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Physician-Assisted Death, Dementia, and Euthanasia: Using an Advanced Directive to Facilitate the Desires of Those with Impending Memory Loss

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PHYSICIAN-ASSISTED DEATH, DEMENTIA, AND EUTHANASIA: USING AN ADVANCED DIRECTIVE TO FACILITATE THE DESIRES OF THOSE WITH IMPENDING MEMORY LOSS

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I. INTRODUCTION

If you don't have liberty and self-determination, you [have] nothing. That's what this country's built on and [it] is the ultimate self-determination to determine when and how you're gonna die when you're suffering.¹

Conversations about death are not commonplace in today's world. The topic is considered taboo by many.² For whatever reason, it is a discussion that many want to avoid.³ This unhealthy view on death often results in individuals not implementing a plan for their eventual demise.⁴ Without proper planning for end-of-life decisions, many have taken matters into their own hands.⁵ Health-related elder

1. *People v. Kevorkian*, 639 N.W.2d 291, 300 (Mich. Ct. App. 2001) (quoting a statement Dr. Jack Kevorkian made during a “60 Minutes” interview).

2. See Beverly Lytton, *Majority of Americans Avoid Addressing End-of-Life Issues, According to New Study*, EUREKALERT (Dec. 10, 2013), http://www.eurekalert.org/pub_releases/2013-12/ehs-moa120413.php; see also Peter Saul, *Let's Talk About Dying*, TEDED (Jun. 9, 2013), <http://ed.ted.com/lessons/let-s-talk-about-dying-peter-saul#review>.

3. Lytton, *supra* note 2.

4. *Id.*

5. DEREK HUMPHRY, FINAL EXIT: THE PRACTICALITIES OF SELF-DELIVERANCE AND ASSISTED SUICIDE FOR THE DYING XXVI (3d ed. 2002).

suicide is an epidemic and considerable sympathy has been given to mercy killers.⁶ Peculiar as it may be, there has even been a “how-to” guide for those that wish to take their own life because of their failing health.⁷ The book, *Final Exit*, is written by Derek Humphry—an active leader in the right-to-die movement and the founder of The Hemlock Society.⁸ *Final Exit* gives the reader a framework of what to do in the event that he or she would like to take his or her own life.⁹ Mr. Humphry provides protective steps that should be taken in the event that someone decides to take their own life.¹⁰ The book also gives the reader a variety of options to carry out their plan, and explains the advantages and disadvantages of each one.¹¹ Mr. Humphry believes that the freedom to die is “the ultimate civil liberty.”¹² Further, he posited the question: “If we cannot go to our deaths in the manner of our own choosing, what liberty do we have?”¹³

That is precisely what this comment is about: the liberty to choose *how* and *when* to end your own life. Specifically, this article is about the liberty to choose how to end your own life in advance of impending cognitive loss. This comment explores the treatment options currently available to those diagnosed with dementia (essentially, palliative care) and finds the current treatment options insufficient for most of those that are suffering. Next, this article examines physician-assisted death, and specifically details which states have legalized it and the conditions of that legalization.

Part III of this comment discusses the history of physician-assisted death (PAD) in the United States. This section focuses largely on the legacy of Dr. Jack Kevorkian and the well-known United States Supreme Court case of *Cruzan v. Missouri Department of Health*,¹⁴ which recognized a right to terminate life-sustaining treatment. Part III also considers the United States Supreme Court cases of *Washington v. Glucksburg*¹⁵ and *Vacco v. Quill*,¹⁶ and their effect on the right the Court recognized in *Cruzan* to terminate life-sustaining treatment. Part IV gives a brief description of some of the shortfalls of the rights recognized by the Supreme Court and the statutes adopted in the states that permit physician-assisted death.

Part V explores the possibility of physician-assisted death for those diagnosed with dementia and addresses the legal, philosophical, and social issues regarding this idea. This comment concludes with a proposed solution to this dilemma. This solution combines guardianship with an advanced directive for healthcare to, essentially, delegate the end-of-life decision to a trusted friend or relative.

6. *Id.* Mercy killing occurs when “desperate people . . . unilaterally kill their loved ones in the belief that it is the only compassionate thing to do.” *Id.*

7. *See generally id.*

8. *Id.*

9. *Id.*

10. *Id.* (Mr. Humphry suggests that individuals contemplating self-deliverance should, in addition to other things, tell their close family and friends, seek counseling, and write letters to loved ones explaining the decision.)

11. *See generally* HUMPHRY, *supra* note 5.

12. *Legalizing Euthanasia: Medical Perspectives on Death and Dying*, SANTA CLARA UNIV., <https://www.scu.edu/ethics/publications/ie/v4n2/euthanasia.html> (last visited Feb. 10, 2015).

13. *Id.*

14. *Cruzan v. Dir., Missouri Dep’t of Health*, 497 U.S. 261 (1990).

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

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

Because we already allow guardians to assume the responsibilities and decision-making (including decisions affecting end-of-life) for those without the capacity to do so, I see no reason as to why this decision-making authority can't extend to other end-of-life decisions, *as long as* there is an advanced directive stating the wishes of the now-demented. Currently, a person can legally delegate all of his decision-making power to a surrogate to make decisions for him if he is ever unable to make decisions for himself. This is evidenced by legal guardianship, do-not-resuscitate orders, powers of attorney, and healthcare directives. If a person expresses his desire to end his life at a certain point when he is unable to legally make that decision for himself because of lack of capacity, he should have the option to set a plan for what is to happen to him when he reaches that point. It seems that this decision is best left to a trusted friend or relative because this threshold is an extremely difficult one to determine—but, it is not an impossible threshold to determine, and delegating this decision to someone you trust is the best option.

II. THE STRUGGLE OF DEMENTIA

If someone were to ask you to imagine your death, how would you picture it? Are you surrounded by loved ones? Are you home or in another comfortable place? Are you doing something you love? Whatever it is that you are imagining, I am certain that it does not involve intense pain and suffering, a loss of self-control, or a loss of dignity. Unfortunately, that is exactly how many lives end in the United States and abroad every year. An appalling number of people die every year from painful, debilitating illnesses.

Alzheimer's disease (#6) is among the top ten causes of death in the United States according to a 2011 report.¹⁷ Interestingly, this disease is not included in the top ten causes of death worldwide.¹⁸ One may speculate that the reason for this discrepancy could be the exceptional medical care and technology in the United States, which allows people to live longer than in many other countries.¹⁹

Over time, Alzheimer's disease destroys a person's memory and other brain functions.²⁰ Alzheimer's is the most common type of dementia.²¹ Dementia is a disease that encompasses several brain disorders that all impair a person's intellectual and social skills.²² Alzheimer's causes brain cells to decay and eventually die,

17. Donna L. Hoyert & Jiaquan Xu, *Deaths: Preliminary Data for 2011*, 61 NAT'L VITAL STAT. REP. 1, 3–4 (Oct. 10, 2012), available at http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_06.pdf (the other causes of death on this list included: heart disease, malignant neoplasms, respiratory diseases, cerebrovascular diseases, accidents, diabetes, influenza & pneumonia, nephritis, and suicide).

18. *The Top 10 Causes of Death*, WORLD HEALTH ORG. (May 2014), <http://www.who.int/mediacentre/factsheets/fs310/en/> (included in the top ten are: heart disease, stroke, respiratory infection, pulmonary disease, diarrheal diseases, HIV/AIDS, trachea bronchus, diabetes, road injury, and prematurity).

19. For a list of the average life expectancy rates in various countries, see *The World Factbook*, CENTRAL INTELLIGENCE AGENCY, <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2102rank.html> (last visited Feb. 10, 2015) (The United States is listed as number 42 highest average life expectancy out of 223).

20. *Diseases and Conditions: Alzheimer's Disease*, MAYO CLINIC (Jun. 17, 2014), <http://www.mayoclinic.org/diseases-conditions/alzheimers-disease/basics/definition/CON-20023871>.

21. *Id.*

22. *Id.*

interfering with a person's daily life.²³ The late stages of Alzheimer's can last as few as several weeks or as long as several years.²⁴ "[A]round-the-clock assistance" is usually required during the late stages of Alzheimer's and the care generally focuses on "preserving quality of life and dignity and treating the person with compassion and respect."²⁵ A person in the late stages of Alzheimer's disease usually "[h]as difficulty eating and swallowing, [n]eeds assistance walking and eventually becomes bed-ridden or chair-bound, [n]eeds full time help with personal care, including toileting, [i]s vulnerable to infections and pneumonia, [and] [l]oses the ability to communicate with words."²⁶ Currently, there is no cure for Alzheimer's disease, and the only treatment option is palliative care.²⁷

A. The Palliative Care Option

Palliative care is, essentially, "end-of-life" treatment that focuses on improving the quality of life and providing comfort to those with serious and life-threatening illnesses.²⁸ Palliative care is used to treat individuals who have been diagnosed with cancer, AIDS, kidney failure, etc.; plainly, it is used for a very wide spectrum of illnesses.²⁹ There are several benefits of palliative care, which can include pain management, integration of the psychological aspect of patient care, development of meaningful relationships, preservation of personal integrity, a sense of control, a sense of dignity, and a sense of autonomy.³⁰

However, there are also several negative aspects of palliative care, particularly for the terminally ill and their families. It can reduce the hope of recovery, diminish savings, and require considerable commitment from family members.³¹ Indeed, palliative care can reduce the hope for recovery because the "focus is on relieving symptoms, not in curing the disease."³² Additionally, the costs of palliative care can be considerable,³³ and insurance companies may be unwilling to help pay these costs so families often have to pay out-of-pocket.³⁴ These costs can be extensive as to drain any inheritance that the patient had planned on distributing.³⁵ A recent study found that the annual cost for a patient with dementia ranges between

23. *Id.*

24. *Late Stage Care*, ALZ.ORG, http://www.alz.org/nyc/in_my_community_17737.asp (last visited Mar. 25, 2015).

