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DEATH AND DIGNITY

*Kelton Gardner*¹

In April 2014, Brittany Maynard, a 29-year-old resident of Anaheim, California and recent graduate student of the University of California, was diagnosed with grade four astrocytoma—a form of brain cancer—and was given a prognosis of six months to live. Brittany and her family moved to Oregon, one of only five states at the time that had legalized physician-assisted suicide. As the quality of her life decreased dramatically, Brittany decided she wanted a physician-assisted suicide. This process would consist of taking prescribed pills (known as barbiturates) in the comfort of her own home at the time of her own choosing. On November 1, 2014, Brittany ended her life as she intended. In an article she posted on CNN’s website, Brittany expressed her gratitude for laws allowing physician-assisted suicide in circumstances of imminent death and tremendous pain. In regards to her right to a physician-assisted suicide, she wrote, “Who has the right to tell me that I don’t deserve this choice? That I deserve to suffer for weeks or months in tremendous amounts of physical and emotional pain? Why should anyone have the right to make that choice for me?”²

In May 2014, in an account not nearly as publicized as that of Brittany Maynard, J.J. Hanson from New Jersey was diagnosed with the same kind of brain cancer as Brittany, but with a prognosis of

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 - 2 Brittany Maynard, *My Right to Death with Dignity* at 29, CNN (Nov 2, 2014) <http://www.cnn.com/2014/10/07/opinion/maynard-assisted-suicide-cancer-dignity>.

only four months to live—even less than that afforded Brittany. Just as Brittany attested, J.J. relayed that the illness is “a big burden on your family and those who are around you.”³ J.J. was told by three doctors that his disease was incurable, and only after a significant amount of persistence did he find a doctor willing to treat him. Twenty months after being told he was going to die (sixteen months longer than his original prognosis), J.J. posted a YouTube video revealing that he was in remission. Unlike Brittany, J.J. expressed his disapproval of the legality of a physician-assisted suicide. He commented, “Assisted suicide is a decision that you can’t unmake. My wife would be without a husband and my son without a father.”⁴

These examples raise important yet difficult moral questions regarding the meaning of life and death and the related right to self-determination. But perhaps just as important as these questions is the question of the state’s interest in either promoting or prohibiting the practice of physician-assisted suicide. Does the state have an interest in allowing citizens the right to a physician-assisted suicide or is there ample reason to prohibit it? Since the Oregon Death with Dignity Act was passed in 1997, terminally ill patients like Brittany (with a prognosis of six months or less to live) now have the option to a physician-assisted suicide after complying with procedural requirements.⁵

This paper does not intend to reason by form of an argument whose premises support a conclusion based solely on legal precedent. While there are two major Supreme Court cases that have ruled on the matter of physician-assisted suicide, these cases ruled only on the constitutionality of an already existing law and did not rule on the matter of a fundamental right to physician-assisted suicide. This left open the possibility of a future ruling that could either deny or

3 John Burger, *J.J. Hanson’s Fight for Life*, ALTEIA, <http://aleteia.org/2016/05/23/j-j-hansons-fight-for-life/> (May 23, 2016).

4 Micaiah Bilger, *This Marine Has the Same Brain Cancer as Brittany Maynard, but His Response is Priceless*, LIFENEWS (Jan. 14, 2016), <http://www.lifenews.com/2016/01/14/this-marine-has-the-same-brain-cancer-as-brittany-maynard-but-his-response-is-priceless>.

5 ORS § 127.800 (1997).

affirm a universal right to physician-assisted suicide or perhaps shift the responsibility of deciding to the states. Law, when first written, is based on moral presumptions, and when precedent is neither clear nor prevalent both philosophical and moral arguments can and must be presented to warrant the passing or preventing of a new law. Because there is little precedent regarding physician-assisted suicide, the arguments I will address consider the moral and philosophical implications of legalizing physician-assisted suicide as well as court precedent thus far established. I will likewise address considerations of autonomy in relation to justifying the practice of euthanasia and the weight such a principle carries in light of other current legal doctrine.

