STATEMENT IN SUPPORT OF S.B. 443 BEFORE THE MARYLAND SENATE JUDICIAL PROCEEDINGS COMMITTEE - FEBRUARY 8, 2024

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I am a law professor at Mitchell Hamline School of Law in Saint Paul, Minnesota. I have published over 300 articles and two books on end-of-life decision making. I write in favor of the bill in my personal capacity.

Maryland Law and Practice Supports End-of -Life Liberty. Over 50,000 Marylanders will die this year. Many of them want to control the timing and the manner of their death. And many already do that: (1) through withholding life-sustaining treatment, (2) through withdrawing life-sustaining treatment, (3) through palliative sedation, and (4) through VSED - voluntarily stopping eating & drinking. Medical aid in dying is just one more option.

Medical Aid in Dying Is Not New. Medical aid in dying is a tested and proven option with a long track record, with a solid track record. S.B. 443 is closely modeled on the Oregon Death with Dignity Act passed by a ballot initiative in 1994 - 30 years ago. Over the past 3 decades, 9 more states and Washington, DC have authorized medical aid in dying based on that same model. 73 million Americans live in those 11 jurisdictions about one-fourth of the entire country.

Medical Aid in Dying Is Safe. Today, we have over 104 years of combined experience with more than 15,000 patients using medical aid in dying in the United States. And that experience shows a solid patient safety track record.

First, each state's department of health publishes an annual report that describes who, where, when, and why patients use medical aid in dying. Second, many health services researchers have conducted their own studies published in peer reviewed medical literature. All that data shows: these laws are working as intended and there is no evidence of abuse.

Indeed, while medical aid in dying has always been safe, it is even safer today. From 2020, we have a professional medical society that offers training, CME, and resources for clinicians. The practice is robust and has a standard of care for everything from patient counseling to pharmacology.

We do not need to speculate or hypothesize about the effects of passing this bill. It includes the same core elements as medical aid in dying laws already in effect in 11 other jurisdictions. It includes the same core elements as medical aid in dying laws in California, Colorado, Hawaii, Maine, New Jersey, New Mexico, Oregon, Vermont, Washington, and Washington DC.

Medical Aid in Dying Has Not Changed. We hear about laws in other countries like those in Europe. Those laws have changed in fundamental ways concerning the eligibility criteria. That has not happened in the United States. In all 11 U.S. jurisdictions, all core elements have remained the same. They have not changed. The patient must:

- Be terminally ill (with a 6 month or less prognosis).
- Have decision making capacity.
- Ingest the medications herself.

Over the past 30 years, only two things have changed. One is the types of licensed clinician. Three states now permit not only physicians but also - APRNs to participate. This follows a broader trend in expanding the scope of practice. The second change is the waiting period. The original model required the patient to make 2 requests separated by 15 days. But substantial evidence showed a large fraction of patients either died - or lost capacity before the end of the 15 days. So, most states have now ether shortened or permit waiver of the waiting period.

Medical Aid in Dying is Optional for Both Patients and Providers. One last point. Medical aid in dying is completely optional for patients, for clinicians, and for healthcare entities. In over 100 years of combined experience in 11 states no patient got MAID who did not want it. No clinician had to participate who did not want to. No entity had to participate that did not want to. Medical aid in dying is opt-in only.

Conclusion. Terminally ill Maryland patients already control the timing and manner of their deaths. Medical aid in dying is another important option. One with a proven track record.

Attachments. In case it might aid the committee, I attach two of my articles reviewing the legal history of medical aid in dying.

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Featured Article

Medical Aid in Dying: Key Variations Among U.S. State Laws

Thaddeus Mason Pope

ABSTRACT: Medical aid in dying (MAID) is legal in eleven U.S. jurisdictions representing one-fourth of the U.S. population, but despite its legality, MAID is practically available to only a subset of qualified patients in these states. MAID's eligibility requirements and procedural safeguards may impede a patient's access. In response, state legislatures have begun to craft more flexible rules as they recalibrate the balance between safety and access. There is already significant variability among U.S. MAID statutes in terms of eligibility requirements, procedural conditions, and other mandates. While the Oregon Death with Dignity Act has served as the template for all subsequent MAID statutes, the states have not copied the Oregon law exactly. Furthermore, this nonconformity grows as states continue to engage in an earnest and profound debate about the practicality of MAID.

Thaddeus Mason Pope, *Medical Aid in Dying: Key Variations Among U.S. State Laws*, J. Health and Life Sci. L., Oct. 2020, at 25.

MAID Variations Among U.S. State Laws

ARTICLE CONTENTS

INTRODUCTION

Medical Aid in Dying (MAID) is an end-of-life option that has been spreading across the United States.[1] It provides assurance that a terminally ill patient can die when she wants based on her own criteria and enjoy life for a longer period of time. Twenty years ago, MAID was available in only one state.[2] Ten years ago, it was available in only two states.[3] Today, MAID is available in eleven U.S. jurisdictions that comprise 25% of the U.S. population.[4]

The expansion of MAID is notable not only for its size but also for its pace. States have been legalizing MAID at an increasingly accelerated speed. Five of today's eleven MAID jurisdictions enacted their statutes in the past four years. Six jurisdictions enacted statutes within the past five years. Two states enacted statutes in 2019 alone,[5] and half of the remaining forty states considered MAID legislation in 2020.[6]

Because of growing public and legislative interest in MAID, it is useful to identify and assess lessons that can be drawn from the existing laws. The eleven MAID jurisdictions have taken three different legal paths to legalization: (1) legislative, (2) judicial, and (3) standard of

1 MAID is also known as "aid in dying," "physician assisted death" "death with dignity," and "voluntary assisted dying." Alan Meisel et al., The Right to Die: The Law of End-of-Life Decisionmaking § 12.04 (3rd ed. 2020). MAID is sometimes referred to as "physician assisted suicide," but that term is generally disfavored because of the strong association of suicide with mental illness. In addition, suicide is typically compulsive, not planned, and suicidal individuals are typically not terminally ill. Press Release, Am. Ass'n of Suicidology, Statement of the American Association of Suicidology: "Suicide" Is Not the Same As "Physician Aid in Dying" (Oct. 30, 2017), https://suicidology.org/wp-content/uploads/2019/07/AAS-PAD-Statement-Approved-10.30.17-ed-10-30-17.pdf.

2 In 1994, Oregon voters approved a ballot initiative enacting the Orgon Death with Dignity Act. *See* Thaddeus Pope, *Legal History of Medical Aid in Dying: Physician Assisted Death in U.S. Courts and Legislatures*, 48 N.M. L. Rev. 267 (2018), https://digitalrepository.unm.edu/nmlr/vol48/iss2/6/; Alan Meisel, *A History of the Law of Assisted Dying in the United States* 73 SMU L. Rev. 119 (2020), https://scholar.smu.edu/smulr/vol73/iss1/8/.

3 In 2008, Washington voters approved a ballot initiative enacting the Washington Death with Dignity Act. *See* Pope, *supra* note 2.

4 *See infra* notes 9, 42, and 47 (collecting citations for California, Colorado, Hawaii, Maine, Montana, New Jersey, North Carolina, Oregon, Vermont, Washington, and Washington, DC). The population of these eleven states totals 82 million. That is 25% of the U.S. population, 330 million. *QuickFacts: United States,* U.S. Census Bureau, https://www.census.gov/quickfacts/fact/map/US/PST045219 (last visited Sept. 8, 2020).

5 Maine Death with Dignity Act, Me. Stat. tit. 22, § 2140 (2020); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-1 to -20 (2020).

6 Eighteen state legislatures considered bills to legalize MAID in 2020. Ariz. H.B. 2582 (2020); S.B. 1384, 54th Leg., 2nd Sess. (Ariz. 2020); H.B. 5420, Gen. Assemb., Feb. Sess. (Conn. 2020); H.B. 140, 150th Gen. Assemb. (Del. 2020); S.B. 1800 (Fla. 2020); Ga. S.B. 291 (2020); H.B. 1020, 121st Gen. Assemb., 2nd Reg. Sess. (Ind. 2020); Iowa S.F. 2156 (2020); S.B. 2156, 88th Gen. Assemb. (Iowa 2020); H.B. 224, Reg. Sess. (Ky. 2020); Md. H.B. 643 (2020); Md. S.B. 701 (2020); H.B. 2152, 91st Leg. (Minn. 2020); S.B. 2286, 91st Leg. (Minn. 2020); N.H. H.B. 1659 (2020); A.B. 2694, Reg. Sess. (N.Y. 2019); H.B. 2033, Reg. Sess. (Pa. 2020); H.B. 7369, Gen. Assemb. (R.I. 2020); H.B. 93, Gen. Sess. (Utah 2020); H.B. 1649 (Va. 2020); A.B. 552 (Wis. 2019); S.B. 499 (Wis. 2020). Some of these bills might have been enacted but for the COVID-19 pandemic. *Legislative Sessions and the Coronavirus,* Nat'l Conference of State Legislatures (Sept. 10, 2020), https://www.ncsl.org/research/about-state-legislatures/legislative-sessions-and-the-coronavirus.aspx. Commentators expect that the next states to enact MAID statutes will be Maryland, Massachusetts, New Mexico, and New York.

care[7]—but most have taken a legislative approach.[8] Nine jurisdictions authorize and regulate MAID through a detailed statute.[9] All nine of these statutes have many common features.

Commentators incessantly emphasize this resemblance. Referencing Oregon, the first state to enact a MAID statute, commentators frequently say that all U.S. MAID laws "have similar provisions based on the Oregon model."[10] Some law professors write that the states have taken a "follow the leader approach."[11] Some write that the states mimic the Oregon "model" or "template."[12] Others write that U.S. MAID laws "closely mirror," "follow" "parrot," or "pattern" the Oregon Act.[13]

However, these commentators overstate the point with this Xerox-like language. While U.S. MAID statutes may copy the Oregon model, they do not copy it exactly. Their approach is better described as "imitation" rather than as "duplication." The nine MAID statutes are not identical. There are material variations among them.[14] This Article identifies and contrasts these differences.

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7 *See* Pope, *supra* note 2.

8 *Id.*

9 End of Life Option Act, Cal. Health & Safety Code §§ 443.1–.22 (2020); Colorado End-of-life Options Act, Colo. Rev. Stat. §§ 25-48-101 to -123 (2020); Death with Dignity Act of 2016, D.C. Code §§ 7-661.01–.16 (2020); Our Care, Our Choice Act, Haw. Rev. Stat. §§ 327L-1 to -25 (2020); Me. Stat. tit. 22, § 2140; N.J. Stat. §§ 26:16-1 to -20; Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.800–.897 (2020); Vt. Stat. Ann. tit. 18, §§ 5281–93 (2020); Washington Death with Dignity Act, Wash. Rev. Code §§ 70.245.010-.220–.904 (2020). One of the best places for tracking the history and status of MAID law is the website of the Death with Dignity National Center and Death with Dignity Political Fund: Death with Dignity, http://www.deathwithdignity.org (last visited Sept. 10, 2020).

10 Queensland Parliament, Health, Cmtys., Disability Servs. & Domestic & Family Violence Prevention Comm., Rep. No. 34, 56th Parliament, Voluntary Assisted Dying 35 (2020), https://www.parliament.qld.gov.au/Documents/TableOffice/TabledPapers/2020/5620T490.pdf [hereinafter Rep. No. 34].

11 Ben White & Lindy Willmott, *Now that VAD Is Legal in Victoria, What Is the Future of Assisted Dying Reform in Australia?*, ABC, June 24, 2019, https://www.abc.net.au/religion/the-future-of-assisted-dying-reform-in-australia/11242116.

12 *See, e.g., id;* Anita Hannig, *Assisted Dying Is Not the Easy Way Out*, The Conversation, Feb. 18, 2020; Pamela S. Kaufmann, Death with Dignity: A Medical-Legal Perspective, AHLA Long-Term Care and the Law Meeting (Feb. 22, 2017), https://theconversation.com/assisted-dying-is-not-the-easy-way-out-129424.

13 Cody Bauer, *Dignity in Choice: A Terminally Ill Patient's Right to Choose*, 44 Mitchell Hamline L. Rev. 1024, 1036 (2018), https://open.mitchellhamline.edu/cgi/viewcontent.cgi?article=1138&context=mhlr; Edward Davies, *Assisted Dying: What Happens after Vermont?*, 346 Brit. Med. J. f4041 (2013); Arthur Svenson, *Physician-Assisted Dying and the Law in the United States: A Perspective on Three Prospective Futures, in* Euthanasia and Assisted Suicide: Global Views on Choosing to End Life 13 (Michael J. Cholbi ed. 2017), https://publisher.abc-clio.com/9781440836800/14; Taimie Bryant, *Aid-in-Dying Nonprofits*, 57 San Diego L. Rev. 147, 181 n.154 (2020), https://digital.sandiego.edu/cgi/viewcontent.cgi?article=3207&context=sdlr; Mary C. Deneen, *Bioethics—"Who Do They Think They Are?": Protecting Terminally Ill Patients Against Undue Influence by Insurers in States Where Medical Aid in Dying Is Legal*, 42 W. New Eng. L. Rev. 63, 76 (2020), https://digitalcommons.law.wne.edu/cgi/viewcontent.cgi?article=1832&context=lawreview ("All nine jurisdictions with MAiD statutes provide similar provisions . . . ."). *See also* Rep. No. 34, at 35 ("Eight other states followed Oregon with similar laws....").

14 This exemplifies the role of states as "laboratories" that try novel social experiments. *See* Wash. v. Glucksberg, 521 U.S. 702, 737 (1997) (O'Connor, J., concurring) (citing New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting)).

In Section One, the author defines MAID and describes its place in end-of-life health care. Section Two describes non-statutory approaches to legalizing MAID that two states have taken. The remainder of the Article focuses on the nine statutes and describes three types of variations.

Section Three describes two variations in eligibility requirements. These differences concern which patients are qualified to receive MAID. The states vary both in how they assess the patient's state residency and in how they assess the patient's decision-making capacity. Section Four describes three variations in procedural requirements. These differences concern how patients obtain and take MAID prescriptions. The states vary in the permitted routes of drug administration and in the duration of the oral and written request waiting periods. Section Five describes five other variations. The states vary in how they permit clinicians and facilities to opt-out; how they permit telehealth; and how they collect and report data. The states also vary in whether they include a sunset clause.

Finally, in Section Six, the author identifies imminent variations in U.S. MAID laws. During the first two decades of U.S. MAID, policymakers placed heavy emphasis on safety at the expense of access. Today, more states are working to recalibrate the balance between safety and access. Consequently, over the next several years, one can expect additional variations among state MAID laws.

Two innovations are particularly likely. First, all states now require the attending and consulting clinician to be a physician; however, some states will probably extend MAID to advanced practice registered nurses (APRNs). Second, all states now require that the patient be terminally ill with a prognosis of six months or less, but some states will probably extend that to twelve months or longer.

MEDICAL AID IN DYING

Before comparing differences among MAID laws, it is important to first clarify what MAID is. Why would someone hasten their own death? How do they do that with MAID? Who is using this end-of-life option?

Why Hasten One's Death?

There are many circumstances under which a longer life is not a better life. When quality of life diminishes, some individuals would prefer to hasten death (or at least not prolong dying)

rather than endure the perils of what, at least to them, is an exceedingly poor quality of life.[15] What exactly comprises a "poor quality of life" covers a broad spectrum that varies significantly from person to person.

For some, loss of independence might diminish quality of life to the point where they would request a hastened death.[16] For others, it may be extreme physical suffering. For these and other reasons, requests to hasten death are common throughout the United States and the world. As Justice Brennan observed, "[f]or many, the thought of an ignoble end, steeped in decay, is abhorrent."[17]

Many seriously ill patients find their lives marked with extreme suffering and both physical and mental deterioration. Unfortunately, many do not have access to a medically supervised, peaceful death. Too many patients commit suicide through violent means such as shooting, hanging, or various other forms of self-deliverance.[18] Moreover, being uncertain about their future options and being worried about future loss of dignity, comfort, and control, many patients hasten their deaths prematurely.[19] Medical aid in dying (MAID) provides an alternative: the assurance that terminally ill patients can die when they want based on their own criteria and can enjoy life for a longer period of time.[20]

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15 *See* Janet L. Abrahm, *Patient and Family Requests for Hastened Death*, 2008 Hematology 475, 475 (2008), https://ashpublications.org/hematology/article/2008/1/475/95873/Patient-and-Family-Requests-for-Hastened-Death ("Patient and family requests for hastened death are not uncommon among patients with advanced malignancies."); Linda Ganzini et al., *Oregonians' Reasons for Requesting Physician Aid in Dying*, 169 Archives Internal Med. 489, 489 (2009), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/414824 ("One in 10 dying patients will, at some point, wish to hasten death."); Jean-Jacques Georges et al., *Requests to Forgo Potentially Life-Prolonging Treatment and to Hasten Death in Terminally Ill Cancer Patients: A Prospective Study*, 31 J. Pain & Symptom Mgmt. 100, 104 (2006), https://www.jpsmjournal.com/action/showPdf?pii=S0885-3924%2805%2900631-7; Joan McCarthy et al., *Irish Views on Death and Dying: A National Survey*, 36 J. Med. Ethics 454, 456 fig. 2 (2010) (finding that a majority of individuals strongly agreed with the statement, "If I were severely ill with no hope of recovery, the quality of my life would be more important than how long it lasted."); Diane E. Meier et al., *A National Survey of Physician-Assisted Suicide and Euthanasia in the United States*, 338 New Eng. J. Med. 1193, 1195 (1998), https://www.nejm.org/doi/pdf/10.1056/NEJM199804233381706?articleTools=true.

16 For years, the three most frequently reported end-of-life concerns of patients using MAID have been (1) decreasing ability to participate in activities that made life enjoyable, (2) loss of autonomy, and (3) loss of dignity. Oregon Health Auth., Public Health Div., Oregon Death with Dignity Act: 2019 Data Summary 6 (2020), https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf.

17 Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 310 (1990) (Brennan, J., dissenting).

18 Peter M. Marzuk, *Suicide and Terminal Illness*, 18 Death Stud. 497, 500 (1994); Matthew Miller et al., *Cancer and the Risk of Suicide in Older Americans*, 26 J. Clinical Oncology 4720, 4722 (2008), https://ascopubs.org/doi/pdf/10.1200/JCO.2007.14.3990.

19 Ladislav Volicer et al., *Assistance with Eating and Drinking Only When Requested Can Prevent Living with Advanced Dementia*, 20 J. Am. Med. Directors Ass'n 1353 (2019).

20 *See* Benzi M. Kluger, *Medical Aid in Living*, JAMA Neurology (Aug. 24, 2020); Stanley A. Terman, The Best Way to Say Goodbye: A Legal Peaceful Choice at the End of Life 326 (Ronald B. Miller & Michael S. Evans eds., 2007).

Certainly, life is valuable, and societal values reinforce attempting to extend life indefinitely. However, death is unavoidable. People suffering from the diseases that cause the most deaths in this country will often experience significant suffering and/or loss of independence.[21] In this situation, the preference, for some, may be to hasten death so that death can be on the individual's own terms and with some predictability, rather than risk the unknown and potential loss of comfort and dignity.[22] Advocates often remark that MAID does not result in more people dying, just in fewer people suffering.

What Is MAID?

MAID is one key last resort "exit option."[23] With MAID, a physician writes a prescription for life-ending medication for an adult patient who is terminally ill and mentally capacitated.[24] The practice has long-standing and well-defined conditions regarding patient eligibility, the role of physicians, and the role of the patient.

Indeed, since the practice is so tightly regulated, the standard of care maps onto the statutory requirements. All nine U.S. MAID statutes have nearly identical conditions and safeguards.[25] Regarding eligibility, the patient must: (1) be over 18 years of age, (2) have decision making capacity, (3) be able to take the medication, and (4) be terminally ill, meaning that they have a prognosis of six months or less.[26]

Regarding physician practice, both the treating physician and a consulting physician must: (1) confirm that the patient satisfies all the eligibility conditions; (2) inform the patient about risks, benefits, and alternatives; and (3) confirm the patient's request for the medication is a settled and voluntary decision. If either the treating or consulting physician suspects that

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21 Judith K. Schwarz, *Stopping Eating and Drinking*, 109 Am. J. Nursing 52, 53–54 (2009).

22 Hastening Death by Voluntarily Stopping Eating and Drinking: Clinical, Ethical, and Legal Dimensions (Timothy Quill et al. eds., Oxford Univ. Press, forthcoming 2021); Thaddeus Mason Pope & Lindsey E. Anderson, *Voluntarily Stopping Eating and Drinking: A Legal Treatment Option at the End of Life*, 17 Widener L. Rev. 363 (2011). Most suffering can be alleviated through palliative care. Therefore, MAID is really for the subset of cases where palliative care is insufficient. As palliative care's toolbox expands, the demand for MAID may diminish. *Cf.* Kathryn L. Tucker, *Oregon's Pioneering Effort to Enact State Law to Allow Access to Psilocybin, a New Palliative Care Tool*, Willamette L. Rev. (forthcoming 2020).

23 *See* Timothy E. Quill et al., *Palliative Options of Last Resort: A Comparison of Voluntarily Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Active Euthanasia*, *in* Giving Death a Helping Hand: Physician-Assisted Suicide and Public Policy: An International Perspective 49 (Dieter Birnbacher & Edgar Dahl eds., 2008).

24 David Orentlicher et al., *Clinical Criteria for Physician Aid in Dying*, 19 J. Palliative Med. 259, 259 (2016).

25 Thaddeus Mason Pope, *Medical Aid in Dying: When Legal Safeguards Become Burdensome Obstacles*, ASCO Post (Dec. 25, 2017); Thaddeus M. Pope, *Current Landscape: Implementation and Practice*, Nat'l Acads. of Scis., Eng'g, & Med. Health & Med. Div. (Feb. 12, 2018), https://www.youtube.com/watch?v=yI58KsPl-HM. While Montana and North Carolina have no MAID statute. But the conditions and safeguards are similar. *See infra* notes 65 to 71.

26 Alan Meisel et al., The Right to Die: The Law of End-of-Life Decisionmaking § 12.04[C] (3rd ed. 2020).

the patient's judgment is impaired, then they must refer the patient for a mental health assessment by a third clinician.[27]

Once the physician writes the prescription, the patient may obtain the medication. Traditionally, the medication has been secobarbital or pentobarbital, a barbiturate originally developed as a sleeping pill.[28] However, price increases and supply problems have led physicians to prescribe other drugs.[29] These include compounded ones like D-DMA or DDMP2.[30] Importantly, the patient must ingest the drugs herself.[31] The patient alone takes the final overt act that causes her death.[32]

Who Uses MAID?

The United States has over sixty years of experience with MAID, when one sums the experience of each state where MAID has been available.[33] Data on most of that experience has been systematically collected and reported by both state departments of health and by academic researchers.[34] They show that physicians wrote prescriptions for over 5,000 individuals. Many

27 *Id*. *But see infra* notes 75 to 78 (explaining how Hawaii requires an automatic mental health assessment for everyone).

28 April Dembosky, *Drug Company Jacks Up Cost of Aid-In-Dying Medication*, NPR (Mar. 23, 2016, 3:24 PM), https://www.npr.org/sections/health-shots/2016/03/23/471595323/drug-company-jacks-up-cost-of-aid-in-dying-medication.

29 Catherine Offord, *Accessing Drugs for Medical Aid-in-Dying*, Scientist (Aug. 16, 2017), https://www.the-scientist.com/?articles.view/articleNo/49879/title/Accessing-Drugs-for-Medical-Aid-in-Dying/.

30 D-DMA entails Digitalis 30 minutes before Diazepam, Morphine, and Amitriptyline. DDMP2 uses Propranolol but results in a longer average time to death. *See, e.g.,* Anita Hannig, *The Complicated Science of a Medically Assisted Death*, Quillette (Mar. 18, 2020), https://quillette.com/2020/03/18/the-complicated-science-of-a-medically-assisted-death/; Christopher Harty et al., Canadian Ass'n of MAiD Assessors & Providers, The Oral MAiD Option in Canada: Part 1: Medication Protocols: Review and Recommendations (2018), https://camapcanada.ca/wp-content/uploads/2019/01/OralMAiD-Med.pdf.

31 Amanda M. Thyden, *Death with Dignity and Assistance: A Critique of the Self-Administration Requirement in California's End of Life Option Act*, 20 Chapman L. Rev. 421, 421 (2017).

32 *See infra* notes 97 to 101.

33 California (2015); Colorado (2016); DC (2017); Hawaii (2018); Maine (2019); Montana (2009); North Carolina (2019); New Jersey (2019); Oregon (1997); Vermont (2017); Washington (2008). There is a longer history of "underground" physician-assisted death. *See generally* Diane E. Meier et al., *A National Survey of Physician-assisted Suicide and Euthanasia in the United States*, 338 New Eng. J. Med 1193 (1998); Ezekiel J. Emanuel et al., *Attitudes and Practices of U.S. Oncologists Regarding Euthanasia and Physician-Assisted Suicide*, 133 Annals Internal Med. 527 (2000); Damien Pearse, *Michael Caine: I Asked Doctor to Help My Father Die,* Guardian (Oct. 8, 2010, 7:56 PM), https://www.theguardian.com/film/2010/oct/09/michael-caine-father-assisted-suicide#:~:text=Sir%20Michael%20Caine%20has%20revealed,he%20agrees%20with%20voluntary%20euthanasia. Because this practice is not transparent, it is not properly described as "MAID."

34 *See infra* notes 168 to 173. *See also* Luai Al Rabadi et al., *Trends in Medical Aid in Dying in Oregon and Washington*, 2 JAMA Network Open 1/7 (2019), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2747692; Charles Blanke et al., *Characterizing 18 Years of the Death with Dignity Act in Oregon*, 3 JAMA Oncology 1403 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5824315/; Huong Q. Nguyen et al., *Characterizing Kaiser Permanente Southern California's Experience with the California End of Life Option Act in the First Year of Implementation*, 178 JAMA Internal Med. 417 (2018).

patients get MAID prescriptions for their peace of mind, to have as "insurance" just in case their condition becomes intolerable. Since that intolerability often does not happen, only 70% of patients take their prescription.[35]

Nearly 90% of these 5,000 terminally ill patients had cancer or amyotrophic lateral sclerosis (ALS).[36] Other terminally ill patients with cardiovascular, respiratory, or other illnesses have rarely used MAID. The average age has been 74, and over 90% were on hospice.[37] Most were college educated.[38] Patients receiving MAID prescriptions have been almost evenly split male and female, but they have been overwhelmingly white even in racially diverse states like California.[39]

NON–STATUTORY APPROACHES

Most states have legalized MAID through a statute enacted either through the legislature or through a ballot initiative.[40] Those nine statutes are the primary focus of this Article. For the sake of completeness, however, the reader should recognize that two other states took a non-statutory approach. Montana legalized MAID through a court decision, and North Carolina took a "standard of care" approach.[41]

Montana

Montana law has long permitted one individual to help another person hasten death with consent, so long as that assistance is not against public policy.[42] In 2009, the Montana Supreme Court held that this exception in the homicide law applies to MAID. Therefore, a physician will not be subject to prosecution for prescribing medication to bring about the peaceful death of a competent terminally ill patient.[43] Relying upon this decision, patients and physicians participate in MAID in Montana.[44]

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35 Compassion & Choices, Medical Aid in Dying: A Policy to Improve Care and Expand Options at Life's End (2020), https://compassionandchoices.org/wp-content/uploads/Medical-Aid-in-Dying-report-FINAL-2-20-19.pdf.

