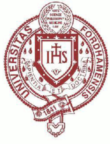

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ONLINE NOTE

REGULATING PHYSICIAN-ASSISTED SUICIDE

Colm O'Connor[*]

The legal practice of physician-assisted suicide provides individuals with the means to hasten the process of dying; this is a unique opportunity one might take for an array of reasons. Legally, the right to die is only vested in individuals with a terminal illness, so the grounds for pursuing a physician-assisted suicide stem from the strains and fears prompted by this illness. Individuals request physician-assisted suicide most commonly for disease-related pain and suffering, inability to enjoy activities, fear of a loss of autonomy or future suffering, and belief their existence is a burden.[2] Although it is a serious and rather somber practice, physician-assisted suicide can be beneficial and necessary given a bleak enough situation, in which an individual's pain crosses into the realm of inhumane. Moreover, the solemnity of such an operation comes with a lot at stake. The law surrounding the practice of physician-assisted suicide must be composed in such a fashion, with certain regulations and restrictions in place, so that its capacities of legally relieving individuals from their agonizing existence does not teeter with the illegal practice of euthanasia.

Although the conversation began in California and Washington, the state of Oregon was the first state to make successful strides in the right to die campaign.[3] Oregon first passed the "Death With Dignity" act during November of 1994 in a referendum that won by a vote of 51% to 49%.[4] However, its implementation was delayed until 1997 due to a legal injunction.[5] This law, having found its first narrow success in Oregon, could be accredited to the progressive sentiment in the state, especially regarding health. The state of Oregon has progressive advance directive laws in place, and the citizens have a tendency to use the initiative power as an instrument of legal and social change as seen throughout history.[6] The "Death With Dignity" law states that terminally ill Oregonians are allowed to end their

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[2] *See* Ellen Wiebe et al., *Reasons for requesting medical assistance in dying*, 64 Canadian Family Physician 674-679 (2018), https://www.researchgate.net/publication/327653265_Reasons_for_requesting_medical_assistance_in_dying.

[3] *See Initiative for Death with Dignity Act*, 1991 Wash. Legis. Serv. Init. Meas. 119 (West); *See California Death With Dignity Act*, 1992 Cal. Legis. Serv. Prop. 161 (West).

[4] *See* Sandra Norman-Eady, *Oregon's Assisted Suicide Law*, cga.ct.gov (2020), https://www.cga.ct.gov/2002/rpt/2002-R-0077.htm.

[5] *Id.*

[6] *See* Tom Bates & Mark O'Keefe, *On Suicide Measure, Oregon Is a Maverick Again*, The Oregonian, (Nov. 13, 1994).

lives through the voluntary self-administration of lethal medications, expressly prescribed by a physician for that purpose.[7] To utilize the Death with Dignity Act, the law requires residency in Oregon, 18 years or more of age, psychological health, and a terminal illness dictating one has less than 6 months to live.[8] These requirements are matched with an appropriately rigorous request process that requires the patient to undergo multiple oral and written requests witnessed by various parties[9], along with certain requirements by the physician ensuring complete certainty and mental coherence in their decision.[10] The law ensures that the act of euthanasia, or any process in which the physician is making the final life-ending action, is strictly prohibited. It reduces physician-assisted death to prescription by the physician, requiring the individual to administer the life-ending medicine themselves. This detail is requisite to avoid infringing upon the pre-existing law in Oregon, amongst other states, that restricts the precipitation of suicide.[11] A facet of the act states that ending one's life in accordance to the law does not constitute suicide, which also contributes to the protection of physicians from criminal prosecution.[12]

The state of Montana currently lacks a law that allows for physician-assisted suicide; so, since the Supreme Court has determined that the right to physician-assisted suicide exists nowhere in the United States Constitution, this right is rooted in the Montana State Constitution.[13] A state constitution can by no means abridge the rights set forth by the United States Constitution, however, it can serve to expand those rights. This was the clear intent of the 1972 Montana Constitution; Article 2, Sections 4 and 10 address an individual's right to privacy and dignity, and these expanded rights apply to an individual in their quest to die with dignity.[14] The State Constitution's Section pertaining to the right to privacy states that "the right of individual privacy is essential to the well-being of a free society and shall not be