25. *Id.*

26. *Id.*

27. *Alzheimer's Disease Health Center*, WEBMD, <http://www.webmd.com/alzheimers/guide/alzheimers-disease-treatment-care> (last visited Feb. 20, 2015).

28. Katherine Kam, *What is Palliative Care?*, WEBMD, <http://www.webmd.com/palliative-care/what-is-palliative-care> (last visited Feb. 20, 2015).

29. *Id.*

30. *See Benefits of Palliative Care*, PALLIATIVE DOCTORS, <http://www.palliativedoctors.org/benefits/index.html> (last visited Feb. 10, 2015); *see also What Are the Pros and Cons of Palliative Care for Cancer?*, WISEGEEK, <http://www.wisegeek.com/what-are-the-pros-and-cons-of-palliative-care-for-cancer.htm> (last visited Feb. 20, 2015) [hereinafter *Pros and Cons*].

31. *Pros and Cons*, *supra* note 30.

32. *Id.*

33. *Id.*

34. *Id.*

35. *Id.*

\$41,000 and \$56,000.³⁶ It is estimated that these costs will more than double by 2040 because of the increase in population.³⁷ Because of the longevity of dementia, one can easily imagine how quickly a life savings can be spent at this rate.

Palliative care is an excellent option for some, but it is certainly not optimal for everyone. The extensive advances in modern healthcare technology and medicine have made it possible to “indiscriminately maintain[] . . . some of the vital functions of the body, but the same technology does not necessarily allow us to heal underlying disease processes.”³⁸ An inadvertent byproduct of these advances in technology has been the ability of doctors and hospitals to preserve the lives of patients in a state of “suspended animation” for extended, and sometimes indefinite, time periods.³⁹ These patients are physically alive because they are supplied with the necessary nutrition, hydration, and ventilation, but they are not alive in the sense that they are able to enjoy life.⁴⁰

In other words, the advances in modern technology have led to a sort of “delayed death” (often under the guise of “pain management”) without treating or curing the actual illness itself. Not everyone wants to delay the inevitable. In fact, some want to hasten it. The primary purpose of palliative care is “pain management”; however, the management of pain in terminally ill patients often leads to over-medication in an attempt to alleviate the patient’s chronic pain. Over-medication can lead to living in a sort-of “haze,” which some would argue is no quality of life at all. But what other options are there for the terminally ill?

B. Physician-Assisted Death

Physician-assisted death (sometimes known as physician-assisted suicide) is an option for the terminally ill in some states,⁴¹ but several states actually criminalize the act.⁴² Physician-assisted suicide and physician-assisted death have essentially the same meaning, explained in detail below.⁴³ Over the years, there has been an abundance of misleading and often confusing information presented to the public (usually through the media) regarding physician-assisted death.⁴⁴ All too often, the

36. Michael D. Hurd et al., *Monetary Costs of Dementia in the United States*, 368 NEW ENG. J. MED. 1326, 1342 (2013), available at <http://www.nejm.org/doi/full/10.1056/NEJMsa1204629#t=article>.

37. *Id.*

38. David Crippen, *Medical Treatment for the Terminally Ill: The ‘Risk of Unacceptable Badness,’* 9 CRIT. CARE 317, 317 (May 10, 2005) available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1269444/>.

39. *Id.*

40. *Id.*

41. See, e.g., OR. REV. STAT. § 127.815 (2014).

42. See, e.g., IDAHO CODE ANN. § 18-4017 (2014). Idaho is one of twenty-five states that make assisted death a felony. *State-by-State Guide to Physician-Assisted Suicide*, PROCON.ORG, <http://euthanasia.procon.org/view.resource.php?resourceID=000132> (last visited Feb. 20, 2015) [hereinafter *State-by-State Guide*]. Additionally, nine states that criminalize physician-assisted death describe it as manslaughter. *Id.*

43. There are several additional terms used to describe this concept, including “physician aid-in-dying” and “death with dignity.” Physician-assisted suicide was the term that was popularized in the 1990s by Dr. Jack Kevorkian, but the more diplomatic terms used today are physician-assisted death, physician aid-in-dying, death with dignity, etc.

44. See e.g., Regan Brown, *My Turn by Reagan Brown: Assisted Suicide is Murder*, SALISBURY POST (Jan. 26, 2015, 12:00 AM), available at <http://www.salisburypost.com/2015/01/26/assisted-suicide-is-murder/>.

terms “physician-assisted suicide/death” and “euthanasia” have been used interchangeably, but there is a very important distinction between these two concepts.⁴⁵

“Assisted suicide” is defined as “[t]he intentional act of providing a person with the medical means or the medical knowledge to commit suicide.”⁴⁶ Further, the definition provides that “physician-assisted suicide” occurs “when a *doctor* provides the means.”⁴⁷ Contrarily, “euthanasia” is defined as “[t]he act or practice of causing or hastening the death of a person who suffers from an incurable or terminal disease or condition, esp[ecially] a painful one, for reasons of mercy.”⁴⁸ Euthanasia is divided into two sub-categories. “Active euthanasia” is defined as “euthanasia performed by a facilitator (such as a healthcare practitioner) who not only provides the means of death but also carries out the final death-causing act.”⁴⁹ “Passive euthanasia” is “[t]he act of allowing a terminally ill person to die by either withholding or withdrawing life-sustaining support such as a respirator or feeding tube.”⁵⁰

In other words, the essential difference between euthanasia and physician-assisted death is the *act* that causes the death. In assisted death, the actual death is *caused by* the patient. In euthanasia, the death is *caused by* another party, usually a physician. Currently, active euthanasia is illegal in every state in the United States.⁵¹ Euthanasia is legal in only a few countries: Belgium, Luxembourg, and the Netherlands.⁵²

i. Legalization

Physician-assisted death is illegal in most states; in fact, it is a felony in Idaho.⁵³ Currently, there are only three⁵⁴ states in the U.S. that statutorily permit physician-assisted death: Oregon, Vermont, and Washington.⁵⁵ Oregon’s Death with Dignity Act (DWDA) was the first of its kind in the United States and faced several

45. Rita L. Marker, *Euthanasia, Assisted Suicide & Health Care Decisions: Protecting Yourself & Your Family*, PATIENTS RIGHTS COUNCIL, <http://www.patientsrightsCouncil.org/site/euthanasia-assisted-suicide-health-care-decisions/> (last visited March 17, 2015).

46. BLACK’S LAW DICTIONARY 1571 (9th ed. 2009).

47. *Id.* (emphasis added).

48. *Id.* at 634.

49. *Id.*

50. *Id.* Euthanasia is further divided into voluntary, involuntary, and nonvoluntary. *Id.* Voluntary is “[e]uthanasia performed with the terminally ill person’s consent.” *Id.* Involuntary is “[e]uthanasia of a competent, nonconsenting, person.” Nonvoluntary is “[e]uthanasia of an incompetent, and therefore non-consenting, person.” *Id.*

51. *State-by-State Guide*, *supra* note 42.

52. *International Perspectives: Legal Status of Euthanasia and Assisted Suicide*, PROCON.ORG, <http://euthanasia.procon.org/view.resource.php?resourceID=000136> (last visited March 27, 2015).

53. IDAHO CODE ANN. § 18-4017 (2011) (Idaho makes it a felony for any person to assist another person in committing suicide, and anyone found guilty under this statute will be sentenced to not more than five years in prison. Additionally, if a health care professional is found guilty under this statute, the health care professional may have his or her license revoked by the licensing authority).

54. *See Death with Dignity Around the U.S.*, DEATH WITH DIGNITY NAT’L CTR. (last updated Feb. 11, 2015), available at <http://www.deathwithdignity.org/advocates/national> (providing the most updated information on current DWDA pending across the nation).

55. Oregon Death with Dignity Act § 127.800–995 (West 2014); Vermont Protection of Patient Choice at the End of Life Act tit. 18, § 5281–92 (West 2013); Washington Death with Dignity Act § 70.245.010–904 (West 2014).

of its own challenges.⁵⁶ The law was approved by Oregon voters in 1994 in a general election.⁵⁷ But implementation of DWDA was delayed by a legal injunction until 1997 when Oregon voters reaffirmed their support for the law.⁵⁸ The law was challenged several times throughout the following ten years but all of the challenges have been futile.⁵⁹

Oregon's DWDA provides for aid-in-dying to Oregon residents who are "terminally ill" and have the capacity to make a voluntary, written request for medication to end his or her life.⁶⁰ To be "terminally ill," a patient must have "an incurable and irreversible disease that has been medically confirmed and will, within a reasonable medical judgment, produce death within six months."⁶¹ The patient must make an informed decision, which means that the patient must be informed of his or her medical diagnosis and prognosis, the potential risks of the prescribed medication, the likely result of taking the prescribed medication, and the feasible alternatives, including but not limited to, comfort care, hospice care, and pain control.⁶² Additional requirements for the patient include: (1) getting a second opinion from another physician who confirms the diagnosis; (2) the second opinion must affirm that the patient is capable and acting voluntarily; (3) if appropriate, the patient must be referred to counseling; and (4) the patient must be informed that he or she can rescind the request at any time and in any manner.⁶³

Oregon releases annual reports regarding its DWDA.⁶⁴ The 2013 report consists of information received by the state as of January 22, 2014.⁶⁵ Since the 1997 enactment of the law, 1,173 Oregon residents have been prescribed DWDA medication; 752 of these individuals ingested the medication and subsequently died.⁶⁶ The following chart provides a helpful visual of the annual proportion of Oregon residents who actually ingested the lethal medication in comparison to those who were prescribed the medication.⁶⁷

56. *Death with Dignity Law*, OR. ENCYCLOPEDIA, http://oregonencyclopedia.org/articles/death_with_dignity_law/#.VND8tFuVJUQ (last visited March 27, 2015).

