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**DIGNITY IN DEATH: WHY THE FUNDAMENTAL RIGHT
OF THE INDIVIDUAL TO CHOOSE THEIR FINAL
MOMENTS OUTWEIGHS THE GOVERNMENT'S
SOCIETAL INTERESTS TO PRESERVE LIFE**

Madison Frank*

“If you don’t have liberty and self-determination, you’ve got nothing, that’s what this country is built on. And this is the ultimate self-determination, when you determine how and when you’re going to die when you’re suffering.” - Dr. Jack Kevorkian¹

I. INTRODUCTION

Many believe that the right to die is a recently developed notion;² however, the concept is deeply rooted in European and American history.³ The right to die is ingrained through three-main strands: “the right to control one’s own body, the right to privacy, and the due process liberty interest.”⁴ American courts have used these three strands to shape the law to adapt (or not adapt) to the right of terminal individuals to choose when they die.⁵

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1. 60 Minutes, *Death by Doctor*, CBS NEWS (Nov. 22, 1998), <https://www.cbsnews.com/news/dr-jack-kevorkians-60-minutes-interview/?subscribed=1> [<http://perma.cc/Z23G-VESB>].
2. John A. Powell & Adam S. Cohen, *The Right to Die*, 10 ISSUES L. & MED. 169, 170 (1994).
3. *See id.*
4. *Id.*
5. *Id.*

Approximately 2.8 million people die every year in the United States.⁶ While many deaths are the result of tragic accidents,⁷ thousands of Americans are diagnosed with terminal illnesses that progress to such a degree that continuing medical treatment is futile.⁸ When a patient reaches this point, death becomes a question of “when”—not “if”—leading many patients to ask that their physicians end their suffering.⁹ The right to die with assistance means a patient’s right to authorize a physician to commit an act that would directly result in the patient’s death, without the doctor being held civilly or criminally liable.¹⁰

Consider Brittany Maynard, who was diagnosed with terminal brain cancer at the young age of twenty-nine.¹¹ After being married for just over a year, Brittany underwent countless surgeries, including a partial craniotomy.¹² A few months after her diagnosis, her doctor informed her that she likely had only six months to live.¹³ After many months of research, meetings with specialists, and conversations with her family, Brittany decided to end her suffering with physician-assisted suicide.¹⁴ Brittany’s wish, however, posed to be a challenge because her home state of California had not yet passed a death with dignity act.¹⁵ She therefore had to establish residency in Oregon in order to follow through with her wish to end her life on her own terms.¹⁶ After moving to and establishing residency in Oregon, she had to find new doctors, buy a new home,

6. Kenneth D. Kochanek et al., *Deaths: Final Data for 2017*, 68 NAT’L VITAL STAT. REP. 1 (2019).

7. *Id.*

8. Jackson Pickett, *Can Legalization Improve End-of-Life Care? An Empirical Analysis of the Results of the Legalization of Euthanasia and Physician-Assisted Suicide in the Netherlands and Oregon*, 16 ELDER L.J. 333, 334 (2009); see, e.g., Kochanek et al., *supra* note 6.

9. See Pickett, *supra* note 8.

10. Note, *Physician-Assisted Suicide and the Right to Die with Assistance*, 105 HARV. L. REV. 2021, 2023 (1992) [hereinafter *Right to Die with Assistance*].

11. Brittany Maynard, *My Right to Die with Dignity at 29*, CNN, <https://www.cnn.com/2014/10/07/opinion/maynard-assisted-suicide-cancer-dignity> [<http://perma.cc/8Q8A-MJJK>] (last updated Nov. 2, 2014, 10:44 PM).