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[7] *See* Oregon Health Authority, *Oregon's Death with Dignity Act*, State of Oregon, oregon.gov (2020), https://www.oregon.gov/oha/PH/ProviderPartnerResources/Evaluationresearch/deathwithdignityact/Pages/index.aspx.
[8] *See* Norman-Eady, *supra* note 4.
[9] *Id.*
[10] *Id.*
[11] *See* G. Alan Tarr, *The Montana Constitution: A National Perspective*, 64 Montana L. Rev. 1-22 (2003), https://scholarship.law.umt.edu/cgi/viewcontent.cgi?article=2268&context=mlr.
[12] *See* Norman-Eady, *supra* note 4.
[13] *See* Tarr, *supra* note 11.
[14] *See* James E. Dallner & D. Scott Manning, *Death with Dignity in Montana*, 65 Montana L. Rev. 1-34 (2004), https://scholarship.law.umt.edu/mlr/vol65/iss2/4/ (last visited Sep 15, 2020).

infringed without the showing of a compelling state interest"[15], while the section pertaining to dignity states "the dignity of the human being is inviolable, no person shall be denied the equal protection of the law."[16] With the unique constitutional language that makes up Montana's state constitution in place, citizens are afforded a greater right to privacy than they are in other states, as stated by the Montana Supreme Court.[17] To exercise one's right to privacy in Montana, an individual is required to elucidate an expectation of privacy that society must agree with; this plays out in court using the Katz test[18] -to determine whether this is valid or not.[19] Thus in the case of a terminally-ill person who is suffering and near death, it must be reasonably recognized by other Montanans that a physician-assisted suicide falls under their state-mandated right to privacy.[20]

In 42 states, there are statutes that prohibit aiding or assisting a suicide, along with 6 other states where this is illegal due to common law.[21] This statue exists in Montana, regarding such an act as either a felony or homicide based on how successful the suicide attempt is.[22] From a regulatory standpoint, Oregon, and the states that have taken after its model, differ from Montana due to the fact that an actual law was passed, which states that "actions taken in accordance with the Act shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law."[23] Montana's method of regulating physician-assisted suicide can be reduced to a singular law criminalizing assisted suicide that, may not withstand the stern test of constitutionality due to its broad and restrictive nature.[24] For this reason, Montana should adopt a model similar to Oregon's Death With Dignity Act to conduct physician-assisted suicide appropriately and avoid legal complications; the state can allow its citizens the freedom of

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[15] Candle M. Wester-Mittan, *Physician-Assisted Death: Four Views on the Issue of Legalizing PAD*, Hein Blog, wshein.com (2009), https://www.wshein.com/blog/2009/06/01/physician-assisted-death-four-views-on-the-issue-of-legalizing-pad/.

[16] *Id.*

[17] *See* Dallner, *supra* note 14.

[18] The Katz Test determines whether an action, or restriction of an action by the government violates an individual's right to privacy. Traditionally, it has served to specify whether the rights granted to citizens in the Fourth Amendment apply to certain individuals given the variables of the situation. *See Passage of Orders, Resolutions, or Votes*, Constitution Annotated, https://constitution.congress.gov/browse/essay/artI_S7_C3_1/ALDE_00001053/.

[19] *See* Dallner, *supra* note 14.

[20] *Id.*

[21] *See* Tarr, *supra* note 11.

[22] *See* Dallner, *supra* note 14.

[23] *See* Tarr, *supra* note 11.