36 *Id.*

37 *Id.*

38 *Id.*

39 *Id.*

40 *See supra* notes 9, 42, and 47; Pope, *supra* note 2.

41 The Montana court only removed the criminal prohibition. It did not supply any standards or rules. Therefore, the practice in Montana is properly described as a standard of care approach. *Cf.* Kathryn L. Tucker, *Aid in Dying in Montana: Ten Years after State v. Baxter,* 81 Mont. L. Rev. 207 (2020); Kathryn L. Tucker, *Give Me Liberty at My Death: Expanding End-of-Life Choice in Massachusetts*, 58 N.Y. L. Sch. L. Rev. 259 (2013/14). North Carolina is different because there is no statute, regulation, or court decision authorizing MAID. North Carolina might be described as taking a "pure" standard of care approach.

42 Mont. Code. Ann. § 45-2-211 (2020).

43 Baxter v. State, 224 P.3d 1211 (Mont. 2009).

44 *Hearing on H.B. 284 Before the H. Judicial Comm.* (Mont. 2019); Eric Kress, *Thoughts from A Physician Who Prescribes Aid in Dying*, Missoulian (Apr. 7, 2013), https://missoulian.com/news/opinion/columnists/thoughts-from-a-physician-who-prescribes-aid-in-dying/article_07680d28-9e0b-11e2-84f1-001a4bcf887a.html; Kathryn L. Tucker, *Aid in Dying in Montana: Ten Years after State v. Baxter,* 81 Mont. L. Rev. 117 (2020).

The Montana Supreme Court declared the permissibility of MAID for capacitated, terminally ill adult individuals, but it otherwise provided no rules or standards. In the following eleven years, neither the legislature nor the health care licensing boards filled this gap and provided rules and standards. The notable consequence is that Montana does not formally require the procedural requirements that are present in the nine statutory states.[45] Still, since MAID, like any medical practice, is governed by the standard of care, Montana guidelines are probably similar to the rules in the statutory states.[46]

North Carolina

Montana is not the only state to take a non-statutory approach to legalizing MAID. Some commentators argue that MAID is legal in North Carolina for the same reason that it is legal in Montana.[47] While there is no state supreme court decision addressing the question in North Carolina, there is arguably no need for such a decision. In North Carolina, as in Montana, MAID is not prohibited under current law. Therefore, like most areas of medical practice, it is permitted so long as it complies with the standard of care.[48]

Given the well-known legal risk averseness of clinicians, a standard of care approach might seem quixotic. Will physicians really write lethal prescriptions without the bright line clarity and permission of black letter law? In fact, the answer may be "yes." In closely analogous areas of end-of-life medicine such as Physician's Orders for Life-Sustaining Treatment (POLST), legal experts also recommend a non-statutory, standard of care approach.[49] Such an approach has been working in states like Minnesota where clinicians both write and follow these transportable do-not-resuscitate orders.[50]

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45 *See infra* §§ III to V.

46 David Orentlicher et al., *Clinical Criteria for Physician Aid-in-Dying*, 19 J. Palliative Med. 259 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4779271/pdf/jpm.2015.0092.pdf.

47 *See, e.g.*, John Carbone et al., *Aid in Dying in North Carolina*, 80 N.C. Med. J. 128 (2019), https://www.ncmedicaljournal.com/content/ncm/80/2/128.full.pdf; Kathryn L. Tucker, *Aid in Dying in North Carolina*, 97 N.C. L. Rev. Addendum 1 (2019); Jeffrey Segal, *Can NC Physicians Legally Prescribe Meds to Suffering Terminally Ill Patients to Precipitate a Peaceful Death?*, Med. Just. (Jan. 12, 2019), https://medicaljustice.com/can-nc-physicians-legally-prescribe-meds-to-suffering-terminally-ill-patients-to-precipitate-a-peaceful-death/. *But see* Bryant A. Murphy et al., *No Consensus on AID, But We Can Agree on Palliative Care*, 81 N.C. Med. J. 213 (2020), https://www.ncmedicaljournal.com/content/81/3/213.

48 Kathryn L. Tucker, *Vermont Patient Choice at End of Life Act: A Historic Next Generation Law Governing Aid in Dying*, 38 Vt. L. Rev. 687 (2014); Daniel Schweppenstedde et al., RAND Europe, Regulating Quality and Safety of Health and Social Care International Experiences 13 (2014), https://www.rand.org/pubs/research_reports/RR561.html. Of course, North Carolina physicians must also comply with many other rules like those from the state Board of Medicine.

49 Charles P. Sabatino & Naomi Karp, AARP Pub. Policy Inst., Improving Advanced Illness Care: The Evolution of State POLST Laws 17, 45 (2011), https://polst.org/wp-content/uploads/2016/06/POLST-Report-04-11.pdf; National POLST Paradigm, POLST Legislative Guide 24 (2014).

50 Alan Meisel et al., The Right to Die: The Law of End-of-Life Decisionmaking § 7.10A (3rd ed. 2020) [hereinafter The Right to Die].

Other Non–Statutory Approaches

While Montana and North Carolina are the only current MAID states that have taken a non-statutory approach, other states previously attempted to follow this pathway.[51] For example, before enacting a statute in 2018, Hawaii attempted to follow a standard of care approach like North Carolina.[52] Vermont nearly took the opposite approach of following a standard of care approach ***after*** enacting a statute. The Vermont Patient Choice at End of Life Act originally included a sunset clause for the procedural requirements. Had that clause not been later repealed, Vermont MAID would have been governed by the standard of care.[53] Finally more than a dozen other states tried (albeit unsuccessfully) to legalize MAID through a court decision like Montana.[54]

VARIATIONS IN ELIGIBILITY REQUIREMENTS

Montana and North Carolina are the exceptions. Nine of eleven U.S. MAID jurisdictions authorize MAID with a statute. Because all nine of these statutes are based on the Oregon "model," they are quite similar, but these nine MAID statutes are not 100% identical. They vary along three dimensions in terms of (1) eligibility requirements, (2) procedural requirements, and (3) other dimensions. Eligibility requirements are addressed in this section, and other variations are addressed in the next two sections.

To qualify for MAID a patient must satisfy several eligibility requirements. She must be (1) an adult, (2) who is terminally ill, (3) a state resident, (4) with decision-making capacity. Every MAID statute includes these four requirements, but they differ in how they measure the last two and in how they mandate assessment of the patient's residency and capacity.

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51 Kathryn L. Tucker & Christine Salmi, *Aid in Dying: Law, Geography and Standard of Care in Idaho*, Advocate, at 1-8 (2010); S.B. 1070, 61st Leg., 1st Reg. Sess. (Idaho 2011), https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2011/legislation/S1070E1.pdf.

52 Kathryn L. Tucker, *Aid in Dying: An End of Life-Option Governed by Best Practices,* 8 J. Health & Biomed. L. 9 (2012), https://cpb-us-e1.wpmucdn.com/sites.suffolk.edu/dist/e/1232/files/2016/12/Aid-in-Dying-An-End-of-Life-Option-Governed-by-Best-Practices.pdf. *See also* Morris v. Brandenburg, 356 P.3d 564, 570 (N.M. 2015); Kevin B. O'Reilly, *5 Hawaii Doctors Offer Assisted Suicide to Terminally Ill Patients*, Am. Med. News (Apr. 17, 2012), https://amednews.com/article/20120417/profession/304179996/8/. *But cf.* Jim Mendoza, *AG Denounces Aid in Dying Ad*, Haw. News Now (Sept. 24, 2013), https://www.hawaiinewsnow.com/story/23521488/ag-denounces-aid-in-dying-ad/.

53 The Right to Die, § 12.02.

54 *See* Pope, *supra* note 2. One such lawsuit is currently on appeal. Kligler v. Healey, No. 2016-03254-F (Mass. Super. Ct. Dec. 31, 2019), https://compassionandchoices.org/wp-content/uploads/Kliger-Memorandum-of-Decision-and-Order-wm.pdf.

State Residency: How to Prove It?

Every MAID statute requires that the terminally ill, adult patient be a resident of that state.[55] For example, the California End of Life Options Act (EOLOA) provides that only "qualified individuals" can access MAID and that only residents of California are qualified individuals.[56]

While every state requires residency, they vary in terms of what evidence is enough to prove it. Most states permit the following four documents to prove state residency:

1. Possession of a driver license or other state-issued identification
2. Registration to vote
3. Evidence that the person owns or leases property in the state
4. Filing of a state return for the most recent tax year[57]

Some statutes specify fewer types of evidence as sufficient to establish residency. For example, Washington permits only the first three.[58] Other states specify more than these four types of evidence, such as Maine, which permits five additional types of evidence.[59] Washington, D.C. lists twelve additional types of evidence, and requires that the patient submit at least two of them.[60]

The ease with which a patient can prove state residency is important. Because only nine jurisdictions have MAID statutes, patients regularly move from non-MAID jurisdictions to MAID jurisdictions.[61] For example, Brittany Maynard, one of the most famous people to use

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55 End of Life Option Act, Cal. Health & Safety Code §§ 443.1(o), 443.2(a)(3) (2020); Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-102(13) (2020); Death with Dignity Act of 2016, D.C. Code § 7-661.01(13) (2020); Our Care, Our Choice Act, Haw. Rev. Stat. § 327L-1 (2020); Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(2)(K), (15) (2020); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. § 26:16-3 (2020); Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.800(11), .805 (2020); Vt. Stat. Ann. tit. 18, § 5281(8) (2020); Washington Death with Dignity Act, Wash. Rev. Code §§ 70.245.010(11), .020(1) (2020).

56 Cal. Health & Safety Code §§ 443.1(o), 443.2(a)(3).

57 *Id.* § 443.2(a)(3); Colo. Rev. Stat. § 25-48-102(14); Haw. Rev. Stat. § 327L-13; N.J. Stat. § 26:16-11; Or. Rev. Stat. § 127.860. The Vermont statute does not specify what makes someone a Vermont resident, but the state Department of Health specifies these same four factors. Vt. Dep't of Health, Act 39 Frequently Asked Questions https://www.healthvermont.gov/sites/default/files/documents/pdf/Act39_faq.pdf.

58 Wash. Rev. Code § 70.245.130. While Washington lists only three documents, it also permits other "[f]actors demonstrating Washington state residency". *Id.*

59 Me. Rev. Stat. Ann. tit. 22, § 2140(15) (also including: the location of a dwelling currently occupied by the person; place where a motor vehicle is registered; address where mail is received, address shown on a hunting or fishing license, receipt of public benefits conditioned upon residency, and any other objective facts tending to indicate a person's place of residence).

60 D.C. Health, Death with Dignity: Patient Education Module (Apr. 26, 2018), https://dchealth.dc.gov/sites/default/files/dc/sites/doh/page_content/attachments/Death%20with%20Dignity%20-%20Education%20Modules.Patient.DC%20HEALTH%20Version.04.26.18.pdf (including: utility bill, telephone bill, mail from a government agency, or student loan statement).

61 *See, e.g.,* Kevin Roster, Opinion, *I'm Dying from Cancer. I Have to Move Across the Country to Die on My Own Terms*, USA Today, June 7, 2019, https://www.usatoday.com/story/opinion/2019/06/07/medical-aid-dying-face-death-own-terms-column/1365567001/.

MAID, moved to Oregon specifically for the purpose of establishing residency and thus eligibility for MAID.[62] This is a form of medical tourism.[63] Because these patients are terminally ill, they must quickly acquire the necessary documents to prove state residency.

Capacity Assessments: Two or Three?

Every MAID statute requires not only that the patient be a terminally ill adult state resident but also that the patient have decision-making capacity. This means two things: first, it means that the patient can understand the significant benefits, risks, and alternatives to MAID, and second, it means that the patient can make and communicate an informed health care decision.[64]

To confirm the patient's capacity, every statute requires at least two assessments by two different physicians.[65] Both an attending physician and a consulting physician must "[d]etermine that the individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision."[66]

If both the attending and consulting physicians are sure that the patient has capacity, then she is qualified. If either the attending or consulting physician is sure that the patient lacks capacity, then she is not qualified. However, if either the attending or consulting physician is unsure or has concerns about the patient's capacity, then they must refer the patient for a third capacity assessment.[67]

For example, the California End of Life Options Act states: "If there are indications of a mental disorder, refer the individual for a mental health specialist assessment."[68] The District of Columbia statute mandates referral when the attending or consulting physician suspects a "psychiatric or psychological disorder or depression causing impaired judgment."[69]

The clinician who performs this third capacity assessment is a mental health specialist, usually a psychiatrist, psychologist, or clinical social worker. They must determine whether

62 Nicole Weisensee Egan, *Terminally Ill Woman Brittany Maynard Has Ended Her Own Life*, People, May 9, 2017, https://people.com/celebrity/terminally-ill-woman-brittany-maynard-has-ended-her-own-life/.

63 *See* I. Glenn Cohen, Patients with Passports: Medical Tourism, Law, and Ethics ch.8 (2014).

64 End of Life Option Act, Cal. Health & Safety Code § 443.1(c) (2020).

65 Our Care, Our Choice Act, Haw. Rev. Stat. §§ 327L-4, -5 (2020).

66 Cal. Health & Safety Code §§ 443.6(c), .8(c)-(d). Some states use the terms "competent" or "capable."

67 Cal. Health & Safety Code §§ 443.5(a)(1), .6(d); Colorado End-of-life Options Act, Colo. Rev. Stat. §§ 25-48-106, -107 (2020); Death with Dignity Act of 2016, D.C. Code § 7-661.03–.04 (2020); Haw. Rev. Stat. § 327L-1; Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(6)–(7) (2020); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-6, -8 (2020); Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.815, .820, .825 (2020); Vt. Stat. Ann. tit. 18, § 5283(a)(8) (2020); Washington Death with Dignity Act, Wash. Rev. Code §§ 70.245.040, .060 (2020).

68 Cal. Health & Safety Code §§ 443.5(a)(1)(A)(ii), .6(d).

69 D.C. Code § 7-661.03–.04.

the patient "is mentally capable and making an informed decision."[70] They do this by determining whether the patient is suffering from impaired judgment due to a mental disorder.[71]

However, decades of government-collected and reported data show that physicians rarely refer patients for this third capacity assessment. Attending and consulting physicians refer only 4% of patients who receive a MAID prescription.[72] Consequently, few MAID patients receive a mental health specialist capacity assessment.[73] Some commentators suggest that this rate may be too low.[74]

But not in Hawaii, where capacity assessment works differently. In Hawaii, every MAID patient gets a third capacity assessment.[75] It is not contingent or conditional on the judgment of the attending or consulting physician. It is automatically and always required.[76] Recognizing that making a terminally ill patient obtain a third clinical assessment could be burdensome, Hawaii

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70 Colo. Rev. Stat. § 25-48-108.

71 Cal. Health & Safety Code § 443.7; Colo. Rev. Stat. § 25-48-108; D.C. Code § 7-661.01(4); Haw. Rev. Stat. § 327L-6; Me. Rev. Stat. Ann. tit. 22, § 2140(8); N.J. Stat. Ann. § 26:16-8; Or. Rev. Stat. § 127.825; Vt. Stat. Ann. tit. 18, § 5283(8); Wash. Rev. Code § 70.245.060.

72 Oregon Health Auth., Public Health Div., Oregon Death with Dignity Act: 2019 Data Summary 11 (2020), https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf; Wash. State Dep't of Health, Disease Control & Health Statistics, Ctr. for Health Statistics, DOH 422-109, 2018 Death with Dignity Act Report (2019), https://www.doh.wa.gov/YouandYourFamily/ IllnessandDisease/DeathwithDignityAct/DeathwithDignityData. Notably, Canada has a similarly low referral rate. James Downar et al., *Early Experience with Medical Assistance in Dying in Ontario, Canada: A Cohort Study,* 192 Canadian Med. Ass'n J. E173 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7043822/pdf/192e173.pdf. Not every state reports data on the rate of mental health referrals. *See infra* note 170.

73 *See generally* Lois A. Weithorn, *Psychological Distress, Mental Disorder, and Assessment of Decisionmaking Capacity Under U.S. Medical Aid in Dying Statutes*, 71 Hastings L.J. 637 (2020), http://www.hastingslawjournal.org/wp-content/uploads/Weithorn_Psychological-Distress-Mental-Disorder-and-Assessment-of-Decisionmaking-Capacity-Under-U.S.-Medical-Aid-in-Dying-Statutes.pdf; Brian D. Carpenter & C. Caroline Merz, *Assessment of Capacity in Medical Aid in Dying, in* Assessing Capacities of Older Adults: A Casebook to Guide Difficult Decisions 243 (Jennifer Moye ed., 2020).

74 *See, e.g.,* Linda Ganzini, *Legalised Physician-Assisted Death in Oregon*, 16 QUT L. Rev. 76 (2016), https://www.deathwithdignity.org/wp-content/uploads/2015/11/623-2243-1-PB-1.pdf; Linda Ganzini & Anthony L. Back, *The Challenge of New Legislation on Physician-Assisted Death*, 176 JAMA Intern Med. 427 (2016); Council on Psychiatry and Law, APA Resource Document on Physician Assisted Death 11-12, 16 (2017).

75 While not legally required in any state except Hawaii, some institutions in other states automatically require a third capacity assessment in their own policies. For example, while California law does not automatically require a third capacity assessment, individual facilities like UCSF do. *See, e.g.,* Barbara Koenig, *Reflections on Preparing for And Responding to Legalization in California, in* Physician-Assisted Death: Scanning the Landscape: Proceedings of a Workshop 89–98 (2018); James A. Bourgeois et al., *Physician-Assisted Death Psychiatric Assessment: A Standardized Protocol to Conform to the California End of Life Option Act*, 59 Psychosomatics 441 (2018), https://escholarship.org/uc/item/7xj942bb.

76 Haw. Rev. Stat. §§ 327L-4(a)(5), -4, -6.

permits it to be performed not only by a physician but also by a psychologist or clinical social worker.[77] Hawaii also permits this third capacity assessment to be performed through telehealth.[78]

VARIATIONS IN PROCEDURAL REQUIREMENTS

MAID statutes vary not only in their eligibility requirements (like residency and capacity) but also in their procedural requirements that dictate how qualified patients may access MAID. Every state requires that the patient: (1) make two oral requests, (2) make one written request, and (3) take the prescription drug themselves. However, the states differ on the details. They vary on the duration of mandated waiting periods between oral requests, the duration of mandated waiting period after the written request, and on the routes by which the drug may be administered.

Oral Request Waiting Period: 0, 15, or 20 Days?

Every MAID statute requires that the patient make two oral requests for MAID. Every statute further requires that those two requests be separated by at least fifteen days.[79] For example, California mandates that "[a]n individual seeking to obtain a prescription for an aid-in-dying drug . . . shall submit two oral requests, a minimum of 15 days apart. . . ."[80] This is designed to assure that the request reflects a considered and voluntary choice by the patient.[81]

While 15 days is the most common duration, some states have longer waiting periods, and some have potentially shorter waiting periods. For example, the Hawaii Our Care, Our Choice

77 *Id*. § 327L-1. Some propose extending this to also include psychiatric mental health nurse practitioners. *Testimony Before the S. Comm. on Commerce, Consumer Protection, and Health* (Haw. 2020), https://www.capitol.hawaii.gov/Session2020/Testimony/SB2582_TESTIMONY_CPH_02-04-20_.PDF.

78 Haw. Rev. Stat. § 327L-1.

79 End of Life Option Act, Cal. Health & Safety Code § 443.3(a) (2020); Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-104(1) (2020); Death with Dignity Act of 2016, D.C. Code § 7-661.02(a)(1) (2020); Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(11)–(13) (2020); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-10 (2020); Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.840, .850 (2020); Vt. Stat. Ann. tit. 18, § 5283(a)(2) (2020); Washington Death with Dignity Act, Wash. Rev. Code §§ 70.245.090, .110(1) (2020).

80 Cal. Health & Safety Code § 443.3(a). Some clinicians have taken the patient's request on the fifteenth day after the first request, but the plain language of every statute requires that the patient make the second request on the sixteenth day or later. Colo. Rev. Stat. § 25-48-104(1) ("separated by at least fifteen days"); D.C. Code § 7-661.02(a)(1) ("separated by at least 15 days"); N.J. Stat. Ann. §§ 26:16-10 ("at least 15 days shall elapse"); Or. Rev. Stat. §§ 127.840, .850 ("no less than 15 days after"); Vt. Stat. Ann. tit. 18, § 5283(a)(2) ("[n]o fewer than 15 days"); Wash. Rev. Code §§ 70.245.090, .110(1) ("at least fifteen days after").

81 State laws often require waiting periods for major life-impacting decisions like abortion, sterilization, marriage, divorce, and adoption. *See* Paul Stam, *Woman's Right to Know Act: A Legislative History*, 28 Issues L. & Med. 3, 66 (2012).

Act requires that the patient's oral requests be separated by at least twenty days, instead of just fifteen days.[82] Hawaii has the longest required waiting period in the United States.[83]

Oregon took the opposite approach, shortening rather than lengthening its waiting period. Between 1994 and 2019, the Oregon Death with Dignity Act required a 15-day waiting period, and this was the model followed by every other state except Hawaii. Effective January 1, 2020, however, Oregon amended its statute to permit waiver of the entire 15 days when the patient will not survive that long.[84]

> [I]f the qualified patient's attending physician has medically confirmed that the qualified patient will, within reasonable medical judgment, die within 15 days after making the initial oral request under this section, the qualified patient may reiterate the oral request to his or her attending physician ***at any time*** after making the initial oral request.[85]

Consequently, an imminently dying patient in Oregon could make both her first and second oral requests on the same day (with no waiting period).

Other states are looking to follow Oregon's lead.[86] They are apparently motivated by significant evidence demonstrating that the 15-day waiting period impedes patient access to

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82 Haw. Rev. Stat. §§ 327L-2, -9 & -11.

83 Mara Buchbinder & Thaddeus M. Pope, *Medical Aid in Dying in Hawaii: Appropriate Safeguards or Unmanageable Obstacles?*, Health Aff. Blog (Aug. 13, 2018) [hereinafter Buchbinder & Pope]. In fact, it often takes Hawaii patients 34 days to navigate the process. *See, e.g., Testimony in SUPPORT of HB 2451 RELATING TO HEALTH* Before the H. Comm. on Health (Haw. 2020) (statement of the State of Hawaii Department of Health), https://www.capitol.hawaii.gov/session2020/testimony/HB2451_TESTIMONY_HLT_01-31-20_.PDF [hereinafter *Testimony in SUPPORT of HB 2451 RELATING TO HEALTH*]; *Testimony in SUPPORT of SB 2582 RELATING TO HEALTH Before the S. Comm. on Commerce, Consumer Protection, & Health* (Haw. 2020) (statement of the State of Hawaii Department of Health), https://www.capitol.hawaii.gov/session2020/testimony/SB2582_TESTIMONY_CPH_02-04-20_.PDF [hereinafter *Testimony in SUPPORT of SB 2582 RELATING TO HEALTH*]. A significant number of patients die before the end of the 20-day waiting period. *Id.* (statement of Charles F Miller, Director, Kaiser Hawaii Medical Aid in Dying Program).

84 S.B. 579, 80th Leg. Assemb., Reg. Sess., 2019 Laws Ch. 624, https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/SB579/Enrolled.

85 Or. Rev. Stat. § 127.840(2) (emphasis added); see also *id.* § 127.850(2).

86 *See, e.g.,* H.B. 2739 (Haw. 2020), https://www.capitol.hawaii.gov/session2018/bills/HB2739_HD1_.pdf; Dep't of Health Office of Planning, Policy, & Program Dev., Report to the Thirtieth Legislature State of Hawaii 2020: Pursuant to Act 2 Session Laws of Hawaii 2019 (HB2739 H.D. 1) (2019), https://health.hawaii.gov/opppd/files/2020/01/OPPPD-Our-Care-Our-Choice-Act-Annual-Report-2019-3.pdf; H.B. 2419, 66th Leg., Reg. Sess. (Wash. 2020), http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/House%20Passed%20Legislature/2419-S.PL.pdf?q=20200913182845; H.B. 171, 53rd Leg., 1st Sess. (N.M. 2017), https://www.nmlegis.gov/Sessions/17%20Regular/bills/house/HB0171.pdf; S.B. 252, 53rd Leg., 1st Sess. (N.M. 2017), https://www.nmlegis.gov/Sessions/17%20Regular/bills/senate/SB0252.pdf, https://www.nmlegis.gov/Sessions/17%20Regular/bills/senate/SB0252.pdf. *See also* Voluntary Assisted Dying Act 2019 § 48(2)(b) (W. Austl. 2019), https://www.legislation.wa.gov.au/legislation/prod/filestore.nsf/FileURL/mrdoc_42491.pdf/$FILE/Voluntary%20Assisted%20Dying%20Act%202019%20-%20%5B00-00-00%5D.pdf?OpenElement.

MAID.[87] Many terminally ill patients do not begin exploring the option until late in their illness trajectory. By that point, they have little remaining time and cannot survive 15 days.[88] For example, one California study shows that one-fourth of patients died or lost capacity during the waiting period.[89] Similarly, in Canada, which has only a 10-day waiting period, more than one-fourth of patients cannot wait even that long.[90]

Written Request Waiting Period: 0 or 48 Hours?

Every MAID statute requires not only that the patient make two oral requests but also that they make a written request.[91] Patients must make this written request on a specified form.[92] Furthermore, just as there is a waiting period between the two oral requests, some states require a 48-hour waiting period between the written request and the writing of the prescription.[93] For example, the New Jersey statute provides: "[A]t least 48 hours shall elapse between the attending physician's receipt of the patient's written request and the writing of a prescription . . . ."[94]

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87 *See, e.g., Testimony in SUPPORT of HB 2451 RELATING TO HEALTH*; *Testimony in SUPPORT of SB 2582 RELATING TO HEALTH*.

88 Buchbinder & Pope, *supra* note 83.

89 Huong Q. Nguyen et al., *Characterizing Kaiser Permanente Southern California's Experience with the California End of Life Option Act in the First Year of Implementation*, 178 JAMA Internal Med. 417 (2018).