57. *Id.*

58. *Id.*

59. *Id.*

60. OR. REV. STAT. ANN. § 127.805 (West 2014).

61. *Id.* § 127.800.

62. *Id.* § 127.815.

63. *Id.* For a documentary detailing the journey of a few Oregon residents who used the Death with Dignity Act to end their own lives, as well as the passage of an assisted death law in Washington state, see *HOW TO DIE IN OREGON* (Clearcut Productions 2011) (this is a critically acclaimed documentary that has won several awards, including the "Grand Jury Prize" for documentaries at the 27th Sundance Film Festival).

64. *Annual Reports*, OR. HEALTH AUTH., <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx> (last visited March 27, 2015).

65. OR. PUB. HEALTH DIV., OREGON'S DEATH WITH DIGNITY ACT—2013 1, 1 (2014), available at <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf>.

66. *Id.* at 2.

67. *Id.* at 1.

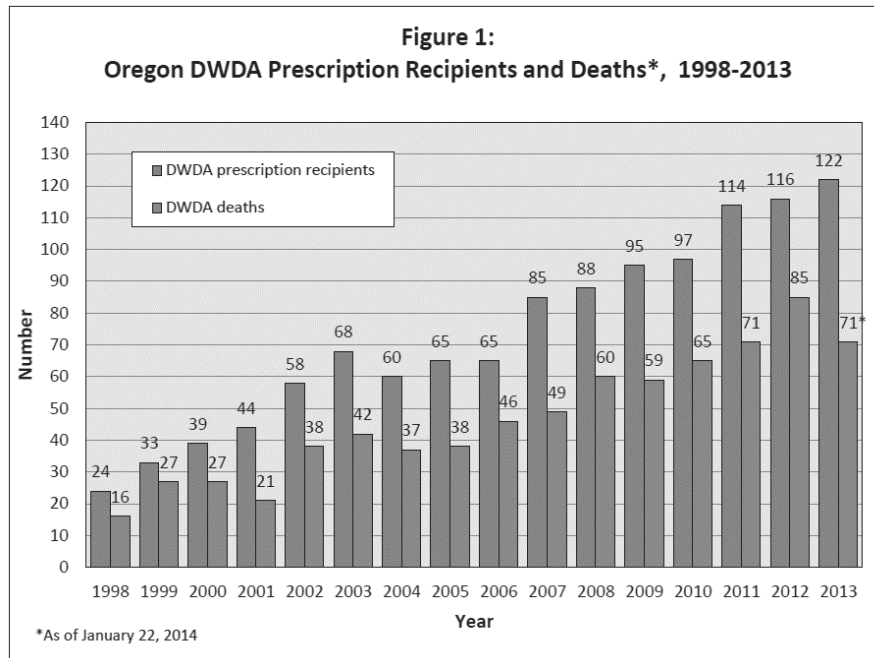


FIGURE 1. Oregon DWDA Prescription Recipients and Deaths, 1998–2013.

In 2013, there were 122 Oregon residents received lethal prescriptions, and at the time of the report, there were 71 known DWDA deaths for that same year.⁶⁸ Out of these 71 DWDA deaths in 2013, 63 of the prescriptions had been written in the same year and 8 of them had been written during the previous years (2011 and 2012).⁶⁹ The following chart provides a helpful visual of the specifics of the 2013 DWDA deaths and written prescriptions.⁷⁰

68. *Id.* at 2.

69. *Id.*

70. *Id.* at 4.

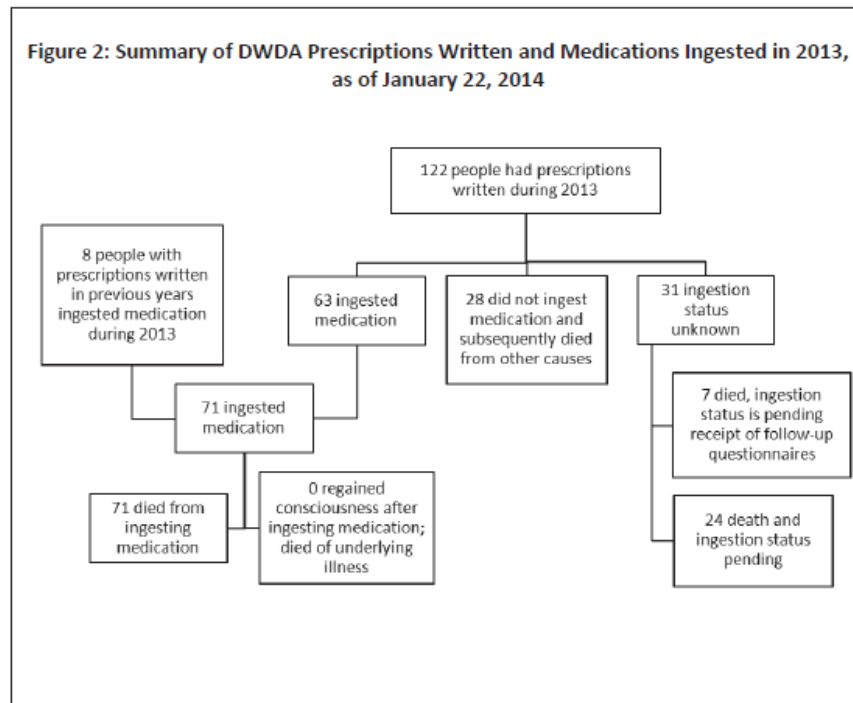


FIGURE 2. Summary of DWDA Prescriptions Written and Medications Ingested in 2013.

The three most frequently mentioned concerns for these patients with the lethal prescription were: “loss of autonomy (93.0%), decreasing ability to participate in activities that made life enjoyable (88.7%), and loss of dignity (73.2%),” the same as in previous years.⁷¹

Washington’s DWDA passed in 2008 and went into effect in 2009.⁷² It is modeled closely after Oregon’s DWDA.⁷³ Vermont was the third (and currently final) state to enact its law to permit physician-assisted death (PAD).⁷⁴ Each of these laws “allow mentally competent, terminally-ill adult state residents to voluntarily request and receive a prescription medication to hasten their death.”⁷⁵

71. OR. PUB. HEALTH DIV., *supra* note 65, at 3.

72. *In Washington*, DEATH WITH DIGNITY NAT’L CTR, <http://www.deathwithdignity.org/in-washington> (last visited Feb. 17, 2015).

73. *Id.*

74. *In Vermont*, DEATH WITH DIGNITY NAT’L CTR., <http://www.deathwithdignity.org/in-vermont> (last visited Mar. 27, 2015).

75. *Death with Dignity: the Laws & How to Access Them*, DEATH WITH DIGNITY NAT’L CTR., <http://www.deathwithdignity.org/access-acts> (last visited Mar. 27, 2015).

There is currently only one other state and one county in another state that recognizes physician-assisted death, but not through statute.⁷⁶ Montana and Bernalillo County in New Mexico both permit PAD through judicial acceptance.⁷⁷ The Montana Supreme Court first upheld PAD in *Baxter v. Montana*.⁷⁸ There, the trial court held “Montana constitutional rights of individual privacy and human dignity, taken together, encompass the right of a competent terminally [ill] patient to die with dignity.”⁷⁹ The judge further stated that doctors who aid their patients’ deaths would not be subject to prosecution.⁸⁰

The plaintiff in the Montana case was a seventy-five-year-old truck driver suffering from a terminal form of leukemia and wanted the option of assisted death when his suffering became unbearable.⁸¹ On appeal, the Montana Supreme Court avoided the constitutional question, but stated that physician-assisted death does not violate Montana’s public policy.⁸² The plaintiff in this case, Mr. Baxter, was quoted as saying:

I have lived a good and long life, and have no wish to leave this world prematurely. As death approaches from my disease, however, if my suffering becomes unbearable I want the legal option of being able to die in a peaceful and dignified manner by consuming medication prescribed by my doctor for that purpose. Because it will be my suffering, my life, and my death that will be involved, I seek the right and responsibility to make that critical choice for myself if circumstances lead me to do so. I feel strongly that this intensely personal and private decision should be left to me and my conscience—based on my most deeply held values and beliefs, and after consulting with my family and doctor—and that the government should not have the right to prohibit this choice by criminalizing the aid in dying procedure.⁸³

Unfortunately, on December 5, 2008, the same day that the district court issued its ruling in his favor, Mr. Baxter died as a result of his leukemia.⁸⁴

The trial court in Bernalillo County, New Mexico held that “terminally ill residents have a constitutional right to obtain ‘aid in dying.’”⁸⁵ The trial court stated, “This court cannot envision a right more fundamental, more private or more integral to the liberty, safety and happiness of a New Mexican than the right of a competent, terminally ill patient to choose aid in dying.”⁸⁶ This case was filed by two doctors who sought protection against prosecution if they provided lethal medication to Aja Riggs, a 49-year-old cancer patient who did not “want to suffer need-

76. Erik Eckholm, *New Mexico Judge Affirms Right to ‘Aid in Dying,’* N.Y. TIMES (Jan. 13, 2014), at A16, http://www.nytimes.com/2014/01/14/us/new-mexico-judge-affirms-right-to-aid-in-dying.html?_r=0.

77. *Id.*; *Baxter v. State*, 224 P.3d 1211, 1215–16 (Mont. 2009).

78. *Id.* at 1222.

79. *Baxter v. Montana*, 2008 Mont. Dist. LEXIS 482, 36 (Mont. Dist. 2008).

80. *Id.*

81. *Id.* at 1–2.

