON REQUEST **APPROVED**
ABSENT
[ ] ROLL CALL VOTE – Result ( )

Councilmember	Aye	Nay	NV	AB	Councilmember	Aye	Nay	NV	AB	Councilmember	Aye	Nay	NV	AB
Chmn. Mendelson	X				Evans	X				Silverman	X			
Alexander		X			Grosso	X				Todd	X			
Allen	X				May	X				White	X			
Bonds	X				McDuffie	X								
Cheh	X				Nadeau		X							
X – Indicate Vote					AB – Absent					NV – Present, Not Voting				

CERTIFICATION RECORD

Secretary to the Council — Date: 12.2.16

[ ] ITEM ON CONSENT CALENDAR
[ ] ACTION & DATE
[ ] VOICE VOTE
RECORDED VOTE ON REQUEST
ABSENT
[ ] ROLL CALL VOTE – Result ( )

Councilmember	Aye	Nay	NV	AB	Councilmember	Aye	Nay	NV	AB	Councilmember	Aye	Nay	NV	AB
Chmn. Mendelson					Evans					Silverman				
Alexander					Grosso					Todd				
Allen					May					White				
Bonds					McDuffie									
Cheh					Nadeau									
X – Indicate Vote					AB – Absent					NV – Present, Not Voting				

CERTIFICATION RECORD

Secretary to the Council — Date

APPENDIX I
Baxter v. Montana
(Supreme Court of Montana, 2009)

APPENDIX I
Baxter v. Montana
(Supreme Court of Montana, 2009)

FILED

Ed Smith
CLERK OF THE SUPREME COURT
STATE OF MONTANA

December 31 2009

DA 09-0051

IN THE SUPREME COURT OF THE STATE OF MONTANA

2009 MT 449

ROBERT BAXTER, STEPHEN SPECKART, M.D., C. PAUL LOEHNEN, M.D., LAR AUTIO, M.D., GEORGE RISI, JR., M.D., and COMPASSION & CHOICES,

Plaintiffs and Appellees,

v.

STATE OF MONTANA and STEVE BULLOCK,

Defendants and Appellants.

APPEAL FROM: District Court of the First Judicial District, In and For the County of Lewis and Clark, Cause No. ADV 07-787 Honorable Dorothy McCarter, Presiding Judge

COUNSEL OF RECORD:

For Appellants:

Hon. Steve Bullock, Montana Attorney General; Anthony Johnstone, Solicitor (argued); Jennifer Anders, Assistant Attorney General; Helena, Montana

For Appellees:

Mark S. Connell (argued); Connell Law Firm; Missoula, Montana

Kathryn L. Tucker; Compassion & Choices; Portland, Oregon

For Amici Curiae:

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Thomas Brejcha; President & Chief Counsel, Thomas More Society (*Physicians for Compassionate Care Education Foundation*)

Nickolas C. Murnion; Nickolas C. Murnion Law Firm; Jordan, Montana
Rita L. Marker; Attorney at Law; Steubenville, Ohio
(*International Task Force on Euthanasia & Assisted Suicide, et al.*)

Duane T. Schmidt, Attorney at Law; Alliance Defense Fund; Scottsdale, Arizona
Steven H. Aden, (of Counsel); Matthew S. Bowman (of Counsel); Alliance Defense Fund; Washington, District of Columbia (*Family Research Council, et al.*)

Patrick Flaherty, Attorney at Law; Great Falls, Montana Daniel Avila;
Attorney at Law; Everett, Massachusetts (*Institute for the Study of Disability & Bioethics, et al.*)

Jon Metropoulos; Gough, Shanahan, Johnson, & Waterman, PLLP; Helena, Montana
Mailee R. Smith; Attorney at Law; Chicago, Illinois (*Coalition of 28 Bipartisan Montana Legislators*)

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Stephen F. Gold; Attorney at Law; Philadelphia, Pennsylvania
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Timothy C. Fox; Gough, Shanahan, Johnson & Waterman, PLLP; Helena Montana; Jeffrey J. Davidson; Wilmer, Cutler, Pickering Hale & Dorr LLP; Washington, District of Columbia
(*Christian Medical Association*)

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Andrée Larose; Reynolds, Motl and Sherwood, PLLP; Helena, Montana (*Disability Rights Montana*)

Peter Michael Meloy; Meloy Law Firm; Helena, Montana Miles J. Zaremski; Zaremski Law Group; Northbrook, Illinois
(*American College of Legal Medicine in Support of Plaintiffs-Appellees*)

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Robert A. Free, Katherine C. Chamberlain; MacDonald Hoague & Bayless; Seattle, Washington (*Surviving Family Members in Support of Aid in Dying in Support of Plaintiffs-Appellees*)

Elizabeth L. Griffing; ACLU of Montana Foundation; Missoula, Montana (*ACLU of Montana as Amicus Curiae in Support of Plaintiffs-Appellees*)

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Jeremy L. Buxbaum; Perkins Coie LLP; Chicago, Illinois
(*Montana Legislators in Support of Privacy and Dignity in Support of Plaintiffs/Appellees*)

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Scott A. Fisk; Crowley Fleck PLLP; Helena, Montana
Nicholas W. van Aelstyn; Beveridge & Diamond, P.C.; San Francisco, California (*Legal Scholars Professors Larry M. Elison, Thomas P. Huff, and Erwin Chemerinsky et al.*)

Lee A. Freeman; Jenner & Block LLP; Chicago, Illinois
Michelle A. Groman, Nicholas O. Stephanopoulos; Jenner & Block LLP; Washington, District of Columbia (*Montana Bioethicists in Support of Plaintiffs-Appellees*)

Michael G. Black; Black Law Office; Missoula, Montana Norman H. Beamer, Aaron S. Jacobs; East Palo Alto, California (*Montana Residents with Disabilities and Autonomy, Inc.*)

Karen Boxx, Professor; Seattle, Washington
Vanessa Soriano Power; Stoel Rives LLP; Seattle, Washington (*Legal Voice, et al.*)

James H. Goetz; Goetz, Gallik & Baldwin, P.C.; Bozeman, Montana Lesli A. Rawles; Covington & Burling LLP, San Diego, California (*American Medical Women's Association, et al.*)

Paul J. Lawrence; K&L Gates LLP; Seattle, Washington
(*Montana Human Rights Network, The Billings Association of Humanists, et al.*)

Argued: September 2, 2009
Submitted: September 3, 2009
Decided: December 31, 2009

Filed:

_____
Clerk

Justice W. William Leaphart delivered the Opinion of the Court.

¶1 The State of Montana appeals from the Order of the First Judicial District Court granting summary judgment in favor of Robert Baxter, Stephen Speckart, M.D., C. Paul Loehnen, M.D., Lar Autio, M.D., George Risi, Jr., M.D., and Compassion & Choices; and from the District Court's decision that a competent, terminally ill patient has a right to die with dignity under Article II, Sections 4 and 10 of the Montana Constitution, which includes protection of the patient's physician from prosecution under the homicide statutes. We affirm in part and reverse in part.

¶2 We rephrase the following issues on appeal:

¶3 I. Whether the District Court erred in its decision that competent, terminally ill patients have a constitutional right to die with dignity, which protects physicians who provide aid in dying from prosecution under the homicide statutes.

¶4 II. Whether Mr. Baxter is entitled to attorney fees.

BACKGROUND

¶5 This appeal originated with Robert Baxter, a retired truck driver from Billings who was terminally ill with lymphocytic leukemia with diffuse lymphadenopathy. At the time of the District Court's decision, Mr. Baxter was being treated with multiple rounds of chemotherapy, which typically become less effective over time. As a result of the disease and treatment, Mr. Baxter suffered from a variety of debilitating symptoms, including infections, chronic fatigue and weakness, anemia, night sweats, nausea, massively swollen glands, significant ongoing digestive problems and generalized pain and

discomfort. The symptoms were expected to increase in frequency and intensity as the chemotherapy lost its effectiveness. There was no cure for Mr. Baxter's disease and no prospect of recovery. Mr. Baxter wanted the option of ingesting a lethal dose of medication prescribed by his physician and self-administered at the time of Mr. Baxter's own choosing.

¶6 Mr. Baxter, four physicians, and Compassion & Choices, brought an action in District Court challenging the constitutionality of the application of Montana homicide statutes to physicians who provide aid in dying to mentally competent, terminally ill patients. The complaint alleged that patients have a right to die with dignity under the Montana Constitution Article II, Sections 4 and 10, which address individual dignity and privacy.

¶7 In December 2008, the District Court issued its Order and Decision, holding that the Montana constitutional rights of individual privacy and human dignity, together, encompass the right of a competent, terminally ill patient to die with dignity. The District Court held that a patient may use the assistance of his physician to obtain a prescription for a lethal dose of medication. The patient would then decide whether to self-administer the dose and cause his own death. The District Court further held that the patient's right to die with dignity includes protection of the patient's physician from prosecution under the State's homicide statutes. Lastly, the District Court awarded Mr. Baxter attorney fees. The State appeals.

STANDARDS OF REVIEW

¶8 We review an order granting summary judgment de novo using the same standards applied by the District Court under M. R. Civ. P. 56. *Bud-Kal v. City of Kalispell*, 2009 MT 93, ¶ 15, 350 Mont. 25, 30, 204 P.3d 738, 743. Where there is a cross-motion for summary judgment, we review a district court's decision to determine whether its conclusions were correct. *Bud-Kal*, ¶ 15. We review an award of attorney fees for abuse of discretion. *Trs. of Ind. Univ. v. Buxbaum*, 2003 MT 97, ¶ 15, 315 Mont. 210, 216, 69 P.3d 663, 667.

DISCUSSION

¶9 The parties in this appeal focus their arguments on the question of whether a right to die with dignity—including physician aid in dying—exists under the privacy and dignity provisions of the Montana Constitution. The District Court held that a competent, terminally ill patient has a right to die with dignity under Article II, Sections 4 and 10 of the Montana Constitution. Sections 4 and 10 address individual dignity and the right to privacy, respectively. The District Court further held that the right to die with dignity includes protecting the patient's physician from prosecution under Montana homicide statutes. The District Court concluded that Montana homicide laws are unconstitutional as applied to a physician who aids a competent, terminally ill patient in dying.

¶10 While we recognize the extensive briefing by the parties and amici on the constitutional issues, this Court is guided by the judicial principle that we should decline to rule on the constitutionality of a legislative act if we are able to decide the case without

reaching constitutional questions. *State v. Adkins*, 2009 MT 71, ¶ 12, 349 Mont. 444, 447, 204 P.3d 1, 5; *Sunburst Sch. Dist. No. 2 v. Texaco*, *Inc.*, 2007 MT 183, ¶ 62, 338 Mont. 259, 279, 165 P.3d 1079, 1093. Since both parties have recognized the possibility of a consent defense to a homicide charge under § 45-2-211(1), MCA, we focus our analysis on whether the issues presented can be resolved at the statutory, rather than the constitutional, level.

¶11 We start with the proposition that suicide is not a crime under Montana law. In the aid in dying situation, the only person who might conceivably be prosecuted for criminal behavior is the physician who prescribes a lethal dose of medication. In that the claims of the plaintiff physicians are premised in significant part upon concerns that they could be prosecuted for extending aid in dying, we deem it appropriate to analyze their possible culpability for homicide by examining whether the consent of the patient to his physician's aid in dying could constitute a statutory defense to a homicide charge against the physician.

¶12 The consent statute would shield physicians from homicide liability if, with the patients' consent, the physicians provide aid in dying to terminally ill, mentally competent adult patients. We first determine whether a statutory consent defense applies to physicians who provide aid in dying and, second, whether patient consent is rendered ineffective by § 45-2-211(2)(d), MCA, because permitting the conduct or resulting harm "is against public policy."

¶13 Section 45-5-102(1), MCA, states that a person commits the offense of deliberate homicide if "the person purposely or knowingly causes the death of another human being . . . ." Section 45-2-211(1), MCA, establishes consent as a defense, stating that the "consent of the victim to conduct charged to constitute an offense or to the result thereof is a defense." Thus, if the State prosecutes a physician for providing aid in dying to a mentally competent, terminally ill adult patient who consented to such aid, the physician may be shielded from liability pursuant to the consent statute. This consent defense, however, is only effective if none of the statutory exceptions to consent applies. Section 45-2-211(2), MCA, codifies the four exceptions:

> Consent is ineffective if: (a) it is given by a person who is legally incompetent to authorize the conduct charged to constitute the offense; (b) it is given by a person who by reason of youth, mental disease or defect, or intoxication is unable to make a reasonable judgment as to the nature or harmfulness of the conduct charged to constitute the offense; (c) it is induced by force, duress, or deception; or (d) it is against public policy to permit the conduct or the resulting harm, even though consented to.

The first three statutory circumstances rendering consent ineffective require case-by-case factual determinations. We therefore confine our analysis to the last exception and determine whether, under Montana law, consent to physician aid in dying is against public policy. For the reasons stated below, we find no indication in Montana law that physician aid in dying provided to terminally ill, mentally competent adult patients is against public policy.