90 James Downar et al., *Early Experience with Medical Assistance in Dying in Ontario, Canada: A Cohort Study,* 192 Canadian Med. Ass'n J. E173 (2020). *See also* Debbie Selby et al., *Medical Assistance in Dying (MAiD): A Descriptive Study from a Canadian Tertiary Care Hospital*, 37 Am. J. Hospice & Palliative Med. 58 (2020) (10 days reduced 39% of the time). Lori Seller et al., *Situating Requests for Medical Aid in Dying Within the Broader Context of End-of-Life Care: Ethical Considerations*, 45 J. Med. Ethics 106 (2019); Health Canada, First Annual Report on Medical Assistance in Dying in Canada: 2019, at 6 (2020), https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying-annual-report-2019/maid-annual-report-eng.pdf (26.5% did not result in a MAID death, because the patients died before receiving MAID). Canadian law permits a waiver of the waiting period if the patient will die or lose capacity before that. S.C. 2016, C-14 (Can.), https://laws-lois.justice.gc.ca/PDF/2016_3.pdf.

91 End of Life Option Act, Cal. Health & Safety Code § 443.3(b) (2020); Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-104 (2020); Death with Dignity Act of 2016, D.C. Code § 7-661.02 (2020); Our Care, Our Choice Act, Haw. Rev. Stat. §§ 327L-2, -9 (2020); Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(4)–(5), (24) (2020); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-4 (2020); Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.810 (2020); Vt. Stat. Ann. tit. 18, § 5283(a)(4) (2020); Washington Death with Dignity Act, Wash. Rev. Code §§ 70.245.030, .090 (2020).

92 Cal. Health & Safety Code § 443.11; Colo. Rev. Stat. § 25-48-112; D.C. Code § 7-661.02(b)–(c); Haw. Rev. Stat. §§ 327L-2, -23; Me. Rev. Stat. Ann. tit. 22, § 2140; N.J. Stat. Ann. §§ 26:16-5, -20; Or. Rev. Stat. §§ 127.810, .897; Wash. Rev. Code § 70.245.220. The Vermont statute does not specify a form, but the state Department of Health has designed forms. https://www.healthvermont.gov/systems/end-of-life-decisions/patient-choice-and-control-end-life. There is variability regarding who may serve as a witness.

93 D.C. Code § 7-661.02(a)(2); Haw. Rev. Stat. § 327L-11; Me. Rev. Stat. Ann. tit. 22, § 2140(13); N.J. Stat. Ann. § 26:16-10; Or. Rev. Stat. § 127.850(1); Wash. Rev. Code § 70.245.110(2). California and Colorado do not require a 48-hour waiting period after the written request. Oregon's waiver of the oral request waiting period also permits waiver of the written request waiting period. Or. Rev. Stat. §§ 127.840(2), .850(2).

94 N.J. Stat. Ann. §§ 26:16-10(a)(6).

Unlike the oral request waiting period, this 48-hour requirement typically does not delay patient access, because this waiting period can run concurrent to the oral request waiting period. For example, the patient could make both her first oral request and her written request on January 1.[95] She could make her second oral request on January 16 and receive a prescription that same day. In this example, the patient satisfies ***both*** the oral and written request waiting period requirements in just 15 days.

However, this is not possible in Vermont. There, the written request waiting period runs consecutively to, not concurrently with, the oral request waiting period. The Vermont Patient Choice at End of Life Act requires that the physician not write the prescription until at least 48 hours "after the last to occur" whether that is the patient's written request or the patient's second oral request.[96] Therefore, the minimum total waiting period in Vermont is 17 days. This is the second longest mandatory waiting period after Hawaii's 20 days.

Route of Drug Administration: GI or IV?

MAID statutes vary not only on the duration of oral and written request waiting periods but also in exactly how the patient can take the prescription drug. Every MAID statute requires that the patient herself take the lethal medication. The patient must take the final overt act causing her death. Accordingly, the California End of Life Options Act requires that the patient "has the physical and mental ability to self-administer the aid-in-dying drug."[97] After all, nobody else may administer it to her or for her.[98]

If the physician or another individual administered the lethal medication to the patient, that would be euthanasia.[99] That is not permitted in any U.S. jurisdiction. Legalizing euthanasia has not even been proposed in any U.S. jurisdiction for over thirty years.[100] Self-administration is a consistent centerpiece of U.S. MAID laws.[101]

But while the MAID statutes uniformly require patient self-administration, they use different verbs to describe how the patient may take the drug. Five statutes use the word

95 There is some variability regarding when the patient may make her written request. Most states permit it after both physicians have confirmed eligibility. New Jersey permits it at the time of the first oral request. *Id.* §§ 26:16-10(a)(3). The District of Columbia permits it between the first and second oral requests. D.C. Code § 7-661.02(a)(2).

96 Vt. Stat. Ann. tit. 18, § 5283(a)(12).

97 Cal. Health & Safety Code § 443.2(a)(5).

98 Confusingly, the term "MAID" in Canada refers to both patient self-administration and to clinician administration (euthanasia). *See* S.C. 2016, C-14 (Can.), https://laws-lois.justice.gc.ca/PDF/2016_3.pdf.

99 Compassion in Dying v. Wash., 79 F.3d 790, 840 (9th Cir. 1996) (Beezer, J., dissenting) ("Euthanasia occurs when the physician actually administers the agent which causes death.").

100 Pope, *supra* note 2.

101 In contrast, Belgium, Canada, and the Netherlands also permit clinician administration. Australian jurisdictions permit clinician administration only when self-administration is not possible. *See Legislative Background: Medical Assistance in Dying (Bill C-14, as Assented to on June 17, 2016)*, Can. Dep't of Justice, https://www.justice.gc.ca/eng/rp-pr/other-autre/adra-amsr/toc-tdm.html (last modified Jan. 23, 2017).

"ingest."[102] California, for example, requires that the individual "self-administer" the drug which means the "individual's affirmative, conscious, and physical act of administering and ***ingesting*** the aid-in-dying drug to bring about his or her own death."[103] Indeed, the California's End of Life Option Act (EOLOA) uses the term "ingest" fifteen times to refer to the manner by which the patient must take the drug.[104]

This language is legally and practically significant. The term "ingest" indicates that the route of administration is gastrointestinal.[105] This usually means the patient will drink the medication from a cup or straw.[106] But some patients cannot consume the medication orally. Fortunately, for them, there are two other ways to "ingest" drugs. Patients dependent upon clinically assisted nutrition and hydration can press a plunger on a feeding tube.[107] Other patients can press the plunger on a rectal tube.[108]

With any of these three modes of ingestion, clinicians or family members can assist the patient (for example, by opening the medication, by mixing it in a cup, or by inserting a tube), but the patient herself must make the drug enter her body. The California End of Life Options Act emphasizes the distinction between preparing the drug and ingesting the 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."[109] Without this language, preparing the drugs would probably constitute felony assisted suicide.[110]

The remaining four states do not use the word "ingest." Instead, they use broader language like "take"[111] "administer"[112] or "self-administer."[113] Again, this language is legally and practically

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102 End of Life Option Act, Cal. Health & Safety Code § 443.1(p); Death with Dignity Act of 2016, D.C. Code §§ 7-661.05(f) & (h)–(i), .09(b), .12, .13(b) (2020); Oregon Death with Dignity Act, Or. Rev. Stat. § 127.875 (2020); Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(2)(L) (2020); Washington Death with Dignity Act, Wash. Rev. Code § 70.245.010(12) (2020).

103 Cal. Health & Safety Code § 443.1(p) (emphasis added).

104 *Id. passim.*

105 United States v. Ten Cartons, 888 F. Supp. 381, 393–94 (E.D.N.Y. 1995), *aff'd*, 72 F.3d 285 (2d Cir. 1995).

106 This is usually a powder mixed with liquid. David Orentlicher et al., *Clinical Criteria for Physician Aid in Dying*, 19 J. Palliative Med. 259 (2016); McGehee v. Hutchinson, No. 4:17-cv-00179, ¶ 310 (E.D. Ark. May 31, 2020).

107 *Id.* ¶ 309.

108 Email from Kimberly Kirchmeyer, Executive Director of the Medical Board of California, to Gary Johanson, MD (Sept. 6, 2016); Thalia DeWolf, *Rectal Administration of Aid-in-Dying Medications*, Am. Clinicians Acad. on Med. Aid in Dying, https://www.acamaid.org/rectal-administration-of-aid-in-dying-medications/ (last visited Sept. 14, 2020).

109 Cal. Health & Safety Code § 443.14(a) (emphasis added).

110 *See* Cal. Penal Code § 401 (2020) ("Any person who deliberately aids . . . another to commit suicide is guilty of a felony.").

111 Our Care, Our Choice Act, Haw. Rev. Stat. § 327L-1 (2020) (defining "self-administer" to means an "individual performing an affirmative, conscious, voluntary act to ***take into the individual's body*** prescription medication to end the individual's life") (emphasis added).

112 Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-3 (2020).

113 Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-102(7), (15) (2020); Vt. Stat. Ann. tit. 18, § 5284 (2020).

significant. These verbs permit routes of administration other than gastrointestinal.[114] Most notably, these other statutes permit intravenous administration. So, rather than having to administer the medication through the gut, the patient can inject it with a needle into a vein.[115]

This is important for two reasons. First, some patients cannot effectively take the drugs through a gastrointestinal route.[116] They may have a bowel obstruction, poor absorption, or uncontrolled vomiting. While ingestion may be possible it is not as effective as intravenous administration, especially for these patients.[117] Second, intravenous administration is safer and faster. The rate of complications (like regurgitation) from ingestion is significant in "ingest only" states like Oregon.[118] These complications could be substantially reduced with intravenous administration.[119]

Furthermore, IV administration is workable. Patients self-administer antibiotics and other medications through IV at home.[120] Evidence on this practice shows that home IV therapy is

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114 *See, e.g.,* Texas Controlled Substances Act, Tex. Health & Safety Code § 481.002 (2020) (defining 'administer" to include "injection, inhalation, ingestion, or other means").

115 Bettie Lilley Nosek & Deborah Trendel-Leader, IV Therapy For Dummies (2012). Note that intravenously administered medication would not be the same medication as that which patients orally ingest. Indeed, U.S. clinicians have not yet worked out protocols and procedures for IV self-administration.

116 *Hearing on H.B. 2217 Before the S. Comm. on Judiciary* (Ore. 2019), https://olis.leg.state.or.us/liz/2019R1/Downloads/CommitteeMeetingDocument/198434 (statement of Charles Blanke); Jody B. Gabel, *Release from Terminal Suffering? The Impact of AIDS on Medically Assisted Suicide Legislation*, 22 Fla. St. U. L. Rev. 369, 426 (1994).

117 H.B. 2217, 80th Leg. Assemb., Reg. Sess. (Or. 2019), https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/HB2217/A-Engrossed (hearing on May 19, 2019). *See also* Queensland Parliament, Health, Cmtys., Disability Servs. & Domestic & Family Violence Prevention Comm., Rep. No. 34, 56th Parliament, Voluntary Assisted Dying 43 (2020) (noting that 9 of 52 people to receive MAID in Victoria needed clinician administration because self-administration was not possible).

118 Oregon Health Auth., Public Health Div., Oregon Death with Dignity Act: 2019 Data Summary 11 (2020), https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf; Washington State Department of Health, 2018 Death with Dignity Act Report 13 (July 2019), https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2018.pdf. These problems were anticipated from the beginning. *See, e.g.,* Timothy Egan, *Suicide Law Placing Oregon on Several Uncharted Paths*, N.Y. Times (Nov. 25, 1994), at A1. They even threatened to cause the repeal of the Oregon Death with Dignity Act in 1997. *See, e.g.,* H.B. 2954 (Or. 1997); *Basics on Ballot Measure 51*, Or. Legis. Pol'y & Res. Off. (1997), https://digital.osl.state.or.us/islandora/object/osl%3A4732/datastream/OBJ/view.

119 Notably, in jurisdictions where both MAID and euthanasia are available, almost no patients use MAID. Health Can., Fourth Interim Report on Medical Assistance in Dying in Canada (2019), https://www.canada.ca/content/dam/hc-sc/documents/services/publications/health-system-services/medical-assistance-dying-interim-report-april-2019/medical-assistance-dying-interim-report-april-2019-eng.pdf. In those rare cases when ingestion is used, Canadian clinicians are prepared to offer "IV rescue" as a backup in case oral self-administration is unsuccessful. Christopher Harty et al., Canadian Ass'n of MAiD Assessors & Providers, The Oral MAiD Option in Canada: Part 1: Medication Protocols: Review and Recommendations (2018).

120 *See generally* Antonella Tonna et al., *Home Self-Administration of Intravenous Antibiotics As Part of an Outpatient Parenteral Antibiotic Therapy Service: A Qualitative Study of the Perspectives of Patients Who Do Not Self-Administer*, 9 BMJ Open 1 (2019), https://bmjopen.bmj.com/content/bmjopen/9/1/e027475.full.pdf; Deepak Agrawal et al., *Patients Welcome IV Self-Care; Physicians Hesitate*, NEJM Catalyst (Dec. 6, 2017); Elizabeth D. Mitchell et al., *Clinical and Cost-Effectiveness, Safety and Acceptability of Community Intravenous Antibiotic Service Models: CIVAS Systematic Review*, 7 BMJ Open 1 (2017), https://bmjopen.bmj.com/content/bmjopen/7/4/e013560.full.pdf.

safe and cost-effective. Consequently, hospitals are increasingly discharging patients with prescriptions for home IV medications.[121] Still, many physicians are uncomfortable with allowing patients to self-administer IV medications. So, the practice is not yet widespread.[122]

Even with MAID specifically there are precedents for patient intravenous self-administration. Physician advocates Jack Kevorkian and Phillip Nitschke created mechanical devices and used them with patients.[123] Note that while Kevorkian set up the IV line for his first patient, "Mrs. Adkins was the one who pushed the button, which began the flow of pain killer and potassium chloride into her system."[124]

Some object that intravenous administration is prohibited even in states that use broad language to define the permissible routes of drug administration.[125] They point to the following language in every MAID statute: "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."[126]

However, this prohibition does not apply on its face. It does not prohibit lethal injection ***by the patient***.[127] The prohibitory language proscribes only lethal injection by "a physician or any

121 *Discharge Instructions: Administering IV Antibiotics,* Fairview, https://www.fairview.org/patient-education/86488 (last visited Sept. 15, 2020).

122 Kavita P. Bhavan et al., *Achieving the Triple Aim Through Disruptive Innovations in Self-Care* 316 JAMA 2081 (2016).

123 Nicole Goodkind, *Meet the Elon Musk of Assisted Suicide, Whose Machine Lets You Kill Yourself Anywhere*, Newsweek (Dec. 1, 2017 8:00 AM), https://www.newsweek.com/elon-musk-assisted-suicide-machine-727874; George J. Annas, *Physician Assisted Suicide: Michigan's Temporary Solution*, 328 New Eng. J. Med. 1573 (1993). Gary Schnabel, a pharmacist with the Oregon Board of Pharmacy, also developed a device. Mark O'Keefe & Tom Bates, *Hearings Reveal Confusion about Committing Suicide*, Oregonian (Mar. 15, 1997).

124 Jennifer Zima, *Assisted Suicide: Society's Response to a Plea for Relief or a Simple Solution to the Cries of the Needs*, 23 Rutgers L.J. 387, 387 n.4 (1992). *See also* Susan Clevenger, Dying to Die - The Janet Adkins Story: A True Story of Dying with the Assistance of Doctor Jack Kevorkian (2019).

125 Personal communications to author after NCCMAID. Lethal injection was proposed and rejected in early MAID bills and ballot initiatives. Pope, *supra* note 2. However, that was lethal injection by the clinician, not by the patient. *See, e.g.,* Washington Physician-Assisted Death, Initiative 119 (1991).

126 End of Life Option Act, Cal. Health & Safety Code § 443.18 (2020); Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-121 (2020); Death with Dignity Act of 2016, D.C. Code § 7-661.15(a) (2020); Our Care, Our Choice Act, Haw. Rev. Stat. §§ 327L-18(a) (2020); Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(20); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-15(a) (2020); Oregon Death with Dignity Act, Or. Rev. Stat. § 127.880 (2020); Vt. Stat. Ann. tit. 18, § 5292 (2020); Washington Death with Dignity Act, Wash. Rev. Code § 70.245.180(1) (2020).

127 Pamela S. Kaufmann, Death with Dignity: A Medical-Legal Perspective, AHLA Long-Term Care and the Law Meeting (Feb. 22, 2017); Council on Psychiatry and Law, APA Resource Document on Physician Assisted Death 8 (2017) (interpreting the "other" as a third person). The language of the prohibition may also not extend to intravenous "infusion" into the blood which is distinct from "injection" which may be intermuscular or subcutaneous.

other person." It references "the individual" as the subject of the injection but not as the agent of the injection.[128] Therefore, this prohibitory language is irrelevant to self-administered MAID.

Legislative history confirms this reading. This "lethal injection" language originated with the 1994 Oregon Death with Dignity Act. The voter pamphlet for the ballot initiative included this language indented under a bold heading that stated: "Under Measure 16, only the dying person may self-administer the medication."[129] This clarifies that "lethal injection" was focused on the agent of administration and not the manner of administration.

An even broader look at the legislative history confirms this. Before 1994, bills and ballot initiatives aimed to legalize both MAID and euthanasia.[130] Those efforts failed because having the physician be the final agent was comparatively more controversial. Therefore, reform efforts since 1994 have focused only on MAID.[131] In short, the point of the prohibition was to authorize MAID yet prohibit euthanasia.[132]

Self-administered IV MAID is consistent with this requirement. It changes only the route of administration, not the agent of administration. The patient ***herself*** pushes the lethal medication. The patient herself causes the "lethal injection." With self-administered IV MAID, the physician only establishes the intravenous line. This is analogous to a third person preparing the medication that the patient then drinks herself.[133] As a recent government report describes it, "the person who provides the assistance, such as a relative or doctor, does not perform the final act that causes the death. The death is caused by the person themselves."[134]

This has already been judicially tested. In December 1990, a Michigan court dismissed criminal charges against Jack Kevorkian for assisting in the death of Janet Adkins. While

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128 Contrast a new law in Victoria, Australia that permits physician administration when the patient cannot self-administer. That changes not only the *route* of administration but also *who* administers the lethal medication. Ben P. White et al., *Does the Voluntary Assisted Dying Act 2017 (Vic) Reflect Its Stated Policy Goals?*, 43 UNSW L.J. 417 (2020), http://www.unswlawjournal.unsw.edu.au/wp-content/uploads/2020/06/02-WHITE-ET-AL.pdf.

129 State of Or. Sec'y of State, Voter's Pamphlet 127 (1994) (although the booklet also says the Measure does not allow "suicide machines").

130 *See, e.g.,* Initiative 119 (Wash. 1991); S.B. 1141 (Or. 1991); Proposition 161 (Cal. 1992); Allan Parachini, *Bringing Euthanasia Issue to the Ballot Box: Group Sponsors State Initiative to Legalize 'Physician-Assisted Suicide'* , L.A. Times (Apr. 10, 1987), https://www.latimes.com/archives/la-xpm-1987-04-10-vw-165-story.html.

131 Timothy E. Quill et al., *Sounding Board: Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician Assisted Suicide*, 327 New Eng. J. Med. 1380 (1992).

132 Several authors of the Oregon Death with Dignity Act opined that it did not prohibit self-administered IV MAID. *See, e.g.,* Mark O'Keefe & Tom Bates, *Hearings Reveal Confusion about Committing Suicide*, Oregonian (Mar. 15, 1997) ("Peter Goodwin . . . a co-author of Measure 16, said, 'My own belief is that medication would cover intravenous medication.'"); Mark O'Keefe, *House Takes Up Assisted Suicide*, Oregonian (May 13, 1997) ("Cheryl Smith, who helped write Measure 16 . . . said, `I believe that Measure 16 allows a machine like Kevorkian's.'"). There were later extensive hearings about routes of administration. H.B. 2954 (Or. 1997).

133 *Cf.* Baxter v. State, 224 P.3d 1211, 1217 (Mont. 2009) ("[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").

134 Queensland Parliament, Health, Cmtys., Disability Servs. & Domestic & Family Violence Prevention Comm., Rep. No. 34, 56th Parliament, Voluntary Assisted Dying 12 (2020).

Michigan has not affirmatively authorized MAID, it had not yet prohibited it. The court explained that "Mrs. Adkins was the proximate cause of her own death."[135] For the same reason, other Michigan courts dismissed charges against Kevorkian in the deaths of Shery Miller and Marjorie Wantz.[136]

The prohibition on lethal injection is written to require self-administration and thereby prohibit euthanasia. It does not address the route of administration.[137] MAID statutes are silent as to the specific means of self-administration. Consequently, commentators have concluded that despite the prohibition on "lethal injection," "self-administered lethal intravenous infusion . . . may not be prohibited."[138] It is permissible if the patient "pushes a switch to trigger a fatal injection after the doctor has inserted an IV needle."[139]

Furthermore, we can look to Swiss law for guidance. Like U.S. MAID laws, Swiss law requires self-administration. "The final action in the process leading to death must always be performed by the patient."[140] Swiss providers have reconciled this self-administration requirement with IV administration. They openly and regularly have patients administer MAID through IV drips.[141] Some have even developed an "easy to handle remote control" that the patient can "activate through a small movement (e.g. a finger, toe, or jaw) to start the

135 George J. Annas, *Physician Assisted Suicide -- Michigan's Temporary Solution*, 20 Ohio N.U. L. Rev. 561 (1993-1994); People v. Kevorkian, No. CR-92-115190 (Mich. Cir. Ct. Oakland Cnty. July 21, 1992).

136 *Michigan v. Kevorkian*, 9 Issues L. & Med. 189, 200 (1993) ("Ms. Miller pulled the screwdriver which caused the flow of carbon monoxide to commence . . . Ms. Miller took her own life."). *Cf.* Sanders v. State, 112 S.W. 68, 70 (Tex. Crim. App. 1908) (distinguishing furnishing poison from "placing it in the mouth or other portions of the body"), *overruled on other grounds*, 277 S.W. 1080 (Tex. Crim. App. 1925).

137 *But see Hearing on H.B. 2217 Before the S. Judiciary Comm.*, Reg. Sess. (Or. 2019), https://olis.leg.state.or.us/liz/2019R1/Downloads/CommitteeMeetingDocument/198274 (statement of Geoff Sugerman, Death with Dignity National Center).

138 Raphael Cohen-Almagor & Monica G. Hartman, *The Oregon Death with Dignity Act: Review and Proposals for Improvement*, 27 J. Legis. 269, 287 (2001), http://www.ethesis.net/cohen/Oregon.pdf.

139 Lynn D. Wardle, *A Death in the Family: How Assisted Suicide Harms Families and Society*, 15 Ave Maria L. Rev. 43, 47 n.11 (2016-2017).

140 Swiss Acad. of Med. Scis., *Medical-Ethical Guidelines: Management of Dying and Death*, 148 Swiss Med. Weekly w14664 § 6.2.1 (2018), https://smw.ch/article/doi/smw.2018.14664.

141 *See, e.g., Swiss Law & Requirements*, Pegasos Swiss Ass'n, https://pegasos-association.com/requirements/ ("Pegasos offers VAD using intravenous transfusion, and even though it is a doctor who will insert the cannula into the person's arm, it is the person, themselves, who must activate the drip delivering the drug."); Dignitas, Dignitas Brochure 7 (15th ed. 2019), http://www.dignitas.ch/images/stories/pdf/informations-broschuere-dignitas-e.pdf ("In every case, for legal reasons, the patient must be able to undertake the last act . . . to open the valve of the intravenous access tube") [hereinafter Dignitas]. *See also* Luke Harding, *A Little Sightseeing, a Glass of Schnapps, then a Peaceful Death in a Suburban Flat*, Guardian (Dec. 4, 2004), https://www.theguardian.com/society/2004/dec/04/health.medicineandhealth1 (interview with Ludwig Minelli, founder of Dignitas Clinic); Susan Stefan, Rational Suicide, Irrational Laws: Examining Current Approaches to Suicide in Policy and Law (American Psychology-Law Society Series 190 (1st ed. 2016); Daniel Sperling, Suicide Tourism: Understanding the Legal, Philosophical, and Socio-political Dimensions 33 (2019); Queensland Parliament, Health, Cmtys., Disability Servs. & Domestic & Family Violence Prevention Comm., Rep. No. 34, 56th Parliament, Voluntary Assisted Dying 34 & n.182 (2020).

attached pump."[142] They even videotape the procedure to document that the patient opened the valve all by herself.[143] There is no legal obstacle to administering MAID the same way in Colorado, Hawaii, New Jersey, and Vermont.

OTHER VARIATIONS AMONG U.S. MAID STATUTES

We have examined five ways in which U.S. MAID statutes vary. Two concern patient eligibility requirements: (1) how to assess the patient's state residency, and (2) how to assess the patient's decision-making capacity. Three differences concern the manner of accessing MAID: (3) the duration of the oral request waiting period, (4) the duration of the written request waiting period, and (5) the permitted route of drug administration.

But the nine MAID statutes vary not only in terms of eligibility and procedural requirements but also along five other dimensions.[144] These include: (a) how clinicians can assert conscience-based objections, (b) how facilities can assert conscience-based objections, (c) whether assessment and counseling can be done through telehealth, (d) how death certificates are completed, (e) how states collect and report data, and (f) whether the statute includes a sunset clause.

Conscience–Based Objections by Clinicians

Every MAID statute makes participation voluntary not only by patients but also by clinicians and facilities.[145] Individual clinicians may assert a conscience-based or personal objection and they cannot be punished for refusing to participate.[146] This means that clinicians can refuse to discuss or educate the patient on eligibility or process. They can refuse to conduct eligibility

142 Dignitas, How Dignitas Works 16 (May 2014), http://www.dignitas.ch/images/stories/pdf/so-funktioniert-dignitas-e.pdf.

143 George Mills, *What You Need to Know About Assisted Suicide in Switzerland*, Local (May 10, 2018), https://www.thelocal.ch/20180503/what-you-need-to-know-about-assisted-death-in-switzerland.

144 There are also other variations. For example, will state Medicaid (or other insurance) pay for MAID consultations and prescriptions? Must facilities post their policies on MAID? How should patients and families dispose of unused drugs? Yet, many of these rights and obligations come from other sources of law, not from the MAID statutes themselves. *See, e.g.,* H.B. 2326, 66th Leg., Reg. Sess. (Wash. 2019), http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/House%20Bills/2326-S.pdf?q=20200915125826. *But cf.* S.B. 3047, 30th Leg. (Haw. 2020), https://www.capitol.hawaii.gov/session2020/bills/SB3047_.pdf.

145 End of Life Option Act, Cal. Health & Safety Code § 443.14(e) (2020); Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-117 (2020); Death with Dignity Act of 2016, D.C. Code § 7-661.10(a) (2020); Our Care, Our Choice Act, Haw. Rev. Stat. §§ 327L-19(a)(2) (2020); Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(21) (2020); Oregon Death with Dignity Act, Or. Rev. Stat. § 127.885(2), (4) (2020); Vt. Stat. Ann. tit. 18, § 5285 (2020); Washington Death with Dignity Act, Wash. Rev. Code § 70.245.190(1)(b), (d) (2020).