82. *Baxter*, 224 P.3d at 1220.

83. *Id.* at 1223.

84. *Id.* at 1240 n.1.

85. Eckholm, *supra* note 76, at A13.

86. *Id.*

lessly at the end.”⁸⁷ The judge held that “the liberty, safety and happiness interest of a competent, terminally ill patient to choose aid in dying is a fundamental right under our New Mexico Constitution.”⁸⁸

III. HISTORY OF PHYSICIAN-ASSISTED DEATH IN THE U.S.

The debate over physician-assisted death in the United States was at its peak in the 1990s. This was in large part due to a few United States Supreme Court cases decided during that decade. But, perhaps a larger reason for this nationwide interest was a man who thrust himself into the forefront of this debate. Jack Kevorkian (A.K.A. “Dr. Death”) was a well-known public advocate of assisted death.⁸⁹

Dr. Kevorkian’s first assisted death was with a patient named Janet Adkins, who was a 54-year-old Oregon woman diagnosed with Alzheimer’s disease.⁹⁰ Ms. Adkins took her own life using a device created by Dr. Kevorkian, which he dubbed “the Mercitron.”⁹¹ The device caused a painless death by first releasing a drug that caused unconsciousness and then releasing a lethal dose of potassium chloride—which stopped Ms. Adkins’ heart as soon as it was reached.⁹² Dr. Kevorkian stated that a death through his device was akin to a death while sleeping.⁹³ Dr. Kevorkian wanted to make assisted death a controlled, regulated medical service.⁹⁴ He pointed out that assisted deaths already occur and spoke of laypeople that have engaged in mercy killings by shooting, drowning, or suffocating one another.⁹⁵ He believed that it was irresponsible for doctors to allow these mercy killings to happen,⁹⁶ and Dr. Kevorkian stated that his purpose was to “demonstrate [his] cardinal rule in ethics, which is, personal autonomy.”⁹⁷

Ms. Adkins wanted to end her life because she was experiencing some of the symptoms of Alzheimer’s disease and did not want to see the illness through.⁹⁸ Ms. Adkins and her husband traveled to Michigan (the home state of Dr. Kevorkian) to meet with the doctor.⁹⁹ After his own personal observations and researching Ms. Adkins’ medical records, Dr. Kevorkian concluded that Ms. Adkins did indeed have symptoms of Alzheimer’s disease, but also that she was rational and in a proper state of mind to make this decision.¹⁰⁰ Ms. Adkins’ death occurred in Dr.

87. *Id.*

88. *Id.*

89. For a fairly accurate detailing of Dr. Kevorkian’s life see *You Don’t Know Jack* (HBO television broadcast Apr. 24, 2010) (Al Pacino plays Dr. Kevorkian in this made for television movie, but it features actual videos that Dr. Kevorkian took of his patients during the interview process).

90. PBS NewsHour, *Dr. Jack Kevorkian on the Assisted Suicide of Janet Adkins*, YOUTUBE (Jun. 3, 2011), <http://www.youtube.com/watch?v=OJsbefxfVsg>.

91. *Id.*; see also Keith Schneider, *Dr. Jack Kevorkian Dies at 83; A Doctor Who Helped End Lives*, N.Y. TIMES (June 3, 2011), available at http://www.nytimes.com/2011/06/04/us/04kevorkian.html?pagewanted=all&_r=0.

92. PBS NewsHour, *supra* note 90.

93. *Id.*

94. *Id.*

95. *Id.*

96. *Id.*

97. *Id.*

98. PBS NewsHour, *supra* note 90.

99. *Id.*

100. *Id.*

Kevorkian's van at a local park (he had tried to find a different setting, but had been turned down at every venue).¹⁰¹ Ms. Adkins laid on a bed in Dr. Kevorkian's van while Dr. Kevorkian connected her to a heart monitor and placed a needle in her arm to start the flow of a harmless saline solution.¹⁰² Ms. Adkins then pushed the button that released the sedative causing unconsciousness followed by the lethal dose of potassium chloride.¹⁰³ Immediately after Ms. Adkins' death, Dr. Kevorkian contacted the authorities to report it.¹⁰⁴ During this procedure, it is reported that Ms. Adkins said, "Thank you, thank you so much," to Dr. Kevorkian.¹⁰⁵

Ms. Adkins' death occurred on June 4, 1990, years before Oregon adopted its DWDA.¹⁰⁶ However, even today, Ms. Adkins would not have been able to access Oregon's DWDA because she would not be considered "terminal."¹⁰⁷ Ms. Adkins' death marked the beginning of Dr. Kevorkian's public crusade as an advocate of physician-assisted death. He claimed to have helped more than 130 patients end their own lives from 1990 to 1998.¹⁰⁸

During the 1990s, Dr. Kevorkian escaped conviction in four separate assisted death trials.¹⁰⁹ Three of those trials resulted in acquittals and one resulted in a mistrial.¹¹⁰ But, in 1999, he was convicted of second-degree murder and delivery of a controlled substance to his last patient, Thomas Youk.¹¹¹ He was sentenced to 10 to 25 years in prison.¹¹² The 1999 trial was different than the previous ones in that it was the first time that a jury was deciding on a murder charge, rather than an assisted death charge; it was also the first time Dr. Kevorkian acted as his own lawyer.¹¹³ So, it begs the question, what was so different about Dr. Kevorkian's last assisted death?

The biggest difference was the patient. Dr. Kevorkian's last patient, Thomas Youk, suffered from Lou Gehrig's disease and had virtually lost all control of his body.¹¹⁴ The critical difference between Mr. Youk's death and the deaths of the other patients was the *act* that caused death.¹¹⁵ Because Mr. Youk had essentially lost control of his bodily functions, Dr. Kevorkian injected Mr. Youk with the le-

101. *Id.*; see also Dennis McLellan, *Dr. Jack Kevorkian Dies at 83; 'Dr. Death' Was an Advocate, Practitioner of Physician-Assisted Suicide*, L.A. TIMES (June 4, 2011), available at <http://articles.latimes.com/2011/jun/04/local/la-me-jack-kevorkian-20110604>.

102. McLellan, *supra* note 101.

103. *Id.*

104. PBS NewsHour, *supra* note 90.

105. McLellan, *supra* note 101.

106. *Id.*

107. Jason Renaud, *Janet Adkins, Jack Kevorkian and the End of an Era*, OREGON LIVE (June 7, 2011), http://www.oregonlive.com/opinion/index.ssf/2011/06/janet_adkins_jack_kevorkian_an.html.

108. McLellan, *supra* note 101.

109. Liz Townsend, *Kevorkian's Nine-Year Euthanasia Crusade Leads to Murder Conviction*, NAT'L RIGHT TO LIFE COMM., <http://www.nrlc.org/archive/news/1999/NRL499/kev.html> (last visited Mar. 27, 2014).

110. *Id.*

111. Frontline, *Chronology of Dr. Jack Kevorkian's Life and Assisted Suicide Campaign*, PBS, <http://www.pbs.org/wgbh/pages/frontline/kevorkian/chronology.html> (last visited Mar. 27, 2014).

112. *Id.*

113. Townsend, *supra* note 109.

114. Dirk Johnson, *Kevorkian Sentenced to 10 to 25 Years in Prison*, N.Y. TIMES (Apr. 14, 1999), available at <http://www.nytimes.com/1999/04/14/us/kevorkian-sentenced-to-10-to-25-years-in-prison.html>.

115. *Id.*

thal dose of medication rather than Mr. Youk controlling the injection of lethal medication himself.¹¹⁶ Additionally, Dr. Kevorkian videotaped the entire procedure and, perhaps as an act of defiance, sent that video to the popular news show *60 Minutes*.¹¹⁷ Thereafter, the video was nationally televised, resulting in even more media attention and debate.¹¹⁸ The judge who presided over Dr. Kevorkian's last trial, Judge Jessica Cooper, said:

This trial was not about the political or moral correctness of euthanasia, it was about you, sir. It was about lawlessness. . . . You had the audacity to go on national television, show the world what you did and dare the legal system to stop you. . . . Well, sir, consider yourself stopped.¹¹⁹

In 2007, after eight years in prison, Dr. Kevorkian was released on the condition that he would never conduct another assisted death.¹²⁰ In 2011, he passed away after a long struggle with kidney and respiratory problems.¹²¹ The official cause of his death was a blood clot.¹²² He passed away in a hospital room while listening to his favorite musical composer, Bach.¹²³ His long-time attorney and friend said that if Dr. Kevorkian could have taken advantage of the option that he had offered others, he would have.¹²⁴

A. Is There a Right to Die?

When discussing physician-assisted death, the initial inquiry must always be: Is there a right to die? Indeed, the Supreme Court has held that there is a right to die in certain circumstances.¹²⁵ Specifically, in *Cruzan v. Missouri Department of Health*, the Supreme Court stated that there is a "constitutionally protected liberty interest in avoiding unwanted medical treatment, including life-sustaining medical treatment such as artificial nutrition and hydration."¹²⁶ In other words, a person has a constitutionally protected right to refuse life-saving treatment.¹²⁷ *Cruzan* involved a patient, Nancy Cruzan, who was in a persistent vegetative state after sustaining severe injuries in an automobile accident.¹²⁸ She exhibited motor reflexes, but there was absolutely no indication of cognitive function.¹²⁹ Nancy survived solely on artificial nutrition and hydration.¹³⁰

116. *Id.*

117. *Id.*

118. *Id.*

119. *Id.*

120. Schneider, *supra* note 91.

121. *Id.*

122. *Id.*

123. *Id.*

124. *Id.* Dr. Kevorkian passed away in his home state of Michigan, which has not recognized a right to physician-assisted death.