In order to identify the flaws of the Death with Dignity Act, I will first discuss two common arguments generally made in favor of laws allowing for a physician-assisted suicide. I will show why these two arguments ultimately fail to justify laws like the Oregon Death with Dignity Act as currently written. I will then proceed to address the variety of compelling interests the state has in upholding a ban on physician-assisted suicide after which I will discuss the negative social implications of enshrining such a practice in law. I will conclude that Oregon's Death with Dignity Act, and any law that legalizes physician-assisted suicide, should be repealed.

I. DEFINITIONS

Euthanasia is defined as “the practice of intentionally ending a life in order to relieve pain and suffering.”⁶ There are typically two classes of euthanasia: active euthanasia and passive euthanasia. The difference between the two involves the distinction between killing someone and letting someone die. Active euthanasia generally implies the practice of directly taking one's life, whereas passive euthanasia commonly implies the act of “pulling the plug” or failing to take action to preserve one's life. A distinction between the two is used in most contemporary codes of medical ethics (e.g., the American

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Medical dictionary, *Euthanasia*, THE FREE DICTIONARY, <http://medical-dictionary.thefreedictionary.com/euthanasia> (last visited Jan. 25, 2017).

Medical Association's Code of Ethics) and is also recognized in the American tradition of law.⁷ This distinction is also supported in the Supreme Court ruling in *Vacco v. Quill* where the justices "recognized, at least implicitly, the distinction between letting a patient die and making that patient die."⁸

Indispensable to an understanding of the implications of legalizing euthanasia is a familiarity with the terms "voluntary," "involuntary," and "nonvoluntary" and their relation to euthanasia. Voluntary euthanasia is the practice of taking one's life by deliberate action. In such cases, "[t]hat the individual explicitly consents to death is a necessary feature of voluntary euthanasia."⁹ Involuntary euthanasia "consists in ending the life of someone contrary to that person's wish."¹⁰ In such cases, the person "not only fails to give consent, but expresses the desire not to be killed."¹¹ Nonvoluntary euthanasia, unlike involuntary euthanasia, is when the "person gives no specific consent or instructions, and the decision [to die] is made by family, friends, or physicians."¹² While these definitions are not always uniform, they generally provide a basis for understanding the forms of euthanasia and their relationship with law and public policy.

II. BACKGROUND

The Hippocratic Oath, originating in Ancient Greece, is an oath that all practitioners of medicine traditionally took upon the initiation of their medical careers. Although it may differ slightly from the original version, modern medical doctors continue to use a contemporary version of the oath, one that is still very similar in

7 Ronal Munson, *Intervention and Reflection*, 579 (Joann Kozgrev and Joshua Duncan eds., 9th ed. 2012).

8 See *Vacco v. Quill*, 521 U.S. 793 case in brief, 4 (1997) (holding that it was consistent with the U.S. Constitution for New York to treat assisted suicide and the refusal of lifesaving treatment differently).

9 Munson, *supra* note 7 at 579.

10 *Id.*

11 *Id.*

12 *Id.*

form and context to that of the Grecian form. One particular passage reads, “I will, according to my ability and judgment, prescribe a regimen for the health of the sick; but I will utterly reject harm and mischief.”¹³ Euthanasia’s compatibility with the Hippocratic Oath is a controversial topic. When considering the oath, some infer that it is the doctor’s moral duty to preserve the lives of his patients, therefore aiding in the death of a patient would directly interfere with this moral obligation. Those who favor euthanasia argue that such a practice respects the will of the patient and is either compatible with certain interpretations of the Hippocratic Oath or argue that the oath should be modified to include the practice of euthanasia as morally permissible.