146 While physicians play a central role, MAID also involves pharmacists, non-physician mental health specialists like social workers and psychologists. Cal. Health & Safety Code § 443.1(l); Colo. Rev. Stat. § 25-48-102(6); Me. Rev. Stat. Ann. tit. 22, § 2140(2)(E) (also including clinical social workers and clinical professional counselors); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-3 (2020) (including clinical social worker).

assessments, write prescriptions, or fill prescriptions for MAID. They can even refuse to make or assist referrals to participating providers.

But the right to refuse is not unlimited. When the patient finds a new physician who is willing to participate, the original objecting physician must transfer the patient's medical records and must do that even if they think it makes them complicit in what they judge to be an immoral act.[147]

The scope of permitted refusal is narrower in Vermont. Most MAID statutes permit objecting physicians not to inform a patient regarding his or her rights and not to refer the patient to a physician who participates.[148] But Vermont has a separate end-of-life informed consent rights statute.[149] A federal court interpreted this statute to require that objecting physicians must either inform patients about their MAID rights or refer them somewhere they can learn their options.[150]

Conscience–Based Objections by Facilities

Not only individual clinicians but also health care entities assert conscience-based objections—many facilities have opted-out. For example, few religiously affiliated institutions participate with MAID.[151] But what about non-objecting individual clinicians that work for such entities (as either employees or independent contractors)? May they participate when their hospital or health care system has opted out?

MAID statutes in every state permit health care facilities to prohibit their employees and staff from participating with MAID while on the premises or while acting within the purview of the entity.[152] The general understanding has been that such clinicians may participate in MAID on their own time. In Colorado, however, a large Catholic system is litigating a claim

147 Cal. Health & Safety Code § 443.14(e)(3); Colo. Rev. Stat. §§ 25-48-113(2), -117; D.C. Code § 7-661.10(b); Haw. Rev. Stat. § 327L-19(a)(4); Me. Rev. Stat. Ann. tit. 22, § 2140(21); N.J. Stat. Ann. § 26:16-17(c); Or. Rev. Stat. § 127.885(4); Wash. Rev. Code § 70.245.190(1)(d).

148 *See, e.g.,* Cal. Health & Safety Code § 443.14(e)(2).

149 Vt. Stat. Ann. tit. 18, § 5282.

150 Vt. All. for Ethical Health Care v. Hoser, 274 F. Supp. 3d 227 (D. Vt. Apr. 5, 2017) (citing Vt. Stat. Ann. tit. 18, § 1871 and Vt. Stat. Ann. tit. 12, § 1909(d)). *Cf.* Mara Buchbinder, *Aid in Dying Laws and the Physician's Duty to Inform,* 43 J. Med. Ethics 666 (2017).

151 Cindy L. Cain et al., *Hospital Responses to the End of Life Option Act: Implementation of Aid in Dying in California*, 179 JAMA Internal Med. 985 (2019). With mergers and consolidation, fewer health systems may participate in the future. *See* Ian D. Wolfe & Thaddeus M. Pope, *Hospital Mergers and Conscience-Based Objections — Growing Threats to Access and Quality of Care,* 382 New Eng. J. Med. 1388 (2020); Harris Meyer, *Proposed Virginia Mason-CHI Franciscan Merger Increases Worry about Catholic Limits on Health Care in Washington State*, Seattle Times (Aug. 3, 2020, 8:24 AM), https://www.seattletimes.com/seattle-news/health/proposed-virginia-mason-chi-franciscan-merger-increases-worry-about-catholic-limits-on-health-care-in-washington-state/.

152 Cal. Health & Safety Code §§ 443.15–.16; Colo. Rev. Stat. § 25-48-118; D.C. Code § 7-661.10(c)-(e); Haw. Rev. Stat. § 327L-19(b)–(e); Me. Rev. Stat. Ann. tit. 22, § 2140(22); Or. Rev. Stat. § 127.885(5); Vt. Stat. Ann. tit. 18, § 5286; Wash. Rev. Code § 70.245.190(2). The New Jersey statute does not contain this language.

that it can prohibit its physicians from participating in MAID even when they act outside the purview of their employment.[153]

Telehealth Assessment and Counseling

Particularly since the COVID-19 pandemic, there has been an increased interest in and use of telehealth.[154] This includes MAID.[155] Indeed, a new professional society, the American Clinicians Academy on Medical Aid in Dying (ACAMAID) released guidance on how to provide MAID through telehealth.[156]

The Hawaii MAID statute addresses telehealth explicitly in the context of the mental health counseling. This is the third clinical assessment for determining that the patient is capable and does not appear to be suffering from undertreatment or nontreatment of depression or other conditions which may interfere with her ability to make an informed decision.[157] The Hawaii law states that these mental health consultations with a psychiatrist, psychologist, or clinical social worker "may be provided through telehealth."

But what about the attending and consulting physician who assess terminal illness and capacity?[158] No U.S. MAID statute specifically says that may be done by telehealth, and none specifically prohibits it. Consequently, one might conclude that clinicians may provide MAID through telehealth to the same extent as they can provide other health care services through telehealth.

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153 Morris v. Centura Health Corp., No. 2019-CV-31980 (Arapahoe Cnty. Dist. Ct., Colo., Dec. 20, 2019). Relatedly, the U.S. Supreme Court is hearing a case that questions the thirty-year old rule that government can enforce laws that burden religious beliefs or practices as long as the laws are "neutral" or "generally applicable." Fulton v. City of Phila., Pa., No. 19-123 (U.S. Nov. 4, 2020) (oral argument). Federal regulations may permit an even broader scope of conscience-based refusal. Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed. Reg. 23,170 (May 21, 2019) (to be codified at 45 C.F.R. pt. 88). These regulations have been enjoined and those injunctions are on appeal. New York v. U.S. Dept. Health & Human Servs., No. 19-4254 (2d Cir. 2020); City and County of San Francisco v. Azar, No. 20-35044 (9th Cir. 2020).

154 Cathleen Calhoun, *Strategic Perspectives: Telehealth Has Taken a Giant Step Forward, But Will the Momentum Continue?*, Wolters Kluwer Health L. Daily (May 20, 2020).

155 *See* Konstantin Tretyakov, *Medical Aid in Dying by Telehealth*, 30 Health Matrix 325 (2020), https://scholarlycommons.law.case.edu/cgi/viewcontent.cgi?article=1650&context=healthmatrix.

156 Comm. to Evaluate Telemedicine for Aid-in-Dying Requests in the Context of the Coronavirus Epidemic, *Telemedicine Policy Recommendations*, Am. Clinicians Acad. on Med. Aid in Dying (Mar. 25, 2020), https://cpsns.ns.ca/wp-content/uploads/2020/09/Medical-Assistance-in-Dying-Standard-Temporary-Amendment-Mar-27-2020-Sept-18-2020.pdf. Medical licensing boards in other jurisdictions have also issued telehealth guidance during the COVID-19 pandemic. *See, e.g.,* Coll. of Physicians & Surgeons of N.S., Temporary Amendments to the College's MAiD Standard (2020), https://cpsns.ns.ca/wp-content/uploads/2020/09/Medical-Assistance-in-Dying-Standard-Temporary-Amendment-Mar-27-2020-Sept-18-2020.pdf; College of Physicians and Surgeons of British Columbia, *Practice Standard: Medical Assistance in Dying* (Mar. 26, 2020).

157 Haw. Rev. Stat. § 327L-1.

158 *Cf.* S.B. 3047, 30th Leg. (Haw. 2020), https://www.capitol.hawaii.gov/session2020/bills/SB3047_.pdf (allowing telehealth for all clinicians when the patient is unable to leave her residence).

On this analysis, telehealth for MAID is not equally available in every state. For example, in Vermont, telehealth can only be provided in the context of a "[b]ona fide physician-patient relationship."[159] That requires not only assessment of the patient's medical history and current medical condition but also a "personal physical examination."[160] So, both the attending and consulting physician must have visited with the patient in person before or concurrent with providing MAID.

Other constraints may also be manageable. For example, California requires that the physician "[c]onfirm 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."[161] While it may be more difficult to know that the patient is alone when meeting through a phone or computer camera, the physician can confirm this by asking the patient to move the camera around the room.[162]

Death Certificate Completion

While most provisions in MAID statutes focus on how patients may obtain MAID, some provisions address what happens ***after*** MAID. One perennially controversial issue concerns whether the patient's death certificate identifies MAID as the cause of death. Here, the states take three different approaches.[163]

Four MAID statutes prohibit MAID from being listed as the cause of death on the patient's death certificate. Instead, the death certificate must list the underlying terminal illness.[164] In four other states the statute is silent, but state agency guidance directs listing the underlying terminal illness.[165] For example, the California Department of Public Health states:

159 Vt. Stat. Ann. tit. 18, § 5281(1) (2020).

160 *Id.*

161 End of Life Option Act, Cal. Health & Safety Code § 443.5(a)(4) (2020).

162 Konstantin Tretyakov, *Medical Aid in Dying by Telehealth*, 30 Health Matrix 325, 343 (2020).

163 Canadian provinces also vary in whether they require or prohibit MAID from being listed as the cause of death. Janine Brown et al., *Completion of Medical Certificates of Death After an Assisted Death: An Environmental Scan of Practices*, 14 Healthcare Pol'y 59 (2018).

164 Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-109(2) (2020); D.C. Code § 7-661.05(h); Our Care, Our Choice Act, Haw. Rev. Stat. §§ 327L-4(b) (2020); Washington Death with Dignity Act, Wash. Rev. Code §§ 70.245.040(2) (2020). Many bills in prospective MAID states also require listing the terminal illness. *See, e.g.*, A.B. 2694 § 2899-p, Reg. Sess. (N.Y. 2019), https://nyassembly.gov/leg/?default_fld=&leg_video=&bn=A02694&term=2019&Summary=Y&Text=Y.

165 New Jersey Medical Aid in Dying for the Terminally Ill Act Frequently Asked Questions 3–4 (July 31, 2019), https://www.state.nj.us/health/advancedirective/documents/maid/MAID_FAQ.pdf ("NJDOH Office of Vital Statistics and Registry recommends that providers record the underlying terminal disease as the cause of death and mark the manner of death as 'natural'."); Or. Health Auth., *Frequently Asked Questions: Oregon's Death with Dignity Act (DWDA)*, Oregon.gov, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/faqs.aspx#deathcert (last visited Sept. 14, 2020) (same); Vt. Dep't of Health, Report to the Vermont Legislature: Report Concerning Patient Choice at the End of Life 4 (2018), https://legislature.vermont.gov/assets/Legislative-Reports/2018-Patient-Choice-Legislative-Report-12-14-17.pdf ("100% of the death certificates listed the appropriate cause (the underlying disease) and manner of death (natural), per Act 39 requirements.").

"Certifiers . . . report the underlying terminal disease as the cause of death on the death certificates. This approach complies with applicable law . . . and effectuates the California Legislature's intent to maintain the confidentiality of individuals' participation in the Act."[166] Only Maine offers no guidance on whether to list MAID on the patient's death certificate.[167]

Data Collection and Reporting

Conscience-based objection and telehealth affect how patients access MAID, but the states also vary in how they collect and report data. Every MAID statute requires that state agencies publish annual reports on usage.[168] The data reports from the first two states (Oregon and Washington) demonstrate a strong safety record that paved the way for enactment of legislation in the subsequent seven states.[169]

But the states vary in terms of what information they collect and report.[170] Oregon and Washington collect and report the broadest range of data. California does less.[171] Colorado, Vermont, and Washington, DC collect and report the least.[172] This variability is unfortunate, because reform is more difficult when one knows less about how the law is working.[173]

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166 Cal. Dep't of Public Health, California End of Life Option Act 2019 Data Report 5 (2020), https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CDPHEndofLifeOptionActReport2019%20_Final%20ADA.pdf. *But see Document #3459: The California End of Life Option Act* ¶ 26, CMA Legal Counsel (2016), https://www.uclahealth.org/workfiles/eol/cma-guidance-end-of-life-option-act-on-call.pdf (directing physicians to list the cause "they feel is the most accurate").

167 Maine legislation originally followed the approach taken in Colorado, DC, Hawaii, and Washington, but as in California and Vermont, that was amended in later versions of the bill.

168 End of Life Option Act, Cal. Health & Safety Code §§ 443.9, .19 (2020); Colo. Rev. Stat. § 25-48-111(2); D.C. Code § 7-661.07; Haw. Rev. Stat. §§ 327L-14, -25; Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(17) (2020); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. § 26:16-13 (2020); Oregon Death with Dignity Act, Or. Rev. Stat. § 127.865 (2020); Wash. Rev. Code § 70.245.150.

169 N.J. Stat. Ann. § 26:16-2(b). Oregon and Washington data were also important to reform in jurisdictions around the world. *See, e.g.,* Carter v. Canada (Attorney General), 2013 BCCA 435, https://www.canlii.org/en/bc/bcca/doc/2013/2013bcca435/2013bcca435.html.

170 Jean T. Abbott et al., *Accepting Professional Accountability: A Call for Uniform National Data Collection on Medical Aid-In-Dying*, Health Aff. Blog (Nov. 20, 2017), https://www.healthaffairs.org/do/10.1377/hblog20171109.33370/full/ [hereinafter Abbott et al.]. This study was published before Maine and new Jersey enacted their statutes, but that would not change the analysis, although the state agencies could promulgate regulations that promote the collection ad reporting of broader data. *See* Me. Rev. Stat. Ann. tit. 22, § 2140(17); N.J. Stat. Ann. § 26:16-13.

171 But in addition to the annual DOH reports, the California Assembly holds periodic hearings on the implementation of the EOLOA. *See, e.g.,* Cal. State Assembly, Assembly Select Committee on End of Life Health Care, Tuesday, February 25th, 2020, https://www.assembly.ca.gov/media/assembly-select-committee-end-life-health-care-20200225/video.

172 Abbott et al.

173 *See* Thaddeus M. Pope, *Extrajudicial Resolution of Medical Futility Disputes: Key Factors in Establishing and Dismantling the Texas Advance Directives Act*, *in* International Perspectives on End of Life Reform: Politics, Persuasion, and Persistence (Ben White & Lindy Wilmott eds., forthcoming 2021); Health Canada, First Annual Report on Medical Assistance in Dying in Canada, 2019 9 (2020), https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying-annual-report-2019/maid-annual-report-eng.pdf ("Nearly all countries that permit some form of medically assisted dying consider public reporting to be a critical component to support transparency and foster public trust in the application of the law.").

Sunset Clauses

The future of most MAID statutes has been threatened by litigation or legislation.[174] But as enacted, those laws were intended to be permanent options. None was enacted on a trial or pilot basis.[175]

In contrast, when California enacted its End of Life Option Act during an extraordinary legislative session in October 2015, it included a sunset clause.[176] "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."[177] Unlike other MAID statutes, the EOLOA expires.[178] Therefore, unless reauthorized, MAID will cease to be a legal practice in California.[179]

FORTHCOMING VARIATIONS

The previous sections described current differences among U.S. MAID laws, but the variability will likely continue to grow as states continue studying "barriers to access."[180] Many are already seeking to recalibrate the balance between safety and access.[181]

Two aspects of MAID laws are especially primed for change: scope of practice and terminal illness. The states are currently uniform in permitting only physicians to provide

174 *See, e.g.,* Ahn v. Hestrin, No. RIC-1607135 (Riverside Cnty. Sup. Ct., Cal.), https://compassionandchoices.org/legal-advocacy/recent-cases/ahn-v-hestrin/; Glassman v. Grewal, No. MER-C-53-19 (Mercer Cnty. Sup. Ct., NJ), https://compassionandchoices.org/legal-advocacy/recent-cases/glassman-v-grewal/.

175 While the Vermont statute's legalization of MAID was permanent, the procedural safeguards were initially designed to sunset. *See* Alan Meisel et al., The Right to Die: The Law of End-of-Life Decisionmaking § 12.05 (3rd ed. 2020).

176 A.B. 15 (Cal. 2015), codified at End of Life Option Act, Cal. Health & Safety Code §§ 443 to 443.22 (2020). The law went into effect on June 9, 2016.

177 Cal. Health & Safety Code § 443.215.

178 *Id.*

179 Without the EOLOA, MAID would be a felony in California. Cal. Penal Code § 401(a) (2020) (Any person who deliberately aids, or advises, or encourages another to commit suicide, is guilty of a felony.").

180 H.B. 2419, Reg. Sess. (Wash. 2020), http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/House%20Passed%20Legislature/2419-S.PL.pdf?q=20200915155130 (passed both chambers but vetoed on April 3, 2020 because of COVID-19); Cal. State Assembly, Assembly Select Committee on End of Life Health Care, Tuesday, February 25th, 2020, https://www.assembly.ca.gov/media/assembly-select-committee-end-life-health-care-20200225/video. *See also* Ben P. White et al., *Does the Voluntary Assisted Dying Act 2017 (Vic) Reflect Its Stated Policy Goals?*, 43 UNSW L.J. 417, 442–43 (2020) (noting that many patients "find the process overwhelming and too difficult to navigate" and that "few medical practitioners will agree to be involved"); Rosalind McDougall & Bridget Pratt, *Too Much Safety? Safeguards and Equal Access in the Context of Voluntary Assisted Dying Legislation*, 21 BMC Med. Ethics 1 (2020), https://bmcmedethics.biomedcentral.com/track/pdf/10.1186/s12910-020-00483-5 (arguing that aiming to maximize safety has negative implications for access).

181 Not every new bill seeks to expand access. For example, one of the newer MAID statutes, in Hawaii, added or increased several procedural requirements. Buchbinder & Pope, *supra* note 83. More recently, a Maryland bill would have significantly constrained access. Md. S.B. 311 / H.B. 399 (2019). On the other hand, states can also expand access through non-legal means like public education and provider outreach.

MAID. However, some states are likely to allow APRNs to provide MAID. The states are also currently uniform in how they define terminal illness, but some states are likely to define terminal illness more broadly than a six-month prognosis. The states may also diverge along several other dimensions.

Scope of Practice: MD or APRN?

Every U.S. MAID statute now requires that both the attending and the consulting clinician (who assesses eligibility, provides counseling, and writes the prescription) be a physician. While most statutes are more flexible about who can perform the mental health assessment (*e.g.* clinical social worker or psychologist), none permit a non-physician to otherwise determine eligibility or write the prescription.

But limiting MAID to physicians constrains access to MAID, especially in rural areas where there is a shortage of physicians. In response, some states have proposed legislation that would allow APRNs to perform these tasks.[182] Already, 6% of MAID in Canada is performed by APRNs,[183] and this makes sense. Across the United States, many states have already expanded scope of practice to permit APRNs to assess capacity and write POLST orders regarding life-sustaining treatment.[184]

Terminal Illness: Six Months or Longer

Every U.S. statute now requires that the patient have a terminal illness. This is typically defined as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months."[185] Both the attending and consulting physician must certify a prognosis that the patient has a terminal disease that will cause her death within six months.

At first glance, the six-month prognosis seems reasonable. It aligns with the eligibility for hospice under Medicare.[186] Hospice, a program of care and support for people who are

182 S.B. 2582, 30th Leg. (Haw. 2020), https://www.capitol.hawaii.gov/session2020/bills/SB2582_SD1_.pdf; S.B. 3047, 30th Leg. (Haw. 2020), https://www.capitol.hawaii.gov/session2020/bills/SB3047_.pdf; H.B. 171, Reg. Sess. (N.M. 2017), https://www.nmlegis.gov/Sessions/17%20Regular/bills/house/HB0171.pdf (also extending to physician assistants); S.B. 252, 53rd Leg., 1st Sess. (N.M. 2017), https://www.nmlegis.gov/Sessions/17%20Regular/bills/senate/SB0252JUS.pdf (same); A.B. 10059 (N.Y. 2016), https://nyassembly.gov/leg/?default_fld=&leg_video=&bn=A10059&term=2015&Summary=Y&Text=Y. MN. *See also* Western Australia Voluntary Assisted Dying Act of 2019 § 54(1)(a), http://www.austlii.edu.au/cgi-bin/viewdb/au/legis/wa/consol_act/vada2019302/. *See also Testimony in SUPPORT of HB 2451 RELATING TO HEALTH* Before the H. Comm. on Health (Haw. 2020); *Testimony in SUPPORT of SB 2582 RELATING TO HEALTH Before the S. Comm. on Commerce, Consumer Protection, & Health* (Haw. 2020).

183 James Downar et al., *Early Experience with Medical Assistance in Dying in Ontario, Canada: A Cohort Study,* 192 Canadian Med. Ass'n J. E173 (2020).

184 Alan Meisel et al., The Right to Die: The Law of End-of-Life Decisionmaking § 7.10A (3rd ed. 2020).

185 Our Care, Our Choice Act, Haw. Rev. Stat. § 327L-1 (2020).

186 42 C.F.R. §§ 418.3, .20 (2020).

terminally ill, focuses on comfort (palliative care) rather than curing illness. Because there are over 4000 hospices used by more one million patients each year, this six-month terminal illness requirement is familiar and salient.[187]

But the six-month requirement has been a big limit on MAID access.[188] Among other things, it wrongly assumes that life expectancy can always be accurately predicted.[189] The arbitrary time scale has meant that patients with cancer are the primary users of MAID. While cancer deaths comprise just 20% of total deaths, cancer accounts for 80% of MAID. Canadian studies have found that an even more flexible standard substantially limits access.[190]

In response, current MAID states have sought to amend their statutes to relax the temporal limit.[191] For example, Oregon has considered bills to extend the terminal illness requirement from six months to ***twelve months***.[192] Bills in other states go even further, eliminating the temporal requirement altogether. For example, a New Mexico bill defines terminal illness as a "disease or condition that . . . will result in death ***within a reasonable time***."[193] Such a standard has proven workable in Canada for years.[194]

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187 *National Center for Health Statistics*: *Hospice Care,* CDC, https://www.cdc.gov/nchs/fastats/hospice-care.htm (last visited Sept. 15, 2020).

188 Queensland Parliament, Health, Cmtys., Disability Servs. & Domestic & Family Violence Prevention Comm., Rep. No. 34, 56th Parliament, Voluntary Assisted Dying 120 (2020); Ben P. White et al., *Does the Voluntary Assisted Dying Act 2017 (Vic) Reflect Its Stated Policy Goals?*, 43 UNSW L.J. 417 (2020).

189 *See* All-Party Parliamentary Grp. for Terminal Illness, Six Months to Live?: Report of the All-Party Parliamentary Group for Terminal Illness Inquiry into the Legal Definition of Terminal Illness (2019), https://www.mariecurie.org.uk/globalassets/media/documents/policy/appg/all-party-parliamentary-group-for-terminal-illness-report-2019.pdf.

190 Truchon v. Procureur Général du Canada, 2019 QCCS 3792, https://www.canlii.org/fr/qc/qccs/doc/2019/2019qccs3792/2019qccs3792.html [hereinafter Truchon].

191 H.B. 2419, Reg. Sess. (Wash. 2020), http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/House%20Passed%20Legislature/2419-S.PL.pdf?q=20200915162544 (commissioning a study on barriers to access).

192 H.B. 2232, 80th Leg. Assemb., Reg. Sess. (Or. 2019), https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/HB2232/Introduced [hereinafter Or. H.B. 2232].

193 H.B. 171 § 2(F), 53rd Leg., 1st Sess. (N.M. 2017) (emphasis added).

194 *Truchon*, *supra* note 190. Even though this is a comparatively flexible standard compared to the U.S. terminal illness requirement, the Quebec court held it unconstitutional, since it is more restrictive than the Supreme Court of Canada judgment that declared a right to MAID.

Other Future Variations

Variability along other dimensions is not as likely as variability in terms of scope of practice and terminal illness. However, there are ongoing academic and policy debates concerning whether MAID should be available: (1) to mature minors,[195] (2) through advance requests,[196] and (3) through third party administration.[197]

CONCLUSION

Medical aid in dying is a legal end-of-life option for one in four Americans. It is, however, one of the most heavily regulated health care services. The scope and manner of that regulation already varies materially across the eleven U.S. MAID jurisdictions. As more states enact MAID statutes and as current states amend their existing statutes, variability is likely to increase. Innovation and non-conformity are positive developments. States considering reform are now less likely to blindly copy and paste older statutes and more likely to engage in "critical review."[198]

In 1997, the U.S. Supreme Court observed: "Americans are engaged in an earnest and profound debate about the morality, legality and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society."[199] More than two decades later, the debate is continuing. Innovation is continuing in the "laboratory of the states."[200] Over the next five years, we will see more states legalize MAID.[201] We will also see more differences among MAID states as some move to recalibrate the balance between access and safety.

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195 Council of Canadian Acads., The State of Knowledge on Medical Assistance in Dying for Mature Minors: The Expert Panel Working Group on MAID for Mature Minors (2018), https://cca-reports.ca/wp-content/uploads/2018/12/The-State-of-Knowledge-on-Medical-Assistance-in-Dying-for-Mature-Minors.pdf .

196 S.B. 893, 79th Leg. Assemb., Reg. Sess. (Or. 2017), https://olis.leg.state.or.us/liz/2017R1/Downloads/MeasureDocument/SB893/Introduced [hereinafter Or. S.B. 893]; S.B. 3047, 30th Leg. (Haw. 2020), https://www.capitol.hawaii.gov/session2020/bills/SB3047_.pdf. *See also* Council of Canadian Acads., The State of Knowledge on Advance Requests for Medical Assistance in Dying: The Expert Panel Working Group on Advance Requests for MAID (2018), https://cca-reports.ca/wp-content/uploads/2019/02/The-State-of-Knowledge-on-Advance-Requests-for-Medical-Assistance-in-Dying.pdf. *Cf.* Nicholas Goldberg, *California's Aid in Dying Law is Working: Let's Expand It to Alzheimer's Patients*, LA Times (July 15, 2020); Elie Isenberg-Grzeda et al., *Legal Assistance in Dying for People with Brain Tumors,* Annals Palliative Med. 1, 4 (2020), http://apm.amegroups.com/article/view/48382/pdf ("Patients with neurologic disease . . . sought MAID earlier in their illness trajectory than if the law allowed for an advanced directive to choose MAID.").

197 *See, e.g.,* Or. S.B. 893 (2017) (allowing request by agent); Or. H.B. 2232 (2019) (changing definition of "self-administration").

198 Ben P. White et al., *Does the Voluntary Assisted Dying Act 2017 (Vic) Reflect Its Stated Policy Goals?*, 43 UNSW L.J. 417 (2020); Taimie Bryant, *Aid-in-Dying Nonprofits*, 57 San Diego L. Rev. 147, 185, 217 (2020). *Cf.* Ed Longlois, *Efforts to Expand Assisted Suicide Underway,* Catholic Sentinel (Oct. 9, 2020).