125. *Cruzan v. Mo. Dep't of Health*, 497 U.S. 261, 302 (1990) (Brennan, J., dissenting).

126. *Id.* at 302.

127. *See id.* at 279.

128. *Id.* at 261.

129. *Id.*

130. *Id.*

Nancy's parents filed a lawsuit in state court after their request was denied to have Nancy's artificial nutrition and hydration terminated.¹³¹ The trial court subsequently authorized the termination of life support, and found that a person in Nancy's condition has a "fundamental right under the State and Federal Constitutions to direct or refuse the withdrawal of death-prolonging procedures."¹³² The trial court also recognized the importance of a statement that Nancy had previously made to a housemate.¹³³ Nancy had previously said that she would "not wish to continue her life if [she were] sick or injured unless she could live at least halfway normally."¹³⁴ The Missouri Supreme Court reversed the trial court's decision, stated that Missouri has a policy interest in the preservation of life, and that Nancy's parents were not entitled to make the end-of-life determination for Nancy without clear and convincing evidence of the her wishes.¹³⁵

The Supreme Court granted certiorari to consider "whether Cruzan has a right under the United States Constitution which would require the hospital to withdraw life-sustaining treatment from her under these circumstances."¹³⁶ The Court discussed, at length, the importance of informed consent, especially regarding medical treatment.¹³⁷ The Court also pointed out the major advances in medical technology that have made it possible to "sustain[] life well past the point where natural forces would have brought certain death in earlier times."¹³⁸ The Court recognized several cases that have upheld the right to refuse life-sustaining treatment, which were based on either the common-law right to informed consent alone, or the right of informed consent coupled with the constitutional right to privacy.¹³⁹ The Court also stated that the Fourteenth Amendment provides a constitutionally protected liberty interest for a competent person to refuse unwanted medical treatment, but this liberty interest must be balanced against the relevant state interests.¹⁴⁰

The Court recognized that the state has several relevant interests to protect, most notably, the preservation of human life and safeguarding against potential abuse of incompetent patients. Further, the Court stated Missouri had rightfully sought to advance these interests "through the adoption of a 'clear and convincing' standard of proof to govern such proceedings."¹⁴¹ The Court affirmed the decision of the Missouri Supreme Court and held that the state could apply a "clear and convincing evidence standard in proceedings where a guardian seeks to discontinue nutrition and hydration of a person in a persistent vegetative state."¹⁴² In other words, although there is a right to refuse unwanted medical treatment, there is not necessarily a right for a surrogate to make that decision for someone else.¹⁴³

131. *Cruzan*, 497 U.S. at 261.

132. *Id.*

133. *Id.*

134. *Id.*

135. *Id.*

136. *Id.* at 269.

137. *Cruzan*, 497 U.S. at 269.

138. *Id.* at 270.

139. *Id.* at 271.

140. *Id.* at 278-79.

141. *Id.* at 282.

142. *Id.* at 284.

143. *See Cruzan*, 497 U.S. at 284.

Justice Brennan wrote for the dissent, joined by Justice Marshall and Justice Blackmun.¹⁴⁴ The beginning of their dissent states:

Medical technology has effectively created a twilight zone of suspended animation where death commences while life, in some form, continues. Some patients, however, want no part of a life sustained only by medical technology. Instead, they prefer a plan of medical treatment that allows nature to take its course and permits them to die with dignity.¹⁴⁵

The dissent further explained “no state interest could outweigh the rights of an individual in Nancy Cruzan’s position.”¹⁴⁶ And there is no “good to be obtained” by keeping Nancy Cruzan alive.¹⁴⁷ Nor is there any benefit to society or any third person, “and no harm to others will be averted.”¹⁴⁸ The dissenters outright disagreed with the majority that the state has any interest in preserving someone’s life.¹⁴⁹ Further, the “only state interest that may be asserted is an interest in safe-guarding the accuracy of [Nancy’s] determination” of how she would “exercise her rights under these circumstances” and therefore the Court’s test should be on the accuracy of the determination.¹⁵⁰

Justice Stevens issued a dissent which began with a discussion of the “right of every person to ‘Life, Liberty, and the pursuit of Happiness.’”¹⁵¹ Stevens wrote that “these three ends are compatible, mutually enhancing, and perhaps even coincident.”¹⁵² He concluded that “the Constitution requires the State to care for Nancy Cruzan’s life in a way that gives appropriate respect to her own best interests.”¹⁵³ Stevens believed that the Court failed Nancy’s best interests by putting this decision in the hands of the state legislature rather than her family.¹⁵⁴ He believed “[t]he best interests of the individual, especially when buttressed by the interests of all related third parties, must prevail over any general state policy that simply ignores those interests.”¹⁵⁵ Stevens argued that Nancy’s interests were essentially commandeered by the state and subsequently ignored.¹⁵⁶

Two months after this Supreme Court ruling, Nancy’s parents requested another hearing at the district court level to present new evidence of their daughter’s wishes from three of her co-workers.¹⁵⁷ Finally, the State of Missouri withdrew from the case because “it had no further role to play” after the legal issue had been decided.¹⁵⁸ At this hearing, Nancy’s co-workers testified that Nancy had said that

144. *Id.* at 301.

145. *Id.* (citing *Rasmussen v. Fleming*, 741 P.2d 674, 678 (Ariz. 1987)).

146. *Id.* at 312.

147. *Id.*

148. *Id.* at 312–13.

149. *Cruzan*, 497 U.S. at 313.

150. *Cruzan*, 497 U.S. at 315.

151. *Id.* at 330 (quoting THE DECLARATION OF INDEPENDENCE para. 2 (U.S. 1776)).

152. *Id.* at 330–31.

153. *Id.* at 331.

154. *Id.* at 338–39.

155. *Id.* at 350.

156. *Cruzan*, 497 U.S. at 351.

157. Tamar Lewin, *Nancy Cruzan Dies, Outlived by a Debate Over the Right to Die*, NY TIMES (Dec. 27, 1990), available at <http://www.nytimes.com/1990/12/27/us/nancy-cruzan-dies-outlived-by-a-debate-over-the-right-to-die.html>.

158. *Id.*

she would “never want to live ‘like a vegetable.’”¹⁵⁹ At the same hearing, Nancy’s doctor recommended that Nancy’s feeding tube be removed and described Nancy’s existence as a “living hell.”¹⁶⁰ Nancy’s court-appointed guardian agreed.¹⁶¹ The district court judge held this was clear and convincing evidence of Nancy’s wishes and permitted Nancy’s feeding tube to be removed.¹⁶² That same day, doctors removed her feeding tube.¹⁶³ Twelve days after the removal of her feeding tube, Nancy died.¹⁶⁴ Finally, eight years after Nancy’s car accident, her parents granted Nancy her last wish.¹⁶⁵

B. Can the Right Recognized in *Cruzan* Extend to Assistance in Dying?

In 1997, seven years after *Cruzan*, the United States Supreme Court decided two cases regarding physician-assisted death. The first of these cases was *Washington v. Glucksberg*, which challenged a Washington state law prohibiting assisted death.¹⁶⁶ The plaintiffs in this case were four Washington physicians, three terminally ill patients (each of whom died before this case made it to the Supreme Court), and a nonprofit organization.¹⁶⁷ Plaintiffs argued that this prohibition on assisted death violated the Fourteenth Amendment’s Due Process Clause.¹⁶⁸ Plaintiffs sought a declaration that this law was, on its face, unconstitutional.¹⁶⁹ They asserted that the Fourteenth Amendment’s Due Process Clause protects the personal choice of a competent, terminally ill adult to engage in physician-assisted death.¹⁷⁰ However, the Supreme Court held that Washington’s ban on assisted death did not violate the Due Process Clause because there is not a “fundamental liberty interest” in physician-assisted death.¹⁷¹ The Court framed the question as follows: “whether the ‘liberty’ specially protected by the Due Process Clause includes a right to commit suicide which itself includes a right to assistance in doing so.”¹⁷²

The Court also recognized that assisted death is a crime in nearly every U.S. state and almost every Western democracy.¹⁷³ The Court characterized these laws as “expressions of the States’ commitment to the protection and preservation of all human life.”¹⁷⁴ The Court held the ban on assisted death was “reasonably related” to furthering Washington’s compelling state interests, including: preservation of human life, prevention of suicide, preservation of the integrity of the medical profession, protection of vulnerable groups (such as children and the elderly), and

159. *Id.*

160. *Id.*

161. *Id.*

162. *Id.*

163. Lewin, *supra* note 157.

164. *Id.*

165. *Id.*

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

167. *Id.* at 707.

168. *Id.* at 708.

169. *Id.*

170. *Id.*

171. *Id.* at 705–06, 728.

172. *Glucksberg*, 521 U.S. at 723.

173. *Id.* at 710.