III. PROOF OF CLAIM

In 1997 the Supreme Court ruled on two cases regarding physician-assisted suicide. In the first, *Washington v. Glucksberg*, the Supreme Court upheld the ban on physician-assisted suicide. It was ruled that the right to a physician-assisted suicide was “not a fundamental liberty interest protected by the Due Process Clause.”¹⁴ Furthermore the court found that the “States may properly decline to make judgments about the ‘quality’ of life that a particular individual may enjoy.”¹⁵ The statute was also legally justified by the state’s interest in “protecting the integrity and ethics of the medical profession,”¹⁶ and in “protecting vulnerable groups—including the poor, the elderly, and disabled persons from abuse, neglect, and mistakes.”¹⁷ While this decision upheld a ban on physician-assisted

13 *The Hippocratic Oath in Latin with English Translation*, Academia, http://www.academia.edu/2638728/The_Hippocratic_Oath_in_Latin_with_English_translation (last visited Jan. 3, 2017).

14 *Washington v. Glucksberg*, 521 U.S. Case summary, (1997). Banning assisted suicide was rationally related to a legitimate government interest and did not violate the Due Process Clause.

15 *Id.* at head note 9.

16 *Id.* at head note 1.

17 *Id.*

suicide, it did so “without expressly condoning or disapproving of assisted suicide in general,”¹⁸ leaving the door open for other states to enact laws that might allow for physician-assisted suicide if they choose.

The second notable case regarding physician-assisted suicide determined by the Supreme Court in 1997, *Vacco v. Quill*, regarded a New York state statute including in its definition of manslaughter “to intentionally cause or aid another to commit suicide.”¹⁹ The court ruled that there is “no constitutional right to commit suicide.”²⁰ Petitioners argued that the statute violated the Equal Protection Clause because New York allowed for “a competent person to refuse life-sustaining medical treatment, which refusal was tantamount to physician-assisted suicide.”²¹ Despite current philosophical debate over the possibility of any moral distinction between “killing” and “letting die,” the court ruled, “There was a difference between allowing a disease to take its natural course and intentionally using an artificial means to produce death.”²² According to Chief Justice William Rehnquist, the state of New York also has an interest “in preserving life and in protecting vulnerable persons,”²³ but the “resolution of this issue was left to the normal democratic processes within the State.”²⁴ Similar to the ruling in *Washington v. Glucksberg*, the court left open the possibility to the states, through democratic process, to enact laws of their choosing on the matter of physician-assisted suicide but they did not define physician-assisted suicide as being a constitutional right.

18 *Vacco v. Quill*, 521 U.S. 793 case in brief, 4 (1997).

19 *Quill*, 521 U.S. 793 case in brief, 4 (1997).

20 *Id.*

21 *Quill*, 521 U.S. at 793 Chief Justice Rehnquist opinion.

22 *Id.* at case in brief, 4 (1997).

23 *Id.*

24 *Id.*

A. *Autonomy*

In his article “When Self-Determination Runs Amok,” Dr. Daniel Callahan confronts two prevalent arguments that serve as a basis for allowing euthanasia or physician-assisted suicide. These two values are self-determination (the right to autonomy) and mercy. When these two values are separated, “assisted suicide for any reason and nonvoluntary euthanasia for the incompetent will become acceptable.”²⁵ In order to understand Callahan’s arguments and how they relate to legal precedent, I will discuss the value of each one. First, a prominent argument for physician-assisted suicide is based on the principle of individual autonomy. I will use “individual autonomy” and “self-determination” synonymously when referencing the ability to exercise agency. When a physician-assisted suicide is based on the principle of one’s right to self-determination, we find that some laws, such as the Oregon Death with Dignity Act, arbitrarily deny certain persons the right to a physician-assisted suicide; the very right that the law originally set out to protect.

For example, John is a 75-year-old man who is diagnosed with a terminal illness that will result in death within three months. His pain is minimal with treatment but he decides that it is “unbearable” enough to think his life is no longer worth living. As long as he complies with the procedural processes²⁶ of the Oregon statute, John will have his wishes respected. George, on the other hand, is a 75-year-old man who is diagnosed with a terminal illness, longer lasting and more degenerative in nature than John’s, which will result in death within eighteen months and likely no less than twelve months without treatment. With or without treatment, George is predicted to suffer tremendous amounts of pain. He already considers his pain to be unbearable and wishes to end his life peacefully and painlessly, but under Oregon statute George is precluded from doing so because he is estimated to have more than six months to live.