¶14 Section 45-2-211(2)(d), MCA, renders consent ineffective if "it is against public policy to permit the conduct or the resulting harm, even though consented to." We

addressed the applicability of this provision in *State v. Mackrill*, 2008 MT 297, 345 Mont. 469, 191 P.3d 451. This Court held that the consent of a victim is not a defense to the charge of aggravated assault under § 45-5-202(1), MCA. *Mackrill*, ¶ 33. The *Mackrill* decision, while not limiting the exception's reach, applied the "against public policy" exception to situations in which violent, public altercations breach public peace and endanger others in the vicinity. Physician aid in dying, as analyzed below, does not fall within the scope of what this Court has thus far identified as "against public policy." ¶15 The *Mackrill* case arose from a particularly violent altercation between Jason Mackrill and Robert Gluesing outside a Livingston bar. Mackrill, who had been drinking heavily, spent the better part of the evening disrupting other bar-goers, including Gluesing. When a bartender refused to serve Mackrill, Gluesing offered Mackrill a few dollars and encouraged him to go elsewhere. Mackrill became obstinate and refused to leave. When the bartender picked up the phone to call the police, Gluesing escorted Mackrill out of the bar. Once outside, Mackrill began punching Gluesing, including a "very solid shot" that caused Gluesing's feet to come off the ground and the back of his head to hit the pavement. A witness called 9-1-1 and paramedics arrived on the scene. They found Gluesing unconscious and bleeding in the street. He was transported to the hospital and treated for head injuries, including a skull fracture.

¶16 The State charged Mackrill with one count of aggravated assault, a felony under § 45-5-202, MCA. He pleaded not guilty and filed a Notice of Affirmative Defenses, in which he stated he would argue consent as a defense at trial. The jury found Mackrill

guilty. He then filed a post-trial motion claiming the State failed to introduce evidence upon which the jury could conclude Gluesing did not consent to the fight. After a hearing on the matter, the district court denied the motion. Mackrill appealed. This Court concluded that consent is not an effective defense against an assault charge under § 45-5-202(1), MCA. *Mackrill*, ¶ 33.

¶17 The *Mackrill* decision is the only Montana case addressing the public policy exception to consent. It demonstrates one set of circumstances in which consent as a defense is rendered ineffective because permitting the conduct or resulting harm is "against public policy." This "against public policy" exception to consent applies to conduct that disrupts public peace and physically endangers others. Clearly, under *Mackrill*, unruly, physical and public aggression between individuals falls within the parameters of the "against public policy" exception. The men were intoxicated, brawling in a public space, and endangering others in the process.

¶18 A survey of courts that have considered this issue yields unanimous understanding that consent is rendered ineffective as "against public policy" in assault cases characterized by aggressive and combative acts that breach public peace and physically endanger others.

¶19 The State of Washington is home to an unusual volume of these "public policy" exception cases. Washington courts have consistently held that the "public policy" exception applies only to brutish, irrational violence that endangers others. In *State v. Dejarlais*, the Supreme Court of Washington held that consent is not a defense to

violations of a domestic-violence protection order. 136 Wn. 2d 939, 942, 969 P.2d 90, 91 (Wash. 1998). In *State v. Hiott*, the court determined that consent is not a defense to a game in which two people agreed to shoot BB guns at each other because it was a breach of the public peace. 97 Wn. App. 825, 828, 987 P.2d 135, 137 (Wash. App. Div. 2 1999). In *State v. Weber*, the court held consent is not a defense to the charge of second degree assault between two incarcerated persons. 137 Wn. App. 852, 860, 155 P.3d 947, 951 (Wash. App. Div. 3 2007). The court noted there "is nothing redeeming or valuable in permitting fighting and every reason to dissuade it." *Weber*, 155 P.3d at 951.

¶20 In *State v. Fransua*, the Court of Appeals of New Mexico held that one person's taunting invitation to "go ahead" and shoot him did not establish a valid consent defense for another person who took him up on the offer. 85 N.M. 173, 174, 510 P.2d 106, 107 (N.M. App. 1973). In the Superior Court of New Jersey, a defendant claimed he was not guilty of assault and battery because he and his wife agreed that if she consumed alcohol he would physically assault her as punishment. *State v. Brown*, 143 N.J. Super. 571, 580, 364 A.2d 27, 32 (N.J. Super. L. Div. 1976). He argued consent as a defense after the state charged him with assault and battery. *Brown*, 364 A.2d at 28. The court held that failing to punish Brown "would seriously threaten the dignity, peace, health and security of our society." *Brown*, 364 A.2d at 32.

¶21 The above acts—including the *Mackrill* brawl—illustrate that sheer physical aggression that breaches public peace and endangers others is against public policy. In contrast, the act of a physician handing medicine to a terminally ill patient, and the

patient's subsequent peaceful and private act of taking the medicine, are not comparable to the violent, peace-breaching conduct that this Court and others have found to violate public policy.

¶22 The above cases address assaults in which the defendant alone performs a direct and violent act that causes harm. The bar brawler, prison fighter, BB gun-shooter, and domestic violence aggressor all committed violent acts that directly caused harm and breached the public peace. It is clear from these cases that courts deem consent ineffective when defendants directly commit blatantly aggressive, peace-breaching acts against another party.

¶23 In contrast, a physician who aids a terminally ill patient in dying is not directly involved in the final decision *or* the final act. He or she only provides a means by which a terminally ill patient *himself* can give effect to his life-ending decision, or not, as the case may be. Each stage of the physician-patient interaction is private, civil, and compassionate. The physician and terminally ill patient work together to create a means by which the patient can be in control of his own mortality. The patient's subsequent private decision whether to take the medicine does not breach public peace or endanger others.

¶24 Although the "against public policy" exception of § 45-2-211(2)(d), MCA, is not limited to violent breaches of the peace as discussed in the above cases, we see nothing in the case law facts or analysis suggesting that a patient's private interaction with his

physician, and subsequent decision regarding whether to take medication provided by a physician, violate public policy. We thus turn to a review of Montana statutory law.

¶25 We similarly find no indication in Montana statutes that physician aid in dying is against public policy. The Montana Rights of the Terminally Ill Act (Terminally Ill Act) and the homicide statute's narrow applicability to "another" human being, do not indicate that physician aid in dying is against public policy.

¶26 Under § 45-5-102, MCA, a "person commits the offense of deliberate homicide if:

(a) the person purposely or knowingly causes the death of another human being . . . ." In physician aid in dying, the physician makes medication available for a terminally ill patient who requests it, and the patient would then choose whether to cause his own death by self-administering the medicine. The terminally ill patient's act of ingesting the medicine is not criminal. There is no language in the homicide statute indicating that killing "oneself," as opposed to "another," is a punishable offense, and there is no separate statute in Montana criminalizing suicide. There is thus no indication in the homicide statutes that physician aid in dying—in which a terminally ill patient elects and consents to taking possession of a quantity of medicine from a physician that, if he chooses to take it, will cause his own death—is against public policy.

¶27 There is similarly no indication in the Terminally Ill Act that physician aid in dying is against public policy. The Terminally Ill Act, by its very subject matter, is an apt statutory starting point for understanding the legislature's intent to give terminally ill patients—like Mr. Baxter—end-of-life autonomy, respect and assurance that their

life-ending wishes will be followed. The Terminally Ill Act expressly immunizes physicians from criminal and civil liability for following a patient's directions to withhold or withdraw life-sustaining treatment. Section 50-9-204, MCA. Indeed, the legislature has criminalized the *failure* to act according to the patient's wishes. Section 50-9-206, MCA. Other parts of the Terminally Ill Act also resonate with this respect for the patient's end-of-life preferences. Section 50-9-205, MCA, explicitly prohibits, "for any purpose," calling the patient's death a "suicide or homicide," and § 50-9-501, MCA, charges the Montana Attorney General with creating a "declaration registry" and waging a statewide campaign to educate Montanans about end-of-life decisionmaking. The statute even establishes a specialized state fund account specifically for the registry and education program. Section 50-9-502(b), MCA.

¶28 The Rights of the Terminally Ill Act very clearly provides that terminally ill patients are entitled to autonomous, end-of-life decisions, even if enforcement of those decisions involves direct acts by a physician. Furthermore, there is no indication in the Rights of the Terminally Ill Act that an additional means of giving effect to a patient's decision—in which the patient, without any direct assistance, chooses the time of his own death—is against public policy.

¶29 The Montana Legislature codified several means by which a patient's life-ending request can be fulfilled. The Terminally Ill Act authorizes an individual "of sound mind and 18 years of age or older to execute at any time a declaration governing the withholding or withdrawal of life-sustaining treatment." Section 50-9-103, MCA. The

Terminally Ill Act defines "life-sustaining treatment" as any medical procedure or intervention that "serves only to prolong the dying process." Section 50-9-102(9), MCA. The declaration is operative when it is communicated to the physician or registered nurse and the declarant is determined to be in a terminal condition and no longer able to vocalize his end-of-life wishes. Section 50-9-105, MCA.

¶30 The Terminally Ill Act, in short, confers on terminally ill patients a right to have their end-of-life wishes followed, even if it requires *direct* participation by a physician through withdrawing or withholding treatment. Section 50-9-103, MCA. Nothing in the statute indicates it is against public policy to honor those same wishes when the patient is conscious and able to vocalize and carry out the decision himself with self-administered medicine and no immediate or direct physician assistance.

¶31 The Terminally Ill Act contains declaration forms a patient may use to legally ensure his end-of-life instructions will be followed. The forms shed critical light on the end-of-life roles of terminally ill Montanans and their physicians, as envisioned and codified by the legislature. The first declaration states:

> If I should have an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician or attending advanced practice registered nurse, cause my death within a relatively short time and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician or attending advanced practice registered nurse, pursuant to the Montana Rights of the Terminally Ill Act, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain.

Section 50-9-103(2), MCA. The declaration language of § 50-9-103, MCA, not only highlights the legislature's intent to provide terminally ill patients with various means to express (and have followed) their autonomous end-of-life preferences, but also authorizes physician involvement in both the terminal diagnosis and the act of withdrawing or withholding treatment.

¶32 The legislature, in creating this legally-enforceable declaration, also immunized physicians and medical professionals who act in accordance with the patient's wishes. The statute shields physicians from liability for following a patient's instructions to stop life-sustaining treatment, or refrain from treating him altogether. Section 50-9-204, MCA. The Dissent states that the Terminally Ill Act only allows the "taking away of, or refraining from giving" life-sustaining medical treatment. The Dissent's definition of "withdraw" confirms that this "taking away" is, itself, a direct act by the physician. "Withdrawal" is "*the act of* taking back or away" something that was granted. *Webster's Third New International Dictionary of the English Language* 2627 (Philip Babcock Gove ed., G. & C. Merriam Co. 1971) (emphasis added). The "giving" is an act, as is the "taking away." The Terminally Ill Act authorizes physicians to commit a direct *act* of withdrawing medical care, which hastens death. In contrast, the physician's involvement in aid in dying consists solely of making the instrument of the "act" available to the terminally ill patient. The patient himself then chooses whether to commit the act that will bring about his own death. The legislature codified public policy by expressly immunizing physicians who commit a direct act that gives effect to the life-ending wishes of a terminally ill patient. Section 50-9-204, MCA. There is no suggestion in the Act

that a lesser physician involvement (making available a lethal dose of medicine)—which is then vetted by a terminally ill patient's intervening choice and subsequent self-administered ingestion—is against public policy.

¶33 The Terminally Ill Act explicitly shields physicians from criminal, civil or professional liability for the act of withdrawing or withholding life-sustaining treatment from a terminally ill patient who requests it. Section 50-9-204, MCA.[1] The legislature devoted an entire section to codifying this immunity, ensuring that physicians and nurses will not be held liable for acting consistent with a terminally ill patient's decision to die. Section 50-9-204, MCA, provides an extensive list of medical professionals and others exempt from prosecution:

> (a) a physician or advanced practice registered nurse who *causes* the withholding or withdrawal of life-sustaining treatment from a qualified patient;
> (b) a person who participates in the withholding or withdrawal of life-sustaining treatment under the direction or with the authorization of the physician or advanced practice registered nurse; (c) emergency medical services personnel who *cause or participate* in the withholding or withdrawal of life-sustaining treatment under the direction of or with the authorization of a physician or advanced practice registered nurse or who on receipt of reliable documentation follow a living will protocol . . . .

Section 50-9-204, MCA (emphasis added). The section also immunizes health care facilities, health care providers, and the patient's designee. Section 50-9-204(e), MCA.

[1] The Dissent has erred in its statement that the operative words in the Terminally Ill Act are those "permitting a patient" to withdraw or withhold life-sustaining treatment. Dissent, ¶ 107. The Rights of the Terminally Ill Act was created to address the situation in which patients *cannot* act on their own behalf and therefore must authorize others to act for them. The only individuals who *act* in this statute are non-patients—particularly, medical professionals—who follow the directions of a terminally ill patient and affirmatively withdraw or withhold treatment.