199 Wash. v. Glucksberg, 521 U.S. 702, 735 (1997).

200 *Id.* at 737 (O'Connor, J., concurring).

201 These states will probably include Maryland, Massachusetts, New Mexico, and New York.

SUMMARY OF VARIATIONS AMONG MAID LAWS									
	CA	CO	DC	HI	ME	NJ	OR	VT	WA
Indicia of residency	4	4	16	4	9	4	4	4	3
Minimum capacity assessments	2	2	2	3	2	2	2	2	2
Minimum total waiting period (days)	15	15	15	20	15	15	0	17	15
Route of administration	GI	Any	GI	GI	Any	Any	GI	Any	GI
Conscience based objection by clinicians	B	B	B	B	B	B	B	N	B
Conscience based objection by institutions	B	XB	B	B	B	B	B	B	B
Death certificate	TI	TI	TI	TI	MAID	TI	TI	TI	TI
Data collection & reporting	B	N	N	M	TBD	TBD	B	N	B
Sunset clause	Yes	No	No	No	No	No	No	No	No

B (broad), GI (gastrointestinal), M (medium), N (narrow), X (extra)

Author Profile

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Legal History of Medical Aid in Dying: Physician Assisted Death in U.S. Courts and Legislatures

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LEGAL HISTORY OF MEDICAL AID IN DYING: PHYSICIAN ASSISTED DEATH IN U.S. COURTS AND LEGISLATURES

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I. INTRODUCTION

Terminally ill patients in the United States have four medical options for controlling the time and manner of their death.[1] Three of these are legally available to certain clinically qualified patients. First, all patients may withhold or withdraw life-sustaining treatment. Second, all patients may voluntarily stop eating and drinking. Third, patients with intractable suffering may receive palliative sedation to unconsciousness.[2] In contrast, the fourth option is available in only seven U.S. jurisdictions.[3] Only there may patients legally obtain a prescription for a lethal medication that they can later self-ingest.

Medical aid in dying (MAID) is not yet legally available in 49 of 56 U.S. jurisdictions.[4] But its legal status has been in a state of rapid change across the country over the past ten years.[5] Before 2008, MAID was legal only in Oregon. Today, it is explicitly lawful in seven U.S. jurisdictions. Moreover, the rate and pace of legalization has been accelerating. Three of the now seven MAID jurisdictions enacted their statutes within only the past two years.[6] Moreover, there are widespread and ongoing legislative and judicial efforts to legalize MAID in more than thirty other states.[7]

I have designed this Article to help inform and guide these expanding law reform efforts. Because a "page of history is worth a volume of logic,"[8] it summarizes earlier efforts (both successful and unsuccessful) to legalize MAID in the United States.[9] In other words, this Article provides a descriptive legal history. It does not normatively assess either whether any efforts to legalize MAID were good public policy. Nor does it assess whether advocates grounded their arguments on

1. There are also non-medical options of hastening death. *See generally, e.g.*, PHILIP NITSCHKE & FIONA STEWART, PEACEFUL PILL HANDBOOK (Exit International, 2017); Michael Majchrowicz, *The Volunteers Who Help People End Their Own Lives,* THE ATLANTIC (July 6, 2016), https://www.theatlantic.com/health/archive/2016/07/the-volunteers-who-help-people-end-their-own-lives/489602.

2. *See, e.g.*, Thaddeus M. Pope & Lindsey Anderson, *Voluntarily Stopping Eating and Drinking: A Legal Treatment Option at the End of Life*, 17 WIDENER L. REV. 363 (2011).

3. *See infra* Sections IV.C, IV.D, and VII.A.

4. MAID is legal in California, Colorado, District of Columbia, Montana, Oregon, Vermont, and Washington. *See infra* Sections IV and VII.A.

5. Other writers have described the same exit option with other terms. These terms include "physician assisted suicide," "physician assisted death," "death with dignity," "aid in dying," and "physician aid in dying." I use "MAID," because that term seems to have the most currency in the primary literature. *See, e.g., Compassion & Choices, Understanding Medical Aid in Dying,* https://www.compassionandchoices.org/understanding-medical-aid-in-dying *(last visited Jan. 31, 2017).*

6. California legalized MAID in October 2015. Colorado legalized MAID in November 2016. Washington DC legalized MAID in 2017. *See infra* Sections IV.B and IV.C.

7. *See infra* Section IV.E.

8. New York Trust Co. v. Eisner, 256 U.S. 345, 349 (1921) (Holmes, J.).

9. *Cf.* Jocelyn Downie, *Permitting Voluntary Euthanasia and Assisted Suicide: Law Reform Pathways for Common Law Jurisdictions,* 16 QUT L. REV. 84 (2016) (discussing exploratory approach in addressing relevant legal pathways).

solid legal analysis. Instead, this Article offers an objective, systematic, and thorough account of what those efforts were.[10]

In Section One, I describe MAID. We must first understand what MAID is before examining attempts to legalize it. Once we grasp the nature of MAID, it starts to become clear why law reformers have concluded that they must affirmatively legalize it. In Section Two, I explain that MAID falls within the prohibitory scope of criminal assisted suicide statutes in almost every state. In other words, MAID is "assisted suicide." Assisted suicide is a crime. Therefore, MAID is a crime. Moreover, in addition to its actual legal status, MAID is widely perceived to be illegal.[11] Therefore, both patients who want to access MAID and physicians who want to provide MAID have strong incentives to change (or at least clarify) its legal status.

In the remainder of the Article, I examine five different paths that reformers have taken to legalize MAID. In Section Three, I start with the most successful approach, statutory enactment. Six states have enacted MAID statutes: three through ballot initiatives and three through legislation. I discuss these six states. I also briefly discuss a few more states that have come close to enacting MAID statutes. Furthermore, more than one-half of the remaining states have recently considered legislation. They are likely to continue this deliberation and debate throughout the 2020s.

In Section Four, I examine attempts to legalize MAID through federal constitutional litigation. Because the U.S. Supreme Court definitively rejected such arguments in 1997, advocates have since refocused their litigation arguments using state law theories. In Section Five, I review cases seeking to legalize MAID through state constitutional litigation. Unfortunately, like federal constitutional claims, state constitutional claims have also been uniformly unsuccessful.

In Section Six, I discuss attempts to legalize MAID through state statutory interpretation litigation. These lawsuits argue that MAID does not even constitute "assisted suicide" in existing criminal statutes. Finally, in Section Seven, I examine two final paths toward "legalizing" MAID: constraining prosecutorial discretion and jury nullification. Unlike other approaches, these do not change the legal status of MAID. Yet, they do change whether prosecutors will or can penalize patient or physician participants.

In sum, the expanded legalization of MAID seems inevitable. Surveys consistently show that more than 70 percent of the American public supports

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10. This Article focuses on only affirmative efforts to legalize MAID. It does not address state efforts to criminalize MAID. *See, e.g.*, SB 202, 64th Leg., Reg. Sess. (Mont. 2015); SB 220, 63d Leg. Reg. Sess. (Mont. (2013); S.B. 167, 62d Leg., Reg. Sess. (Mont. 2011). Nor does it address federal efforts to challenge the legitimacy of state MAID statutes. *See, e.g.*, Assisted Suicide Funding Restriction Act, 42 U.S.C. § 14401 (2012): Gonzales v. Oregon, 546 U.S. 243 (2006); Assisted Suicide Prevention Act, S. 3788, 109th Cong. (2006); Pain Relief Promotion Act, H.R. 2260 & S. 1272, 106th Cong. (1999); Lethal Drug Abuse Prevention Act, H.R. 4006 & S. 2151 105th Cong. (1998).

11. *But cf.* Kathyrn L. Tucker, *Aid in Dying: An End-of-Life Option Governed by Best Practices*, 8 J. HEALTH & BIOMEDICAL L. 9 (2012); Scott Foster, *Expert Panel Concurs: Hawaii Physicians Can Provide Aid in Dying*, HAWAII REPORTER (Oct. 5, 2011), http://www.hawaiireporter.com/expert-panel-concurs-hawaii-physicians-can-provide-aid-in-dying.

MAID.[12] But the battle will be fought bill-by-bill and lawsuit-by-lawsuit in each state. I hope to inform these efforts with lessons from the legal history of MAID described below.

II. WHAT IS MEDICAL AID IN DYING?

There are many circumstances under which a longer life is not a better life. When quality of life diminishes, some individuals would prefer to hasten death (or at least not prolong dying) rather than endure the perils of what, at least to them, is an exceedingly poor quality of life.[13] What exactly comprises a "poor quality of life" covers a broad spectrum that varies significantly from person to person.

For some, loss of independence might diminish quality of life to the point where they would request a hastened death. For others, it may be extreme physical suffering. For these and other reasons, requests to hasten death are common throughout the United States and the world. As Justice Brennan observed, "[f]or many, the thought of an ignoble end, steeped in decay, is abhorrent."[14]

Many seriously ill patients find their lives marked with extreme suffering and both physical and mental deterioration. Unfortunately, many do not have access to a medically supervised, peaceful death. Too many patients commit suicide through violent means such as shooting, hanging, or various other forms of self-deliverance.[15] Moreover, being uncertain about their future options and being worried about future loss of dignity, comfort, and control, many patients hasten their deaths prematurely. Medical aid in dying (MAID) provides an alternative: the assurance that terminally ill patients can die when they want based on their own criteria and can enjoy life for a longer time.[16]

Certainly, life is valuable; and societal values reinforce attempting to extend life indefinitely. But death is unavoidable. People suffering from the diseases that cause most deaths in this country will often experience significant suffering and loss

12. *Polling on Voter Support for Medical Aid in Dying for Terminally Ill Adults*, COMPASSION & CHOICES, https://www.compassionandchoices.org/wp-content/uploads/2016/07/FS-Medical-Aid-in-Dying-Survey-Results-FINAL-7.21.16-Approved-for-Public-Distribution.pdf (last visited Feb. 23, 2017).

13. *See* Janet L. Abrahm, *Patient and Family Requests for Hastened Death,* HEMATOLOGY 475, 457 (2008) ("Patient and family requests for hastened death are not uncommon among patients with advanced malignancies."); Linda Ganzini et al., *Oregonians' Reasons for Requesting Physician Aid in Dying,* 169 ARCHIVES INTERNAL MED. 489, 489 (2009) ("One in 10 dying patients will, at some point, wish to hasten death."); Jean-Jacques Georges et al., *Requests to Forgo Potentially Life-Prolonging Treatment and to Hasten Death in Terminally Ill Cancer Patients: A Prospective Study,* 31 J. PAIN & SYMPTOM MGMT. 100, 104 (2006); J. McCarthy et al., *Irish Views on Death and Dying: A National Survey*, 36 J. MED. ETHICS 454, 456 (2010) (finding that a majority of individuals strongly agreed with the statement, "If I were severely ill with no hope of recovery, the quality of my life would be more important than how long it lasted."); Diane E. Meier et al., *A National Survey of Physician-Assisted Suicide and Euthanasia in the United States,* 338 NEW ENG. J. MED. 1193, 1195 (1998).

14. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 310 (1990) (Brennan, J., dissenting).

15. Peter M. Marzuk, *Suicide and Terminal Illness,* 18 DEATH STUDIES 497, 500 (1994); Matthew Miller et al., *Cancer and the Risk of Suicide in Older Americans*, 26 J. CLINICAL ONCOLOGY 4720, 4722 (2008).

16. *See* STANLEY A. TERMAN, THE BEST WAY TO SAY GOODBYE: A LEGAL PEACEFUL CHOICE AT THE END OF LIFE 326–27 (2007).

of independence.[17] In this situation, the preference, for some, may be to hasten death so that death can be on an individual's terms and with some predictability, rather than risking the unknown and potential loss of comfort and dignity.

MAID is one key "exit option."[18] With MAID, a physician writes a prescription for life-ending medication for a terminally ill and mentally capacitated adult.[19] The practice has long-standing and well-defined conditions regarding patient eligibility, the role of physicians, and the role of the patient. All six statutes have nearly identical conditions and safeguards.[20] Regarding eligibility, the patient must: (1) be over 18 years of age, (2) have decision making capacity, (3) be able to self-ingest the medication, and (4) be terminally ill, meaning that they have a prognosis of six months or less.[21]

Regarding physician practice, both the treating physician and a consulting physician must: (1) confirm that the patient satisfies all the eligibility conditions; (2) inform the patient about risks, benefits, and alternatives; and (3) confirm the patient's request for the medication is a settled and voluntary decision. If either the treating or consulting physician suspects that the patient's judgement is impaired, then they must refer the patient for a mental health assessment.[22]

Once the physician writes the prescription, the patient may obtain the medication. Traditionally, the medication has been secobarbital or pentobarbital, a barbiturate originally developed as a sleeping pill.[23] However, price increases have led physicians to prescribe other drugs including compounded ones.[24] Importantly, the patient must ingest the drugs herself.[25] The patient alone takes the final overt act that cases her death.

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17. Judith K. Schwarz, *Stopping Eating and Drinking*, AM. J. NURSING, Sept. 2009, at 53, 54.

18. *See* Timothy E. Quill et al., *Palliative Options of Last Resort: A Comparison of Voluntarily Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Active Euthanasia, in* GIVING DEATH A HELPING HAND: PHYSICIAN-ASSISTED SUICIDE AND PUBLIC POLICY: AN INTERNATIONAL PERSPECTIVE 49 (Dieter Birnbacher & Edgar Dahl eds., 2008).

19. David Orentlicher, Thaddeus M. Pope & Ben A. Rich, *Clinical Criteria for Physician Aid in Dying*, 19 J. PALLIATIVE MED. 259, 259 (2016).

20. Thaddeus M. Pope, *Medical Aid in Dying: When Legal Safeguards Become Burdensome Obstacles*, THE ASCO POST (Dec. 25, 2017), http://www.ascopost.com/issues/december-25-2017/medical-aid-in-dying-when-legal-safeguards-become-burdensome-obstacles/; National Academies of Science, Engineering, and Medicine, *Physician Assisted Death: Current Landscape: Implementation and Practice*, YOUTUBE (Feb. 12, 2018), https://www.youtube.com/watch?v=yI58KsPl-HM (presentation by Thaddeus M. Pope). While Montana has no statute, the conditions and safeguards are similar.

21. ALAN MEISEL, KATHY L. CERMINARA & THADDEUS M. POPE, THE RIGHT TO DIE: THE LAW OF END-OF-LIFE DECISIONMAKING § 12.04[C] (3d ed. 2017 Supp.) [hereinafter THE RIGHT TO DIE].

22. *Id.*

23. April Dembosky, *Drug Company Jacks Up Cost Of Aid-In-Dying Medication*, NPR (Mar. 23, 2016), https://www.npr.org/sections/health-shots/2016/03/23/471595323/drug-company-jacks-up-cost-of-aid-in-dying-medication.

24. Catherine Offord, *Accessing Drugs for Medical Aid-in-Dying*, THE SCIENTIST (Aug. 17, 2017), https://www.the-scientist.com/?articles.view/articleNo/49879/title/Accessing-Drugs-for-Medical-Aid-in-Dying/.

25. Amanda M. Thyden: *Death with Dignity and Assistance: A Critique of the Self-Administration Requirement in California's End of Life Option Act*, 20 CHAPMAN L. REV. 421, 421 (2017).

III. MOST STATES CRIMINALLY PROHIBIT ASSISTED SUICIDE, AND THEREFORE MAID

Almost every U.S. jurisdiction criminally prohibits assisting another person to commit suicide.[26] Moreover, as the Supreme Court has observed, these assisted suicide prohibitions are deeply rooted in our nation's legal history.[27] In fact, those roots date back 150 years. As early as 1868, most states held that assisting suicide was a criminal offense. The criminal status of assisted suicide has persisted ever since. Nearly one hundred years later, the American Law Institute included the crime in its 1962 Modern Penal Code, the seminal work on substantive criminal law.[28] Most recently, many states have reexamined and reaffirmed their bans on assisted suicide.[29]

Assisted suicide statutes typically include plain yet broad language. For example, the New Mexico statute provides: "Assisting suicide consists of deliberately aiding another in the taking of his own life. Whoever commits assisting suicide is guilty of a fourth-degree felony."[30] Similarly, the California Penal Code states: "Every person who deliberately aids, or advises, or encourages another to commit suicide, is guilty of a felony."[31] Penalties for violation include felony probation, up to three years in state prison, and/or a fine up to $10,000.[32]

In addition, for physicians, assisted suicide also constitutes "unprofessional conduct" that may result in state medical board discipline up to and including

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26. ALASKA STAT. § 11.41.120 (2006); ARIZ. REV. STAT. ANN. § 13-1103 (2014); ARK. CODE ANN. § 5-10-104 (2007); CAL. PENAL CODE § 401 (1995); COLO. REV. STAT. § 18-3-104 (2012); CONN. GEN. STAT. § 53a-56 (1971); DEL. CODE ANN., tit. 11, § 645 (1995); FLA. STAT. ANN. § 782.08 (1971); GA. CODE ANN. § 16-5-5 (2015); HAWAII REV. STAT. § 707-702 (2006); IDAHO CODE § 18-4017 (2011); 720 III. COMP. STAT. ANN., § 5/12-34.5 (2012); IND. CODE ANN. § 35-42-1-2.5 (2014); IOWA CODE ANN. § 707A.2 (1996); KAN. STAT. ANN. § 21-3406 (2011); KY. REV. STAT. ANN. § 216.302 (1994); LA. STAT. ANN. § 14:32.12 (1995); MD. CODE, CRIM. LAW, § 3-102 (2002); ME. REV. STAT. ANN. tit. 17-A, § 204 (1977); MICH. COMP. LAWS ANN. § 750.329A (1998); MINN. STAT. ANN. § 609.215 (1998); MISS. CODE ANN. § 97-3-49 (2013); MO. ANN. STAT. § 565.021(2017); MONT. CODE ANN. § 45-5-105 (1981); NEB. REV. STAT. § 28-307 (1977); N.H. REV. STAT. ANN. § 630:4 (1973); N.J. STAT. ANN. § 2C:11-6 (1979); N.M. STAT. ANN. § 30-2-4 (1963); N.Y. PENAL LAW § 120.30 (1965); N.D. CENT. CODE § 12.1-16-04 (1991); OHIO REV. CODE § 3795.02 (2003); OKLA. STAT. ANN., tit. 21, § 813 (1910); OR. REV. STAT. § 163.125 (1999); 18 PA. CONSOL. STAT. ANN. § 2505 (1973); P.R. LAWS ANN., tit. 33, § 4738 (2005); R.I. GEN. LAWS § 11-60-3 (1996); S.C. CODE ANN. § 16-3-1090 (1998); S.D. CODIFIED LAWS § 22-16-37 (2005); TENN. CODE ANN. § 39-13-216 (1993); TEX. PENAL CODE ANN. § 22.08 (1994); VA. CODE § 8.01-622.1 (2015); V.I. CODE, tit 14, § 2141 (1993); WASH. REV. CODE ANN. § 9A.36.060 (2011); WIS. STAT. ANN. § 940.12 (2001). Statutes in other states imply criminal prohibition of assisted suicide. *See, e.g.*, ALA. CODE § 22-8A-10 (1997); D.C. CODE § 7-651.13 (2016); NEV. REV. STAT. § 449.670 (1995); W. VA. CODE § 16-30-15 (2000); WYO. STAT. § 6-2-107 (1985).

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

28. MODEL PENAL CODE § 210.5 (AM. LAW INST., Proposed Official Draft 1962).

29. Washington v. Glucksberg, 521 U.S. 702, 716 (1997) ("Though deeply rooted, the States' assisted-suicide bans have in recent years been reexamined and, generally, reaffirmed.").

30. N.M. STAT. ANN. § 30-2-4.

31. CAL. PENAL CODE § 401.

32. CAL. PENAL CODE § 18(a) (2011); CAL. PENAL CODE § 672 (1983).

revocation of the license.[33] For example, in Minnesota "aiding suicide or aiding attempted suicide" is "prohibited and is grounds for disciplinary action" even without a criminal conviction, guilty plea, or other judgment under the assisted suicide statute.[34]

While most states have only a "general" assisted suicide statute, six states have enacted statutes that target MAID specifically. Alabama, Arkansas, Georgia, Idaho, Ohio, and Rhode Island do not just outlaw assisted suicide. They expressly outlaw MAID specifically.[35] For example, Arkansas provides that "it is unlawful for any physician or health care provider to commit the offense of physician-assisted suicide by . . . prescribing any drug, compound, or substance to a patient with the express purpose of assisting the patient to intentionally end the patient's life."[36]

Specifically targeting MAID in a penal statute eliminates any residual uncertainty. It sends a clear, strong message to both patients and clinicians. Yet, this degree of precision is probably unnecessary. Even broad, general assisted suicide statutes probably also cover MAID.[37] First, courts have specifically held that criminal assisted suicide statutes cover MAID.[38] Second, almost all legislative and litigation efforts to legalize MAID have assumed that MAID is illegal. Moreover, advocates imply (though certainly do not concede) MAID's illegality by their efforts to legalize it affirmatively. If the penal code does not now prohibit MAID, then why do we need legislation to permit it?

Notably, during the 1980s and 1990s, clinicians were concerned that even long-accepted treatment decisions like Do-Not-Resuscitate (DNR) orders and withholding or withdrawing life-sustaining treatment might fall within the scope of assisted suicide prohibitions.[39] This fear of criminal liability is logical. "[W]hen life-sustaining treatment is withheld or withdrawn, the patient's death results from the acts or omissions of those who have withheld or withdrawn treatment and those who have authorized this conduct."[40] The Washington Supreme Court summed up the reasoning this way:

Under Washington's criminal code, homicide is "the killing of a human being by the act, procurement or omission of another" and it is murder in the first degree when, "with a premeditated intent to cause the death of another person, [one] causes the death of such person." Thus, the potential for criminal liability for withdrawing life-sustaining mechanisms appears to exist.[41]

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33. THE RIGHT TO DIE, *supra* note 21, § 12.04[C]; *see, e.g.*, VA. CODE ANN. § 8.01-622.1(D) (2015); *In re* Egbert, No. 2011-0870 (Md. State Bd. Physicians Dec. 12, 2014) (revoking physician license for assisted suicide).

34. MINN. STAT. § 147.091(1)(w) (2017).

35. Assisted Suicide Ban Act, Ala. H.B. 96 (2017); ARK. CODE ANN. § 5-10-106(b) (2007); GA. CODE ANN. § 16-5-5(b) (2015); IDAHO CODE § 18-4017(1) (2011); N.D. CENT. CODE ANN. § 12.1-16-04(1) (1991); OHIO REV. CODE § 3795.04 (2003); 11 R.I. GEN. LAWS § 11-60-3 (1996).

36. ARK. CODE ANN. § 5-10-106(b)(1) (2007).

37. In addition, many states have enacted civil legislation that provides for the issuance of an injunction, an award of damages, and attorneys' fees. THE RIGHT TO DIE, *supra* note 21, § 12.04[B].

38. *See infra* Part VII.

39. *Cf.* Satz v. Perlmutter, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978); *In re* Farrell, 529 A.2d 404, 411 (N.J. 1987); *In re* Requena, 517 A.2d 886, 887 (N.J. Super. Ct. Ch. Div. 1986).

40. THE RIGHT TO DIE, *supra* note 21, § 12.01.

41. *In re* Colyer, 660 P.2d 738, 751 (Wash. 1983) (en banc) (internal citations omitted).

To eliminate uncertainty or fear of criminal liability, many state legislatures amended their healthcare decision-making acts to exclude such acts.[42] For example, the Virginia Code provides: "This section shall not apply to a . . . health care [professional] who . . . withholds or withdraws life-prolonging procedures."[43]

MAID statutes are designed to offer this same type of clear exemption. For example, a 2017 New Mexico bill redefined "assisted suicide" to exclude "an attending health care provider who provides medical aid in dying, in accordance with the provisions of the End of Life Options Act, to an adult patient who has capacity and who has a terminal illness."[44]

IV. LEGALIZING MAID THROUGH STATUTE

Before 1990, there were few serious efforts to legalize MAID.[45] After all, policymakers were focusing their attention on other end-of-life medical decision-making issues. Specifically, during the 1970s and 1980s, courts and legislatures across the country were still struggling with defining a right to die. They were articulating a right to refuse 1960s medical technology such as CPR, mechanical ventilation, and dialysis. By 1990, the patient's "right to die" through passive refusal was substantially settled.[46] Therefore, policymakers turned their attention to active means of hastening death like MAID.

Since the early 1990s, the most successful strategy for legalizing MAID has been through enacting a statute. Six states have enacted nearly identical statutes. These statutes have two types of distinctive features. First, they specify detailed procedures for accessing life-ending medication. Second, they offer civil, criminal, and disciplinary immunity for compliance.

Three key events accelerated the public policy discussion of MAID by drawing massive academic and community attention to the issue. First, in January 1988, the Journal of the American Medical Association published a provocative op-ed. In *It's Over, Debbie*, the anonymous physician author described administering a lethal dose of morphine to a terminally ill patient.[47] The article stimulated "substantial reaction from the medical profession, the public, the media, and legal authorities."[48]

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42. THE RIGHT TO DIE, *supra* note 21, § 12.02[C][5].

43. VA. CODE ANN. § 8.01-622.1(E) (2015); *see also* N.M. STAT. ANN. § 24-7A-13(B)(1) (1997) ("Death resulting from the withholding or withdrawal of health care in accordance with the Uniform Health-Care Decisions Act does not for any purpose . . . constitute a suicide, a homicide or other crime.").

44. H.B. 171, 53d Leg., 1st Sess., § 10 (N.M. 2017).

45. *But cf. DEATH WITH DIGNITY An Inquiry into Related Public Issues: Hearing Before the Special Committee on Aging*: *Hearings Before the Special Committee on Aging*, 92d Cong. 2d Sess. (1972).

46. The Supreme Court issued its decision in *Cruzan decided on June 25, 1990. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261 (1990).*

47. *Name Withheld by Request, It's Over, Debbie,* 259(2) JAMA 272, 272 (1988).

48. George D. Lundberg, *'It's Over, Debbie' and the Euthanasia Debate*, 259(14) JAMA 2142, 2142 (1988).

Second, in June 1990, Jack Kevorkian received enormous media attention when he helped Janet Adkins commit suicide.[49] Over the following three and a half years, Kevorkian was present at the deaths of 20 other individuals.[50] Michigan state attorneys prosecuted him (unsuccessfully) four times.[51] Through these and other newsworthy events, Kevorkian received "international attention" and "provoked a national discussion."[52] MAID pervaded the public consciousness.

Third, in 1991, Derek Humphry published Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying. This how-to guide for terminally ill people who wish to kill themselves remained on the New York Times bestseller list for 18 weeks.[53] In short, both through high-profile publications and through high profile, colorful advocates, the issue of MAID was placed squarely on the public policy table by the early 1990s.