25 Daniel Callahan, *When Self-Determination Runs Amok*, 22 Hastings Ctr. Rep. 52 (1992).

26 ORS § 127.800 (1997).

Considering this example, can one say that it is fair to respect John's autonomy and not George's? Why is John's autonomy more deserving of respect than George's? It appears completely arbitrary to deny certain people the right to their autonomy and not deny others, especially when that "right" seems to be respected only when based on a subjective timeframe. Further applying the principle of autonomy, it would be unfair logically to assume that the right to self-determination exists only under certain circumstances such as a terminal illness or a crippling accident, rather than as an inherent right possessed by all. If individual autonomy is the determining factor for physician-assisted suicide, then the lovelorn teenager who wishes to end his or her life must also be granted the ability to do so. As Callahan asks concerning those who would be denied the decision to die, "Whatever the person's motives may be, why are they not sufficient?"²⁷ Those who say that limiting self-determination in certain circumstances is justified must show why those circumstances make that particular person's autonomy of more worth or respectability than another's without being arbitrary or inconsistent.

B. Mercy

The second value discussed by Callahan is mercy. Many who advocate for policies allowing physician-assisted suicide base them on the principle of "mercy" in order to relieve suffering. Intuitively it seems unfair to allow someone to suffer a tremendous amount of pain if the option to end his or her life is available. However, if we put aside the right to self-determination and consider the justification of euthanasia solely on the grounds of a right to the relief of suffering then we run into a similar problem of applying the principle consistently. Callahan invites us to consider the person "who is suffering but not competent, who is perhaps demented or mentally retarded."²⁸ Most who favor physician-assisted suicide would deny that such persons qualify for euthanasia. But why is that the case? Callahan continues, "[I]f a person is suffering but not competent,

27 Callahan, *supra* note 25 at 54.

28 *Id.*

then it would seem grossly unfair to deny relief solely on the grounds of incompetence.”²⁹ If relief of suffering is the principle upon which we justify euthanasia, then it follows that any who are suffering are entitled to relief, not just those who are competent. This would ultimately justify nonvoluntary euthanasia for the incompetent, a practice that very few, if any, would condone.

One might argue that a combination of these two values, mercy and self-determination, is where the true and consistent justification for euthanasia lies. In considering the possibility of combining these two discussed values, as Callahan notices, “It is said that a competent, adult person should have a right to euthanasia for the relief of suffering.”³⁰ But if it is true that an adult person should have such a right, Callahan continues, “why must the person be suffering? Does not that stipulation already compromise the principle of self-determination?”³¹ As Callahan argues, the combination of the two values of self-determination and mercy lead us back to the same problem faced in justifying euthanasia solely on self-determination. Why must suffering be a necessary condition for respecting one’s autonomy? Thus, it must be the case that we either deny everyone the right to a physician-assisted suicide or we permit it to all who so choose regardless of circumstances. Otherwise, it is not logically consistent in its application to afford an inherent human right to all who qualify as autonomous human beings. Because most who favor euthanasia do not support a unilateral right to a physician-assisted suicide, as this would certainly prejudice the elderly and the mentally ill and encourage suicide in general, we conclude that we must not allow euthanasia at all.

C. Constitutional Claims

In *Lawrence v. Texas*, we see a focus on the relationship between the principle of autonomy and how it relates to the way individuals choose to direct their lives. In this case the court ruled that a Texas