The Terminally Ill Act's second enactment expands this immunity to include emergency medical service personnel. Section 50-9-204(c), MCA. The statute explicitly states that the above individuals are "not subject to civil or criminal liability or guilty of unprofessional conduct." Section 50-9-204(1), MCA. This encompassing immunity for medical professionals reinforces the terminally ill patient's right to enforce his decision without fear that those who give effect to his wishes will be prosecuted.

¶34 Further, the legislature criminalized the failure to follow a patient's end-of-life instructions. A physician "who willfully fails to record the determination of terminal condition or the terms of a declaration" is punishable by a maximum $500 fine, a maximum one year in jail, or both. Section 50-9-206(2), MCA. A person who "purposely conceals, cancels, defaces, or obliterates the declaration of another without the declarant's consent" is punishable by the same. Section 50-9-206(3), MCA. The statute's message is clear: failure to give effect to a terminally ill patient's life-ending declaration is a crime.

¶35 Other parts of the Terminally Ill Act similarly reflect legislative respect for the patient's end-of-life autonomy and the physician's legal obligation to comply with the patient's declaration. Section 50-9-205, MCA, prohibits, *for any purpose*, treating the death as either "suicide or homicide." The legislature, by prohibiting anyone from deeming the act a homicide or suicide, ensured that insurance companies cannot punish a terminally ill patient and his family for the patient's choice to die.

¶36 The provision also lists behaviors not supported by the statute. Notably, physician aid in dying is not listed. Section 50-9-205(7), MCA, reads: "This chapter does not condone, authorize, or approve mercy killing or euthanasia." Physician aid in dying is, by definition, neither of these. Euthanasia is the "intentional putting to death of a person with an incurable or painful disease intended as an act of mercy." *Stedman's Medical Dictionary* 678 (28th ed., Lippincott Williams & Wilkins 2006). The phrase "mercy killing" is the active term for euthanasia defined as "a mode of ending life in which the intent is to cause the patient's death in a single act." *Stedman's Medical Dictionary* at

678. Neither of these definitions is consent-based, and neither involves a patient's

679. autonomous decision to self-administer drugs that will cause his own death.

¶37 The final part of the Terminally Ill Act orders the Montana Attorney General to "establish and maintain a health care declaration registry" in which declarations are stored and updated. Section 50-9-501, MCA. The provision also creates a health care declaration account in the state special revenue fund, which the Attorney General must use to "create and maintain the health care declaration registry" and to create an education and outreach program. Section 50-9-502(b), MCA. The program must pertain to "advance health care planning and end-of-life health care decision-making." Section 50-9-505(1), MCA. The program must also "explain the need for readily available legal documents that express an individual's health care wishes." Section 50-9-505(c), MCA. The registry requirement, outreach and education provisions, and state funding for both, indicate legislative intent to honor and promulgate the rights of terminally ill patients to

autonomously choose the direction of their end-of-life medical care. There is no indication in the statutes that another choice—physician aid in dying—is against this legislative ethos of honoring the end-of-life decisions of the terminally ill.

¶38 There is no indication in the Rights of the Terminally Ill Act that physician aid in dying is against public policy. Indeed, the Act reflects legislative respect for the wishes of a patient facing incurable illness. The Act also indicates legislative regard and protection for a physician who honors his legal obligation to the patient. The Act immunizes a physician for following the patient's declaration even if it requires the physician to directly unplug the patient's ventilator or withhold medicine or medical treatment that is keeping the patient alive. Physician aid in dying, on the other hand, does not require such *direct* involvement by a physician. Rather, in physician aid in dying, the final death-causing act lies in the patient's hands. In light of the long-standing, evolving and unequivocal recognition of the terminally ill patient's right to self-determination at the end of life in Title 50, chapter 9, MCA, it would be incongruous to conclude that a physician's indirect aid in dying is contrary to public policy.

¶39 There are three central problems with the Dissent's response. First, the Dissent applies § 45-5-105, MCA—a statute that factually does not apply to Mr. Baxter's appeal. This statute only applies if the suicide does not occur. Second, the Dissent massages the statute's legislative history into makeshift legislation, which it then proffers as public policy. Such analysis directly violates this Court's precedent regarding statutory interpretation.

¶40 The Dissent first cites § 45-5-105, MCA, stating that a person may be prosecuted for aiding or soliciting suicide only if the individual *does not die*. Dissent, ¶ 101. The statute's plain meaning is clear. It is also inapplicable. The narrow scenario we have been asked to consider on appeal involves the situation in which a terminally ill patient affirmatively seeks a lethal dose of medicine and subsequently self-administers it, causing his own death. Section 45-5-105, MCA, unambiguously applies *only* when the suicide *does not* occur.

¶41 Under this Court's precedent, the inquiry stops there. We have repeatedly held that we will not interpret a statute beyond its plain language if the language is clear and unambiguous. *Mont. Sports Shooting Ass'n v.* State, 2008 MT 190, ¶ 11, 344 Mont. 1, 4, 185 P.3d 1003, 1006; *State v. Letasky*, 2007 MT 51, ¶ 11, 336 Mont. 178, 181, 152 P.3d 1288, 1290 ("We interpret a statute first by looking to the statute's plain language, and if the language is clear and unambiguous, no further interpretation is required."). Here, the legislature could not have provided clearer, more unambiguous language. If the person does not die, the statute is triggered. If they do die, the statute is not triggered. The statute provides only *one* clear set of circumstances where a person may be prosecuted. There is simply nothing ambiguous about it.

¶42 While conceding on the one hand that § 45-5-105, MCA, applies only when the suicide *does not* occur, the Dissent nonetheless unilaterally revises the statute, stating that "under Montana law, physicians who assist in a suicide are subject to criminal prosecution irrespective of whether the patient *survives* or *dies*." Dissent, ¶ 102. This is

incorrect under the law. Not only does the language of the statute clearly and *only* address the scenario in which the "suicide *does not* occur" but the Commission comments themselves do not even provide enlightenment on the legislature's intent regarding the language of the aid or soliciting suicide statute itself. Instead, the Commission comments speak of a different statute (and crime) altogether: Homicide. In fact, the comments analyze language, such as "agent of death," that does not even appear in the aid or soliciting statute or anywhere else in the Montana code. The Dissent not only disregards this Court's precedent regarding statutory interpretation, but it also grants the uncodified comments of eleven unelected individuals the weight of law.

¶43 The Dissent argues that consent to physician aid in dying is against public policy simply because the conduct is defined as an offense under the criminal statutes. That reasoning is circular. The Dissent cannot obviate a separate consent statute by simply saying that all statutory crimes are by definition against public policy, therefore consent to that conduct is *also* against public policy. If that were the case, the legislature would not have felt compelled to enact a separate consent statute. By enacting this separate consent statute, the legislature obviously envisioned situations in which it is not against public policy for a victim to consent to conduct that would otherwise constitute an offense under the criminal statutes.

¶44 Even if this Court were to extend consideration to § 45-5-105, MCA, as a generalized reflection of the legislature's views on third party involvement in suicides, there remains no indication that the statute was ever intended to apply to the very narrow

set of circumstances in which a terminally ill patient *himself* seeks out a physician and asks the physician to provide him the means to end his own life. As the Dissent states, the original enactment addressed situations of a third party "encouraging" a suicide. Dissent, ¶ 99. The present version reflects the same focus in the "soliciting" language. The statute's plain language addresses the situation in which a third party unilaterally solicits or aids another person. In physician aid in dying, the solicitation comes from the patient himself, *not* a third party physician.

¶45 There is no indication that the 1973 Montana legislators contemplated the statute would apply to this specific situation in which a terminally ill patient seeks a means by which he can end his own incurable suffering. In fact, it was not until twelve years later in 1985, that the legislature enacted the Rights of the Terminally Ill Act, which squarely addresses the modern complexities of physician- and technology-dependent end-of-life care provided to terminally ill Montanans. Since then, the legislature—as illustrated in the Terminally Ill Act analysis above—has carefully cultivated a statutory scheme that gives terminally ill Montanans the right to autonomously choose what happens to them at the end of painful terminal illness.

¶46 Finally, we determine whether the District Court erred in awarding Mr. Baxter attorney fees. Following entry of the District Court's judgment on the constitutional claims, Mr. Baxter moved to amend under M. R. Civ. P. 59(g) to include an award of attorney fees as supplemental relief under § 27-8-313, MCA, and the private attorney general doctrine. The District Court awarded attorney fees to Mr. Baxter under the

private attorney general doctrine. We review a grant or denial of attorney fees for abuse of discretion. *Trs. of Ind. Univ. v. Buxbaum*, 2003 MT 97, ¶ 15, 315 Mont. 210, 216, 69 P.3d 663, 667.

¶47 The private attorney general doctrine applies when the government fails to properly enforce interests which are significant to its citizens. *Montanans for the Responsible Use of the Sch. Trust v. State ex rel. Bd. of Land Commissioners,* 1999 MT 263, ¶ 64, 296 Mont. 402, 421, 989 P.2d 800, 811. The private attorney general doctrine, however, applies only when constitutional interests are vindicated. *Am. Cancer Soc'y v. State*, 2004 MT 376, ¶ 21, 325 Mont. 70, 78, 103 P.3d 1085, 1091. Our holding today is statute-based. Therefore, without the vindication of constitutional interests, an award of fees under the private attorney general doctrine is not warranted.

¶48 Although attorney fees may be appropriate "further relief" under § 27-8-313, MCA, "such fees are only appropriate if equitable considerations support the award." *United Nat'l Ins. Co. v. St. Paul Fire & Marine Ins. Co.*, 2009 MT 269, ¶ 38, 352 Mont. 105, 118, 214 P.3d 1260, 1271. As in *United National*, the equitable considerations here do not support an award of attorney fees. Mr. Baxter is accompanied by other plaintiffs, including four physicians and Compassion & Choices, a national nonprofit organization. The relief herein granted to the Plaintiffs is not incomplete or inequitable without the Montana taxpayers having to pay the attorney fees.

¶49 In conclusion, we find nothing in Montana Supreme Court precedent or Montana statutes indicating that physician aid in dying is against public policy. The "against

public policy" exception to consent has been interpreted by this Court as applicable to violent breaches of the public peace. Physician aid in dying does not satisfy that definition. We also find nothing in the plain language of Montana statutes indicating that physician aid in dying is against public policy. In physician aid in dying, the patient— not the physician—commits the final death-causing act by self-administering a lethal dose of medicine.

¶50 Furthermore, the Montana Rights of the Terminally Ill Act indicates legislative respect for a patient's autonomous right to decide if and how he will receive medical treatment at the end of his life. The Terminally Ill Act explicitly shields physicians from liability for acting in accordance with 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. There is no statutory indication that lesser end-of-life physician involvement, in which the patient himself commits the final act, is against public policy. We therefore hold that under § 45-2-211, MCA, a terminally ill patient's consent to physician aid in dying constitutes a statutory defense to a charge of homicide against the aiding physician when no other consent exceptions apply.

¶51 The District Court's ruling on the constitutional issues is vacated, although the court's grant of summary judgment to Plaintiffs/Appellees is affirmed on the alternate statutory grounds set forth above. The award of attorney fees is reversed.

/S/ W. WILLIAM LEAPHART

We concur:

/S/ PATRICIA O. COTTER
/S/ JOHN WARNER
/S/ BRIAN MORRIS

Justice John Warner concurs.

¶52 I concur.

¶53 The Court's opinion today answers the statutory question: is it, as a matter of law, against the public policy of Montana for a physician to assist a mentally competent, terminally ill person to end their life? The answer provided is: "No, it is not, as a matter of law."

¶54 This Court correctly avoided the constitutional issue Baxter desires to present. No question brought before this Court is of greater delicacy than one that involves the power of the legislature to act. If it becomes indispensably necessary to the case to answer such a question, this Court must meet and decide it; but it is not the habit of the courts to decide questions of a constitutional nature unless absolutely necessary to a decision of the case. *See e.g. Ex parte Randolph*, 20 F. Cas. 242, 254 (C.C.Va. 1833) (Marshall, Circuit Justice); *Burton v. United States*, 196 U.S. 283, 295, 25 S. Ct. 243, 245 (1905); *State v. Kolb*, 2009 MT 9, ¶ 13, 349 Mont. 10, 200 P.3d 504; *Common Cause of Montana v. Statutory Committee to Nominate Candidates for Commr. of Political Practices*, 263

Mont. 324, 329, 868 P.2d 604, 607 (1994); *Wolfe v. State, Dept. of Labor and Industry, Board of Personnel Appeals*, 255 Mont. 336, 339, 843 P.2d 338, 340 (1992).

¶55 This Court has done its job and held that pursuant to § 45-2-211, MCA, a physician who assists a suicide, and who happens to be charged with a crime for doing so, may assert the defense of consent. I join the opinion, and not the thoughtful and thought provoking dissent, because the Legislature has not plainly stated that assisting a suicide is against public policy. This Court must not add such a provision by judicial fiat. Section 1-2-101, MCA.