A. Very Early Efforts in the 1900s

Long before and wholly unconnected with contemporary efforts to legalize MAID were several bills in the early 20th century.[54] In 1906, the Ohio legislature considered a bill titled "An Act Concerning Administration of Drugs etc. to Mortally Injured and Diseased Persons."[55] The bill applied to "any person of lawful age and of sound mind" who is "so ill of disease that recovery is impossible or who is suffering great pain or torture."[56] If "three reputable physicians" concurred with the patient's request to "be put to death," then clinicians could administer an anesthetic until death ensures.[57]

That same year, Iowa considered a similar bill titled "A Bill for An Act Requiring Physician to Take Human Life."[58] In 1937, Nebraska considered an even

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49. *See, e.g.*, Lisa Belkin, *Doctor Tells of First Death Using His Suicide Device*, N.Y. TIMES (June 6, 1990), http://www.nytimes.com/1990/06/06/us/doctor-tells-of-first-death-using-his-suicide-device.html.

50. Silvia Sara Canetto & Janet D. Hollenshead, *Gender and Physician-Assisted Suicide: An Analysis of the Kevorkian Cases, 1990–1997*, 40(1) OMEGA - J. DEATH & DYING 165, 170–71 (2000).

51. Charles H. Baron, *Assisted Dying: As the Population Ages, Assisted Suicide—With the Help of a Physician or Loved One—Will Continue to be Controversial*, 35-JUL TRIAL 44, 50 (1999). Kevorkian was eventually convicted for active euthanasia, not MAID. *See infra* Section VIII.

52. *Jack Kevorkian: How He Made Controversial History*, BBC NEWS (June 3, 2011), http://www.bbc.com/news/world-us-canada-13649381.

53. MICHAEL R. LEMING & GEORGE E. DICKINSON, UNDERSTANDING DYING, DEATH, AND BEREAVEMENT 273 (Wadsworth Cengage Learning, 7th ed.).

54. These bills extended an earlier debate about the ethics of euthanasia. The most notable contribution to that debate was Samuel Williams' widely printed proposal in 1870. *See* Ezekiel J. Emanuel, *Whose Right to Die?*, THE ATLANTIC (Mar. 1997); *see also* Ezekiel J. Emanuel, *The History of Euthanasia Debates in the United States and Britain*, 121(10) ANNALS INTERNAL MED. 793, 794 (1994).

55. *See* GIZA LOPES, DYING WITH DIGNITY: A LEGAL APPROACH TO ASSISTED DEATH 20 (2015) (citing H.B. 145 (Ohio 1906)); *Euthanasia*, 8 ST. LOUIS MED. REV. 66, 66 (1906).

56. *See id.*

57. Jacob M. Appel, *A Duty to Kill? A Duty to Die? Rethinking the Euthanasia Controversy of 1906*, 78(3) BULLETIN HIST. MED. 610, 618 (2004).

58. *See* LOPES, *supra* note 55, at 21 (citing H.F. 367 (Iowa 1906)); *see also* DEMETRA M. PAPPAS, THE EUTHANASIA/ASSISTED-SUICIDE DEBATE 444 (2012).

broader MAID bill.[59] All three of these Midwestern state bills were soundly defeated. MAID legislation then entered a nearly fifty-year dormancy. Expectedly, interest in this type of legislation waned after World War II.[60] Euthanasia had become too closely associated with Nazi eugenics and involuntary killing.

B. Early Efforts in the 1980s and 1990s

Interest in MAID reemerged in the late 1980s and early 1990s as a logical extension of the then newly established right to refuse life-sustaining treatment. Initially, efforts to enact MAID statutes focused on the ballot initiative process. Available in half the states, this process allows a public vote on a proposed statute based on a petition signed by a certain minimum number of registered voters.[61] Between 1988 and 1994, advocates proposed MAID ballot initiatives in California, Washington, and Michigan.[62]

In 1988, California organizers did not get enough signatures to place the "Humane and Dignified Death Act" on the ballot.[63] Apparently, the inclusion of both euthanasia and MAID dissuaded voters. Therefore, organizers later removed "mercy killing" from the ballot language and required the patient to take the final overt at causing death. They obtained enough signatures, and placed Proposition 161 on the 1992 ballot. Still, the initiative was defeated 54% to 46 percent.[64] In 1991, Washington placed Initiative 119 on the ballot. Like the California initiative, it was also defeated 54 to 46 percent.[65]

In January 1994, Jack Kevorkian launched a petition drive to place MAID on the November ballot in Michigan. Kevorkian's petition offered an amendment to the state constitution that read: "The right of competent adults, who are incapacitated by incurable medical conditions, to voluntarily request and receive medical assistance with respect to whether or not their lives continue, shall not be restrained or abridged."[66] Like the 1988 California ballot initiative that similarly included both MAID and euthanasia, Kevorkian's effort did not obtain enough signatures.[67]

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59. *See* IAN DOWBIGGIN, A CONCISE HISTORY OF EUTHANASIA: LIFE, DEATH, GOD, AND MEDICINE 85 (2005); LOPES, *supra* note 55, at 48 n.14 (2015).

60. *But cf.* Morton L. Yanow, Letter to the Editor, *Continue the Debate* N.Y. TIMES (July 25, 1997), http://www.nytimes.com/1997/07/27/opinion/l-continue-the-debate-335681.html (noting the Connecticut Act to Legalize Euthanasia in 1959, the Idaho Voluntary Euthanasia Act in 1969 and the Oregon Voluntary Euthanasia Act and the Montana Euthanasia Act in 1973). *See also* JOEL FEINBERG, HARM TO SELF 367 (1986).

61. *Initiative Process 101,* NATIONAL CONFERENCE OF STATE LEGISLATURES, http://www.ncsl.org/research/elections-and-campaigns/initiative-process-101.aspx (last visited Jan. 25, 2018).

62. *See infra* notes 64–68 and accompanying text.

63. SUSAN STEFAN, RATIONAL SUICIDE, IRRATIONAL LAWS: EXAMINING CURRENT APPROACHES TO SUICIDE IN POLICY AND LAW 138 (2016).

64. *The California Propositions in Brief*, LONG BEACH PRESS- TELEGRAM, Nov. 5, 1992, 1992 WLNR 1033302.

65. *See* Jane Gross, *Voters Turn Down Mercy Killing Idea*, N.Y. TIMES, Nov. 7, 1991, at A10.

66. *Kevorkian Begins Ballot Drive for Suicide Measure*, N.Y. TIMES, Jan. 31, 1994, http://www.nytimes.com/1994/01/31/us/kevorkian-begins-ballot-drive-for-suicide-measure.html.

67. *Kevorkian's Ballot Drive on Suicide Aid Stumbles*, N.Y. TIMES, July 6, 1994, http://www.nytimes.com/1994/07/06/us/kevorkian-s-ballot-drive-on-suicide-aid-stumbles.html.

C. Three Successful Ballot Initiatives

The earliest ballot initiative efforts in California, Washington, and Michigan failed. Yet, three other ballot initiatives successfully passed. Oregon, Washington, and Colorado all legalized MAID through the ballot initiative process. Furthermore, other states have come very close, and more states are still trying to emulate Oregon, Washington, and Colorado.

1. Oregon 1994 Ballot Initiative

Building off the earlier experience in California and Washington, Oregon placed a ballot measure in the November 1994 election. In contrast to the earlier ballot initiatives, the citizens of Oregon approved Measure 16 by a vote of 51 to 49 percent.[68] Two factors leading to success included avoiding the term "mercy killing" and reframing the legislation as the "Death with Dignity Act."[69]

Before the Death with Dignity Act became effective, litigation delayed its implementation for three years.[70] Nevertheless, the delay did not dampen enthusiasm. In November 1997, the margin of approval grew even wider when Oregon citizens rejected a ballot measure to repeal the law 60 to 40 percent.[71] Subsequently, while the Oregon Death with Dignity Act was the subject of several (ultimately unsuccessful) federal challenges for years, it has remained in effect since 1998.[72] Notably, once those federal challenges stopped in 2006, remaining "clouds" of legal uncertainty lifted. Other states began more seriously to consider copying the Oregon model.

The Oregon Death with Dignity Act is so carefully crafted, so narrowly drawn, and so laden with procedural safeguards, that it may well demand more energy and fortitude to comply with it than some terminally ill people are likely to have.[73] To qualify for "death with dignity," a person must be a resident of the state,[74] over age 18,[75] "capable"[76] (that is, in possession of decision-making capacity),[77] and suffering from a terminal disease that will lead to death within six months.[78]

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68. DEPARTMENT OF HUMAN RESOURCES, OREGON HEALTH DIVISION, CENTER FOR DISEASE PREVENTION AND EPIDEMIOLOGY, OREGON'S DEATH WITH DIGNITY ACT: THE FIRST YEAR'S EXPERIENCE 1 (Feb. 18, 1999).

69. Kathryn L. Tucker, *In the Laboratory of the States: The Progress of Glucksberg's Invitation to States to Address End-of-Life Choice*, 106 MICH. L. REV. 1593, 1594 (2008).

70. Lee v. Oregon, 869 F. Supp. 1491 (D. Or. Dec. 27, 1994) (issuing preliminary injunction), 891 F. Supp. 1429 (D. Or. Aug. 3, 1995) (issuing permanent injunction), *vacated and remanded*, 107 F.3d 1382 (9th Cir. Feb. 17, 1997) (lack of federal jurisdiction), *cert. denied sub nom.* Lee v. Harcleroad, 522 U.S. 927 (Oct. 14, 1997).

71. William Claiborne & Thomas B. Edsall, *Oregon Suicide Law May Spur Movement*, WASH. POST, Nov. 6, 1999, http://www.washingtonpost.com/wp-srv/politics/daily/nov99/suicide6.htm.

72. THE RIGHT TO DIE, *supra* note 21, § 12.06[A][1] (citing federal cases).

73. *See* OR. REV. STAT. §§ 127.800 to .897 (1995). *See also* OR. ADMIN. R. 333-009-0000 to -0030 (2001).

74. OR. REV. STAT. §§ 127.805, .860.

75. *Id.* §§ 127.800, .805.

76. *Id.* § 127.805.

77. *Id*. § 127.800.

78. *Id.* § 127.805, .800.

The patient must make one written[79] and two oral requests[80] for medication to end his life. The written request must be "substantially in the form" provided in the Act, signed, dated, witnessed by two persons, in the presence of the patient, who attest that the patient is "capable, acting voluntarily, and not being coerced to sign the request."[81] There are stringent qualifications as to who may act as a witness.[82]

The patient's decision must be an "informed" one.[83] Therefore, the attending physician is obligated to provide the patient with information about the diagnosis, prognosis, potential risks and probable consequences of taking the medication to be prescribed, and alternatives, "including but not limited to, comfort care, hospice care and pain control."[84] Another physician must confirm the diagnosis, the patient's decision-making capacity, and voluntariness of the patient's decision.[85] There are requirements for counseling, if either the attending or consulting physician thinks the patient is further suffering from a mental disorder.[86] There are requirements for documentation in the patient's medical record,[87] for a waiting period,[88] for notification of the patient's next of kin,[89] and for reporting to state authorities.[90] The patient has a right to rescind the request for medication to end his life at any time.[91]

Having complied with these requirements, the patient is entitled only to a prescription for medication. The Act does not "authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia."[92] In other words, the statute accepts MAID but rejects what the law calls active euthanasia.

The Oregon legislature amended the Death with Dignity Act in 1999.[93] The definitional sections clarified that an "adult" is a person 18 years of age or older[94] and that pharmacists fall within the definition of "health care provider."[95] The amendments expanded and clarified the responsibilities of attending physicians. One important added responsibility is to counsel patients "about the importance of having another person present when the patient takes the medication . . . and of not taking the medication in a public place. . . ."[96] Some pharmacists have wished to refrain

79. *Id.* § 127.805, .840.
80. *Id.* § 127.840, .897.
81. *Id.* §127.810.
82. *Id.*
83. *Id.* § 127.815, .830.
84. *Id.* § 127.815.
85. *Id.* § 127.820.
86. *Id.* § 127.825.
87. *Id.* § 127.855.
88. *Id.* § 127.850.
89. *Id.* § 127.835.
90. *Id.* § 127.865.
91. *Id.* § 127.845.
92. *Id.* § 127.880.
93. 1999 Or. Laws 1098.
94. OR. REV. STAT. §127.800(1).
95. *Id.* §127.800(6).
96. *Id.* §127.815.

from dispensing lethal prescriptions.[97] In recognition of this, the legislation included a provision in the Act expressly authorizing physicians to dispense the lethal medications rather than having pharmacists do so.[98]

To address the concerns that have been raised that people will be motivated by depression to seek a physician's assistance in ending their lives, the 1999 amendments to the Act added "depression causing impaired judgment" to the generic "psychiatric or psychological disorder" that the attending physician must determine the patient does not have before medications may be prescribed.[99]

A concern about the original statute was that although its provisions were limited to Oregon residents, there was no definition of "residence." Thus, the 1999 amendments specified factors demonstrating Oregon residence.[100] The amendments also added an important new reporting requirement: any health care provider who dispenses medication under the statute must file a copy of the dispensing record with the state health division.[101]

Finally, the 1999 amendments included several provisions expanding immunities. The Act now permits a health care provider to prohibit another health care provider from participating in "death with dignity" on the premises of the first health care provider if they gave prior notice of such prohibition.[102] This is probably the most far-reaching aspect of the amended legislation.

If a health care provider violates this prohibition, the provider issuing the prohibition may impose sanctions including loss of medical staff privileges, termination of a lease or other property contract, and termination of employment contract.[103] However, even if prohibited from doing so under one of the preceding provisions, a health care provider may provide assistance under the statute if he does so outside the course of employment.[104]

The Death with Dignity Act requires the state health division to issue an annual report summarizing the experience with the statute.[105] The statistics summarized in these reports do not seem to bear out the fears of the opponents of "death with dignity." Individuals availing themselves of this statute were insured, were disproportionately white rather than racial minorities, were better educated than the general population, and were not disproportionately female.[106] Individuals who requested lethal prescriptions were concerned with loss of autonomy, their

97. *See* Jennifer Fass & Andrea Fass, *Physician-assisted Suicide: Ongoing Challenges for Pharmacists*, 68(9) AM. J. HEALTH SYS. PHARMACISTS 846, 848 (2011).

98. *See* OR. REV. STAT. §127.815.

99. *See id.* §127.825.

100. *Id.* §127.860.

101. *See id.* §127.865; *see also* Or. Admin. R. 333-009-0000 to -0030 (2011) (regulations implementing the reporting requirements).

102. OR. REV. STAT. §127.885; *see also* 49 Or. Op. Att'y Gen. 161, No. 8264 (1999) (interpreting OR. REV. STAT. §127.885).

103. OR. REV. STAT. §127.885.

104. *Id.*

105. *See id.* §127.865(3).

106. PUB. HEALTH DIV., OREGON HEALTH AUTH., OREGON DEATH WITH DIGNITY ACT DATA SUMMARY 2017 (Feb. 9, 2018); *see also* Barbara Coombs Lee, *Oregon's Experience with Aid in Dying: Findings from the Death with Dignity Laboratory*, ANN. N.Y. ACAD. SCI. 94, 96 (2014).

decreasing ability to participate in activities that made their lives enjoyable, and loss of bodily functions.[107]

2. Washington 2008 Ballot Initiative

Based on the thorough and virtually unblemished record from Oregon, other states have followed. The first state to copy Oregon was its northern neighbor, Washington. In November 2008, Washington State voters approved an initiative modeled closely on Oregon's law. Initiative 1000 passed by a 58 to 42 percent margin.[108] The Washington Death with Dignity Act became effective in early 2009.[109] Data from Washington State's annual published reports show operation and usage very similar to that in Oregon.[110]

3. Colorado 2016 Ballot Initiative

In 2016, Colorado voters approved an initiative modeled closely on Oregon's law by a 65 to 35 percent margin.[111] The Colorado End of Life Options Act went into effect on December 16, 2016.[112] Data from Colorado's first annual report is consistent with Oregon and Washington data.[113]

D. Three Successful Legislative Enactments

After Oregon and Washington legalized MAID through ballot initiatives in 1994 and 2008, many commentators thought that direct democracy voting was the only viable path.[114] They determined that the issue was just too controversial for the political process. It turned out that this assessment was too pessimistic. Since 2013, three states have legalized MAID through a legislative process: Vermont, California, and Washington, DC. Furthermore, several other states have come close.

1. Vermont 2013 Legislation

In 2013, Vermont joined the list of states affirmatively approving the practice of MAID, this time through legislation rather than a ballot initiative

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107. *Id.*

108. Robert Steinbrook, *Physician-Assisted Death — From Oregon to Washington State*, 359 NEW ENG. J. MED. 2513, 2513 (2008).

109. WASH. REV. CODE §§ 70.245.010 to .220, 70.245.901 to .903 (effective Mar. 5, 2009); WASH. ADMIN. CODE §§ 246-978-001 to -040 (2009). *See generally* Linda Ganzini & Anthony L. Back, *The Challenge of New Legislation on Physician-Assisted Death*, 176 JAMA INTERNAL MED. 427 (2016).

110. *See* WASH. STATE DEP'T OF HEALTH, WASHINGTON STATE 2016 DEATH WITH DIGNITY ACT REPORT (Sept. 2017).

111. Jennifer Brown, *Colorado Passes Medical Aid in Dying, Joining Five Other States*, DENVER POST (Nov. 8, 2016), https://www.denverpost.com/2016/11/08/colorado-aid-in-dying-proposition-106-election-results.

112. COLO. REV. STAT. §§ 25-48-101 to -123 (effective Dec. 16, 2016); 6 COLO. CODE REGS. § 1009-4 (effective June 14, 2017).

113. *See Medical Aid in Dying,* COLO. DEP'T OF PUB. HEALTH AND ENV'T, https://www.colorado.gov/pacific/cdphe/medical-aid-dying (last visited Jan. 31, 2018).

114. *But see* GUENTER LEWY, ASSISTED DEATH IN EUROPE AND AMERICA: FOUR REGIMES AND THEIR LESSONS 127 (Oxford Univ. Press) (2011) (Oregon State Senator Frank Roberts introduced legislation in 1987, 1989, and 1991).

process.[115] Uniquely, as originally enacted, the Vermont MAID law would have diverged from those in California, Oregon, and Washington after July 1, 2016. As originally enacted, on that day, the section of the Vermont statute imposing stringent procedural safeguards would sunset.[116] In 2015, the Vermont legislature repealed that sunset provision.[117] Like the Oregon Death with Dignity Act, opponents attacked the Vermont law in court.[118] Those challenges have been unsuccessful.

2. California 2015 Legislation

On October 5, 2015, California became the fourth state to enact a statute allowing physicians to prescribe terminally ill patients medication to end their lives.[119] The California End of Life Option Act is virtually identical to MAID statutes in Oregon, Washington, and Vermont. [120] Still, unlike the other MAID statutes, the California law will sunset on January 1, 2026.[121] The first published report from California shows operation and usage very similar to that in Oregon and Washington.[122]

Finally, reminiscent of the post-statute litigation in Oregon and Vermont, physicians and advocacy groups filed suit to enjoin the operation of the California statute, arguing that the law was unconstitutional for a variety of reasons.[123] The court refused to enjoin operation of the law, but also refused to dismiss the case.[124]

3. Washington, DC 2017 Legislation

In 2017, the District of Columbia enacted a statute also modeled closely on Oregon's law.[125] Just as there was federal interference with the Oregon legislation, there has also been federal interference with the D.C. legislation. Given the District of Columbia's unique status in the federal system, Congress sought to exert its authority to disapprove the law. Nevertheless, the D.C. law became effective in February 2017, after Congress failed to pass a "resolution of disapproval."[126] In

115. VT. STAT. ANN. tit. 18, §§ 5281–5293 (effective May 20, 2013). *See* Kathryn L. Tucker, *Vermont's Patient Choice at End of Life Act: A Historic "Next Generation" Law Governing Aid in Dying*, 38 VT. L. REV. 687, 687 (2014).

116. 2013 Vt. Acts & Resolves 292, 296.

117. 2015 Vt. Acts & Resolves 296.

118. Vt. All. for Ethical Healthcare, Inc., v. Hoser, 2017 WL 1284815 (D. Vt. Apr. 5, 2017); *see also* Vt. All. for Ethical Healthcare, Inc., v. Hoser, 2016 WL 7015717 (D. Vt. Dec. 1. 2016).

119. *Assemb. B 15, Stats. 2015, Ch.1 (2015).*

120. *See* CAL. HEALTH & SAFETY CODE §§ 443.1 to 443.22 (effective June 9, 2016).

121. *See* CAL. HEALTH & SAFETY CODE § 443.215 (2016) ("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.").

122. *See* CAL. DEP'T OF PUB. HEALTH, CALIFORNIA END OF LIFE OPTION ACT 2016 DATA REPORT (2017).

123. Ahn v. Hestrin, No. RIC-1607135 (Riverside Cnty. Sup. Ct., Cal. June 8, 2016) (Complaint).

124. Ahn v. Kestrich, No. RIC-1607135 (Riverside Cnty. Sup. Ct., Cal. June 9, 2017) (Order denying preliminary injunction but allowing lawsuit to proceed).

125. D.C. Act 21-577 (Dec. 19, 2016).

126. H.R.J. Res. 27, 115th Cong. (2017). The law went into effect in February 2017 after Congress failed to pass resolution of disapproval within 30 legislative days after the city government passed the law.

September 2017, the House of Representatives passed a bill that would repeal the D.C. Death with Dignity Act.[127]

E. Other Notable Efforts to Enact MAID Statutes

By the end of 2017, only Oregon, Colorado, and Washington have successfully passed ballot initiatives. Yet, other states have come very close. For example, a 2012 Massachusetts ballot initiative failed on a 49 to 51 percent vote.[128] Similarly, a 2000 Maine ballot initiative also failed on a 49 to 51 percent vote.[129] A 1998 Michigan ballot initiative did not do as well, failing on a 71 to 29 percent vote.[130] Additional states are continuing to explore the ballot initiative process to legalize MAID.[131]

By the end of 2017, only California, Vermont, and Washington, DC have enacted legislation. Yet, other states have come very close. For example, in 2017, the Hawaii Senate passed a MAID bill on a vote of 22 to 3. The Hawaii House later deferred the bill.[132] Also in 2017, the Maine Senate passed a MAID bill that died in the House.[133] Likewise, in 2015 the Maine Senate passed a bill that died in the House.[134] In 2016, the New Jersey Assembly passed a MAID bill on a vote of 41 to 28. That bill even then passed a key Senate committee.[135] As in Maine, this was not the first time that legislation advanced in New Jersey. In 2014, the Assembly passed a bill by a vote of 41 to 31.[136]

Recent near successes in Hawaii and Maine are not the only reason to expect more states to legalize MAID. First, nearly half of the states considered MAID legislation in 2016 and 2017.[137] Second, proponents are introducing more and more bills in more and more states. Third, today, there is more support from the public, healthcare professionals, medical societies and medical associations.[138]

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127. H.R. 3354, 115th Cong. § 818 (2017); J. Portnoy, *House Votes to Repeal D.C.'s Death with Dignity Law; Senate Has Yet to Act,* WASH. POST, Sept. 14, 2017.

128. *See* Carolyn Johnson, *Assisted Suicide Measure Narrowly Defeated; Supporters Concede Defeat,* BOSTON GLOBE, Nov. 7, 2012.

129. Michael Moore, *Suicide Opponents Claim Win*, BANGOR DAILY NEWS (Nov. 8, 2000).

130. *1998 Michigan Election Results*, MICH. DEP'T OF ST., http://miboecfr.nictusa.com/election/results/98gen/ (last visited Mar. 12, 2018).

131. *See, e.g.*, *Voters May See Cannabis, Tobacco Tax on South Dakota Ballot,* ARGUS LEADER, Nov. 6, 2017. Some states have considered ballot initiatives not only to enact a MAID statute but also to amend the state constitution.

132. *See* S.B. 1129, 29th Leg. (Haw. 2017).

133. *See* Legis. Doc. 347, 128th Leg., 1st Sess. (Me. 2017).

134. *See* Legis. Doc. 1270, 127th Leg., 1st Sess. (Me. 2015).

135. Assemb. B. 2451, 217th Leg. (N.J. 2016).

136. Assemb. B. 2270, 216th Leg. (N.J. 2014).

137. Two public websites appear to collect state-by-state legislation comprehensively and accurately. DEATH WITH DIGNITY NATIONAL CENTER, https://www.deathwithdignity.org/take-action/ (last visited Jan. 31, 2018); PATIENT RIGHTS COUNCIL, http://www.patientsrightscouncil.org/site/laws-issues-by-state/ (last visited Jan. 31, 2018).

138. *See* COMPASSION & CHOICES, *supra* note 12; Michael Ollove, *Aid in Dying Gains Momentum as Erstwhile Opponents Change their Minds,* STATELINE, (Mar. 9, 2018), http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/03/09/aid-in-dying-gains-momentum-as-erstwhile-opponents-change-their-minds.

V. LEGALIZING MAID THROUGH FEDERAL CONSTITUTIONAL LITIGATION

While the most successful method of legalizing MAID has been by enacting statutes, the most prominent early method was by seeking a right under the U.S. Constitution. During the 1990s, physician and patient plaintiffs brought several cases in state and federal courts. Several even sought certiorari from the U.S. Supreme Court. That court ultimately agreed to adjudicate the issue. In 1997, the Court ruled that state criminalization of MAID does not violate constitutional due process or equal protection rights.[139]

A. Early Efforts before 1997

Before the U.S. Supreme Court issued its decisions in June 1997, four other courts had already ruled that there was no federal constitutional right to MAID.

1. Donaldson v. Lundgren *(Cal. App. 1992)*

The earliest case was not a typical MAID case. Indeed, it was so unusual that it was not really a MAID case at all. Mathematician and computer software scientist, Thomas Donaldson, suffered from an incurable brain disease. He wanted to cryogenically preserve his body in hopes that sometime in the future, when a cure for his disease is found, his body may be brought "back to life."[140] Since the process would require Donaldson's death, the court interpreted the request for declaratory and injunctive relief for "pre-mortem cryogenic suspension" as seeking a right to assisted suicide. The trial court dismissed the action and the court of appeals affirmed.[141]

2. State v. Kevorkian *(Mich. 1994)*

Jack Kevorkian was one of the most prolific litigants in the MAID movement. Most of his lawsuits were criminal prosecutions and not actions for declaratory and injunctive relief like most other cases discussed in this article. Yet, in at least one of these cases, Kevorkian raised constitutional arguments before the Michigan Supreme Court.