29 *Id.*

30 *Id.*

31 *Id.*

statute that banned homosexual sodomy between consenting adults was unconstitutional.³² Justice Kennedy, who delivered the majority opinion of the court, referred to *Griswold v. Connecticut* as precedent for a “right to privacy” not necessarily explicit but certainly implicit in the Constitution. *Griswold v. Connecticut* ruled that a state ban on contraceptives was unconstitutional in light of a couple’s right to privacy.³³ Consequently, in *Lawrence v. Texas* Kennedy claimed, “[I]f the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.”³⁴ At the beginning of Justice Kennedy’s opinion, he discusses the value of liberty, which is an idea that “presumes an autonomy of self that includes freedom of thought, belief, expression, and certain intimate conduct.”³⁵ If precedent from cases such as *Lawrence v. Texas* and *Griswold v. Connecticut* grants a right to privacy and protection from government intrusion in matters that “deal with belief, expression and certain intimate conduct,”³⁶ then certainly the intimate choice of when and how to die should be just as protected if not more so under such legal principles. Privacy, as related to physician-assisted suicide, must be everyone’s right or nobody’s, otherwise it is inconsistent. Most people would disagree with granting anyone the right to a physician-assisted suicide for any given reason. Thus we must eliminate physician-assisted suicide completely to be legally consistent with the law as it stands in light of the principles of privacy.

The *Obergefell v. Hodges* case justified a right to same-sex marriage under the Equal Protection Clause based on a myriad of reasons including the personal and intimate nature of the choice regarding

32 See *Lawrence v. Texas*, 539 U.S. 558 (2003) (striking down the sodomy law in Texas invalidated sodomy laws in thirteen other states, making same-sex sexual activity legal in every U.S. state and territory).

33 See *Griswold v. Connecticut* 381 U.S. 479 (1965) (ruling on the use of contraceptives being protected by the individual’s privacy).

34 *Lawrence v. Texas* 539 U.S. at 7.

35 *Id.*

36 *Id.*

whom to marry. The court argued that such a right should be afforded to same-sex couples because “decisions about marriage are among the most intimate that an individual can make.”³⁷ If it is the case that such a decision justifies an equal protection claim, then the same standard must apply in the case of physician-assisted suicide. Certainly the right to choose when and how to die is a decision not only of great intimate and personal worth but one that deals with the essence of life itself. If choosing whom to marry is personal enough to warrant a fundamental right to all adults regardless of gender, then we must treat all similar cases alike. A case that involves an intimate and personal choice similar to that of marriage, such as choosing when to die, must also be allowed to all adults regardless of circumstance. Therefore, if we allow a physician-assisted suicide in only some cases, by the precedent set forth in *Obergefell v. Hodges*, we must be ready to allow it in all cases of adulthood for any reason. Once again, most people would not agree with granting any adult the right to a physician-assisted suicide for any reason whatsoever. Thus we must eliminate physician-assisted suicide completely to be legally consistent with the law as it stands in light of equal protection principles.

If the right to privacy, along with other rights protected under the Equal Protection and the Due Process Clauses, legally justify same-sex marriage, abortion, the use of contraceptives, and homosexual sodomy among consenting adults, then it seems grossly unfair to allow a state to ban physician-assisted for any reason. A citizen in one state who is not legally entitled to a physician-assisted suicide, and who does not have the financial resources to move where it is legal, has a strong if not legally sound argument under the Equal Protection Clause, Due Process Clause and the right to privacy for legalizing physician-assisted suicide in all states for adults and their consenting doctors.

Understanding the principles behind the defense for euthanasia allows us to examine pro-euthanasia laws as they stand and determine whether they are beneficial in their enactment or whether their negative aspects justify their repeal. Perhaps analyzing the statistics

37 *Obergefell v. Hodges* 83 U.S. Syllabus (2015).

compiled following the law's enactment can allow us to ascertain its justifiability. In 2015, out of the 218 citizens of Oregon who were prescribed a barbiturate to kill themselves, only 132 were actually reported to have died by the same.³⁸ Likewise, when surveyed, 92.4% of these patients did not profess to be petitioning for their prescription because of conditions of tremendous pain or suffering, but rather because they were suffering a "loss of autonomy" as cited by Oregon's formal statistical report for the Death with Dignity Act.³⁹ This suggests that although suffering is a plausible reason for why some may want a physician-assisted suicide, the more prevalent reason is self-determination or the right to choose when and how to end one's life. If this is true, then the law is arbitrary in its distinction of persons qualified for the right to that choice.