12. *Id.*

13. *Id.* Her doctor suggested brain radiation, which would have left painful first-degree burns on her scalp, among other symptoms. *Id.* This treatment would not cure her but only prolong what little time she had left. *Id.*

14. *Id.*

15. *Id.*

16. *Id.*

obtain an Oregon driver's license, and change her voter registration.¹⁷ As if Brittany's life was not uprooted enough, her husband had to take a leave of absence from his job in California so he could move with her.¹⁸ Most Americans are not in the financial position to make such drastic changes in their lives.¹⁹

Seven out of ten Americans support a terminally ill individual's right to physician-assisted suicide;²⁰ however, only nine states currently permit this choice.²¹ The concept of an individual's personal liberty, which originates in the Fourteenth Amendment of the United States Constitution, is deeply rooted in a person's right to end their own life.²² American law protects from government interference in profoundly personal aspects of our lives including "marriage, procreation, contraception, family relationships, child rearing, and education"²³; however, there is overwhelming resistance that prevents an individual from determining how they wish to live the final moments of their life.²⁴ While protecting the lives of its citizens is within the government's interest, a person's fundamental right to determine when and how to end their life outweighs the government's interest because of America's respect for individual liberty.²⁵

This Article proceeds in three main parts: starting with the history of the right to die doctrine and an exploration of the concept of physician-assisted suicide,²⁶ followed by theories of opposition to and support for physician-assisted suicide laws.²⁷ This Article will then address the current law in Maryland and analyze the success of the law in Oregon.²⁸

17. *Id.*

18. *Id.*

19. *Id.*

20. *Stories*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/stories/> [<http://perma.cc/7NQL-3NTZ>] (last visited Dec. 26, 2019).

21. *States with Legal Physician-Assisted Suicide*, PROCON.ORG, <http://euthanasia.procon.org/view.resource.php?resourceID=000132> [<http://perma.cc/78DN-CV9Z>] (last updated July 25, 2019, 8:48 AM). States with legislation legalizing physician-assisted suicide include: California, Colorado, Hawaii, Maine, New Jersey, Oregon, Vermont, and Washington. *Id.* Montana permits physician-assisted suicide via court ruling. *Id.*

22. *See* *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992).

23. *Id.*

24. *See States with Legal Physician-Assisted Suicide*, *supra* note 21.

25. *See Right to Die with Assistance*, *supra* note 10, at 2025, 2032–33.

26. *See infra* Part II.

27. *See infra* Part III.

28. *See infra* Part IV.

II. HISTORY OF THE RIGHT TO DIE DOCTRINE

A. *From the Classical Antiquity Era to Modern Times*

Current medical practice permits competent, terminal patients to cease medical treatment, even though the removal of treatment will result in death.²⁹ The right to die is not a new ideology but rather dates back to the time of Augustus Caesar, when many ancient Greek and Roman physicians supported voluntary death as opposed to living a prolonged, painful life.³⁰ Physicians often complied with requests by supplying poison to end their patients' lives.³¹ A resistance to euthanasia and physician-assisted suicide strengthened through the centuries due to the rise of Christianity and Judaism.³² The act of euthanasia³³ and physician-assisted suicide continued to meet opposition in Colonial America and well into the late eighteenth century, as the First and Second Great Awakenings³⁴ created

29. See *Right to Die with Assistance*, *supra* note 10, at 2021–22.

30. See *History of Euthanasia and Physician-Assisted Suicide*, PROCON.ORG, <http://euthanasia.procon.org/view.timeline.php?timelineID=000022> [<http://perma.cc/E7E6-MV7J>] (last updated July 23, 2013) [hereinafter *History of Euthanasia and PAS*].

31. *Id.*

32. *Id.* Thomas Aquinas, a notable Christian figure, solidified the Christian belief that suicide, in any fashion, goes against God's teachings and violates the sanctity of life. *Id.* This mindset prevailed through the Middle Ages, the Renaissance, the Reformation, and still pervades Christian teachings today. *Id.*

33. Active euthanasia allows a physician to actively administer the method that will cause the patient's death, either by prescribing a lethal dose of medication or using a poisonous injection. Raphael Cohen-Almagor, *Euthanasia and Physician-Assisted Suicide in the Democratic World: A Legal Overview*, 16 N.Y. INT'L L. REV. 1, 2–3 (2003); see also Maria T. CeloCruz, *Aid-in-Dying: Should We Decriminalize Physician-Assisted Suicide and Physician-Committed Euthanasia?*, 18 AM. J.L. & MED. 369, 379–80 (1992) (explaining that physician-assisted active euthanasia contains four main elements: "(1) a direct killing performed by someone other than the victim; (2) at the victim's request; (3) where the other is motivated by mercy or at least not ill-will; and (4) is a physician").