¶56 The logic of the Court's opinion is not necessarily limited to physicians. In my view, the citizens of Montana have the right to have their legislature step up to the plate and squarely face the question presented by this case, do their job, and decide just what is the policy of Montana on this issue.

¶57 As for the constitutional analysis requested by Baxter, I have found many times in my judicial career that Viscount Falkland is correct: when it is not necessary to make a decision, it is necessary to not make a decision. A question of constitutional law should not be anticipated in advance of the necessity of deciding it. *Ashwander v. Tennessee Valley Authority*, 297 U.S. 288, 346-47, 56 S. Ct. 466, 483 (1936) (Brandeis, J., concurring) (quoting *Liverpool, N.Y. & Phila. Steamship Co. v. Emigration Commissioners*, 113 U.S. 33, 39, 5 S. Ct. 352, 355 (1885)).

/S/ JOHN WARNER

Justice James C. Nelson, specially concurring.

¶58 *I have lived a good and a long life, and have no wish to leave this world prematurely. As death approaches from my disease, however, if my suffering becomes unbearable I want the legal option of being able to die in a peaceful and dignified manner by consuming medication prescribed by my doctor for that purpose. Because it will be my suffering, my life, and my death that will be involved, I seek the right and responsibility to make that critical choice for myself if circumstances lead me to do so. I feel strongly that this intensely personal and private decision should be left to me and my conscience – based on my most deeply held values and beliefs, and after consulting with my family and doctor – and that the government should not have the right to prohibit this choice by criminalizing the aid in dying procedure.*[1]

¶59 With the exception of the Court's decision to vacate the District Court's ruling on the constitutional issues, Opinion, ¶ 51, I otherwise join the Court's Opinion. For the reasons which follow, I agree with the Court's analysis under the consent statute (§ 45-2-211, MCA), and I further conclude that physician aid in dying is protected by the Montana Constitution as a matter of privacy (Article II, Section 10) and as a matter of individual dignity (Article II, Section 4).

I. STATUTORY ANALYSIS

¶60 The Court and the Dissent offer two conflicting analyses of "public policy" under the consent statute. *See* Opinion, ¶¶ 14-45; Dissent, ¶¶ 99-110. In my view, the Court has the better argument. As the Court points out, the consent statute plainly contemplates that it is not against public policy in certain situations for a victim to consent to conduct

[1] Aff. Robert Baxter ¶ 9 (June 28, 2008). Baxter (one of the plaintiffs-appellees in this case) died of leukemia on December 5, 2008—the same day the District Court issued its ruling in his favor, holding that under the Montana Constitution a mentally competent, incurably ill patient has the right to die with dignity by obtaining physician aid in dying.

that otherwise would constitute an offense under the criminal statutes. Opinion, ¶ 43. I agree with the Court that there is no indication in Montana caselaw or statutory law that physician aid in dying is against public policy. In this regard, the Dissent is incorrect in stating that *the Legislature* eliminated the consent defense for aiding suicide under § 45-5-105, MCA. Dissent, ¶ 105. The Dissent points to nothing in the plain language of the consent statute standing for this proposition. Rather, the Dissent relies on the uncodified 1973 Criminal Law Commission Comments to § 45-5-105, MCA. *See* Dissent, ¶¶ 101-103, 105. Of course, these Commission Comments do not carry the weight of law. Opinion, ¶ 42. Moreover, I do not find the presumed statements of public policy reflected in these 1973 Commission Comments to be of any persuasive value here. The Legislature has since codified a different public policy in the 1985 Montana Rights of the Terminally Ill Act—specifically, that a mentally competent, incurably ill individual should have autonomy with regard to end-of-life decisions and should be afforded respect and assurance that her life-ending wishes will be honored, even if enforcement of the patient's instructions involves a direct act by the physician (such as withdrawing life-sustaining medical treatment) which in turn causes the patient's death. *See generally* Opinion, ¶¶ 27-38; Title 50, chapter 9, MCA.

¶61 Our decision today, therefore, provides a mentally competent, incurably ill individual with at least one avenue to end her mental and physical suffering with a physician's assistance. Under the consent statute, it is not against public policy for the physician to provide the individual with the prescription for a life-ending substance to be

self-administered by the individual at her choice of time and place. As an obvious corollary to this, the individual retains the right to change her mind as her condition progresses for better or worse—i.e., the patient retains the absolute right to make the ultimate decision of whether to take the life-ending substance. As such, in physician aid in dying the physician simply makes medication available to the patient who requests it and the patient ultimately chooses whether to cause her own death by self-administering the medicine—an act which itself is not criminal. Opinion, ¶¶ 26, 32.

¶62 I accordingly agree with the Court's analysis and conclusion that the patient's consent to physician aid in dying constitutes a statutory defense to a charge of deliberate homicide against the aiding physician under § 45-5-102, MCA, where the patient takes the life-ending substance and ends her life. Opinion, ¶ 50. This same conclusion, of course, applies to a charge of aiding suicide under § 45-5-105, MCA, where the patient does not take the substance. In either event, the physician is not culpable.

¶63 For these reasons, I concur in the Court's Opinion—except, as noted, the decision to vacate the District Court's ruling on the constitutional issues.

II. CONSTITUTIONAL ANALYSIS

¶64 Although the Court has chosen to decide this case on the narrow statutory ground suggested by the State of Montana (as an alternative approach) in its briefs on appeal, Opinion, ¶ 10, and although physician aid in dying is protected statutorily (as the Court holds under this alternative approach), physician aid in dying is also firmly protected by Montana's Constitution. In this regard, I compliment District Court Judge Dorothy

McCarter for her well-written, compassionate, and courageous—indeed, visionary—interpretation of our Constitution. The parties have extensively briefed the constitutional issues, *see* Opinion, ¶ 10, and the Dissent touches on them as well, *see* Dissent,

> ¶¶ 112-116. For these reasons, and because I so passionately believe that individual dignity is, in all likelihood, the most important—and yet, in our times, the most fragile—of all human rights protected by Montana's Constitution, I proceed to explain what I believe the right of dignity means within the context of this case—one of the most important cases the courts of this state have ever considered.

¶65 The District Court's decision is grounded in both the right of individual dignity guaranteed by Article II, Section 4 and the right of individual privacy guaranteed by Article II, Section 10. Likewise, the Plaintiff-Appellee patients (Patients) and their amici present arguments under both provisions. With regard to Article II, Section 10, they persuasively demonstrate that under *Gryczan v. State*, 283 Mont. 433, 942 P.2d 112 (1997), and *Armstrong v. State*, 1999 MT 261, 296 Mont. 361, 989 P.2d 364, physician aid in dying is protected by the right of individual privacy. Indeed, this Court held in

Armstrong that "the personal autonomy component of this right broadly guarantees each individual the right to make medical judgments affecting her or his bodily integrity and health in partnership with a chosen health care provider free from the interference of the government . . . ." *Armstrong*, ¶ 75. As noted, however, I believe that this case—aid in dying so as to die with dignity—is most fundamentally and quintessentially a matter of

human dignity. Accordingly, it is to that right that I direct my comments below. But before doing so, it is necessary to define and explain my choice of terms and language.

A. Terminology and Language

¶66 First, let me be clear about one thing: This case is not about the "right to die." Indeed, the notion that there is such a "right" is patently absurd, if not downright silly. No constitution, no statute, no legislature, and no court can grant an individual the "right to die." Nor can they take such a right away. "Death is the destiny of everything that lives. Nothing ever escapes it."[2] Within the context of this case, the only control that a person has over death is that if he expects its coming within a relatively short period of time due to an incurable disease, he can simply accept his fate and seek drug-induced comfort; or he can seek further treatment and fight to prolong death's advance; or, at some point in his illness, and with his physician's assistance, he can embrace his destiny at a time and place of his choosing. The only "right" guaranteed to him in any of these decisions is the right to preserve his personal autonomy and his individual dignity, as he sees fit, in the face of an ultimate destiny that no power on earth can prevent.

¶67 Thus noted, the Patients and the class of individuals they represent are persons who suffer from an illness or disease, who cannot be cured of their illness or disease by any reasonably available medical treatment, who therefore expect death within a relatively short period of time, and who demand the right to preserve their personal autonomy and their individual dignity in facing this destiny.

[2] John Shelby Spong, *Eternal Life: A New Vision*, 73 (HarperCollins 2009).

¶68 In choosing this language, I purposely eschew bright-line tests or rigid timeframes. What is "relatively short" varies from person to person. I take this approach[3] for the following nonexclusive reasons. **First,** the amount of physical, emotional, spiritual, and mental suffering that one is willing or able to endure is uniquely and solely a matter of individual constitution, conscience, and personal autonomy. **Second,** "suffering" in this more expansive sense may implicate a person's uniquely personal perception of his "quality of life." This perception may be informed by, among other things, one's level of suffering, one's loss of personal autonomy, one's ability to make choices about his situation, one's ability to communicate, one's perceived loss of value to self or to others, one's ability to care for his personal needs and hygiene, one's loss of dignity, one's financial situation and concern over the economic burdens of prolonged illness, and one's level of tolerance for the invasion of personal privacy and individual dignity that palliative treatment necessarily involves. Suffering may diminish the quality of life; on the other hand, the lack of suffering does not guarantee a life of quality. There is a difference between living and suffering; and the sufferer is uniquely positioned and, therefore, uniquely entitled to define the tipping point that makes suffering unbearable. **Third,** while most incurable illnesses and diseases follow a fairly predictable symptomatology and course, every illness and disease is a unique and very personal experience for the afflicted person. Thus, the afflicted individual's illness or disease informs his end-of-life choices and decisions in ways unique and personal to that

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[3] *See generally* Raphael Cohen-Almagor, *The Right to Die with Dignity*, 27-33, 52-79, 96-112 (Rutgers University Press 2001).

individual's life, values, and circumstances. **Fourth,** advancements in medical treatment may become available during the period between the time when he is diagnosed as being incurably ill and the predicted (estimated) time of death. With those advancements, a person initially given three months to live may well expect to live two more months or two more years with a new medicine or treatment. **Fifth,** individual access to medical care may vary. A person living in proximity to a medical research facility may have access to medicines and treatments as part of a clinical trial, while another person living in a sparsely populated rural area may not have that opportunity. One individual may have access to hospice care; another may not. Sadly, an insured individual may have access to medicine and treatment that an uninsured individual does not. **Sixth,** each individual's family situation is different. One individual may not have close family relationships; another may have a strongly involved and supportive family. One person's family may live within a short distance, while another person's family may be spread across the country or around the globe. The ability to say final goodbyes and the ability to die, at a predetermined time and place, perhaps in the company of one's partner or friends and loved ones, is important to many individuals and to their families. **Seventh,** and lastly, to many who are incurably ill and dying, the prospect of putting their partner or family through their prolonged and agonizing death is a source of deep emotional and spiritual distress.

¶69 Additionally, in my choice of language, I have intentionally chosen not to use emotionally charged and value-laden terms such as "terminal" and "suicide." "Terminal"

conjures up the notion that the individual is on some sort of inevitable slide or countdown to death. This term trivializes the fact that many individuals, with what appear to be medically incurable diseases, nevertheless retain steadfast hope and faith that their condition will be reversed, along with a personal resolve to fight for life until the very end. Labeling an individual as "terminal" may not only discourage the individual from seeking treatment but may also discourage further treatment efforts by healthcare providers. A "terminal" diagnosis fails to acknowledge that medicine usually cannot predict the time of death with the sort of exactitude that the use of the term connotes.

¶70 Similarly, the term "suicide" suggests an act of self-destruction that historically has been condemned as sinful, immoral, or damning by many religions. Moreover, in modern parlance, "suicide" may be linked with terrorist conduct. Importantly, and as reflected in the briefing in this case, society judges and typically, but selectively, deprecates individuals who commit "suicide." On one hand, the individual who throws his body over a hand grenade to save his fellow soldiers is judged a hero, not a person who committed "suicide." Yet, on the other hand, the individual who shoots herself because she faces a protracted illness and agonizing death commits "suicide" and, as such, is judged a coward in the face of her illness and selfish in her lack of consideration for the pain and loss her act causes to loved ones and friends. Assisting this person to end her life is likewise denounced as typifying " 'a very low regard for human life.' " Dissent, ¶ 118 (quoting the Commission Comments to § 45-5-105, MCA). To the contrary, however, the Patients and their amici argue that a physician who provides aid in

dying demonstrates compassionate regard for the patient's suffering, recognition of the patient's autonomy and dignity, and acknowledgement of death's inevitability.