For example, Jack is a 26-year-old man who was divorced four years ago. He does not suffer clinical depression but has been discontent with his life ever since his divorce. He has felt the desire to end his life but has never wanted to do so in a manner that would burden others. He does not want to cause any pain to his family or society and prefers to end his life in the quiet of his home as painlessly as possible. He lives in Oregon where physician-assisted suicide is legal but only for those with a terminal illness. He decides to file suit against the state of Oregon on an equal protection claim basis. He argues that it is unfair that only those with terminal illnesses have the right to choose when to end their lives while he does not. He argues that his mental anguish is just as painful to him as is the physical pain of those with terminal diseases. Because his life is his, he feels that he should be able to end it when he chooses. If the Oregon statute allows some a right to choose how and when to end their lives, then it must recognize John's right do the same in order to avoid an inconsistent application of this fundamental choice.

How could the court deny Jack's request and remain consistent without striking down the currently arbitrary law in Oregon?

38 *Oregon Death with Dignity Act: 2015 Data Summary*, PUBLIC HEALTH DIVISION, 2 (2015), <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf>.

39 *Id.* at 4.

In *Washington v. Glucksberg*, respondents argued that “[t]he decision of how and when to die is one of the most intimate and personal choices a person may make in a lifetime, a choice central to personal dignity and autonomy.”⁴⁰ Although the court upheld a ban on physician-assisted suicide, the arguments made by respondents have held a lot of weight in light of recent court decisions such as *Obergefell v. Hodges*. The *Obergefell* case ruled that gay marriage is a fundamental right supported by constitutional interpretation and was justified partially by the Due Process Clause. This clause protects liberties that “extend to certain personal choices central to individual dignity and autonomy, including intimate choices defining personal identity and beliefs.”⁴¹ At the federal level, abortion and the right to a same-sex marriage are both considered choices immune to regulation by the state. If such choices are fundamentally each individual’s to make, then it seems grossly unfair to deny someone the right to choose how and when to die regardless of why that might be. Legally speaking, if we do not question why someone wants to marry a person of the same gender, or why a woman wants to have an abortion but we allow either one for the sake of it being an intimate choice, then why must we question the reasons a person might have in choosing how and when to die?

As it stands, the law in Oregon is arbitrary in its designation of which classes of persons qualify as having an inherent right to choose how and when to end their lives. In the Oregon statute, “terminal disease” is defined as “an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.”⁴² Even defining such a term, as we have seen, unfairly precludes those who do not have a terminal disease or who have one with a longer and possibly more painful prognosis. As Dr. Callahan argues, “A requirement that a medical condition be ‘terminal’ will run aground on the notorious

40 *Washington v. Glucksberg*, 521 U.S. 702, end footnote, (1997).

41 *Obergefell v. Hodges*, 83 U.S. 609, Syllabus, (2015).

42 ORS § 127.800 (1997).

difficulties of knowing when an illness is actually terminal.”⁴³ As was the case with J.J., his terminal disease was not actually terminal, nor was his prognosis of four months correct. Even in the case of Brittany Maynard, her prognosis of six months was incorrect because she lived longer than expected. We also do not know with absolute certainty whether or not the cancer would have taken her because in the end a self-administered barbiturate was the actual cause of death.

D. The State's Interest

Apart from the ambiguity and apparent lack of fairness in regard to current physician-assisted suicide laws, there are social and practical implications of legalizing physician-assisted suicide and the question of whether or not the state has compelling interests in upholding a ban on physician-assisted suicide. The state cannot in any situation give a compelling interest for the approval and legalization of physician-assisted suicide in light of the consequences of doing so. Granted, there are costs and benefits of both propositions in regards to legalizing physician-assisted suicide. However, the costs of legalizing such a practice outweigh the benefits, whereas the benefits of prohibiting its practice outweigh the costs.