34. See *History of Euthanasia and PAS*, *supra* note 30. The First Great Awakening, starting in the early eighteenth century, is known for its emphasis on the New Testament as a renewal movement that simplified the gospel to embrace the common man. See *History of American Awakenings*, HELPER CONNECTION, <https://thehelperconnection.org/ministries/the-helper/history-of-american-awakenings/> [<http://perma.cc/KFW8-N7P5>] (last visited Dec. 26, 2019). During the nineteenth century, The Second Great Awakening emerged as a way to fix the "waning spiritual condition" taking place in America during the westward expansion. See *id.* With a focus on spiritual renewal, the concept of protracted (drawn out) revivals often took the place of traditional churches. *Id.*

insurmountable opposition to the action of taking one's own life.³⁵ This belief, among others, largely contributes to the lack of state laws that permit such an action.³⁶

The Hemlock Society, a well-known organization that advocates for the right to die, was formed in 1980.³⁷ The idea of physician-assisted suicide began to take hold in the '80s due to the relentless efforts of the Hemlock Society and other like-minded organizations.³⁸ The recognition of one's right to die as a fundamental interest founded in constitutional liberty became a mantra for groups in support of physician-assisted suicide and remains one of the major arguments for developing physician-assisted suicide legislation.³⁹

35. See *History of Euthanasia and PAS*, *supra* note 30.

36. See *id.*; see also *Euthanasia Statement*, U.S. CONF. OF CATH. BISHOPS (Sept. 12, 1991) <http://www.usccb.org/issues-and-action/human-life-and-dignity/end-of-life/euthanasia/statement-on-euthanasia-1991.cfm> [https://perma.cc/E5VT-4Y55]. The views of the Catholic Church on euthanasia were made clear from a statement issued by the Administrative Committee at the National Conference of Catholic Bishops:

As Catholic leaders and moral teachers, we believe that life is the most basic gift of a loving God--a gift over which we have stewardship but not absolute dominion. Our tradition, declaring a moral obligation to care for our own life and health and to seek such care from others, recognizes that we are not morally obligated to use all available medical procedures in every set of circumstances. But that tradition clearly and strongly affirms that as a responsible steward of life one must never directly intend to cause one's own death, or the death of an innocent victim, by action or omission. As the Second Vatican Council declared, "euthanasia and willful suicide" are "offenses against life itself" which "poison civilization"; they "debase the perpetrators more than the victims and militate against the honor of the creator."

Euthanasia Statement, *supra*.

37. See *History of Euthanasia and PAS*, *supra* note 30. Derek Humphrey formed the group after he assisted his wife in her death after she was diagnosed with terminal breast cancer. *Id.*; see also Derek Humphrey, *Farewell to Hemlock: Killed by Its Name*, ASSISTED SUICIDE: EUTHANASIA RES. & GUIDANCE ORG. (Feb. 21, 2005), <http://www.assistedsuicide.org/farewell-to-hemlock.html> [http://perma.cc/GMP8-SRAX]. The Hemlock Society, now known as Compassion & Choices, was the largest and oldest right-to-die organization in America that fought for voluntary euthanasia and physician-assisted suicide for terminally ill adults. Humphrey, *supra*.

38. See Humphrey, *supra* note 37.

39. *Id.*

B. *Physician-Assisted Suicide and the Rise of Dr. Death*

1. Physician-Assisted Suicide

The Anglo-American common law prohibition of suicide is derived from three main reasons: “religious belief—the origin of the ignominious burial penalty; sovereign cupidity—the rationale for declaring suicide a felony at common law; and protection of a vulnerable minority—the movement to abolish penalties for suicide and substitute treatment for those unsuccessfully attempting it.”⁴⁰ Notably, suicide is not considered a crime in any U.S. state; thus, the volitional act of the patient in physician-assisted suicide is not illegal.⁴¹ Further, a physician will not be held liable for withholding or withdrawing treatment at the patient’s request.⁴² This concept similarly aligns with physician-assisted suicide: if the patient has a right to die with assistance, the physician would not be held criminally or civilly responsible by a court of law.⁴³ Alternatively, active euthanasia allows a physician to administer the method that will cause the patient’s death by prescribing a lethal dose of medication or using a poisonous injection.⁴⁴