¶71 "Suicide" is a pejorative term in our society. Unfortunately, it is also a term used liberally by the State and its amici (as well as the Dissent) in this case. The term denigrates the complex individual circumstances that drive persons generally—and, in particular, those who are incurably ill and face prolonged illness and agonizing death—to take their own lives. The term is used to generate antipathy, and it does. The Patients and the class of people they represent do not seek to commit "suicide." Rather, they acknowledge that death within a relatively short time is inescapable because of their illness or disease. And with that fact in mind, they seek the ability to self-administer, at a time and place of their choosing, a physician-prescribed medication that will assist them in preserving their own human dignity during the inevitable process of dying. Having come to grips with the inexorability of their death, they simply ask the government not to force them to suffer and die in an agonizing, degrading, humiliating, and undignified manner. They seek nothing more nor less; that is all this case is about.

¶72 Finally, I neither use the terms nor address "euthanasia" or "mercy killing." Aside from the negative implications of these terms and the criminality of such conduct, the Patients clearly do not argue that incompetent, nonconsenting individuals or "vulnerable" people may be, under any circumstances, "euthanized" or "murdered." To read their arguments as suggesting either is, in my view, grossly unfair and intellectually dishonest. The only reason that "homicide" is implicated at all in this case is because (a) the State

contends that a licensed physician who provides a mentally competent, incurably ill patient with the prescription for a life-ending substance, to be self-administered by the patient if she so chooses, is guilty of deliberate homicide and (b) our decision holds that it is not against public policy under the consent statute to permit the physician to do so.

¶73 With that prefatory explanation, I now turn to Article II, Section 4 and the right of individual dignity.

B. Construction of Article II, Section 4

¶74 Article II, Section 4 of Montana's 1972 Constitution provides:

> **Individual dignity.** The dignity of the human being is inviolable. No person shall be denied the equal protection of the laws. Neither the state nor any person, firm, corporation, or institution shall discriminate against any person in the exercise of his civil or political rights on account of race, color, sex, culture, social origin or condition, or political or religious ideas.

While there are differing interpretations of this language, which I note below, it is my view that the first clause of Article II, Section 4 (the Dignity Clause) is a stand-alone, fundamental constitutional right. *See Walker v. State*, 2003 MT 134, ¶¶ 74, 82, 316 Mont. 103, 68 P.3d 872 (explaining that the rights found in Article II are "fundamental" and that the plain meaning of the Dignity Clause "commands that the intrinsic worth and the basic humanity of persons may not be violated").

¶75 First, I categorically reject the notion that the Dignity Clause is merely some "aspirational introduction" to the equal protection and nondiscrimination rights which follow it—a proposition for which there is no authority. Our Constitution is "a limitation upon the powers of government," *Cruse v. Fischl*, 55 Mont. 258, 263, 175 P. 878, 880

(1918), and in construing a constitutional provision, we are required "to give meaning to every word, phrase, clause and sentence therein, if it is possible so to do," *State ex rel. Diederichs v. State Highway Commn.*, 89 Mont. 205, 211, 296 P. 1033, 1035 (1931). Accordingly, the command that "[t]he dignity of the human being is inviolable" must be acknowledged as the freestanding limitation it is on the power of the government—much in the same way we recognize that trial by jury, which is similarly "inviolate" (Mont. Const. art. II, § 26), is not merely "aspirational" but is in fact a concrete right guaranteed by the Constitution.

¶76 Second, I likewise reject the notion that the right of dignity is fully implemented by the Equal Protection and Nondiscrimination Clauses or that these clauses are the sole "operative vehicles" for achieving dignity. In other words, I cannot agree that the inviolable dignity of a human being is infringed only when the person is denied equal protection of the laws or suffers discrimination for exercising his or her civil or political rights. Indeed, such an interpretation of Article II, Section 4 attributes an implausibly narrow meaning to the term "dignity." As the Dissent notes, the Dignity Clause can be traced to West Germany's 1949 Constitution, which was developed in response to the Nazi regime's treatment of the Jewish people (as well as homosexuals, Gypsies, persons with disabilities, and political opponents). Dissent, ¶ 116 n. 4. These "inferior" people

(so-called "useless eaters"[4]) were not merely denied equal protection of the laws. The

[4] George J. Annas, *The Man on the Moon, Immortality, and other Millennial Myths: The Prospects and Perils of Human Genetic Engineering*, 49 Emory L.J. 753, 758 2000)

government placed them in concentration camps and used them for slave labor. Medical experiments were performed on them. They were persecuted and killed. They were viewed and treated as subhuman, without any dignity. The West German Constitution and its command that "[t]he dignity of man shall be inviolable" must be understood in this context. Doing so, it simply cannot be maintained that Article II, Section 4 prohibits only discrimination and the denial of equal protection. The Dignity Clause broadly prohibits any law or act that infringes upon our inviolable dignity as human beings. This is not some "vague, lurking" right as the Dissent suggests. Dissent, ¶ 116. Rather, it is an imperative; an affirmative and unambiguous constitutional mandate.

¶77 This interpretation is supported by the structure of Article II, Section 4. In this connection, I agree with the construction proffered by Matthew O. Clifford and Thomas P. Huff in their article *Some Thoughts on the Meaning and Scope of the Montana Constitution's "Dignity" Clause with Possible Applications*, 61 Mont. L. Rev. 301, 305-07 (2000). They point out that the language of Article II, Section 4 (which is titled "Individual Dignity") moves in a logical progression from the general to the specific. The first sentence (the Dignity Clause) declares that human dignity is inviolable. The second sentence (the Equal Protection Clause) goes on to declare one way in which human dignity can be violated: by denying someone the equal protection of the laws based on some sort of arbitrary classification. They observe that our legal tradition has long recognized such classifications as affronts to the dignity of persons (citing as an example of this *Brown v. Board of Education*, 347 U.S. 483, 74 S. Ct. 686 (1954)).

Finally, the third sentence (the Nondiscrimination Clause) fleshes out the meaning of the equal protection right by enumerating certain types of classifications which the framers of Article II, Section 4 believed to be arbitrary: race, color, sex, culture, social origin or condition, and political or religious ideas.

¶78 Clifford and Huff note that the classifications identified in the Nondiscrimination Clause cannot be read as an exhaustive list of all possible arbitrary classifications. Otherwise, if the list were exhaustive, the Equal Protection Clause would be surplusage. The more reasonable interpretation, they conclude, is that by including the separate and more general Equal Protection Clause, the framers intended to leave open the possibility that there are other prohibited classifications beyond those which were recognized at that point in history (i.e., in 1972). And by the same logic, the inclusion of a more general prohibition against the violation of human dignity leaves open the possibility that human dignity can be violated in ways that do not involve some sort of arbitrary classification. Indeed, they argue, and I agree, that in order to give distinct and independent meaning to the Dignity Clause, avoiding redundancy, "this clause should be applied separately when there is a violation of the dignity of persons that does not reflect the forms of unequal treatment or invidious discrimination prohibited by the two subsequent clauses. Presumably anyone could experience such a violation of dignity, not just persons who are

members of protected classes."[5] Clifford and Huff, 61 Mont. L. Rev. at 306-07.

[5] Such is the case here, and that fact distinguishes my analysis herein from my analysis in *Snetsinger v. Montana University System*, 2004 MT 390, 325 Mont. 148, 104 P.3d 445. *Snetsinger* involved discrimination and equal protection issues relating

¶79 This interpretation is consistent with the debate on Article II, Section 4 at the 1971-1972 Constitutional Convention.[6] During the debate, Delegate Jerome T. Loendorf inquired whether the express prohibition against discrimination was necessary, given that the right of equal protection already prohibits discrimination. Delegate Wade J. Dahood (chair of the Bill of Rights Committee) acknowledged that the Nondiscrimination Clause was "subsumed in" the Equal Protection Clause, but he explained that "when we're dealing with this type of right, Delegate Loendorf, and we are dealing with something that is this basic, to an orderly and progressive society perhaps sometimes the sermon that can be given by constitution, as well as the right, becomes necessary." Montana Constitutional Convention, Verbatim Transcript, Mar. 7, 1972, pp. 1643-44. Thus, the delegates decided that it was preferable to include the additional language making certain facets of the equal protection right explicit. This same principle supports the notion that denying someone the equal protection of the laws is but *one* way in which human dignity can be violated, as discussed above.

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sexual orientation. Thus, applying Clifford and Huff's analytical model, I analyzed these issues under each sentence of Article II, Section 4. *See Snetsinger*, ¶¶ 71-97 (Nelson, J., specially concurring). The present case, however, does not involve discrimination or equal protection claims. It is appropriate, therefore, to apply only the Dignity Clause, as a stand-alone constitutional protection.

[6] I acknowledge that the intent of the framers should be determined from the plain meaning of the words used and, if that is possible (as it is here), then we apply no other means of interpretation. Indeed, "[w]e are precluded . . . from resorting to extrinsic methods of interpretation." *Great Falls Tribune Co. v. Great Falls Public Schools*, 255 Mont. 125, 128-29, 841 P.2d 502, 504 (1992) (internal quotation marks omitted). The Dissent, however, relies on the Constitutional Convention record. Dissent, ¶¶ 112-116. Thus, I discuss this record for purposes of responding to the Dissent's arguments.

¶80 In arguing against this interpretation of Article II, Section 4, the Dissent points to Delegate Dahood's statement that "[t]here is no intent within this particular section to do anything other than to remove the apparent type of discrimination that all of us object to with respect to employment, to rental practices, to actual associationship in matters that are public or matters that tend to be somewhat quasi-public." Montana Constitutional Convention, Verbatim Transcript, Mar. 7, 1972, p. 1643. This statement, however, must be understood in context. Dahood was not purporting to limit the scope of Article II, Section 4. In fact, he was trying to keep the provision broad. Delegate Otto T. Habedank had voiced a concern that the language "any person, firm, corporation, or institution" in the Nondiscrimination Clause would prohibit private organizations from limiting their membership and would force individuals to associate with people they otherwise would choose not to associate with. *See* Montana Constitutional Convention, Verbatim Transcript, Mar. 7, 1972, p. 1643. Habedank therefore had moved to delete the "any person, firm, corporation, or institution" language from the Nondiscrimination Clause, thereby rendering the clause applicable to only the state. *See* Montana Constitutional Convention, Verbatim Transcript, Mar. 7, 1972, p. 1642. Dahood, in turn, argued against this amendment (which ultimately was defeated 76 to 13) and in favor of applying the nondiscrimination prohibition to entities other than the state, such as employers, landlords, and public or quasi-public associations. Dahood made no remarks about the Dignity Clause itself.

¶81 In contrast, Delegate Proposal No. 33 specifically recognized an independent right of individual dignity. It stated: "The rights of individual dignity, privacy, and free expression being essential to the well-being of a free society, the state shall not infringe upon these rights without the showing of a compelling state interest." *See* Montana Constitutional Convention, Delegate Proposals, Jan. 26, 1972, p. 127. This proposal was referred to the Bill of Rights Committee, which adopted the proposal *in its entirety*. *See* Montana Constitutional Convention, Bill of Rights Committee Proposal, Feb. 23, 1972, p. 647. The right of individual dignity, the right of privacy, and the right of free expression were then incorporated, respectively, into Sections 4, 10, and 7 of Article II.[7]

¶82 In sum, given the plain language of Article II, Section 4 and the structure of this provision, I conclude that the Dignity Clause—stating that the dignity of the human being is inviolable—is a stand-alone, fundamental constitutional right. This conclusion is supported by the record from the Constitutional Convention. I now turn to the substance of this right.

C. The Right of Human Dignity

[7] In this regard, the Dissent points out that the Bill of Rights Committee did not adopt Delegate Robert L. Kelleher's Proposal No. 103, which stated: "A human fetus has the right to be born. The incurably ill have the right not to be kept alive by extraordinary means." *See* Dissent, ¶¶ 113-115. Of course, we are not dealing in this case with "the right not to be kept alive by extraordinary means"—a matter already addressed statutorily by the Montana Rights of the Terminally Ill Act (Title 50, chapter 9, MCA). Moreover, the reasons behind the committee's decision on Proposal No. 103 are not stated in the Constitutional Convention record, and this Court has already rejected a similar attempt to read more than is warranted into the disposition of this proposal (*see Armstrong v. State*, 1999 MT 261, ¶¶ 43-48, 296 Mont. 361, 989 P.2d 364). In short, the disposition of Kelleher's proposal is simply not instructive here.

¶83 Human dignity is, perhaps, the most fundamental right in the Declaration of Rights. This right is "inviolable," meaning that it is "[s]afe from violation; *incapable* of being violated." *Black's Law Dictionary* 904 (Bryan A. Garner ed., 9th ed., West 2009) (emphasis added). Significantly, the right of human dignity is the only right in Montana's Constitution that is "inviolable."[8] It is the only right in Article II carrying the *absolute prohibition* of "inviolability." No individual may be stripped of her human dignity under the plain language of the Dignity Clause. No private or governmental entity has the right or the power to do so. Human dignity simply cannot be violated—no exceptions. *Snetsinger v. Montana University System*, 2004 MT 390, ¶ 77, 325 Mont. 148, 104 P.3d 445 (Nelson, J., specially concurring).