First, we must consider the interests the state has in upholding a ban on physician-assisted suicide as recognized by the courts, and then we can consider the consequences of legalizing its practice. In *Washington v. Glucksberg*, the court ruled that the state of Washington “had an unqualified interest in the preservation of human life, an interest in protecting the integrity of the medical profession, protecting medical groups, and an interest in preventing the path to voluntary or involuntary euthanasia.”⁴⁴ According to the court, the state’s interest in preserving human life outweighs any alleged right to a physician-assisted suicide, a right which the court went so far as to say is not a “due process right”⁴⁵ at all. Likewise, the court found the

43 Callahan, *supra* note 25 at 54.

44 *Washington v. Glucksberg*, 521 U.S. 702, Footnote III (1997).

45 *Id.* at End Footnote II.

interest of “protecting the integrity of the medical profession”⁴⁶ to be a compelling state interest as well in upholding a ban on physician-assisted suicide. Because the Hippocratic Oath professes the duties of medical doctors to be primarily, if not entirely, concerned with promoting health and preventing sickness, it seems as though aiding a patient in dying directly contradicts the social role doctors have had for centuries. Should physician-assisted suicide be legalized, it would grant doctors the option to simply suggest physician-assisted suicide to a patient on whom they have given up. This could very well lead to the pressuring of the elderly, either by doctors or family members, to have a physician-assisted suicide which would be very similar, if not lead directly to, nonvoluntary and involuntary euthanasia. Even the Supreme Court recognized the possibility of a slide towards euthanasia as an interest among many others that were all “valid and important public interests, which satisfy the constitutional requirement that a legislative classification bear a rational relation to some legitimate end.”⁴⁷

Supreme Court case *Vacco v. Quill* likewise articulated several state interests in upholding a ban on physician-assisted suicide. According to the holding of the court these interests included but were not limited to: “prohibiting intentional killing and preserving life; preventing suicide; maintaining physicians’ roles as their patients’ healers; protecting vulnerable people from indifference, prejudice, and psychological and financial pressure to end their lives; and avoiding a possible slide toward euthanasia.”⁴⁸ Once again, the court recognized the possibility of a slide towards euthanasia, most likely referring to involuntary or nonvoluntary euthanasia, and cited the legalization of physician-assisted suicide being what would potentially lead to such immoral practices. Whenever the state denies certain rights that are alleged to be constitutional or fundamental, the state must provide rational reasons for doing so in order for the ban to be considered tenable or constitutional. In this case the court considered these particular interests in upholding the ban on physician-assisted

46 *Id.*

47 *Vacco v. Quill*, 521 U.S. 793, End Footnote I (1997).

48 *Id.* at Head note I.

suicide as “valid and important public interests that easily satisfied the constitutional requirement that a legislative classification bear a rational relation to some legitimate end.”⁴⁹

The argument against physician-assisted suicide that claims it will lead to involuntary and nonvoluntary euthanasia, the corruption of the medical profession or the pressuring of certain persons to kill themselves with the aid of a physician, is not merely a slippery slope fallacy. These are consequential concerns that even the Supreme Court deemed worthy to constitute a state ban on the practice of physician-assisted suicide. Proof that drastic change in law and its application can occur in short periods of time is evidenced in the same-sex marriage movement. In 2003, just fourteen years ago, it was considered a crime to engage in homosexual sodomy in thirteen states. With the recent ruling in *Obergefell v. Hodges* that reached the Supreme Court in 2015, the right to marry someone regardless of gender is now considered a fundamental and constitutional right. Without placing any value judgment on this new right, it becomes quite clear that drastic change can occur quickly, so it is illogical to dismiss the potential consequences of allowing something like physician-assisted suicide as a slippery slope appeal and brush it off without considering its true implications.