174. *Id.*

avoidance of the “slippery slope” to voluntary and involuntary euthanasia.¹⁷⁵ The Court concluded with an important caveat, stating: “Throughout the Nation, 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.”¹⁷⁶

Justice O’Connor was the swing vote in *Glucksberg* and issued a concurrence.¹⁷⁷ Justice O’Connor agreed there was not a general right to commit suicide, but stated that the line between assisted death and legitimate medical care is a thin one.¹⁷⁸ She said that patients in Washington who are experiencing great pain from a terminal illness can legally obtain necessary pain medication “to alleviate that suffering, even to the point of causing unconsciousness and hastening death.”¹⁷⁹ In other words, the United States has effectively permitted hastening death as long as the purpose of the medication is pain prevention rather than suicide. In this particular instance, the death of the patient is considered a “side effect rather than a goal.”¹⁸⁰

Justice Stevens filed a separate concurrence in *Glucksberg*, and emphasized that the debate is still open regarding the limits that the Constitution has on the States’ power to punish physician-assisted death.¹⁸¹ He pointed out that there is “no absolute requirement that a State treat all human life as having an equal right to preservation.”¹⁸² Stevens argued that the fundamental liberty interest held by the three terminally ill plaintiffs in this case *may* have been higher than the liberty interest held by Nancy Cruzan because of their constant pain and suffering.¹⁸³ “Avoiding intolerable pain and the indignity of living one’s final days incapacitated and in agony is certainly ‘[a]t the heart of [the] liberty . . . to define one’s own concept of existence, of meaning, of the universe, and of the mystery of human life.’”¹⁸⁴ He argued that the liberty interest in this case was stronger than the right to refuse medical treatment.¹⁸⁵ “It is an interest in deciding how, rather than whether, a critical threshold shall be crossed.”¹⁸⁶ Justice Stevens argued that there is little difference between the terminally ill patient who decides to remove her life support and a terminally ill patient who seeks assistance in ending her life, because in both situations, the patient is seeking to hasten her imminent death.¹⁸⁷ Further, the doctor’s intent is essentially the same when terminating life support and when prescribing lethal medication.¹⁸⁸

175. *Id.* at 728–33.

176. *Id.* at 735.

177. *Id.* at 736.

178. *Glucksberg*, 521 U.S. 736–37.

179. *Id.* at 736–37.

180. DANIEL A. FARBER, RETAINED BY THE PEOPLE: THE “SILENT” NINTH AMENDMENT AND THE CONSTITUTIONAL RIGHTS AMERICANS DON’T KNOW THEY HAVE 127 (2007).

181. *Glucksberg*, 521 U.S. at 738.

182. *Id.*

183. *Id.* at 745.

184. *Id.* (quoting Justice O’Connor in *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992)).

185. *Id.*

186. *Id.*

187. *Glucksberg*, 521 U.S. at 750.

188. *Id.*

Vacco v. Quill, another landmark case in the physician-assisted death debate, was also decided in 1997.¹⁸⁹ In *Vacco*, the Supreme Court held that New York's ban on assisted death did not violate the Equal Protection Clause of the Fourteenth Amendment.¹⁹⁰ The plaintiffs in *Vacco* included several New York public officials and three mentally competent terminally ill patients—all of whom died before the case reached the U.S. Supreme Court.¹⁹¹ The plaintiffs filed a lawsuit challenging the constitutionality of the New York statute prohibiting assisted death.¹⁹² The plaintiffs argued that “because New York permits a competent person to refuse life-sustaining medical treatment, and because the refusal of such treatment is ‘essentially the same thing’ as physician-assisted suicide, New York’s assisted-suicide ban violates the Equal Protection Clause.”¹⁹³

The Court stated that the Equal Protection Clause does not create any substantive rights and refused the argument that New York’s law drew any distinctions between different classes of people.¹⁹⁴ The Court stated, “[e]veryone, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; *no one* is permitted to assist a suicide. Generally, laws that apply evenhandedly to all ‘unquestionably comply’ with the Equal Protection Clause.”¹⁹⁵ The Court concluded that New York’s ban on assisted death was related to a legitimate end, and upheld the same compelling state interests that the Court discussed in *Glucksburg*.¹⁹⁶

Neither *Glucksburg* nor *Vacco* recognized a constitutional right to physician-assisted death; nor did they enforce a total ban. These cases kept the door open for state democratic processes to determine policies and laws for end-of-life care.

In 2006, the Supreme Court implicitly addressed the right to physician-assisted death when it ruled on the validity of Oregon’s DWDA in *Gonzales v. Oregon*.¹⁹⁷ The issue in this case was the authority of the Attorney General (AG) to interpret the Controlled Substances Act (CSA)—the federal statute that regulates the lethal drugs that Oregon doctors prescribe to assist in death under the DWDA.¹⁹⁸ The AG at the time, John Ashcroft, issued interpretive rules that determined that “using controlled substances to assist suicide is not a legitimate medical practice and that dispensing or prescribing them for this purpose is unlawful under the CSA.”¹⁹⁹ The issue before the Court was the validity of the interpretive rule under the CSA.²⁰⁰ The Court resolved this issue based on statutory interpretation and concluded that the CSA did not authorize the AG to forbid doctors from prescribing federally regulated drugs to terminally ill patients to assist in their

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

190. *Id.* at 799.

191. *Id.* at 797.

192. *Id.* at 798.

193. *Id.* at 797.

194. *Id.* at 799.

195. *Vacco*, 521 U.S. at 800.

196. *Id.* at 808–09.

197. *Gonzales v. Oregon*, 546 U.S. 243 (2006).

198. *Id.* at 249.

199. *Id.*

200. *Id.*

deaths.²⁰¹ In other words, the Court had the opportunity to strike down the flagship DWDA in the United States, but chose not to do so.

IV. IS THIS PROGRESS ENOUGH?

Although the statutes passed by Oregon, Washington, and Vermont, along with the judicial acceptance in Montana and Bernalillo County in New Mexico represent considerable progress, it is not enough. After Dr. Kevorkian's release from prison, he said: "They just don't get it in Oregon . . . [o]r in Washington state or Montana . . ."²⁰² Dr. Kevorkian was not only an advocate for assisted death, he was also an advocate of human rights.²⁰³ In short, he believed every person should have the ability "to do whatever they wanted to do, without interference from doctors, the states or the federal government."²⁰⁴

In fact, after Dr. Kevorkian's release from prison, he zealously advocated for the Ninth Amendment of the United States Constitution.²⁰⁵ The Ninth Amendment states, "[t]he enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people."²⁰⁶ Dr. Kevorkian interpreted this to mean that every person in the United States can do whatever he or she wants, as long as it does not harm anyone else or anyone else's property.²⁰⁷ He believed the Ninth Amendment gives us the freedom to live any way we choose, and to die in any way we choose.²⁰⁸ This freedom, he believed, includes the right to die with the help of a doctor, as long as the doctor has his or her consent.²⁰⁹ Dr. Kevorkian believed that, in addition to giving us the right to die, the Ninth Amendment gives us "[t]he right, he says in a stark example, to kill and eat someone, if that is their wish and they give their full consent to the act."²¹⁰

Unfortunately, the United States Supreme Court has never viewed the Ninth Amendment as a source of any substantive rights.²¹¹ Rather, the Court has said that the Ninth Amendment plays a supportive role in the liberty rights that are implied in other amendments, but not specifically enumerated.²¹² Dr. Kevorkian was not alone in believing that the Ninth Amendment protects a wide array of liberties for Americans.²¹³ Some commentators have even gone so far as to say that the Ninth Amendment has been "forgotten" by American jurisprudence.²¹⁴ Perhaps the Supreme Court will change its analysis of the Ninth Amendment and determine that it

201. *Id.* at 274–75.

202. Dr. Sanjay Gupta, *Kevorkian: 'I Have No Regrets'*, CNNHEALTH (June 14, 2010), <http://www.cnn.com/2010/HEALTH/06/14/kevorkian.gupta/>.

203. *Id.*

204. *Id.*

205. Ben Murray, *Jack Kevorkian Talks Personal Liberties, Suicide and the Future of America*, TAKEPART (June 23, 2010), <http://www.takepart.com/article/2010/06/23/jack-kevorkian-talks-personal-liberties-suicide-and-future-america>.

206. U.S. CONST. amend. IX.

207. Murray, *supra* note 205.

208. *Id.*

209. *Id.*

210. *Id.*

211. *See* *Griswold v. Connecticut*, 381 U.S. 479, 492–93 (1965).

212. *Id.*

213. *See, e.g.,* FARBER, *supra* note 180.

214. *Id.*

holds substantive rights retained by the people, rather than just using it as support for rights impliedly mentioned in the Constitution. But, until then, it is imperative that we extend the reach of the laws adopted in Oregon, Washington, and Vermont.

The statutes adopted in Oregon, Washington, and Vermont do not go far enough. It is, of course, somewhat appealing that there has been some progress in this field, but these statutes do not reach enough people. The stringent requirements to qualify for these laws drastically limits the number of people that have access to them.²¹⁵ Among the several other requirements previously listed, a person must have a prognosis of six months to live in order to qualify for any of these state statutes.²¹⁶

A. The Arbitrary “Six Month” Requirement

When asked about the requirement of having a terminal disease in states with DWDAs, Dr. Kevorkian replied, “[w]hat difference does it make if someone is terminal? . . . We are all terminal.”²¹⁷ Oregon²¹⁸ defines a “terminal disease” as “an incurable and irreversible disease that has been medically confirmed and will, within reasonable judgment, produce death within six months.”²¹⁹ Dr. Kevorkian thought this six-month requirement was arbitrary, and believed that physician-assisted death should be open to anyone who clearly expresses a desire to die.²²⁰

In fact, Dr. Kevorkian went so far as to say that the laws in Oregon and Washington were “wrong” and aren’t providing a medical service.²²¹ He believed doctors should be able to engage in euthanasia, meaning that doctors would complete the act that causes the death.²²² Even though Oregon, Washington, and Vermont all have statutes permitting physician-assisted death, they all outlaw euthanasia.²²³

These laws adopted in Oregon, Washington, and Vermont do not reach patients that are unable to take the lethal medication due to physical constraints.²²⁴ Individuals that are physically unable to move or physically unable to swallow cannot take advantage of the DWDAs even if they meet all the other requirements.²²⁵ The current DWDAs, although a step in the right direction, only apply to a very small group of people—those with capacity to make the decision who have been diagnosed with a terminal illness and have a prognosis of only six months to live.

215. Helene Starks *et al.*, *Physician Aid-in-Dying*, UNIV. OF WASH. SCHOOL OF MEDICINE (2013), available at <http://depts.washington.edu/bioethx/topics/pad.html>.