2. The Rise of Dr. Death

Jack Kevorkian, widely known as “Dr. Death,” single handedly helped over 130 people end their lives through his “mercy machine,”⁴⁵ a contraption he invented to end a patient’s life.⁴⁶ A

40. CeloCruz, *supra* note 33, at 375.

41. *See Right to Die with Assistance*, *supra* note 10, at 2024.

42. *Id.*

43. *Id.*

44. *See* Raphael Cohen-Almagor & Monica G. Hartman, *The Oregon Death with Dignity Act: Review and Proposals for Improvement*, 27 J. LEGIS. 269, 270 (2001); *see also* CeloCruz, *supra* note 33, at 379–80.

45. *See* Nicholas Jackson, *Jack Kevorkian’s Death Van and the Tech of Assisted Suicide*, ATLANTIC (June 3, 2011), <http://www.theatlantic.com/technology/archive/2011/06/jack-kevorkians-death-van-and-the-tech-of-assisted-suicide/239897/> [<http://perma.cc/FD5N-MKNU>]. Commonly referred to as the “mercy machine,” the device that was built out of random household items and consisted of two parts: the “Thanatron” (the Death Machine) and the “Mercitron” (mercy machine). *Id.* For the Thanatron, Dr. Kevorkian would hook the patient up to an intravenous saline drip, and when the patient pressed the button, the machine would release a dose of thiopental (which puts the patient to sleep) and is then followed by a lethal dose of potassium chloride. *Id.* The Mercitron, which was used far more often than the Thanatron, would release a deadly gas and travel to the patient wearing a mask; because Kevorkian always made sure his patients took the final act, he outfitted the Mercitron

believer in assisting his patients to their unavoidable death, Dr. Kevorkian has become a name recognized by medical institutions and households alike.⁴⁷ Dr. Death made it his life's work to have the medical field acknowledge not only their responsibility to assist its patients in life but also in death.⁴⁸ Between 1994 and 1997, Dr. Kevorkian stood trial four times.⁴⁹ Each time he walked back into a courtroom, he garnered more publicity for his cause, making it almost impossible for citizens and legislatures across the country to avoid discussing the controversial topic.⁵⁰ Dr. Kevorkian's flagrant method of performing physician-assisted suicides convinced many people that legalizing the act will lead to abuse of it.⁵¹

III. SUPPORT AND OPPOSITION TO THE RIGHT TO DIE WITH DIGNITY

For centuries, politicians and citizens alike have debated the issues surrounding a person's right to die.⁵² Advocates of physician-assisted suicide contend that although a person's life is always valuable, "a patient's desire to control his or her manner of death and to die a more painless and/or dignified death should be given precedence over the value of his or her life."⁵³ Opponents, however, sort their argument into two main categories: protecting the interests of the individual and protecting the interests of society.⁵⁴ Regardless,

with a lever that would release the gas. *Id.* Even the most debilitated of patients would be able to push the lever. *Id.*

46. Keith Schneider, *Dr. Jack Kevorkian Dies at 83; a Doctor Who Helped End Lives*, N.Y. TIMES (June 3, 2011), <http://www.nytimes.com/2011/06/04/us/04kevorkian.html> [<http://perma.cc/5PR2-M3U4>].

47. *Id.*

48. *Id.*

49. *Id.* Three of Dr. Kevorkian's trials ended in acquittals and the fourth resulted in a mistrial. *Id.* Ultimately, Dr. Kevorkian was sentenced to twenty-five years in prison in 1999 but was released after he assured the court he would no longer conduct assisted-suicides. *Id.*

50. *Id.*

51. *See generally* T. Howard Stone & William J. Winslade, *Physician-Assisted Suicide and Euthanasia in the United States: Legal and Ethical Observations*, 16 J. LEGAL MED. 481, 492 (1995) (discussing the reasons for opposition and concern over the legalization of Dr. Kevorkian's method of physician-assisted suicide).