In February 1993, the Michigan legislature enacted a ban on assisted suicide. Kevorkian challenged that statute both in defense to criminal prosecutions

139. Washington v. Glucksberg, 521 U.S. 702 (1997). Coincidentally, the same year that the U.S. Supreme Court found no constitutional right to MAID, the Constitutional Court in Colombia found there was such a right. Mariana Parreiras Reis de Castro et al., *Euthanasia and Assisted Suicide in Western Countries: A Systematic Review,* 24(2) REV. BIOETHICS 355 (2016); s*ee also* Carter v. Canada, [2015] S.C.R. 331 (Can.).

140. Donaldson v. Lungren, 4 Cal. Rptr. 2d 59, 60 (Ct. App. 1992). The television series, *LA Law,* dramatized the case. *LA Law: The Good Human Bar*, YOUTUBE (Jan. 31, 2018), https://www.youtube.com/watch?v=Rzpda6cpYQU.

141. *Donaldson*, 4 Cal. Rptr. 2d 59. The court rejected claims under both the U.S. Constitution and the California Constitution. *Id.*

and in an action for declaratory relief.[142] Kevorkian met with some success at the trial level. In 1994, the Court of Appeals consolidated those several cases. The appellate court then overturned the new statute outlawing assisted suicide. While the court did not hold that there was a constitutional right to assisted suicide, it held that the statute violated a provision in the Michigan Constitution that "no law shall embrace more than one object."[143]

The Michigan Supreme Court reversed, upholding the assisted suicide statute. It held that the act was not constitutionally defective for having more than one object. Like the court of appeals, the state supreme court denied that the Fourteenth Amendment included a constitutional right to die.[144] The court held that there was a valid distinction between the right to refuse life-continuing treatment and the right to insist on life-ending treatment.

3. Kevorkian v. Arnett *(C.D. Cal. 1996)*

While most of Kevorkian's cases were in Michigan state courts, he had two in federal court. He filed one in Los Angeles.[145] There, he asserted claims under the Fourteenth Amendment Due Process clause and the Equal Protection clause. He also asserted privacy and equal protection claims under the California Constitution. Notably, the U.S. District Court for the Central District of California decided the case after the favorable federal appellate decisions in *Glucksberg* and *Quill*.[146] Nevertheless, the court still denied all of Kevorkian's claims.[147] The Ninth Circuit dismissed the appeal because by then the U.S. Supreme Court had already adjudicated the issues in other cases.[148]

4. Kevorkian v. Thompson *(E.D. Mich. 1997)*

Kevorkian filed his second federal action in Michigan with Janet Good, a patient with terminal pancreatic cancer.[149] Like the California federal court, the U.S. District Court for the Eastern District of Michigan declined to follow the still-standing federal appellate decisions in *Glucksberg* and *Quill*.[150] The court held that a mentally competent, terminally ill or intractably suffering adult does not have a liberty interest protected by the Fourteenth Amendment's Due Process Clause in MAID. The court further held that the Equal Protection Clause of the Fourteenth Amendment is not violated by denying a mentally competent, terminally ill or intractably suffering adult not on life support the right to MAID.

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142. *See* Janet M. Branigan, *Michigan's Struggle with Assisted Suicide and Related Issues as Illuminated by Current Case Law: An Overview of People v. Kevorkian*, 72 U. DET. MERCY L. REV. 959 (1995).

143. Hobbins v. Attorney General, 518 N.W.2d 487, 489 (Mich. App. 1994).

144. People v. Kevorkian, 527 N.W.2d 714, 728 (Mich. 1994), *cert denied*, 514 U.S. 1083 (1995).

145. Kevorkian v. Arnett, 939 F. Supp. 725 (C.D. Cal. Sept. 11, 1996).

146. *See infra* Sections V.B & V.C.

147. *See Kevorkian*, 939 F. Supp., at 731–732. *The court also rejected an asserted right under the California constitution,* c*iting Donaldson* v. Lungren, 4 Cal. Rptr. 2d 59 (Ct. App. 1992)*. Id.*

148. Kevorkian v. Arnett, 136 F.3d 1360 (9th Cir. Mar. 31, 1998) (vacating judgment and dismissing appeal).

149. Kevorkian v. Thompson, 947 F. Supp. 1152 (E.D. Mich. Jan. 6, 1997).

150. *See infra* Sections V.B & V.C.

B. SCOTUS 1: *Quill v. Vacco*

During the early 1990s, several cases in California and Michigan had sought a federal constitutional right to MAID. Still, the most notable constitutional rights cases were out of Washington and New York. In 1994, advocates filed two federal lawsuits challenging the constitutionality of Washington and New York statutes criminalizing aiding suicide.

The Washington and New York lawsuits claimed that criminal assisted suicide statutes constituted denials of due process and equal protection as applied to terminally ill, competent persons voluntarily requesting assistance from licensed physicians. These claims met some success. In both cases, federal courts of appeals upheld the claims and held the statutes unconstitutional. Nevertheless, the U.S. Supreme Court reversed, holding that there is no constitutional barrier to states criminalizing MAID.

The specific question presented in the Second Circuit case was whether New York's ban on MAID violated the Fourteenth Amendment's Equal Protection Clause.[151] The plaintiffs alleged that the law treats similarly situated terminally ill patients disparately. On the one hand, New York law (like laws in almost every state) allows competent terminally ill adults to hasten their death by withholding or withdrawing their own lifesaving treatment. On the other hand, New York law denies the same right to patients who could not withdraw their own treatment even if they are terminally ill or in great pain.

The District Court rejected these claims and ruled for the State of New York.[152] The Second Circuit reversed, holding that New York's ban was unconstitutional.[153] The court of appeals held that the statute treated similarly situated terminally ill patients differently. On the one hand, those who required life-sustaining treatment were entitled under New York law to die by having that treatment withheld or withdrawn. On the other hand, patients whose suffering might be equal or greater, but who did not require life-sustaining treatment, were denied the same right to die because New York statutory law made it a crime to provide them with the assistance necessary to die.

The U.S. Supreme Court reversed, holding that there was no fundamental liberty interest and that New York's distinction between active and passive means of death was legitimate. Having determined that there was no fundamental right at stake, the Court needed only to apply a minimal scrutiny test and was able to accord the statute a strong presumption of validity. Thus, the Court would uphold the law so long as it bore a rational relation to some legitimate end.

Employing a rationality test to examine the guarantees of the Equal Protection Clause, the Court held that New York's ban bore a rational relationship to the state's legitimate interest in protecting medical ethics, preventing euthanasia, shielding the disabled and terminally ill from prejudice that might encourage them to end their lives, and, above all, the preservation of human life. Moreover, while acknowledging the difficulty of its task, the Court distinguished between the refusal of lifesaving treatment and assisted suicide, by noting that the latter involves the

151. Quill v. Vacco, 521 U.S. 793 (1997).

152. Quill v. Vacco, 870 F. Supp. 78 (S.D.N.Y. 1994).

153. Quill v. Vacco, 80 F.3d 716, 718 (2d Cir. 1996).

criminal elements of causation and intent. It found the distinction between assisting suicide and withdrawing life-sustaining treatment to be a rational one because it is "a distinction widely recognized and endorsed in the medical profession and in our legal traditions."[154]

C. SCOTUS 2: *Washington v. Glucksberg*

While the New York case presented an equal protection question, a parallel case from Washington State presented the question whether Washington State's ban on MAID violated the Fourteenth Amendment's Due Process Clause. The plaintiffs alleged that the same principle that grounded the right to refuse treatment also encompassed a right to choose the time and manner of one's death. Therefore, they argued, Washington's law denied competent terminally ill adults this fundamental liberty.

The District Court ruled for the plaintiffs.[155] While a three-judge panel of the U.S. Court of Appeals for the Ninth Circuit reversed,[156] a rare en banc Ninth Circuit affirmed the district court.[157] The U.S. Supreme Court granted certiorari to the state of Washington, and upheld the constitutionality of the state law.[158]

The Supreme Court concluded that no fundamental right was at stake. It further concluded that the state's interests were legitimate and that the statute bore a rational relationship to furthering those interests. Accordingly, the Court held that the Washington statute making assisted suicide a crime "does not violate the Fourteenth Amendment, either on its face or as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors."[159]

D. Later Efforts after 1997

By June 1997, the U.S. Supreme Court had rejected both due process and equal protection arguments. Nevertheless, some litigants continued to press such claims in federal courts. Predictably, those courts denied the claims.

1. Mahorner v. Florida *(M.D. Fla. 1998)*

Unlike the patient plaintiffs in most other MAID lawsuits, James Mahorner was not terminally ill. Instead, the seventy-six-year-old former practicing attorney was suffering increasing "diminished mental capacity."[160] Mahorner sought judicial approval to "hire a physician to inject him with 'a lethal pain-relieving' drug to hasten his demise."[161] The court expectedly held that to the extent that the complaint

154. *Quill*, 521 U.S. at 800.

155. Compassion in Dying v. Washington, 850 F. Supp. 1454, 1467 (W.D. Wash. May 3, 1994).

156. Compassion in Dying v. Washington, 49 F.3d 556 (9th Cir. Mar. 9, 1995).

157. Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir. Mar. 8, 1996) (en banc).

158. Washington v. Glucksberg, 521 U.S. 702 (1997).

159. *Id.* at 732.

160. *See* Mahorner v. Florida, No. 3:08-cv-300-J-33TEM, 2008 WL 2756481 (M.D. Fla. July 14, 2008).

161. *See id.* Technically, the plaintiff was seeking active euthanasia and not MAID.

sought relief under the Fourteenth Amendment, it was subject to dismissal under *Glucksberg*, *Vacco*, and *Krischer*.[162]

2. Calon v. United States *(D. Kan. 2009)*

In 1999, John Calon asserted a constitutional right to MAID in a claim for benefits before the U.S. Court of Appeals for the Tenth Circuit.[163] That court held that Calon could not state a cognizable claim that state laws prohibiting MAID violated the First Amendment, the Due Process Clause, or the Equal Protection Clause. The court further ruled that any other constitutional claim challenging state laws regarding assisted suicide was too vague to confer federal question jurisdiction.

Nearly ten years later, Calon made similar claims in the U.S. District Court for the District of Kansas.[164] He asserted various violations of federal law, including the First, Eighth, Ninth, Thirteenth, and Fourteenth Amendments to the United States Constitution. Yet, Calon did not assert any such claims in his complaint. Nor did he allege sufficient facts to allege a real and immediate threat of injury to support any claim for prospective relief.

VI. LEGALIZING MAID THROUGH STATE CONSTITUTIONAL LITIGATION

Because the U.S. Supreme Court decided that there is no constitutional right to MAID, litigation efforts after June 1997 have focused elsewhere.[165] Specifically, they have focused either on grounding the right in state constitutions or on establishing that MAID falls outside the scope of assisted suicide statutes. This section examines cases asserting state constitutional claims. The next section examines cases asserting statutory interpretation claims.

Initially, advocates identified the most promising theories to be state constitutional privacy claims. After all, some state supreme courts had previously given rather expansive readings to the privacy clauses in their state constitutions. Nonetheless, the courts have proved unwilling to strike down criminal prohibitions on assisted suicide as a violation of a terminally ill person's right to privacy.

Admittedly, some plaintiffs have obtained favorable state constitutional judgments from trial courts.[166] Yet, no plaintiff has ever obtained an appellate court ruling that the prohibition of MAID violates a right afforded by state constitution. Indeed, "not a single plaintiff has asserted a successful constitutional challenge to an assisted suicide ban."[167]

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162. *See supra* Sections V.B-C & *infra* Section VI.A.2.

163. Calon v. Apfel, No. 98-3190, 1999 WL 415340, at *1 (10th Cir. Apr. 26,1999).

164. Calon v. United States, No. 08–2608–JWL, 2009 WL 248430 (D. Kan. Feb 3, 2009) (dismissing for lack of jurisdiction).

165. Litigation has appeared an attractive pathway, because ballot initiatives are cumbersome and legislation is controversial. *See* Alan Meisel, *Physician-Assisted Suicide: A Common Law Roadmap for State Courts*, 24 FORDHAM URBAN L.J. 817, 819 (1997).

166. *See* discussion of the state constitutional litigation in Florida, Montana, and New Mexico *infra* Section VI.A.2, 4, 5

167. Myers v. Schneiderman, 85 N.E.3d 57, 92 (N.Y. Ct. App. 2017) (Garcia, J., concurring).

A. State Supreme Court Rulings

Six constitutional rights cases have reached the state supreme courts in Michigan, Florida, Alaska, Montana, New Mexico, and New York. I discuss those six cases immediately below. In the next section, I discuss constitutional rights cases decided by trial courts or intermediate appellate courts.

1. Michigan v. Kevorkian *(Mich. 1994)*

In February 1993, the Michigan legislature enacted a ban on assisted suicide. Kevorkian challenged that statute both in defense to criminal prosecutions and in an action for declaratory relief.[168] Several circuit court judges held that MAID was a constitutional right.[169] As discussed above, neither the intermediate court of appeals nor the Michigan Supreme Court found there was a federal constitutional right.[170]

Nevertheless, the Court of Appeals overturned the new statute outlawing assisted suicide on state constitutional grounds. While the court did not hold that there was a constitutional right to assisted suicide, it held that the statute violated a provision in the Michigan Constitution that "no law shall embrace more than one object."[171] The Michigan Supreme Court reversed, upholding the assisted suicide statute. It held that the act was not constitutionally defective for having more than one object. Like the court of appeals, the state supreme court denied that the Fourteenth Amendment included a constitutional right to die.[172]

2. Krischer v. McIver *(Fla. 1997)*

Charlie Hall was terminally ill with AIDS. Along with his physician, Hall sought a declaratory judgment that Florida's assisted suicide statute was unconstitutional as applied to MAID. Hall contended that Florida's statutory prohibition on assisted suicide violated the state constitutional right of privacy.[173] The trial court rejected the fundamental liberty interest but accepted the equal protection argument and enjoined the attorney general.[174]

The Florida Supreme Court reversed.[175] The court held there was no fundamental right and that there were compelling state interests in any case. The court's analysis was a straightforward rejection of the application of the

168. *See* Janet M. Branigan, *Michigan's Struggle with Assisted Suicide and Related Issues as Illuminated by Current Case Law: An Overview of People v. Kevorkian*, 72 U. DET. MERCY L. REV. 959, 962 (1995).

169. *See, e.g.*, Hobbins v. Attorney General, No. 93-306-178CZ, 1993 WL 276833 (Mich. Cir. Ct. May 20, 1993), *aff'd in part, rev'd in part,* 518 N.W.2d 487 (Mich. Ct. App. May 10, 1994), *rev'd sub nom.* People v. Kevorkian, 527 N.W.2d 714 (Mich. December 13, 1994).

170. *See* discussion *supra* Section V.A.2.

171. Hobbins v. Attorney General, 518 N.W.2d 487, 489 (Mich. Ct. App. 1994) (quoting MICH. CONST. art. 4, §24) *rev'd sub nom.* People v. Kevorkian, 527 N.W.2d 714 (Mich. Dec. 13, 1994).

172. *See* People v. Kevorkian, 527 N.W.2d 714, 728 (Mich. 1994), *cert denied sub nom.* Hobbins v. Kelley, 514 U.S. 1083 (1995).

173. FLA. CONST. art. I, §23; *see also* Eryn R. Ace, *Krischer v. Mciver: Avoiding the Dangers of Assisted Suicide,* 32 AKRON L. REV. 723, 724 (1999).

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

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

constitutional privacy provision to permit terminally ill patients to obtain the aid of physicians in actively ending their lives. Central to the holding was the court's acceptance of the conventional distinction between passive and active means of dying, reaffirming its commitment to the former while rejecting the latter.

The Florida Supreme Court followed the U.S. Supreme Court's analysis in *Glucksberg* in finding that important state interests justify the differential treatment of actively and passively hastening death. Specifically, the court held that "three of the four recognized state interests are so compelling as to clearly outweigh Mr. Hall's desire for assistance in committing suicide" [176] These interests are preserving life,[177] preventing suicide,[178] and protecting the ethical integrity of the medical profession.[179]

3. Sampson v. Alaska *(Alaska 2001)*

In 1998, a patient with breast cancer and a patient with AIDS sought a declaratory judgment that Alaska's assisted suicide statute was unconstitutional as applied to MAID. The trial court rejected the plaintiffs' claims. The Alaska Supreme Court affirmed. The court held there was no fundamental right and that the state had a rational basis for prohibiting MAID. The court also denied the equal protection claim holding that the active passive distinction was valid. Furthermore, the court concluded that this was a "quintessentially legislative matter" and it would not make social policy.[180]

The Alaska Supreme Court found that, "[t]o the extent that the . . . statute's general prohibition of assisted suicide prevents terminally ill patients from seeking a physician's help in ending their lives, . . . the provision substantially interferes with [patients'] general privacy and liberty interests, as guaranteed by the Alaska Constitution."[181] Nevertheless, the court determined that the state's ban on such assistance, through its manslaughter statute, was constitutional because it both served a legitimate governmental purpose and bore a substantial relationship to that purpose.[182]

The court also expressed concern that permitting assisted suicide in cases involving competent, terminally ill patients would put courts in difficult positions in terms of determining competency and terminal condition.[183] Finally, the court seemed concerned that permitting assisted suicide in the case of competent patients would open the door to assisted suicide by advance directive.[184]

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176. *McIver*, 697 So. 2d at 103.

177. *Id.* (citing Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261 (1990)).

178. *Id.* ("[L]egal physician-assisted suicide could make it more difficult for the State to protect depressed or mentally ill persons, or those who are suffering from untreated pain, from suicidal impulses.").

179. *Id.* at 104.

180. Sampson v. State, 31 P.3d 88, 98 (Alaska Sept. 21, 2001).

181. *Id.* at 95.

182. *Id.* at 95–96.

183. *Id.* at 97–98.

184. *Id.* at 97.

4. Baxter v. State *(Mont. 2009)*

In December 2008, a Montana trial court ruled that the Montana Constitution protected MAID.[185] While the trial court rejected the equal protection argument, it accepted the privacy and dignity argument. The court also found there were no compelling state interests requiring the state to treat MAID as homicide. As discussed below, the Montana Supreme Court resolved the right to MAID at the statutory level, obviating the need to resolve the constitutional question.[186]

5. Morris v. Brandenburg *(N.M. 2016)*

In early 2014, a trial court in New Mexico invalidated that state's statutory prohibition on MAID, ruling that it violated the provision of the New Mexico constitution guaranteeing not only "the rights of enjoying life and liberty" but also "the right to seek and obtain happiness."[187]

In 2015, the intermediate court of appeals reversed that judgment.[188] In 2016, the New Mexico Supreme Court affirmed the appellate court's reversal of the trial court ruling.[189] While agreeing that New Mexico could grant its citizens more constitutional rights than those guaranteed by the federal Constitution, the court followed the reasoning of *Glucksberg*. The court held there was no "special characteristic of New Mexico law that makes physician aid in dying a fundamental right in this state."[190] In doing so, it refused to hold that United States Supreme Court jurisprudence had moved beyond "the careful substantive due process approach announced in *Glucksberg*, effectively overruling it."[191]

Finally, the court interpreted Article II, Section 4 (the Inherent Rights Clause) of the New Mexico Constitution as creating no judicially enforceable rights but instead guaranteeing New Mexicans an expansive view of rights otherwise existing in its constitution. While the portion of New Mexico's Constitution that refers to "seeking and obtaining . . . happiness" might, under other circumstances, ensure greater due process protections that those of the federal government, "the Inherent Rights Clause has never been interpreted to be the exclusive source for a fundamental or important constitutional right, and on its own has always been subject to reasonable regulation."[192]

The court ruled that the New Mexico statute bore a rational relationship to the legitimate governmental interest in "providing positive protection to ensure that a terminally ill patient's end-of-life decision is informed, independent, and procedurally safe." Setting forth such procedures is a job for the legislature, not the judiciary. The New Mexico legislature can and should draw the line between the

185. Baxter v. State, No. ADV-2007-787, 2008 Mont. Dist. LEXIS 482 (Mont. Dist. Ct. Dec. 5, 2008), *aff'd in part, rev'd in part*, 224 P.3d 1211 (Mont. 2009).

186. Baxter v. State, 224 P.3d 1211, 1220 (Mont. 2009).

187. Morris v. Brandenburg, No. D-202-CV 2012-02909, 2014 WL 10672986, at *6–7 (2d Jud. D. Ct. N.M., Jan. 13, 2014) (citing to N.M. CONST. art. II, §4) *rev'd* Morris v. Brandenburg, 2015-NMCA-100, 356 P.3d 564, *aff'd*, Morris v. Brandenburg, 2016-NMSC-027, 376 P.3d 836.

188. *See Morris*, 2015-NMCA-100 (decided Aug. 11, 2015).

189. *See Morris*, 2016-NMSC-027 (decided June 30, 2016).

190. *Id.* ¶ 36.

191. *Id.* ¶ 23 (citing Obergefell v. Hodges, 135 S.Ct. 2584, 2620–21 (2015) (Roberts, C.J., dissenting).

192. *Id.* ¶ 51.

state's legitimate interest and the state's conceded lack of "interest in preserving a painful and debilitating life that will end imminently."[193]

6. Myers v. Schneiderman *(N.Y. 2017)*

Constitutional litigation in New York turned out no better than in New Mexico. The Appellate Division dismissed plaintiffs' state equal protection claim quickly, saying that the right to equal protection under the New York Constitution was coextensive with the right under the United States Constitution, and the Supreme Court in *Vacco v. Quill* had already decided that issue. The Appellate Division also rejected arguments that a strong liberty interest existed for due process purposes. The court refused to alter its constitutional analysis based on evidence amassed over the two decades since *Vacco* and *Glucksberg*. "We are not persuaded . . . aid-in-dying is an issue where a legitimate consensus has formed. . . . we defer to the political branches of government. . . . "[194]

The Court of Appeals affirmed, holding that applying New York's statutes criminalizing assisted suicide to MAID violated neither due process nor equal protection rights under the New York state constitution. "Although New York has long recognized a competent adult's right to forgo life-saving medical care, we reject plaintiffs' argument that an individual has a fundamental constitutional right to aid-in-dying as they define it. We also reject plaintiffs' assertion that the State's prohibition on assisted suicide is not rationally related to legitimate state interests."[195]

B. *Baxter v. Montana* (1st Jud. Dist. Ct. 2008)

As with lower courts in Florida and New Mexico, Montana plaintiffs were able to obtain a trial court judgment that Montana's prohibition of MAID violated patients' privacy, and dignity rights under the state constitution.[196] In December 2008, the Montana First Judicial District Court ruled that the state constitution protected MAID.[197] Yet, as discussed below, the Montana Supreme Court vacated the judgment.[198] That court found a right to MAID at the statutory level, obviating the need to resolve the constitutional question.[199]

The plaintiff argued that the statute was unconstitutional under the Montana Constitution's equal protection clause, individual dignity clause, and express right of privacy. The trial court ruled that the statute did not violate the state constitution's equal protection clause for the same reasons the United States Supreme Court had ruled to that effect with respect to the U.S. Constitution's Equal Protection Clause.

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193. *Id.*

194. Myers v. Schneiderman, 140 A.D. 3d 51, 65 (N.Y. App. Div. 2016).

195. Myers v. Schneiderman, 85 N.E.3d 57, 65 (N.Y. Ct. App. 2017) (decided Sept. 7, 2017).

196. *See* Baxter v. State, No. ADV-2007-787, 2008 Mont. Dist. LEXIS 482 (Mont. Dist. Ct. Dec. 5, 2008), *aff'd in part, rev'd in part*, 224 P.3d 1211 (Mont. 2009) (holding that the prohibition violated MONT. CONST. art. II, §§ 4, 10).

197. *Id.*

198. *See infra* Section VII.A.

199. Baxter v. State, 224 P.3d 1211, 1220 (Mont. 2009). One Justice wrote separately to express agreement with the trial court's reasoning on the constitutional issue. *Id.* at 1223.

Nevertheless, the trial court ruled that the statute was unconstitutional, holding that the state constitution's individual dignity clause and right of privacy combined to "mandate that a competent terminally ill person has the right to choose to end his or her life." [200]

Moreover, the right necessarily includes a right to have the assistance of a physician, for if a patient were forced to proceed without physician assistance he might end his life "sooner rather than later . . . and the manner of the patient's death would more likely occur in a manner that violates his dignity and peace of mind."[201]

The trial court then considered the state interests that Montana had advanced to convince the court that the statute was constitutional. The state asserted an interest in the preservation of life. The court ruled that such an interest is compelling in general, but "diminishes in the delicate balance against the individual's constitutional rights of privacy and individual dignity" when a patient is terminally ill.[202]

The court ruled that the state did have compelling state interests in "protecting vulnerable groups from potential abuses" and "protecting the integrity and ethics of the medical profession." Yet the court held the statute unconstitutional despite the existence of these compelling state interests because it was overbroad. The court suggested that the state of Montana should seek to serve these compelling state interests by enacting statutory protections such as those contained within Oregon's Death with Dignity Act rather than by prohibiting suicide assistance as a blanket matter, sweeping within the reach of its statutes decisions of competent, terminally ill patients choosing to end their own lives with the assistance of physicians.[203]

C. Other Court Rulings

While only six state supreme courts have analyzed the constitutionality of MAID under state constitutions, seven other trial and intermediate appellate have also adjudicated state constitutional claims. Trial courts in Florida, Montana, and New Mexico ruled that prohibition of MAID violated state constitutional rights. Yet, no appellate court sustained those judgments. Nearly fifteen other trial and appellate courts to reach the issue all found that there was no state constitutional right to MAID.

Two California cases asserted both federal and state constitutional claims. The adjudication of the federal claims is discussed above.[204] The state claims fared no better. First, Thomas Donaldson brought claims under both the U.S. Constitution and the California Constitution. Both the Superior Court and the Court of Appeal denied the states claims just as they denied the federal claims.[205] Second, Jack Kevorkian brought claims under both the U.S. Constitution and the California

200. *Baxter*, 2008 Mont. Dist. LEXIS 482, at *26. The court recognized that the state may want to erect some safeguards but could do so afterwards. *Id.* at *29.

201. *Id*. at *29.

202. *Id*. at *30.

203. *See id.* at *15.

204. *See supra* Section V.A.

205. *See* Donaldson v. Lungren, 4 Cal.Rptr.2d 59, 60 (Cal. Ct. App. Jan. 29, 1992).

Constitution. The U.S. District Court denied the states claims just as it denied the federal claims.[206]

1. Sanderson v. Colorado *(Colo. App. 2000)*

The MAID issue in Sanderson differed significantly from that in other cases. Robert Sanderson was an 81-year-old former judge. Although in good health, Sanderson wanted to execute an advance directive authorizing his wife "to end his life by euthanasia, provided that two physicians agree his medical condition is hopeless."[207] He sought a declaratory judgment to assure himself that neither his wife nor the physician who actually engaged in the euthanasia would be subject to criminal liability.

Sanderson asserted claims under several federal constitutional provisions, but on appeal after dismissal of the complaint, he pursued only a claim under the free exercise clause of the First Amendment. Sanderson described his personal religious beliefs as including beliefs that the free will of man included an ability to direct euthanasia, and that man could delegate to another to authorize euthanasia.