216. See *e.g.*, OR. REV. STAT. ANN. §§ 127.800(12) & 127.815(1)(a).

217. Gupta, *supra* note 202.

218. Washington and Vermont’s definitions are essentially identical to the Oregon definition.

219. OR. REV. STAT. ANN. § 127.800(12) (West 1995).

220. Schneider, *supra* note 91.

221. Gupta, *supra* note 202 (see video attached to article).

222. *Id.*

223. *E.g.*, OR. REV. STAT. ANN. § 127.880 (West 1995).

224. Gupta, *supra* note 202.

225. *Id.*; for a full discussion on how the Oregon and Washington laws ignore the needs of those that are physically unable to ingest lethal medication, see Cyndi Bollman, *A Dignified Death? Don’t Forget About the Physically Disabled and Those Not Terminally Ill: An Analysis of Physician-Assisted Suicide Laws*, 34 S. ILL. U. L.J. 395 (Winter 2010).

The right to physician-assisted death and euthanasia should extend to more individuals than it currently does. It should be an option available for all individuals who are free from mental illness and who clearly express a wish to die. This right should extend to more than just those who have a prognosis of six months to live. As such, the remainder of this article will focus on physician-assisted death as an option for those with dementia.

V. PHYSICIAN-ASSISTED DEATH AND DEMENTIA

Two of the most oft-used phrases in the physician-assisted death debate are “death with dignity” and “unbearable suffering.”²²⁶ Undoubtedly, suffering from dementia can easily be associated with both a loss of dignity and unbearable suffering.²²⁷ Yet, the physician-assisted death movement in the United States has essentially ignored the suffering of people diagnosed with dementia. Although patients suffering from Alzheimer’s disease will likely die from the disease, it is impossible to make any bright-line determinations similar to the “six months to live” requirement in current DWDAs.²²⁸

In 2012, an estimated 35.6 million people were living with dementia worldwide, with 7.7 million new cases every year.²²⁹ Also in 2012, an estimated 5.4 million Americans were living with Alzheimer’s disease, the most common form of dementia.²³⁰ By 2050, it is estimated that this number may rise to 14 million, unless a cure is found.²³¹ Alzheimer’s disease is the sixth most common cause of death in the U.S.²³² With no cure in sight, it will likely stay in the top ten most common causes of death in the U.S. for the foreseeable future.

A. Is Physician-Assisted Death for the Demented Possible?

So, is physician-assisted death for the demented even possible? When answering this question, the biggest concern is the issue of consent. Contemporaneous consent is simply not possible for individuals diagnosed with dementia.²³³ The issue of consent arises for anyone considering physician-assisted death.²³⁴ There will always be concerns about coercion by family members or physicians and about the mental health of the individual seeking physician-assisted death.²³⁵ But, today’s laws permitting physician-assisted death ensure that the patient makes an autonomous decision by ensuring that the patient has full information and assuring that the patient has the capacity to make the decision.²³⁶

226. John B. Mitchell, *Physician-Assisted Suicide and Dementia: The Impossibility of a Workable Regulatory Regime*, 88 OR. L. REV. 1085, 1086 (2009).

227. *Id.* at 1086–87.

228. *Id.* at 1089.

229. *Dementia Fact Sheet*, WORLD HEALTH ORG., <http://www.who.int/mediacentre/factsheets/fs362/en/> (last visited Feb. 12, 2015).

230. Alzheimer’s Ass’n, *2012 Alzheimer’s Disease Facts and Figures*, ALZHEIMER’S AND DEMENTIA 8(2), 14 (2012), available at http://www.alz.org/downloads/facts_figures_2012.pdf.

231. Mitchell, *supra* note 226, at 1090.

232. Hoyert & Xu, *supra* note 17, at 3.

233. Mitchell, *supra* note 226, at 1092.

234. *Id.* at 1121–22.

235. *Id.* at 1121.

236. *Id.* at 1122.

For example, a cancer patient with six months to live has the knowledge and the mental capacity to make an autonomous choice, but a patient with dementia does not.²³⁷ Prior to the onset of dementia a patient has the capability to make autonomous decisions, but he or she does not have full knowledge to make decisions about subsequent events.²³⁸ One could argue that making an end-of-life decision for some time in the future is similar to making any other choice regarding the future, albeit at a more significant juncture.²³⁹ Indeed, we often make decisions regarding our future selves; whether that be getting engaged, paying for an education, or booking plane tickets.²⁴⁰ The reality is that none of these plans may turn out as we projected, but the basic way that our mind functions will still be the same.²⁴¹

Making these sort of future plans is not akin to planning for middle to late stages of dementia.²⁴² “In this situation, you are literally considering how you would think if your mechanisms for thinking and communicating were radically different.”²⁴³ Dementia affects each individual differently, in part due to the area and magnitude of the damage to the brain, but also because of the uniqueness of each individual.²⁴⁴ Some sufferers of dementia may retain their personality while others may experience dramatic personality changes; there is simply no way to know how the disease will affect a person or how the person will feel about their quality of life once the disease has set in.²⁴⁵ Additionally, all proposed and enacted statutes permitting physician-assisted death require persistent requests to die from the patient.²⁴⁶ While this type of consent would be possible for people in the early stages of dementia, it is unlikely that patients with middle- to late-stage dementia will be able to understand and evaluate the information necessary to make these requests.²⁴⁷

B. Can a Living Will or Some Other Advanced Directive Resolve This Issue?

Can the issue of contemporaneous consent be resolved with a living will or an advanced directive? The main goals of end-of-life care are to respect the choices of the patient and protect the best interests of the patient; however, these goals do not always align.²⁴⁸ Further, the law may not always advance these goals and may not provide assistance for resolving the conflicts between them.²⁴⁹ The purpose of a living will is to guide a patient’s family and physicians in making decisions regarding end-of-life care.²⁵⁰ A durable power of attorney for healthcare appoints some-

237. *Id.*

238. *Id.*

239. Mitchell, *supra* note 226, at 1122.

240. *Id.*

241. *Id.* at 1122–23.

242. *Id.* at 1123.

243. *Id.*

244. *Id.* at 1123–24.

245. Mitchell, *supra* note 226, at 1123–24.

246. *Id.* at 1124.

247. *Id.*

248. Leslie Pickering Francis, *Decisionmaking at the End of Life: Patients with Alzheimer’s or Other Dementias*, 35 GA. L. REV. 539, 539 (2001).

249. *Id.*

250. *End-of-Life Decisions: It’s About How You LIVE*, CARING CONNECTIONS 2, available at http://www.caringinfo.org/files/public/brochures/End-of-Life_Decisions.pdf (last visited Feb. 24, 2015).

one to act as a principal's agent and authorizes that person to deal with all medical situations when the patient is unable to speak for him or herself.²⁵¹ Demented patients add a complexity to the law of living wills because of the disconnect between past self and present self, and because the level of capacity is constantly changing.²⁵² Even though a dementia patient may not have the capacity to consent, he still may have a firm attitude and opinion on how he should live out the remainder of his days.²⁵³

Even without these additional complications, living wills can fail for several reasons.²⁵⁴ First, people are simply unable to predict what they will want in every possible situation, which makes it impossible for living wills to encompass every possible situation.²⁵⁵ Second, health care providers may be unaware that a living will exists.²⁵⁶ And third, poorly drafted living wills can be, and often are, ambiguous.²⁵⁷

A person in the early stages of dementia can still have the mental capacity to execute an advanced directive laying out the terms under which the demented person would want to end his or her own life.²⁵⁸ But, there are practical issues, philosophical issues, and social issues that attach themselves to this possibility.²⁵⁹

i. Practical Issues

The practical issues that arise in this situation include drafting, interpretation, and implementation of the advanced directive.²⁶⁰ For example, when drafting this document, what would the demented person list as the criteria that would trigger the termination of life and how would these terms be measured?²⁶¹ Suppose the criteria stated were the inability to recognize his spouse.²⁶² When can the doctor be sure that this criteria has been met?²⁶³ This is not as transparent as one might initially imagine.²⁶⁴ How would the doctor tell when the demented no longer recognizes his spouse?²⁶⁵ Is it when he no longer remembers her name, or is it when he no longer acts as if she holds sentimental meaning; and how do we decide that?²⁶⁶

It may seem essentially impossible to draft an advanced directive that would unambiguously outline the criteria for a doctor to decide when the next steps should be taken, which is why it would be unwise to leave this final decision up to a phy-

251. *Id.* at 3.

252. Stephen R. Latham, *Living Wills and Alzheimer's Disease*, 23 QUINNIPIAC PROB. L.J. 425, 426 (2010).

253. *Id.*

254. *Id.* at 425.

255. *Id.*

256. *Id.*

257. *Id.*

258. Mitchell, *supra* note 226, at 1126.

259. *Id.* at 1127.