[24] *See* Dallner, *supra* note 14.

a hastened demise without teetering with situations of euthanasia. Along with the concise language that properly regulates the practice of physician-assisted suicide within the Act, it also features reasonable safeguards necessary for dealing with fragile patients nearing the end of their lives. These safeguards include presenting patients with the option for palliative care, ensuring competency in all patients making end-of-life decisions for themselves, ensuring voluntariness in requests, obtaining a second opinion on the case, requiring persistence in their request spanning over a two-week interval, encouraging the involvement of the next of kin, and requiring physicians to notify OPHD of all cases in which a prescription for the purpose of assisted suicide has been written.[25]

The practice of physician-assisted suicide is very advantageous, which is why installing the proper regulatory measures is such an important matter. This notion can be elucidated best by an example from David Orentlicher. He describes a young adult, disheartened from a recent romantic breakup, who is temporarily ventilator-dependent due to asthma-related issues. On the other hand, you have an individual plagued by widely metastatic cancer, nearing the end of a thorough and rewarding life. They are looking for an option to hasten the dying process because they cannot seem to physically endure the pain and struggle to justify why they would prolong this inevitable conclusion.[26] This situation takes place in a state that has not granted its citizens the right to a physician-assisted suicide. Given that competent individuals have the freedom to refuse life-sustaining treatment as declared in *Cruzan vs. Director*, yet they do not have the freedom to a physician-assisted suicide, the young individual with asthma has the ability to end his suffering, while the older individual with metastic cancer does not.[27] Not only does this dichotomy reveal how similar the practices of physician-assisted suicide and treatment withdrawal can be, but it highlights how situations requiring treatment withdrawal can look just as questionable as those requiring physician-assisted suicide. At the end of the day, they are both means to die, and more specifically, ways to end the suffering that an individual deems as inhumane.

Orentlicher also brings up that "if the right to die reflects the individual's right to be free of inhumane suffering, then it is hard to distinguish in principle between persons who are terminally ill and those who

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[25] *See* Herbert Hendin & Kathleen Foley, *Physician-Assisted Suicide in Oregon: A Medical Perspective*, 106 Michigan L. Rev. 1613-1640 (2008), https://repository.law.umich.edu/cgi/viewcontent.cgi?article=1374&context=mlr.
[26] *See* David Orentlicher, *The Legalization of Physician Assisted Suicide: A Very Modest Revolution*, 38 Boston College Law Review 443-475 (1997), https://lawdigitalcommons.bc.edu/cgi/viewcontent.cgi?article=2067&context=bclr.
[27] *See Cruzan by Cruzan v. Director, Missouri Department of Health,* Oyez, https://www.oyez.org/cases/1989/88-1503.

are not."[28] Although this logic is sound, the restriction of physician-assisted suicide to the terminally ill is the only way individuals in need can benefit from this practice without negative repercussions like the normalization of suicide. The laws in Montana that allow physician-assisted suicide fall within the Montana State Constitution, and pertain to an individual's right to "inviolable dignity"[29] and "essential privacy"[30].These laws must be justified by a compelling state interest and narrowly tailored to effectuate only that interest.[31] Any right that a healthy individual might have to take his or her own life is outweighed by the state's compelling interest in the preservation of life.[32] When viewing this right at its core of granting individuals an end to inhumane suffering, the terminally ill in particular have a right to physician-assisted suicide over the healthy because it is a matter the state interest is less compelled to restrict. Moreover, the right to physician-assisted suicide is such a salient matter for the terminally ill because they lack the agencies to produce this same effect given that they are bedridden in a safe, surveyed environment unlike healthy individuals who have access to instruments that would make a physician-assisted suicide more or less irrelevant.[33] Physician-assisted suicide is a practice that can produce the desired effect for many individuals, it just needs proper regulation.

Montana's restriction of physician-assisted suicide to strictly the terminally ill by subjecting the matter to the state's compelling interest is valid, but the state's regulation of this matter as a mere statute is insufficient given its vulnerability to constitutional incongruency. When viewed under the scope of constitutionality, Montana's current law restricting assisted suicide might not survive to serve its purpose because it is problematically broad and strict. The lack of regulation could teeter with offenses like euthanasia and could yield many legal drawbacks. Considering that the practice of physician-assisted suicide is advantageous in delivering individuals from inhumane suffering, the state of Montana should take the same regulatory steps as Oregon to properly conduct this beneficial practice.

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[28] *See* Orentlicher, *supra* note 26.
[29] *See* Tarr, *supra* note 11.
[30] *Id.*
[31] *See State v. Siegal*, 281 Mont. 250, 263, 934 P.2d 176, 184 (1997).
[32] *See* Orentlicher, *supra* note 26.
[33] *Id.*