The Colorado Court of Appeals ruled that the free exercise clause did not exempt the plaintiffs from the state law criminalizing their conduct, in large part because the law was an "'across-the-board' criminal prohibition on a particular form of conduct." Because Colorado's prohibition of assisted suicide fell into this category, the court ruled, it constituted a "valid, religiously-neutral, and generally-applicable criminal statute that prohibits conduct a state is free to regulate."[208]

In addition to its unique First Amendment argument, *Sanderson* is interesting, and differs from the other cases, in that the plaintiff was asserting a right to choose death through an advance directive rather than a right to commit suicide with assistance. Thus, the plaintiff was arguing that, while competent, he could direct others to euthanize him later, when he was incompetent. Rather than asserting his own right to take action, Sanderson sought to authorize others to take action, and he wanted to ensure that the state would not prosecute those who acted at his request.

The court noted the incongruity by describing his claim as weak, because he does not just seek a limited exemption from the assisted suicide statute for himself so that he may freely practice his religion without fear of criminal prosecution. He also seeks exemptions for third parties—his wife and his physician—based on his personal religious beliefs, which they may not share. Even assuming Sanderson had standing to raise such claims on behalf of third persons, the court found "no precedent for such a broad application of the Free Exercise Clause in First

206. *See* Kevorkian v. Arnett, 939 F. Supp. 725, 731–32 (C.D. Cal. 1996), *vacated, appeal dismissed*, Kevorkian v. Arnett, 136 F.3d 1360 (9th Cir. 1998).

207. *See* Sanderson v. People, 12 P.3d 851 (Colo. App. June 8, 2000); *see also* Allison Sherry, *Ex-Judge Seeks Right to Die*, DENVER POST (June 9, 2000), www.extras.denverpost.com/news/news0609.htm (explaining that Sanderson was in good health despite his interest in the medical aid in dying cause).

208. *Sanderson*, 12 P.3d at 854.

Amendment jurisprudence."[209] The Colorado Supreme Court declined to hear the case.[210]

2. People v. Kevorkian *(Mich. App. 2001)*

In 1999, a Michigan jury convicted Jack Kevorkian of second-degree murder and unlawful delivery of a controlled substance.[211] Kevorkian appealed. [212] He contended that his conviction was unlawful under the Ninth and the Fourteenth Amendments of the U.S. Constitution, as well as under their counterparts in the Michigan Constitution.[213]

The Ninth Amendment provides that "[t]he enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people."[214] Dr. Kevorkian claimed that the "right to be free from inexorable pain and suffering must be among" the rights so protected.[215] The court summarily rejected this argument because of Kevorkian's failure to pursue it beyond its mere assertion.

The court dealt far more extensively, however, with Dr. Kevorkian's Fourteenth Amendment liberty interests argument. Using the U.S. Supreme Court's assisted-suicide jurisprudence as a base, Kevorkian argued that the "necessary and direct corollary" of the concern expressed in *Quill* about patients dying in pain was "that a person should not be forced to suffer unbearably."[216] While acknowledging the Supreme Court's concerns about pain, the court refused to rule that it was unconstitutional to apply Michigan's murder statute to active euthanasia based on those concerns.

The court articulated three bases for its ruling. First, the court expressed a concern that "expanding the right to privacy would begin, as the steps in the progression of defendant's argument supporting voluntary euthanasia clearly indicate, the slide down the slippery slope toward euthanasia."[217] Second, the court hesitated to take such a step because it believed that "[i]f society is to recognize a right to be free from intolerable and irremediable suffering, it should do so through the action of the majority of the legislature, whose role it is to set social policy, or by action of the people through ballot initiative."[218]

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209. *Id.*

210. *See id.* (indicating that certiorari was denied on October 23, 2000 due to an unsuccessful attempt at making a first amendment challenge); *cf.* Final Exit Network, Inc. v. Georgia, 722 S.E. 2d 722, 725 (Ga. 2012) (making a successful first amendment challenge); *see also* State v. Melchert-Dinkel, 844 N.W.2d 13, 18 (Minn. 2014), rev'g 816 N.W.2d 703 (Minn. Ct. App. 2012) (succeeding on first amendment grounds).

211. *See* Dirk Johnson, *Kevorkian Sentenced to 10 to 25 Years in Prison*, N.Y. Times, (Apr. 14, 1999) http://www.nytimes.com/1999/04/14/us/kevorkian-sentenced-to-10-to-25-years-in-prison.html.

212. People v. Kevorkian, 639 N.W.2d 291, 296 (Mich. App. 2001).

213. *See id.* at 300–303; *see also* Monica Davey, *Kevorkian Speaks After His Release From Prison*, N.Y. TIMES, (June 4, 2007), http://www.nytimes.com/2007/06/04/us/04kevorkian.html (indicating that even after eight years of imprisonment, Dr. Kevorkian still felt strongly about MAID).

214. U.S. CONST. amend. IX.

215. *Kevorkian*, 639 N.W.2d at 303.

216. *Id.* at 304 (citing Vacco v. Quill, 521 U.S. 793 (1997)).

217. *Id.* at 306.

218. *Id.*

Finally, the court expressed concern about judging quality of life. "Expanding the right of privacy to include a right to commit euthanasia . . . to end intolerable and irremediable suffering we would inevitably involve the judiciary in deciding questions that are simply beyond its capacity."[219]

3. Hooker v. Slattery *(Davidson County, Tenn. 2016)*

In May 2015, John Jay Hooker filed a lawsuit asserting a right to MAID under the Tennessee Constitution. In September 2015, the trial court held that Hooker had no right to MAID under the Tennessee Constitution.[220] In any case, the state had compelling state interests to prohibit MAID. Hooker unsuccessfully sought review directly from Supreme Court of Tennessee.[221] Hooker then voluntarily dismissed the appeal before a ruling from the intermediate appellate court.[222]

4. Donorovich-O'Donnell v. Harris *(Cal. App. 2015)*

Before California enacted the End of Life Options Act in October 2015, two separate sets of plaintiffs filed separate lawsuits seeking to establish a state constitutional right to MAID. In May 2015, Christy Lynne Donorovich-O'Donnell with other terminally ill patients and a physician filed in San Diego Superior Court.[223] In July 2015, the court sustained the defendants' demurrers, holding that no state constitutional right to privacy, free speech, or equal protection extended to MAID.[224]

By the time the California Court of Appeal issued its opinion, the legislature had already enacted the End of Life Options Act. Yet, that did not moot the case because the law was not yet in effect.[225] In October 2015, the Court of Appeal affirmed the Superior Court.[226] The California Supreme Court declined to hear the case.[227]

The plaintiffs in *Donorovich-Odonnell* argued that, as applied to competent, terminally ill persons seeking lethal medication to end their lives, the application of the criminal assisted suicide law to MAID deprived citizens of "autonomy privacy."[228] The California Constitution's explicit grant of a right to privacy could indeed protect more than the federal Constitution does, but the court in refused to so hold because the plaintiffs had not "parse[d] out why the reasoning of *Glucksberg* or *Vacco* is ostensibly inapplicable."[229] It also cited *Donaldson* as holding that the state

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219. *Id.* at 307 (emphasis in original).

220. *See* Hooker v. Slatery, No. 15061511 (Davidson Cty. Ch. Ct., Tenn. Sept. 29, 2015).

221. *See* Hooker v. Slatery, No. M2015-01982-SC-RDM-CV (Tenn. Nov. 9, 2015).

222. *See* Hooker v. Slatery, No. M2015-01982-COA-R3-CV (Tenn. Ct. App. May 20, 2016).

223. *See* Complaint at 1, Donorovich-O'Donnell v. Harris, No. 37-2015-00016404-CU-CR-CTL (San Diego Sup. Ct. May 15, 2015).

224. *See* Ruling on Demurrer, Donorovich-O'Donnell v. Harris, No. 37-2015-00016404-CU-CR-CTL (San Diego Sup. Ct. July 24, 2015).

225. In addition, it is worth ruling on the constitutionality of MAID, because the California End of Life Options Act is scheduled to sunset in 2026.

226. *See* Donorovich-O'Donnell v. Harris, 194 Cal. Rptr. 3d 579, 582 (Ct. App. Oct 29, 2015).

227. *Donorovich-Odonnell v. Harris*, No. S230918, 2016 Cal. LEXIS 646 (Feb. 3, 2016).

228. *See Donorovich-O'Donnell*, 194 Cal. Rptr. 3d at 590.

229. *Id.* at 594.

constitution could not shield a third person from criminal liability for assisting a person in committing suicide.[230]

In sum, the court ruled that the plaintiff's asserted right to obtain "assistance of a third party in committing suicide" was not fundamental. Even if it were, the state had compelling interests in enforcing its statutory prohibition of suicide assistance in cases of MAID. Specifically, the state has an interest in ensuring that people are not influenced to kill themselves, and interests in preserving life, maintaining the ethics of the medical profession, protecting vulnerable groups, and guarding against a slippery slope toward involuntary euthanasia.

Overridingly, however, the court opined that the matter was one for the legislature rather than the courts. In doing so, it focused on the legislative imposition of many safeguards on the process of MAID in California's End of Life Options Act. "If the law were changed by judicial opinion, these extensive safeguards would not be in place."[231]

5. Brody v. Harris *(San Francisco Sup. Ct. 2016)*

In February 2015, another set of California plaintiffs filed in San Francisco Superior Court. They also made state constitutional claims. In February 2016, the court sustained the defendants' demurrers.[232] The trial court ruled that the right to privacy did not include MAID.[233] It also ruled that disallowing MAID did not violate equal protection.[234] Moreover, the court observed that the legislature had recently acted. The plaintiffs appealed but later voluntarily dismissed.[235]

D. Ongoing Litigation in 2018

While plaintiffs have been unable to establish a state constitutional right to MAID in any jurisdiction, they keep trying. There are two active cases: one in Hawaii and one in Massachusetts.

1. Radcliffe v. Hawaii *(1st Cir. Ct., Haw. 2016)*

In January 2017, John Radcliffe filed a lawsuit seeking declaratory and injunctive relief. But in July 2017, the trial court refused to address the merits of Radcliffe's challenge to the Hawaii assisted suicide statute, deferring the questions to the political branches of government.[236] First, the court held that plaintiffs cannot challenge a criminal statute through declaratory judgment. Second, the court held that it would not interfere with the state medical board and declare that MAID was

230. *See id.* at 592–93 (citing Donaldson v. Lungren, 4 Cal. Rptr. 2d 59 (Ct. App. 1992)).

231. *Id.* at 595.

232. Order Sustaining Demurrers at *4–5, Brody v. Harris, 2016 Cal. Super. LEXIS 1564 (No. CGC-15-544086) (San Francisco Sup. Ct. Feb. 16, 2016).

233. *See id.* at 3 (citing *Donorovich-O'Donnell*, 194 Cal. Rptr. 3d 579 and *Donaldson*, 4 Cal. Rptr. 2d 59).

234. *See id.* at 3–4 (citing Vacco v. Quill, 521 U.S. 793 (1997)).

235. Brody v. Harris, No. A148572 (Cal. Ct. App. Oct. 14, 2016).

236. Radcliffe v. Hawai'i, No. 17-1-0053-1-KKH, slip op. at 12–13 (1st Cir., Haw. July 14, 2017).

legitimate medical practice. Third, the court refused to issue an injunction, because the statute was presumed valid. The case is now on appeal.[237]

2. Kligler v. Healy *(Suffolk County Sup. Ct., Mass. 2017)*

In October 2016, two physicians filed a lawsuit in Suffolk County, Massachusetts court seeking a declaration that the state attorney general and a district attorney could not prosecute them for engaging in MAID.[238] One of the plaintiff physicians was terminally ill and seeking the option, while the other was willing to write the prescription if he would not be criminally punished for doing so. The plaintiffs asserted that the state's prohibition of MAID violated the Massachusetts constitution. Specifically, the plaintiffs alleged that MAID was protected by the state constitutional rights to privacy, liberty, free speech, and equal protection.

In May 2017, the trial court denied the defendants' motions to dismiss.[239] The court ruled that the case could proceed in the face of arguments that the court lacked jurisdiction over it and that the court should dismiss it either because any judicial decision would not completely resolve the dispute or because the matter of MAID is best left to the legislature. The court noted several times that it was not opining on the merits of the case, merely ruling that it had jurisdiction and would retain the case on the docket.

VII. LEGALIZING MAID THROUGH STATUTORY LITIGATION

In addition to making claims under the U.S. Constitution and under state constitutions, advocates have also brought statutory interpretation claims. They argue that MAID is not encompassed within the criminal prohibition of "assisted suicide." Advocates maintain that MAID and assisted suicide are such different acts that the prohibition of one does not entail the prohibition of the other.

The argument maintains that the choice of a competent dying patient for a peaceful death through MAID is not "suicide." MAID involves the rational choice of a competent, terminally ill patient who finds herself trapped in an unbearable dying process to precipitate death in order to avoid further suffering and preserve her personal dignity. Suicide, by contrast, is a person's choice to prematurely cut short a viable life, usually for reasons of a transient nature and often involving depression or other mental health impairments, recovery from which may be possible with counseling, support, and/or medication. Because MAID is not suicide, it is not covered by the assisted suicide statutes.

Indeed, a growing consensus of medical, mental health and health policy professionals recognize that the choice of a dying patient for a peaceful death through aid in dying is not "suicide." For example, the American Psychological Association

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237. *See* Radcliffe v. State, No. CAAP-17-000594, ECOURT KŌKUA, http://www.courts.state.hi.us/legal_references/records/jims_system_availability (follow "Click Here to Enter eCourt* Kokua"; then follow "Search for case details by case ID or citation number," and search with case ID: "CAAP-17-0000594") (last visited Jan. 31, 2018).

238. *See* Kligler v. Healy, 34 Mass. L. Rptr. 239 (Super. Ct. 2017). *See generally* Roger Kligler, *The Death I Want,* BOS. MAG. (Jan. 15, 2017, 6:05 am), http://www.bostonmagazine.com/health/2017/01/15/the-death-i-want-roger-kligler/.

239. *See id.*

recognizes that "the reasoning on which a terminally ill person (whose judgments are not impaired by mental disorders) bases a decision to end his or her life is fundamentally different from the reasoning a clinically depressed person uses to justify suicide."[240] Even more recently, the American Association of Suicidology concluded that "suicide and physician aid in dying are conceptually, medically, and legally different phenomena."[241]

Yet, despite the semantic and logical cogency of the argument differentiating "suicide" and "MAID," no court has ever accepted it. On the other hand, the Supreme Court of Montana did accept a statutory interpretation argument based on the unique consent defense in its statute.

A. *Baxter v. Montana* (Mont. 2009)

As discussed above, the Montana trial court in Baxter found a state constitutional right to MAID.[242] The Montana Supreme Court neither affirmed nor reversed that holding, but vacated it. Because the court found a statutory ground for MAID, it did not need to reach the constitutional issue. The Montana Supreme Court ruled that physicians may legally assist competent, terminally ill patients in dying by writing prescriptions for lethal medications at their request.[243]

Suicide is not a crime in Montana, and aiding or soliciting a suicide is only a crime if the victim does not die. Instead, the crime that applies to aiding or soliciting a successful suicide is homicide.[244] Yet, the Montana legislature provides that consent is generally a defense to criminal charges, except in four enumerated situations.

The issue for the Montana Supreme Court was whether the consent that a competent, terminally ill patient would be giving for MAID was against public policy.[245] The court ruled that it was not, in part based on statutory interpretation and in part based on the "legislative respect for the wishes of a patient facing incurable illness" that appeared throughout Montana's statutes authorizing withholding and withdrawal of treatment.[246] Significantly, the Montana Supreme Court noted: "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 [the Montana statutes], it would be incongruous to conclude that a physician's indirect aid in dying is contrary to public policy."[247]

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240. *Patients' Rights to Self-Determination at the End of Life*, AM. PSYCHOL. ASS'N (Oct. 28 2008), https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/29/13/28/patients-rights-to-self-determination-at-the-end-of-life.

241. AM. ASS'N OF SUICIDOLOGY, STATEMENT OF THE AMERICAN ASSOCIATION OF SUICIDOLOGY: "SUICIDE" IS NOT THE SAME AS "PHYSICIAN AID IN DYING" 4 (2017), http://www.suicidology.org/Portals/14/docs/Press%20Release/AAS%20PAD%20Statement%20Approved%2010.30.17%20ed%2010-30-17.pdf.

242. *See supra* Section VI.B.

243. *See* Baxter v. State, 2009 MT 449, ¶ 50, 224 P.3d 1211 (2009).

244. *See id.* ¶ 11.

245. *See id.* ¶ 13 ("Consent is ineffective if: . . . it is against public policy to permit the conduct or the resulting harm, even though consented to.") (quoting MONT. CODE ANN. § 45-2-211(2)).

246. *Id.* ¶ 38.

247. *Id.*

Unlike the six states that enacted MAID statutes, Montana has no legal requirements concerning eligibility criteria or request and prescription procedures. Consequently, the practice of MAID in Montana is presumably governed by the professional standard of care and regulatory process.[248]

B. *Blick v. Connecticut* (Hartford Jud. Dist., Conn. 2010)

In October 2009, Gary Blick brought a lawsuit seeking a declaratory judgment that the Connecticut assisted suicide statute did not cover MAID. The court rejected the argument, observing that the statute's application to MAID is amply demonstrated by multiple legislative attempts to amend the assisted suicide law to permit MAID.[249] The court declined to usurp a legislative function. Furthermore, because the attorney general would not exceed its authority by prosecuting MAID, the lawsuit was barred by sovereign immunity.[250]

C. Other Cases

Almost every recent case asserting state constitutional claims has also made statutory interpretation claims.[251] Yet, not a single court has accepted the statutory interpretation argument. As in *Blick*, every court agreed that MAID was encompassed within the state's prohibition of suicide assistance, as a matter of statutory interpretation.

For example, in *Morris*, the New Mexico Supreme Court found that MAID constitutes "deliberately aiding another in the taking of his own life," and thus constitutes suicide assistance under the statute.[252] The court found "compelling" evidence indicating that medical and psychological professionals do not consider MAID to be suicide and that the deaths in cases of MAID are considered to result from the underlying disease, not the taking of the medication. Nevertheless, the legislature had explicitly distinguished "assisted suicide" from withholding and withdrawal elsewhere in New Mexico's statutory scheme. The court held that the practice came within the statutory definition of suicide assistance.[253]

VIII. OTHER MEANS OF LEGALIZING MAID

While only a statute or appellate judgment provides patients and clinicians with clear sufficient ex ante permission to engage in MAID, there are two other means of "legalizing" the practice. First, lawmakers can limit prosecutorial discretion, thus making it unlikely that MAID participants will be arrested or

248. *Cf.* Kathryn L. Tucker, *Aid in Dying*, 142 CHEST. 218, 220 (2012) (noting that MAID is protected in Montana and that "absent a prohibition, the practice . . . can proceed subject to the best practices and an emerging standard of care").

249. *See* Blick v. Office of the Div. of Criminal Justice, No. CV095033392, 2010 Conn. Super. LEXIS 1412, at *21 (2010).

250. *See id.* at *42.

251. *See supra* Sections VI.A & VI.C (including *Morris, Myers, O'Donnell,* and *Brody*).

252. Morris v. Brandenburg, 2016-NMSC-027, ¶ 15, 376 P.3d 836 (2016) (quoting N.M. STAT. ANN. § 30-2-4).

253. *See id.*

prosecuted. Second, even if MAID participants are prosecuted, juries can refuse to convict.

A. Prosecutorial Discretion

The eminent Canadian health law scholar Jocelyn Downie observes that "guidelines for how prosecutorial discretion should be exercised . . . may also be a pathway to a more permissive legal regime."[254] Prosecutors already exercise significant discretion as to which cases to pursue.[255] Downie argues that while MAID would remain illegal, prosecutors could publish guidelines indicating the factors and circumstances under which they would prosecute.

There is substantial track record for this approach outside the United States. For example, before affirmative legalization in 2002, MAID was tolerated for decades in the Netherlands.[256] In Switzerland, MAID is widely practiced, yet still not affirmatively regulated.[257] In the UK, MAID is clearly prohibited by the Suicide Act of 1961.[258] Nevertheless, in 2010, the Crown Prosecution Service introduced guidelines.[259] At least one U.S. jurisdiction has taken a similar approach.[260]

Surprisingly, physicians provide MAID with significant frequency even in those jurisdictions where it remains illegal. Still, there have been few prosecutions. The paucity of reported legal cases is probably attributable primarily to the failure by law enforcement authorities to detect their occurrence. Yet, even when these cases "come to the attention of the authorities, by dint of pervasive discretion in the criminal justice system," prosecutors do not bring indictments.[261] If prosecutors

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254. Jocelyn Downie, *Permitting Voluntary Euthanasia and Assisted Suicide: Law Reform Pathways for Common Law Jurisdictions,* 16 QUT L. REV. 84, 91 (2016); *see also* Ben White & Jocelyn Downie, *Prosecutorial Guidelines for Voluntary Euthanasia and Assisted Suicide: Autonomy, Public Confidence and High Quality Decision-Making,* 36 MELB. U. L. REV. 656 (2012).

255. *See generally* ANGELA J. DAVIS, ARBITRARY JUSTICE (2007).

256. *See* Agnes van der Heide et al., *End-of-Life Decisions in the Netherlands over 25 Years*, 377 NEW ENG. J. MED. 492 (2017).

257. *See* Samia A. Hurst & Alex Mauron, *Assisted Suicide in Switzerland: Clarifying Liberties and Claims*, 31 BIOETHICS 199, 199 (2017).

258. *See* R (*In re* Purdy) v. Dir. of Pub. Prosecutions [2009] UKHL 45, [2010] 1 AC (HL) 345 (appeal taken from Eng.).

259. THE DIR. OF PUB. PROSECUTIONS, POLICY FOR PROSECUTORS IN RESPECT OF CASES OF ENCOURAGING OR ASSISTING SUICIDE (2010); *see also* R (Nicklinson) v. Ministry of Justice [2013] EWCA (Civ) 961, [2015] AC 657 (Eng.) (involving prosecution after the guidelines were created), *rev'd*, [2014] UKSC 38; Alexandra Mullock, *Compromising on Assisted Suicide: is 'Turning a Blind Eye' Ethical?,* 7 CLINICAL ETHICS 17 (2012) (discussing the effects of the guidelines); *Assisted Suicide*, CROWN PROSECUTION SERV. (Jan. 31, 2018), https://www.cps.gov.uk/publication/assisted-suicide (providing the latest assisted suicide figures).

260. *See Bisbee Taking a Stance on Assisted Suicide*, KVOA.COM (Sept. 4, 2015), http://www.kvoa.com/story/29964343/bisbee-taking-a-stance-on-assisted-suicide (reporting a city council resolution asking the Cochise County Attorney to "deprioritize" prosecuting anyone involved in MAID).

261. *See* THE RIGHT TO DIE, *supra* note 21, § 12.04[D]; *see also* Kenneth A. De Ville, *Physician Assisted Suicide and the States: Short, Medium, and Long Term*, *in* PHYSICIAN ASSISTED SUICIDE: WHAT ARE THE ISSUES? 171, 173–75 (Loretta M. Kopelman & Kenneth A. De Ville eds., 2001). For example, Dr. Rodney Syme was never prosecuted after admitting to assisting the suicide of Steve Guest. *See* Jeff Turnbull, *'Benign Conspiracy' over a Death*, SYDNEY MORNING HERALD (April 21, 2009),

provide ex ante guidance in when they will bring charges, then patients and physicians might have sufficient comfort and clarity to engage in MAID despite its illegality.

B. Jury Nullification

Closely related to prosecutorial discretion is jury nullification. Just as prosecutors can decline to prosecute illegal activity, jurors can decline to convict when there is prosecution. Even when evidence of factual guilt is clear, and the jury believes beyond a reasonable doubt that the defendant engaged in MAID, the jury can still vote the defendant "not guilty."[262] Juries can and do refuse to convict when they think the underlying law is unjust.

Jury nullification is common in MAID cases.[263] For example, Tim Quill wrote in the New England Journal of Medicine that he participated in MAID.[264] This was a very public confession. And MAID is criminally prohibited in New York.[265] Nevertheless, a Rochester grand jury refused to indict Dr. Quill.[266] Similarly, Michigan juries repeatedly refused to convict Jack Kevorkian despite his clear violation of laws in that state.[267] In short, while not the same as decriminalization, jury nullification, like prosecutorial discretion, could help pave a pathway to MAID.[268]

IX. CONCLUSION

The legalization is MAID in the United States is a train that has left the station. It will eventually reach most of the other forty-nine U.S. jurisdictions where it is not yet legal. Yet, policymakers must then grapple with next-generation issues such as the appropriate eligibility criteria and process requirements. The safeguards built into the existing six statutes may unduly restrict access to MAID.[269]

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http://www.smh.com.au//breaking-news-national/benign-conspiracy-over-assisted-death-20090421-adie.html.

262. *See* Morissette v. United States, 342 U.S. 246, 276 (1952) ("[J]uries are not bound by what seems inescapable logic to judges."). *See generally* JEFFREY ABRAMSON, WE, THE JURY 57–97 (1994); CLAY S. CONRAD, JURY NULLIFICATION (Cato Inst. Press 2014).

263. *See generally* Liana C Peter-Hagene & Bette L Bottoms, *Attitudes, Anger, and Nullification Instructions Influence Jurors' Verdicts in Euthanasia Cases*, 23 PSYCHOL., CRIME & L. 983 (2017) (researching the potential for nullification due to MAID attitudes).

264. *See* De Ville, *supra* note 261, at 173.

265. *See* Myers v. Schneiderman, 85 N.E.3d 57 (N.Y. Ct. App. 2017).

266. *See* Lawrence K. Altman, *Jury Declines to Indict a Doctor Who Said He Aided in a Suicide*, N.Y. TIMES (July 27, 1991), http://www.nytimes.com/1991/07/27/nyregion/jury-declines-to-indict-a-doctor-who-said-he-aided-in-a-suicide.html.

267. Michigan juries repeatedly acquitted Jack Kevorkian, in trials over the suicide of: Thomas Hyde (May 1994), Ali Khalil and Merian Frederick (March 1996), and Sherry Miller and Marjorie Wantz (May 1996). *See* NEAL NICOL & HARRY WYLIE, BETWEEN THE DYING AND THE DEAD 185–187 (Univ. of Wis. 2006) (2006). Only when Kevorkian moved from assisted suicide to active euthanasia was he convicted of second degree murder in the killing of Thomas Youk. *See Jail Time for Dr. Kevorkian,* N.Y. TIMES (April 15, 1999), http://www.nytimes.com/1999/04/15/opinion/jail-time-for-dr-kevorkian.html.

268. In addition, even when there are convictions, the sentences are often very light.

269. *See* Pope, *supra* note 20.