260. *Id.*

261. *Id.*

262. *Id.*

263. *Id.*

264. Mitchell, *supra* note 226, at 1127.

265. *Id.*

266. *Id.*

sician. Rather, this decision should be left to a trusted friend or relative that would better know what the demented person would have wanted.

ii. Philosophical Issues

The philosophical issues that arise when considering physician-assisted death or euthanasia for the demented mostly include issues of personal autonomy. Adults with mental capacity are free to make their own autonomous decisions, whether those decisions are good or bad.²⁶⁷ What matters is the freedom to choose.²⁶⁸ Ronald Dworkin, a legal philosopher and public intellectual²⁶⁹ believed that when talking about the autonomy of a now-demented person, we should consider his rights and interests in two separate ways.²⁷⁰ Dworkin argued that we should consider the autonomy of the person both “as a *demented* person, emphasizing his present situation and capacities, [and] as a person who has *become* demented, having an eye to the course of his whole life.”²⁷¹ He phrased the question as: “Should what is done for him then be in his contemporary best interests, to make the rest of his life as pleasant and comfortable as possible, or in the best interests of the person he has been?”²⁷²

Dworkin’s proposed solution to this issue is an idea that he called “precedent autonomy.”²⁷³ Precedent autonomy is the idea that we should give effect to an advanced directive executed by an individual that has since lost all mental capacity, even if the advanced directive asks for death.²⁷⁴ Dworkin posited several hypotheticals about a woman who executed a formal advanced directive for several different possibilities.²⁷⁵ The first involved a directive stating that if she were to develop dementia, her property should be given to a charity so that none of it could be sold to pay for her care.²⁷⁶ Another hypothetical posed by Dworkin involved the woman requesting that she not receive treatment for any other life-threatening disease she may contract.²⁷⁷ In yet another hypothetical, the woman requested that she be killed as quickly and painlessly as possible if she were to contract a life-threatening disease.²⁷⁸ If this woman expressed these wishes when she had the mental capacity, would autonomy require that these wishes be respected?²⁷⁹ I believe that it would.

Perhaps the best example of precedent autonomy is individuals who sign do-not-resuscitate orders.²⁸⁰ These individuals object to treatment in advance, and are

267. RONALD DWORIN, *LIFE’S DOMINION: AN ARGUMENT ABOUT ABORTION, EUTHANASIA, AND INDIVIDUAL FREEDOM* 222 (1993).

268. *Id.*

269. Adam Liptak, *Ronald Dworkin, Scholar of the Law, Is Dead at 81*, N.Y. TIMES (Feb. 14, 2013) available at http://www.nytimes.com/2013/02/15/us/ronald-dworkin-legal-philosopher-dies-at-81.html?pagewanted=all&_r=0.

270. Dworkin, *supra* note 267 at 221.

271. *Id.*

272. *Id.*

273. *Id.* at 226.

274. *Id.*

275. *Id.*

276. Dworkin, *supra* note 267, at 226.

277. *Id.*

278. *Id.*

279. *Id.*

280. *Id.* at 227.

unconscious when they are in need of the treatment.²⁸¹ This patient's "former decision remains in force because no new decision by a person capable of autonomy has annulled it."²⁸² Essentially, "precedent autonomy allows a now-capable person to control decisionmaking at a later point in time when he no longer has the capacity to do so."²⁸³

Precedent autonomy can be exercised through the use of a living will, durable power of attorney for health care, or even in less formal ways—telling family and friends your preferences in certain circumstances.²⁸⁴ Each of these examples essentially delegates an incapacitated person's decision-making power to someone else to follow the desires previously expressed. Dworkin said, "[w]hen one person is entrusted to the charge or care of another, the former has what I shall call a right to beneficence—a right that the latter make decisions in the former's best interest."²⁸⁵ He equated this right to beneficence with the fiduciary duties of trustees and directors of corporations.²⁸⁶

But what *are* the best interests of the demented?²⁸⁷ There simply cannot be a bright line rule created to answer this question. The best interests of a demented individual will always have to be determined on a case-by-case basis. Although a medical professional's opinion can be helpful in making this determination, this decision should not be left entirely up to a doctor. The person best suited to make this determination would be someone who knows the demented person well, both before and after the dementia reached the late stages.

iii. Social Issues

Some commentators have expressed concern that permitting physician-assisted death for those diagnosed with dementia could lead to a "social expectation," or even a "social obligation" that once you've been diagnosed with dementia, you should sign an advanced directive so that "when the time comes" you will be injected with lethal medication.²⁸⁸ The idea behind this line of reasoning is that the U.S. has limited health care resources and people with dementia use up a large part of these already limited funds that could otherwise "go to treating sick young children or finding a cure for Alzheimer's."²⁸⁹ It is imagined that if physician-assisted death or euthanasia becomes a welcome practice for the demented, then it could become culturally accepted dogma, especially since there is a "cultural belief that the severely demented are effectively dead, that their lives are indistinguishable from cabbages."²⁹⁰

This is essentially a "slippery slope" argument. The unfortunate fact about slippery slope arguments is that they can be made about practically anything. Slip-

281. *Id.*

282. *Id.*

283. Francis, *supra* note 248, at 551.

284. *Id.* at 552.

285. Dworkin, *supra* note 267, at 229.

286. *Id.*

287. *Id.*

288. Mitchell, *supra* note 226, at 1133.

289. *Id.*

290. *Id.* at 1134.

perly slope arguments are often used when discussing social or ethical issues.²⁹¹ These arguments assert that if a certain practice is accepted (here, physician-assisted death or euthanasia), then society will plunge down a slippery slope and begin permitting more extreme, immoral actions.²⁹² Several proponents of the slippery slope argument use the Dutch as an example.²⁹³ Initially in the Netherlands, euthanasia was permitted only for the terminally ill who requested it, then for the chronically ill, then for those suffering psychologically, and now for incompetent patients, including children.²⁹⁴ But, this argument fails to point to the existence of a pernicious slippery slope.²⁹⁵

When using the Dutch example, proponents of the slippery slope argument automatically presume that the expansion of the physician-assisted death laws is morally wrong.²⁹⁶ But, in fact, most of the defenders of a legal right to die see nothing morally wrong with these instances of euthanasia.²⁹⁷ Many defenders of the right to die movement do not think that the option of physician-assisted death or euthanasia should be limited to only the “terminally” ill.²⁹⁸ There are other types of suffering that are intolerable, including mental suffering for the competent as well as the incompetent.²⁹⁹

Another issue regularly raised by opponents of the right to die movement is the possibility that this practice will be abused because there aren’t any legal safeguards to prevent such abuse.³⁰⁰ Essentially, this argument states that even if written consent is required, it will not always be obtained and it will lead to mass involuntary euthanasia.³⁰¹ Although this argument is valid in some respects, it is not a sufficient argument to justify withholding the right altogether.³⁰² “If the likelihood of abuse were thought to be grounds for withholding a right, then much more than euthanasia would have to be banned.”³⁰³ For example, the right to drive is a right that has the potential to be abused, and is abused daily.³⁰⁴ People often break the speed limit, run stop signs, drive without a license, or drive under the influence of alcohol; however, these risks of abuse are not enough to ban driving altogether.³⁰⁵

The abuse argument also fails to recognize that abuse is possible even when physician-assisted death or euthanasia is prohibited.³⁰⁶ We see stories of “mercy killings” often in the news, including spouses taking each other’s lives to grant

291. David Benatar, *A Legal Right to Die: Responding to Slippery Slope and Abuse Arguments*, 18 CURRENT ONCOLOGY 206 (2011), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3185895/>.

292. *Id.*

293. *Id.*

294. *Id.*

295. *Id.*

296. *Id.*

297. Benatar, *supra* note 291, at 206.

298. *Id.*

299. *Id.*

300. *Id.*

301. *Id.*

302. *Id.*

303. *Id.* at 206–07.

304. *Id.* at 207.

305. *Id.*

306. *Id.*

their last wish to end their suffering.³⁰⁷ It is simply ignorant to think that a legal ban on this practice will prevent it from occurring.³⁰⁸ “[T]he choice is not between legalizing euthanasia and no euthanasia, with abuse occurring in the former. Instead the choice is between euthanasia with or without regulation.”³⁰⁹

Opponents of the right to die movement believe that “freedom has its limits” and do not believe that the right to die is within those limits.³¹⁰ Society may restrict a person’s freedom when that freedom will inflict harm on others, but it is difficult to “justify restricting a person’s freedom when that restriction will result in an immense personal harm.”³¹¹ Here, restricting a person’s right to die when she is going through intense suffering forces her to endure that suffering, even when she would prefer not to.

VI. CONCLUSION

My proposed solution to this complicated issue is a rather simple one: an advanced directive delegating this decision to a trusted friend or relative. *Cruzan* implicitly recognized that states must honor living wills or advanced healthcare directives.³¹² In fact, after *Cruzan*, every state adopted a provision to honor living wills, health care proxies, or both.³¹³ Because states already allow for guardians to make all decisions regarding someone else’s well-being, it seems natural that this delegation of decision-making could and should extend to end-of-life decisions.

The differing opinions in the argument over physician-assisted death and euthanasia all seem to stem from the concept of paternalism.³¹⁴ People tend to believe that they always know what is in the best interest for someone else.³¹⁵ Generally, it is thought that the continuation of life is always in the best interest of everyone.³¹⁶ However, living just to be alive is not always in the best interest for every person. In fact, there are several instances where a hastened death is in the best interest of an individual.

The fundamental disagreement in this debate is the same as the disagreement that is in the center of the abortion debate—the value of human life.³¹⁷ Opponents of physician-assisted death, euthanasia, and abortion all argue that these actions are a denigration of the sanctity of life.³¹⁸ However, this ideology could not be further from the truth. Individuals that want a hastened, peaceful death for themselves are not denigrating the sanctity of life at all. Actually, a quicker, peaceful death shows more respect for life than a prolonged, insufferable one.³¹⁹ Both sides of the physi-

307. See, e.g., Associated Press, *Police Find Elderly Couple Dead in Home*, KTVB.COM (Oct. 14, 2009, 10:13 AM), available at <http://www.ktvb.com/story/news/local/2014/06/27/11477527/>.

308. See Benatar, *supra* note 291, at 207.

309. *Id.*

310. *Id.*

311. *Id.*

312. DWORKIN, *supra* note 267, at 181.

313. *Id.* at 188.

314. *Id.* at 192–93.

315. *Id.*

316. *Id.*

317. *Id.* at 238.

318. DWORKIN, *supra* note 267, at 238.

319. *Id.*

cian-assisted death argument are united by the value of the sanctity of life, but are divided by the best way to interpret it.³²⁰

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320. *Id.*

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