The possibilities of what legalizing physician-assisted suicide can lead to are quite apparent in the Netherlands, a country that legalized physician-assisted suicide in 2002. As current laws stand, children are now allowed to have a physician-assisted suicide with the consent and aid of their parents.⁵⁰ Although currently not a law, on the upcoming ballot for next term voting in the Netherlands there is a bill that would allow for the elderly to end their lives with a

49 *Id.*

50 David Chazan, *Terminally Ill Child Becomes First Euthanized Minor in Belgium*, THE TELEGRAPH (Sep. 17, 2016), <http://www.telegraph.co.uk/news/2016/09/17/terminally-ill-child-becomes-first-euthanised-minor-in-belgium/>.

physician-assisted suicide without proof of any terminal illness.⁵¹ If the elderly citizen is lonely or deems life too burdensome he or she will be allowed to have a physician-assisted suicide. The fact that this proposed bill has no minimum age requirement will allow for virtually anyone to have a physician-assisted suicide for any reason at all, as long as his or her subjective considerations conform to the belief that life is no longer worth living. Of course, this is merely a proposed bill and could be struck down, but this is strong evidence that physician-assisted suicide is not something that will stop at allowing only those with a terminal illness (and with six months to live) the right to end their own lives. Clearly, it has the potential to go further.

Suicide is already considered an epidemic in American society, so what effect would the government putting its stamp of approval on the practice of euthanasia have on an already-persistent problem? If the practice of physician-assisted suicide is pushed to its logical limits, then why is there any reason to prevent attempts at suicide if the agent is choosing to do so? Self-determination is the driving principle behind the practice of physician-assisted suicide, and the law can only make unjust distinctions in not recognizing the autonomy of everyone by allowing only terminally ill patients the right to end their lives at the time of their choosing. Either the law must be changed to deny certain persons a fundamental right, which would be detrimental to society, or we must not allow anyone the right to a physician-assisted suicide. Nevertheless, just because medicine has the means to allow someone a painless death does not mean that the medical profession is somehow obligated to prescribe death or assist in its administration. If it is true that we all have a right to choose when to die, then we certainly can do so whenever we want with whatever means we so choose. But forcing the medical profession to recognize this right and putting the government's stamp of approval on

51 Dan Bilefsky, *Dutch Law Would Allow Assisted Suicide for Healthy Older People*, N.Y. Times (Oct 13, 2016), https://www.nytimes.com/2016/10/14/world/europe/dutch-law-would-allow-euthanasia-for-healthy-elderly-people.html?rref=collection%2Ftimestopic%2FAssisted%2FSuicide&action=click&contentCollection=timestopics®ion=stream&module=stream_unit&version=latest&ch.

it will be wholly detrimental to public health in general and threaten the lives of the old, poor, and vulnerable.

IV. CONCLUSION

Upholding a ban on the practice of physician-assisted suicide would have negative implications of its own. People might have to suffer unnecessarily. Or perhaps denying people a right to have a painless death with the aid of a physician would undermine the value of autonomy. However, I contend that with the increase in technology and a focus on palliative and hospice care we can eliminate the high occurrence of painful deaths. Furthermore, in regards to undermining autonomy, just because the medical profession exists and people have autonomy does not imply that we ought to morally or even legally require physicians to respect the individual wishes of patients in this regard. Autonomy is preserved in the fact that people can end their lives whenever they want with the means they so choose. Just because medicine might make death easier and more convenient does not imply that we should coerce doctors to assist a patient in committing suicide simply because that patient wants to exercise his or her autonomy. Surely people will always be able to make the choice to commit suicide at any time they want. Thus, while there is never a perfect solution in determining whether a particular law should or should not be enacted, the negative consequences of permitting the Oregon Death with Dignity Act, or any pro physician-assisted suicide law, far outweigh the benefits.

Ultimately, the Oregon Death with Dignity Act is a law that should be repealed. If its policy considerations are based on a presumption of autonomy then, as the law is written, it arbitrarily denies certain people a right to choose when to end their lives without compelling justification. It must be expanded to include a significantly larger group of people, which would have negative social and practical implications especially in regards to the elderly and the mentally ill. If the law was written based on a principle of a presumed right to relief of suffering, then nonvoluntary euthanasia for the incompetent would become acceptable. Furthermore, the state has compelling interests in upholding a ban on physician-assisted suicide including,

but not limited to preserving human life, protecting the integrity of the medical profession, and avoiding the path leading to nonvoluntary and involuntary euthanasia.