¶84 But what exactly is "dignity"? It would be impractical here to attempt to provide an exhaustive definition. Rather, the meaning of this term must be fleshed out on a case-by-case basis (in the same way that the parameters of substantive due process have been determined on a case-by-case basis). I note, however, a couple of interpretations that are useful for purposes of the present discussion. Law professor Raphael Cohen-Almagor states that the concept of dignity "refers to a worth or value that flows from an inner source. It is not bestowed from the outside but rather is intrinsic to the person." Raphael Cohen-Almagor, *The Right to Die with Dignity*, 17 (Rutgers University Press 2001). He argues that "[t]o have dignity, means to look at oneself with self-respect, with some sort

[8] As noted, the right of trial by jury is "inviolate." Mont. Const. art. II, § 26. "Inviolate," however, means "[f]ree from violation; not broken, infringed, or impaired," *Black's Law Dictionary* 904, which is not the same as "incapable of being violated."

of satisfaction. We feel human, not degraded." Cohen-Almagor, *The Right to Die with Dignity* at 17. Similarly, Clifford and Huff explain that in our Western ethical tradition, especially after the Religious Reformation of the 16th and 17th centuries, dignity has typically been associated with the normative ideal of individual persons as intrinsically valuable, as having inherent worth as individuals, at least in part because of their capacity for independent, autonomous, rational, and responsible action. Clifford and Huff, 61 Mont. L. Rev. at 307. Under this conception, dignity is *directly* violated by degrading or demeaning a person. Clifford and Huff, 61 Mont. L. Rev. at 307; *see also e.g. Walker v. State*, 2003 MT 134, ¶¶ 81-84, 316 Mont. 103, 68 P.3d 872 (recognizing this principle and holding that the correctional practices and living conditions to which Walker was subjected at the Montana State Prison violated his right of human dignity). Or dignity is *indirectly* violated by denying a person the opportunity to direct or control his own life in such a way that his worth is questioned or dishonored. For example, dignity could be indirectly undermined "by treatment which is paternalistic—treating adults like children incapable of making autonomous choices for themselves, or by trivializing what choices they do make about how to live their lives." Clifford and Huff, 61 Mont. L. Rev. at 307-08; *cf. Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 289, 110 S. Ct. 2841, 2857 (1990) (O'Connor, J., concurring) (requiring a competent adult to endure the procedures of being fed artificially by means of a tube against her will "burdens the patient's liberty, dignity, and freedom to determine the course of her own treatment"). Significantly, this Court has held that "[r]espect for the dignity of each individual . . .

demands that people have for themselves the moral right and moral responsibility to confront the most fundamental questions about the meaning and value of their own lives and the intrinsic value of life in general, answering to their own consciences and convictions." *Armstrong v. State*, 1999 MT 261, ¶ 72, 296 Mont. 361, 989 P.2d 364.

¶85 Clifford and Huff also point out that if the Dignity Clause is to maintain its force as a shared public ethical norm,

> the substantive meaning of the clause must not be identified with, or justified by, any specific controversial religious or philosophical doctrines. The only reasonable political compromise we can reach in modern times (after the Reformation), when we must accept as fact that different segments of society will have deeply conflicting personal, religious, and philosophical views about how one ought to live one's life, is to agree to treat each other, and our respective values, with mutual respect and tolerance. This compromise makes possible the modern constitutional democracy, focused on securing the liberty and protecting the dignity of each person. Thus, the only conception of dignity that we can *all* share as citizens, despite our other differences, in a post-Reformation state (the conception of dignity that, for example, the delegates to the Constitutional Convention could share), must focus on honoring the worth of autonomous individuals. To remain consistent with this shared, public ideal of dignity, the right to treatment with dignity must not be defined according to some parochial, sectarian religious or some controversial, philosophical notion of human dignity—those richer conceptions of dignity about which we have agreed to disagree.

Clifford and Huff, 61 Mont. L. Rev. at 326-27 (footnote omitted).

¶86 Given its intrinsic nature, it is entirely proper, in my view, that the right of dignity under Article II, Section 4 is absolute. Indeed, human dignity transcends the Constitution and the law. Dignity is a fundamental component of humanness. It is inherent in human self-consciousness. Dignity belongs, intrinsically, to our species—to each of us—as a natural right from birth to death. It permeates each person regardless of who that person

is or what he does. It cannot be abrogated because of one's status or condition. While the government may impinge on privacy rights, liberty interests, and other Article II rights in proper circumstances (e.g., when one becomes a prisoner), the individual always retains his right of human dignity. So too with persons suffering from mental illness or disability and involuntary commitment: Each retains the right to demand of the State that his dignity as a human being be respected despite the government's sometimes necessary interference in his life.

¶87 I am convinced that each of us recognizes this intrinsic, elemental nature of human dignity. Indeed, that recognition explains why we collectively recoil from the pyramid of naked enemy soldiers prodded by troops with guns and dogs at Abu Ghraib; why disgust fills most of us at the descriptions and depictions of water boarding and torture; and why we revolt from ethnic cleansing and genocide. It is why we should collectively rebel, as well, when we see our fellow human beings in need from lack of food, clothing, shelter, medical care, and education.

¶88 Experience teaches, and we understand innately, that once we strip an individual of dignity, the human being no longer exists. A subhuman is easy to abuse, torture, and kill, because the object of the abuse is simply that—an object without worth or value and devoid of the essential element of humanness: dignity. Six million Jewish people, along with homosexuals, Gypsies, and persons with disabilities stand as mute testament to what happens when human beings are stripped of their dignity.

¶89 I believe this is why we also collectively recoil from accounts of our fellow human beings forced to endure the humiliation and degradation of an agonizing death from an incurable illness.[9] Pain may, in theory, be alleviated to the point of rendering the person

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[9] In this regard, twelve individuals who identify themselves as "surviving family members" submitted an amicus curiae brief with attached affidavits in support of the Patients. I note two of the stories here, though each story is compelling. These stories demonstrate that the State's "palliative care is the answer" argument has real limitations and grossly dehumanizing failures.

Richard's Story

First, one of the surviving family members describes the death of her longtime companion, Richard, who died of Lou Gehrig's disease:

During the last two weeks of Richard's life, despite the conscientious efforts of his personal doctor, hospice nurses, and caregivers to provide comfort, he endured both physical and emotional pain of stunning magnitude. His mind was haunted by an acute awareness that his body was stiffening, becoming rigid, and rendering him immobile. He described a sense of being "stuck," "trapped," "chained to the bed," "tied down," "in prison." He suffered anxiety, panic attacks, and claustrophobia. In addition, he endured severe muscle spasms, frequent episodes of shortness of breath and the fear of suffocation, swallowing difficulty, and soreness of limbs.

Richard eventually stopped eating and drinking, went into a coma, and died shortly thereafter. Notably, before his death, Richard explored various death-with-dignity options but did not find a Montana doctor willing to aid him in this manner. Aff. Doris Fischer ¶¶ 3-6 (May 11, 2009).

Betty's Story

Second, another of the surviving family members describes the death of her sister, Betty, who died of multiple sclerosis:

[T]he ravages Betty suffered from MS left her unable to simply hold a book and to turn its pages; she could no longer hold utensils with which to feed herself; she could no longer hold up her head and, therefore, spent all the waking hours of her day slouched with her chin resting on her chest, in her wheelchair. She was essentially paralyzed. Because swallowing was nearly impossible, she could choke while attempting to swallow even the slightest bit of liquid or puréed foods. Her body would endure terrible, even violent and uncontrollable spasms. One of those spasms actually

unconscious. But in those circumstances, we still cannot deny that the individual's human dignity has been dealt a grievous blow long before death claims her body. Indeed, in response to the State's argument that palliative care is a reasonable alternative to physician aid in dying, Mr. Baxter explained:

> I am appalled by this suggestion and the loss of personal autonomy it involves. I understand that terminal or palliative sedation would involve administering intravenous medication to me for the purpose of rendering me unconscious, and then withholding fluids and nutrition until I die, a process that may take weeks. During this final period of my life I would remain unconscious, unaware of my situation or surroundings, unresponsive from a cognitive or volitional standpoint, and uninvolved in my own death. My ability to maintain personal hygiene would be lost and I would be dependent on others to clean my body. My family would be forced to stand a horrible vigil while my unconscious body was maintained in this condition, wasting away from starvation and dehydration, while they waited for me to die. I would want to do whatever I could to avoid subjecting my family to such a painful and pointless ordeal.
> While the option of terminal sedation might be acceptable to some individuals – and I respect the right of others to choose this course if they wish to do so – it is abhorrent to me. The notion that terminal sedation should be the only option available to me if my suffering becomes intolerable is an affront to my personal values, beliefs and integrity. I have always been an independent and proud individual, and consider this form of medical treatment to be dehumanizing and humiliating. I feel strongly that my privacy, dignity and sense of self-autonomy will be forfeit if my life has to end in a state of terminal sedation.

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threw her from the confines of her wheelchair and resulted in a broken femur. Additionally, she had obscenely huge bed sores, as a result of her incapacity to move, as well as the fact that her body's protein was breaking down. . . . [T]hese bedsores were so large in some areas of her body that her bones were visible. It was an absolute nightmare for both of us – for her to bear, and for me to treat.
Betty made plans to move to Oregon, but she had to be hospitalized because of her broken femur. "She was painfully wasting away and was exhausted – beyond imagination." Although Betty was a stoic person, she often pleaded with her sister: "This is no life and I cannot stand it." She ultimately slipped into a coma and died shortly thereafter. Aff. Mary Fitzgerald ¶¶ 3-6 (May 12, 2009).

Supp. Aff. Robert Baxter ¶¶ 3-4 (Aug. 25, 2008).

¶90 Few of us would wish upon ourselves or upon others the prolonged dying that comes from an incurable illness. And it is for this reason that some of our fellow human beings demand—rightfully, in my view—that we respect their individual right to preserve their own human dignity at a time when they are mentally competent, incurably ill, and faced with death from their illness within a relatively short period of time.

¶91 The State asserts that it has compelling interests in preserving life and protecting vulnerable groups from potential abuses. This broad assertion, however, is entirely inadequate to sustain the State's position in opposition to physician aid in dying. We are dealing here with persons who are mentally competent, who are incurably ill, and who expect death within a relatively short period of time. The State has failed to explain what interest the government has in forcing a competent, incurably ill person who is going through prolonged suffering and slow, excruciating physical deterioration to hang on to the last possible moment. Moreover, the State has not come close to showing that it has any interest, much less a "compelling" one, in usurping a competent, incurably ill individual's autonomous decision to obtain a licensed physician's assistance in dying so that she might die with the same human dignity with which she was born. In point of fact, the State's position in this appeal is diametrically in opposition to the public policy reflected in the Montana Rights of the Terminally Ill Act: that a mentally competent, incurably ill individual should have autonomy with regard to end-of-life decisions and should be afforded respect and assurance that her life-ending wishes will be honored.

¶92 Furthermore, it must be remembered that an individual's right of human dignity is inviolable; it is incapable of being violated. Thus, there is absolutely no merit to the State's suggestion that it may strip a human being of his dignity in order to satisfy an interest that the government believes is "compelling." The right of dignity is absolute, and it remains absolute even at the time of death. It may not be stripped from the individual by a well-meaning yet paternalistic government. Nor may it be stripped by third parties or institutions driven by political ideology or religious beliefs. *Cf.* Clifford and Huff, 61 Mont. L. Rev. at 330 ("To be forced into degrading or dehumanizing pain or suffering because of someone else's conception of a good or proper death exacerbates the loss of dignity . . . ."). Dignity defines what it means to be human. It defines the depth of individual autonomy throughout life and, most certainly, at death. Usurping a mentally competent, incurably ill individual's ability to make end-of-life decisions and forcing that person against his will to suffer a prolonged and excruciating deterioration is, at its core, a blatant and untenable violation of the person's fundamental right of human dignity.

III. CONCLUSION

¶93 In conclusion, while I join the Court's decision, I also would affirm the District Court's ruling on the constitutional issues. I agree with the Court's statutory analysis, but I also agree with Judge McCarter that physician aid is dying is firmly protected by Article II, Sections 4 and 10 of the Montana Constitution. Under these sections, individuals who are mentally competent and incurably ill and face death within a relatively short period of time have the right to self-administer, at a time and place of

their choosing, a life-ending substance prescribed by their physician. The physician simply makes the medication available to the patient who requests it and the patient ultimately chooses whether to cause her own death by self-administering the medicine.

¶94 This right to physician aid in dying quintessentially involves the inviolable right to human dignity—our most fragile fundamental right. Montana's Dignity Clause does not permit a person or entity to force an agonizing, dehumanizing, demeaning, and often protracted death upon a mentally competent, incurably ill individual for the sake of political ideology, religious belief, or a paternalistic sense of ethics. Society does not have the right to strip a mentally competent, incurably ill individual of her inviolable human dignity when she seeks aid in dying from her physician. Dignity is a fundamental component of humanness; it is intrinsic to our species; it must be respected throughout life; and it must be honored when one's inevitable destiny is death from an incurable illness.

¶95 I specially concur.

/S/ JAMES C. NELSON

Justice Jim Rice, dissenting.

¶96 The prohibition against homicide—intentionally causing the death of another— protects and preserves human life, is the ultimate recognition of human dignity, and is a

foundation for modern society, as it has been for millennia past. Based upon this foundation, Anglo-American law, encompassing the law of Montana, has prohibited the enabling of suicide for over 700 years. *Wash. v. Glucksberg*, 521 U.S. 702, 711, 117 S. Ct. 2258, 2263 (1997) (citations omitted). However, in contradiction to these fundamental principles, the Court concludes that physician-assisted suicide does not violate Montana's public policy. In doing so, the Court has badly misinterpreted our public policy: assisting suicide has been explicitly and expressly prohibited by Montana law for the past 114 years. More than merely setting aside the District Court's order herein, I would reverse the judgment entirely.

¶97 A flaw that underlies the Court's analysis is its failure to distinguish between the physician's basic intention in the assisted-suicide case from the physician's intention while rendering treatment in other cases. As developed further herein, the intentions in these two cases are diametrically opposed, and create the very difference between a criminal and noncriminal act. Physician-assisted suicide occurs when a physician provides a lethal drug with the *intent* to cause, when the drug is taken by the patient, the patient's death. With palliative care, the physician does not *intend* his or her actions to cause the patient's death, but rather intends to relieve the patient's pain and suffering. For this reason a physician providing palliative care, even in cases where the treatment arguably contributes to the patient's death, lacks the requisite mental state to be charged under homicide statutes. *Kan. v. Naramore*, 965 P.2d 211, 214 (Kan. App. 1998) (quoting Gordon & Singer, *Decisions and Care at the End of Life*, 346 Lancet 163, 165

(July 15, 1995)); *see also* §§ 45-5-102, -103, -104, MCA (2007). A similar distinction arises in the withholding or withdrawal of medical treatment that merely prolongs the dying process, pursuant to the Montana Rights of the Terminally Ill Act. Under the Act, a patient may refuse treatment and allow death to occur naturally, and physicians incur no liability, having not administered any death-causing treatment. Sections 50-9-103, -204, MCA.

¶98 Criminal acts may be defended on the basis of a victim's consent to the act in certain circumstances. Section 45-2-211(1), MCA. However, this statute makes consent "ineffective" if "it is against public policy to permit the conduct or the resulting harm." Section 45-2-211(2), MCA. The Court concludes from its review of Montana law that "it would be incongruous to conclude that a physician's indirect aid in dying is contrary to public policy." Opinion, ¶ 38. Because, generally, "the public policy of the State of Montana is set by the Montana Legislature through its enactment of statutes" *Duck Inn, Inc. v. Mont. State University-Northern*, 285 Mont. 519, 523-24, 949 P.2d 1179, 1182 (1997) (citations omitted), I turn to the very statutes which address the assisting of suicide.

The Statutory Prohibition on the Aiding or Soliciting of Suicide

"If the conduct of the offender made him the agent of the death, the offense is criminal homicide notwithstanding the consent or even the solicitations of the victim." ~ Commission Comments, § 45-5-105, MCA.

¶99 Montana originally enacted a prohibition on the aiding or soliciting of suicide statute in 1895, providing that "[e]very person who deliberately aids, or advises or

encourages another to commit suicide is guilty of a felony." Section 698, Mont. Penal Code (1895). The prohibition on aiding suicide has been the formally enacted public policy of our state for the succeeding 114 years. Under the 1895 enactment, the death or survival of the victim was irrelevant, as the crime only required that a defendant deliberately aid, advise, or encourage another to commit suicide. The Legislature left the statute untouched for over seventy years.

¶100 In 1973, the Legislature revised the statute to read:

> (1) A person who purposely aids or solicits another to commit suicide, but such suicide does not occur commits the offense of aiding or soliciting suicide.
>
> (2) A person convicted of the offense of aiding or soliciting a suicide shall be imprisoned in the state prison for any term not to exceed ten (10) years.

Section 94-5-106, RCM (1973). The Legislature codified this provision within the homicide statutes. The current version of the statute is the same as the 1973 version, except that the Legislature has increased the potential punishment for the crime by authorizing a $50,000 penalty. Section 45-5-105(2), MCA (2007).

¶101 Under the wording of the current version of the statute, a person may be prosecuted for aiding or soliciting another to commit suicide only if the victim *survives*. The purpose of this change of the statutory language from the pre-1973 version was explained by the Criminal Code Commission that proposed it. When the victim *dies*, the act is to be prosecuted as a homicide. "If the conduct of the offender made him the agent of the death, the offense is *criminal homicide* . . ." Commission Comments, § 45-5-105, MCA (emphasis added). The Commission Comments then direct attention to the other

crimes codified within the same homicide section—deliberate homicide, mitigated deliberate homicide, and negligent homicide. Commission Comments, § 45-5-105, MCA (citing §§ 45-5-102, -103, -104, MCA). Like the other homicide statutes, the statute prohibiting the aiding or soliciting of suicide makes the offense a felony. Sections 45-5-102(2), -103(4), -104(3), -105(2), MCA. The justification for the felony designation of the offense, despite the fact the victim has survived, was provided by the Commission: "The rationale behind the felony sentence for the substantive offense of aiding or soliciting suicide is that *the act typifies a very low regard for human life.*" Commission Comments, § 45-5-105, MCA (emphasis added). This clear statement of the State's policy to protect human life is steadfastly avoided by the Court in its analysis.

¶102 Thus, under Montana law, physicians who assist in a suicide are subject to criminal prosecution irrespective of whether the patient *survives* or *dies*. If the patient survives, the physician may be prosecuted under aiding or soliciting suicide. Section 45-5-105, MCA. If the patient *dies*, the physician may be prosecuted under the homicide statutes. Commission Comments, § 45-5-105, MCA (citing §§ 45-5-102, -103, -104, MCA).

¶103 Importantly, it is also very clear that a patient's consent to the physician's efforts is of no consequence whatsoever under these statutes. The Commission Comments explain that a physician acting as the agency of death may not raise "*consent or even the solicitations of the victim*" as a defense to criminal culpability. Commission Comments, § 45-5-105, MCA (emphasis added). This principle has likewise been stated and restated

by courts around the country: *Mich. v. Kevorkian*, 639 N.W.2d 291, 331 (Mich. App. 2001) ("consent and euthanasia are not recognized defenses to murder"); *Gentry v. Ind.*, 625 N.E.2d 1268, 1273 (Ind. App. 1st Dist. 1993) ("consent is not a defense to conduct causing another human being's death") (citation omitted); *Pa. v. Root*, 156 A.2d 895, 900 (Pa. Super. 1959) ("The Commonwealth is interested in protecting its citizens against acts which endanger their lives. *The policy of the law is to protect human life, even the life of a person who wishes to destroy his own. To prove that the victim wanted to die would be no defense to murder.*" (Emphasis added.)), *overruled on other grounds*, *Pa. v. Root*, 170 A.2d 310 (Pa. 1961).

¶104 The Court offers curious reasons for rejecting these clear and express statements of the State's public policy. Opinion, ¶ 39-42. It criticizes the citation to the Criminal Law Commission's Comments about the intent and the structure of the homicide statutes, despite the fact the Court has repeatedly used the Commission Comments in the application of our statutes. *See e.g. State v. Wooster*, 1999 MT 22, ¶ 34 n. 1, 293 Mont. 195, 974 P.2d 640; *State v. Hawk*, 285 Mont. 183, 187, 948 P.2d 209, 211 (1997); *State v. Shively*, 2009 MT 252, ¶ 17, 351 Mont. 513, 216 P.3d 732; *State v. Price*, 2002 MT 229, § 18, 311 Mont. 439, 57 P.3d 42; *State v. Meeks*, 2008 MT 40, ¶ 9, 341 Mont. 341, 176 P.3d 1073. The Comments are critical here because they provide the intent behind and the interrelation among the homicide statutes—how they are designed to work together and the inapplicability of the defense of consent—and thus answer the specific question before the Court, an answer not made clear from the wording of the statutes themselves.

The reader should find it astonishing that, in this case only, involving an issue of life and death, the Court refuses to consider the Comments which stand in direct contradiction to its decision. Dispensing with the Comments allows the Court to construct an artificial artifice between the aiding suicide statute and the other statutes in the homicide section of the Criminal Code, when the clear intent was just the opposite—that there was to be no artifice.[1]

¶105 The Court then criticizes this Dissent as offering circular reasoning. Opinion, ¶43 The Court believes the Dissent is arguing that the consent statute is inapplicable merely because the conduct of physician-assisted suicide is defined as an offense and that such reasoning would obviate the consent statute for all offenses. However, the Court has misstated the Dissent. The consent statute is inapplicable, not simply because physician-assisted suicide is defined as illegal conduct, but because the intent of the Legislature was that the consent defense would not apply to this particular crime. Again, "[i]f the conduct of the offender made him the agent of the death, the offense is criminal homicide notwithstanding the consent or even the solicitations of the victim."

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[1] If further demonstration of the propriety of consulting the Commission Comments is desired, the District Court's observations about the statute may be considered:

The Court: I thought "How strange," but then I realized, thought later *maybe it's because* if the person does die, they aren't charged with assisted suicide, they'd be charged with a homicide.

Mr. Johnstone: That's what my criminal Counsel, Ms. Anders, has told me.

The Court: But it was really strange when I first ran across that. I had to read it ten times to figure that one out.

Hrg. Transcr. 63:3-12 (Oct. 10, 2008) (emphasis added).

Commission Comments, § 45-5-105, MCA. Application of the consent statute to other crimes is not affected by the Legislature's elimination of the consent defense for this particular crime. If this is circular or illogical, then the blame rests with the Legislature, because the only reasoning here offered by the Dissent is to point out the plain explanation of the working of the statutes. The Dissent has added nothing more. It is the Court who offers many words in an effort to reason away from this plain language and clear intent, when it is not our duty to agree or disagree with the Legislature's determination. "[T]his Court may not concern itself with the wisdom of such statutes" by arguing the Montana Legislature's logic is somehow circular or otherwise inappropriate. *Duck Inn, Inc.*, 285 Mont. at 523-24, 949 P.2d at 1182. The Court's role is simply to *find* the public policy. The homicide statutory framework and the prohibition against consent, by itself, is more than enough to foreclose any suggestion that Montana even remotely

favors or supports physician-assisted suicide.[2] However, there is further evidence.

The Montana Rights of the Terminally Ill Act

¶106 In 1991, the Legislature enacted the Montana Rights of the Terminally Ill Act (Montana Act) by substantially adopting the Uniform Rights of the Terminally Ill Act (Uniform Act). Secs. 1-16, Ch. 391, L. 1991 (codified at §§ 50-9-101 to -206, MCA).

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[2] The Court's approach is also disconcerting when considering the ambiguity this Opinion will bring for those who are not physicians. Physician assistants, nurse-practitioners, nurses, friends, and family do not qualify as physicians, but they will all undoubtedly be involved to varying degrees in the process of physician-assisted suicide. Yet, the Court's public policy reasoning is based upon the role of a physician. The net result of the decision, whether intended or not, is to leave "non-physicians" with the question of whether the decision premised upon a physician-based policy will apply to them as well.

The Prefatory Note in the Uniform Act explains that "[t]he scope of the Act is *narrow*. Its impact is limited to treatment that is merely *life-prolonging* . . . ."[3] Uniform Rights of Terminally Ill Act (1989), 9C U.L.A. 311, 312 (2001) (emphasis added). The form Declaration provided by the Montana Act for patients, by its plain language, further supports the scope of the purposes articulated in the Uniform Act:

> If I should have an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician or attending advanced practice registered nurse, cause my death within a relatively short time and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician or attending advance practice registered nurse, pursuant to the Montana Rights of the Terminally Ill Act, *to withhold or withdraw treatment that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain*.

Section 50-9-103(2), MCA (emphasis added). And, as the Court acknowledges, the Montana Act is careful to explain that it "does not condone, authorize, or approve mercy killing or euthanasia." Section 50-9-205(7), MCA.

¶107 The operative words in the Montana Act are those permitting a patient to "withhold" and "withdraw" life-sustaining treatment. *See* §§ 50-9-103(2), -106, -204,

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[3] The quoted passage, in its entirety, is as follows:

> The scope of the Act is narrow. Its impact is limited to treatment that is merely life-prolonging, and to patients whose terminal condition is incurable and irreversible, whose death will soon occur, and who are unable to participate in treatment decisions. Beyond its narrow scope, the Act is not intended to affect any existing rights and responsibilities of persons to make medical treatment decisions. The Act merely provides alternative ways in which a terminally-ill patient's desires regarding the use of life-sustaining procedures can be legally implemented.

Uniform Rights of Terminally Ill Act (1989), 9C U.L.A. at 312.

-205, MCA. Largely self-evident, to "withhold" means "to desist or refrain from granting, giving, or allowing." *Webster's Third New International Dictionary of the English Language* 2627 (Philip Babcock Gove ed., G. & C. Merriam Co. 1971). Similarly, "withdraw" is defined as "to take back or away (something bestowed or possessed)." *Webster's Third New International Dictionary of the English Language* at 2626. Neither word incorporates the concept of affirmatively issuing a life-ending drug to a patient. Rather, the plain language permits only the taking away of, or refraining from giving, certain medical treatment—that which merely prolongs the dying process. Sections 50-9-102(9), -103(2), -106, -204, -205, MCA.

¶108 Although the Court reasons that because the Montana Act permits the withholding or withdrawal of treatment prolonging the dying process, "it would be incongruous to conclude that a physician's indirect aid in dying is contrary to public policy," the opposite is true: it is incongruous to conclude there is no legal distinction between the withdrawal of life-prolonging medical treatment and the provision of life-ending treatment. This distinction is clearly recognized by the wording of our statutes, discussed above, and by the courts. *See e.g. Vacco v. Quill*, 521 U.S. 793, 800, 808, 117 S. Ct. 2293, 2297-98, 2302 (1997) (distinguishing between physician-assisted suicide and refusal of medical treatment does not violate equal protection); and *compare Glucksberg*, 521 U.S. at 705-06, 117 S. Ct. at 2261 (holding there is no constitutional right to physician-assisted suicide) *with Cruzan v. Mo. Dept. of Health*, 497 U.S. 261, 277-79,

110 S. Ct. 2841, 2851-52 (1990) (assuming a constitutional right for competent person to refuse unwanted medical treatment).

¶109 To further illustrate the Legislature's policy preference in respecting a person's right to refuse medical treatment, Montana allows a person to forego cardiopulmonary resuscitation (CPR). Sections 50-10-101 to -107, MCA. To the extent a patient refuses the receipt of CPR, physicians must either refrain from conducting CPR or transfer the patient into the care of a physician who will follow the do not resuscitate protocol. Section 50-10-103(2), MCA. As with the Rights of the Terminally Ill Act, a person may refuse treatment, but the tenor of the statute provides no support for physicians shifting from idle onlookers of natural death to active participants in their patients' suicides.

¶110 Thus, the law accommodating a patient's desire to die of *natural* causes by withholding treatment does not, as the Court posits, support a public policy in favor of the deliberate action by a physician to cause a patient's *pre-natural*, or premature, death.

The 1972 Montana Constitution

¶111 Montana's longstanding public policy against the assistance of suicide was continued by adoption of the 1972 Constitution. It supports neither the Court's public policy determination, nor the District Court's constitutionally based decision.

¶112 No statement concerning a "right to die" is included within the Constitution's Declaration of Rights. This absence is neither accidental nor the product of ignorance. In this regard, it is important to note that "[n]o proposal was adopted or rejected without

considered deliberation." Montana Constitutional Convention, Bill of Rights Committee Proposal, February 22, 1972, p. 618.

¶113 One of the proposals receiving such careful deliberation was Proposal No. 103. Montana Constitutional Convention, Minutes of the Bill of Rights Committee, February 9, 1972, p. 2. Submitted to the Bill of Rights Committee by Delegate Robert L. Kelleher, Proposal No. 103 would have included a right to die within the Constitution's Declaration of Rights. Montana Constitutional Convention, Delegate Proposals, February 2, 1972, p. 223.

¶114 Delegate Kelleher's proposal provided, in pertinent part, "The incurably ill have the right not to be kept alive by extraordinary means." Montana Constitutional Convention, Delegate Proposals, February 2, 1972, p. 223. Delegate Kelleher testified before the Bill of Rights Committee, "that the person with an incurable disease should have the right to choose his own death." Montana Constitutional Convention, Minutes of the Bill of Rights Committee, February 12, 1972, p. 5. Alternatives offered to Kelleher's proposal covered the broad spectrum of "right to die" scenarios. Joe Roberts testified on the same day as Delegate Kelleher, advocating for broader language: "There shall be a right to die. The legislature shall make appropriate provisions therefore." Montana Constitutional Convention, Minutes of the Bill of Rights Committee, February 12, 1972, p. 6; Montana Constitutional Convention, Testimony of Joe Roberts Before the Bill of Rights Committee Concerning the Right to Die, February 12, 1972, p. 4. Mr. Roberts referenced the "very poignant testimony" of witness Joyce Franks and her "personal

encounter with the agonizing death of her father." Montana Constitutional Convention, Testimony of Joe Roberts Before the Bill of Rights Committee Concerning the Right to Die, February 12, 1972, p. 1. Ms. Franks' testimony had described the death of her 86-year-old father and his wish that a doctor "give him something to put him to sleep right then." Montana Constitutional Convention, Testimony of Joyce M. Franks Before the Bill of Rights Committee, February 3, 1972, p. 5A. Ms. Franks stated to the Bill of Rights Committee, "What I am working for is that every person shall have the right to determine, barring accident, the manner of his dying. And then, I am advocating the twin right to make it legal, if he desires this type of death, for a person to receive a quick and easy medicated death somehow." Montana Constitutional Convention, Testimony of Joyce M. Franks Before the Bill of Rights Committee, February 3, 1972, p. 1. Ms. Franks therefore urged adoption of an amendment stating: "Every citizen shall be allowed to choose the manner in which he dies." Montana Constitutional Convention, Testimony of Joyce M. Franks Before the Bill of Rights Committee, February 3, 1972, p. 2; *see also* Charles S. Johnson, *Right to Die Resurfaces in Montana*, Independent Record F1 (Aug. 23, 2009) (describing Constitutional Convention's consideration and rejection of a right to die).

¶115 However, the Bill of Rights Committee rejected Kelleher's proposal in its entirety and also rejected all of the alternatives which had been offered in conjunction with Kelleher's proposal to incorporate a "right to die" of any kind within the new

Constitution. *See* Montana Constitutional Convention, Minutes of the Bill of Rights Committee, February 9, 1972, p. 2.

¶116 Nor were other provisions of the Constitution, such as the Individual Dignity and the Right of Privacy provisions, drafted to include a right to die. The Constitutional Convention adopted the Individual Dignity Section for the express purpose of providing equal protection and prohibiting discrimination. The Bill of Rights Committee proposed the Individual Dignity Section "with the *intent* of providing a Constitutional impetus for the eradication of public and private discriminations based on race, color, sex, culture, social origin or condition, or political or religious ideas." Montana Constitutional Convention, Bill of Rights Committee Proposal, February 22, 1972, p. 628 (emphasis added). During the floor debate on the provision, Delegate Otto Habedank expressed concern that he would be required "to associate with people that I choose not to associate with." Montana Constitutional Convention, Verbatim Transcript, March 7, 1972, p. 1643. Delegate Wade J. Dahood, Chairman of the Bill of Rights Committee, responded to Delegate Habedank's concern by stating, "There is no intent within this particular section to do anything other than to remove the apparent type of discrimination that all of us object to with respect to employment, to rental practices, to actual association in matters that are public or matters that tend to be somewhat quasi-public." Montana Constitutional Convention, Verbatim Transcript, March 7, 1972, p. 1643. Delegate Dahood's statement was consistent with the expressed intent of the Bill of Rights Committee Proposal, which was, in consideration of the entirety of Article II, Section 4,

to provide "a Constitutional impetus for the eradication of public and private discriminations . . . ." *See* Montana Constitutional Convention, Bill of Rights Committee Proposal, February 22, 1972, p. 628; Montana Constitutional Convention, Verbatim Transcript, March 7, 1972, p. 1643. Nothing within these discussions or explanations suggests even a thought that the dignity clause contained vague, lurking rights that might someday manifest themselves beyond what the delegates or the citizens of Montana who approved the Constitution believed, and overturn long-established law, here, the policy against assisted suicide. The reference to dignity therefore provides an aspirational introduction to the already well-established substantive legal principles providing the operative vehicles to achieve dignity: equal protection and the prohibition upon discrimination.[4] Likewise, the right to privacy did not alter the State's policy against assisted suicide. There is nothing within either the language of the provision or the convention proceedings which would reflect any such intention. *See e.g.* Montana Constitutional Convention, Verbatim Transcript, March 7, 1972, pp. 1680-82; Montana

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[4] The historical origins of the dignity clause are enlightening. At the Constitutional Convention, delegates reviewed two foreign constitutions, the 1949 West Germany Constitution and the 1951 Puerto Rico Constitution. Montana Constitutional Convention Commission, *Constitutional Convention Studies No. 10: Bill of Rights* 242 (1972); Montana Constitutional Convention, Bill of Rights Committee Proposal, February 22, 1972, p. 628. The West German Constitution, the eldest of the two, provided, "The dignity of man shall be inviolable." Montana Constitutional Convention Commission, *Constitutional Convention Studies No. 10: Bill of Rights* at 242 (citing West German Const. art. I). The Montana Constitution contains the identical provision, adopted word-for-word except for the use of the gender-neutral "human being" instead of "man." The West German Constitution was developed in response to the Nazi regime's unequal treatment, persecution, and ultimate killing of the Jewish people. *See e.g.* Gregory H. Fox & Georg Nolte, *Intolerant Democracies*, 36 Harv. Intl. L.J. 1, 32 (1995); George J. Annas, *The Man on the Moon, Immortality, and other Millennial Myths: The Prospects and Perils of Human Genetic Engineering*, 49 Emory L.J. 753, 758-59 (2000).

Constitutional Convention, Bill of Rights Committee Proposal, February 22, 1972, pp. 632-33. For such reasons, not one court of last resort has interpreted a constitutional right of privacy to include physician-assisted suicide. *Kirscher v. McIver*, 697 So. 2d 97, 100, 104 (Fla. 1997); *Sampson v. Alaska*, 31 P.3d 88, 98 (Alaska 2001); *Glucksberg*, 521 U.S. at 705-06, 117 S. Ct. at 2261. No evidence exists that the delegates intended the right of privacy to change the state's longstanding public policy. Since adoption of the 1972 Constitution, the Legislature has continued to enact legislation prohibiting assisted suicide. Indeed, the Legislature directed the Department of Public Health and Human Services to "implement a suicide prevention program by January 1, 2008," including a plan that must delineate "specific activities to reduce suicide." Sections 53-21-1101(1), -1102(2)(b), MCA. This is further indication of a state public policy against assisted suicide.

¶117 Because we live in a democracy, this policy may someday change. Controlling their own destiny, Montanans may decide to change the State's public policy after what would be, no doubt, a spirited public debate. In fact, efforts in that regard have already started. *See e.g.* Bill Draft LC1818, 61st Leg., Reg. Sess. (Jan. 9, 2008) (The proposed "Montana Death with Dignity Act" had the stated purpose of "allowing a terminally ill patient to request medication to end the patient's life."). This Court should allow the public debate to continue, and allow the citizens of this State to control their own destiny on the issue.

¶118 Until the public policy is changed by the democratic process, it should be recognized and enforced by the courts. It is a public policy which regards the aiding of suicide as typifying "a very low regard for human life," Commission Comments, § 45-5-105, MCA, and which expressly prohibits it. Instead, the Court rejects the State's longstanding policy. It ignores expressed intent, parses statutes, and churns reasons to avoid the clear policy of the State and reach an untenable conclusion: that it is *against* public policy for a physician to assist in a suicide if the patient happens to *live* after taking the medication; but that the very same act, with the very same intent, is *not* against public policy if the patient *dies*. In my view, the Court's conclusion is without support, without clear reason, and without moral force. ¶119 I would reverse.

/S/ JIM RICE

Hon. Joe L. Hegel, District Court Judge, sitting in place of Chief Justice Mike McGrath, joins in the dissenting Opinion of Justice Jim Rice.

/S/ JOE L. HEGEL
Honorable Joe L. Hegel, District Judge

APPENDIX J
Institutional Review Board
Protocol Exemption Report

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Institutional Review Board (IRB)

For the Protection of Human Research Participants

PROTOCOL EXEMPTION REPORT

PROTOCOL NUMBER:	**03605-2018**	**INVESTIGATOR:**	**Anthony W. Duva**
		SUPERVISING FACULTY:	**Jim Peterson & Bonnie Peterson**
PROJECT TITLE:	***The "Right to Die" with Dignity: A Policy Evaluation Study of Assisted Suicide Laws in 18 States in the U.S.A.***		

INSTITUTIONAL REVIEW BOARD DETERMINATION:

This research protocol is **Exempt** from Institutional Review Board (IRB) oversight under Exemption **Category 4**. You may begin your study immediately. If the nature of the research project changes such that exemption criteria may no longer apply, please consult with the IRB Administrator (irb@valdosta.edu) before continuing your research.

ADDITIONAL COMMENTS:

☒ ***If this box is checked, please submit any documents you revise to the IRB Administrator at irb@valdosta.edu to ensure an updated record of your exemption.***