52. *See infra* Sections III.A–C.

53. Cohen-Almagor & Hartman, *supra* note 44, at 272; *see also* Stone & Winslade, *supra* note 51, at 483, 507.

54. *See Right to Die with Assistance*, *supra* note 10, at 2031–32.

the issues surrounding the right to die are classified into ethical, philosophical, religious, and legal considerations.⁵⁵

A. Legal Arguments

Advocates of physician-assisted suicide believe that the act is rooted in the common law of informed consent, which is grounded in the concept of individual autonomy.⁵⁶ Furthermore, “[i]nformed consent gives patients power over medical decisions—the power to ‘overcome the paternalistic attitudes of doctors generated by the inequality of knowledge that exists between them.’”⁵⁷ Many states resist decriminalizing physician-assisted suicide because they believe allowing physician-assisted suicide threatens society’s sanctity of life.⁵⁸ While advocates and opponents feel differently about physician-assisted suicide,⁵⁹ the components are the same—they are just balanced and weighed differently.⁶⁰ Additionally, the lack of criminal enforcement for doctors who provide physician-assisted suicide indicates support for a death with dignity act, especially when juries regularly seem unwilling to convict.⁶¹

B. Constitutional Concepts

When deciding whether a patient has a right to die, courts have generally used a balancing test between the patient’s interest in self-

55. *See id.* at 2040.

56. *See id.* at 2025–26. The doctrine of informed consent “seeks to vindicate the right of every person to determine what will be done to his body.” *Id.* at 2026.

57. *Id.*

58. *Id.* at 2032–33.

59. *See supra* notes 52–54 and accompanying text.

60. *See Right to Die with Assistance, supra* note 10, at 2032. While explaining how the interests are weighed, proponents of physician-assisted suicide proclaim:

The only conflict, then, between criminal statutes that prohibit [physician-assisted] suicide . . . and right-to-die doctrine is how the various interests are weighed and reconciled. The same purposes are served, but in different ways. The criminal law’s blunt prohibition of all suicide assistance is based on the assumption that this best serves the various individual and societal interests at stake. By contrast, current right-to-die case law delicately balances the various interests, which have different weights and sometimes even conflict, in light of the circumstances of each case.

Id.

61. *See CeloCruz, supra* note 33, at 369–70.

determination and the state's interest in life preservation.⁶² Supporters of the right to die have enveloped their legal arguments within the U.S. Constitution, particularly the Due Process Clause of the Fourteenth Amendment.⁶³ Yet, in June of 1997, the United States Supreme Court upheld two different state laws that prohibited physician-assisted suicide.⁶⁴ The law in Washington, which prohibited physician-assisted suicide, was challenged on Fourteenth Amendment Due Process grounds.⁶⁵ In New York, physicians and terminally ill patients challenged a law on Equal Protection grounds that allowed a patient to reject life-sustaining treatment, but did not permit a physician to assist in that action.⁶⁶ In rejecting the challenges to these two state laws, the Court distinguished a patient's right to withdraw medical treatment from a patient choosing to end their life via physician-assisted suicide.⁶⁷

Proponents of physician-assisted suicide also categorize the right to die as a privacy right.⁶⁸ When addressing the issue from a privacy perspective, the Court in *In re Quinlan* analogized a woman's right to decide whether to terminate her pregnancy to an individual's right to decline medical treatment.⁶⁹ Further, courts have also based the right to die on a liberty due process interest, which was the reasoning employed by the Court in *Cruzan* when establishing that there is a fundamental liberty interest in refusing unwanted medical treatment.⁷⁰ Essentially, the right to be free from government interference in making fundamental personal decisions, like the choice to end your life, is the basis of due process liberty.⁷¹ Moreover, privacy rights, which are often cited by courts when

62. Using this balancing approach, courts use a variety of factors including whether the patient is terminally ill, their mental state, if they can receive treatment at home or are forced to remain at the hospital, and the level of health care they are receiving. *Right to Die with Assistance*, *supra* note 10, at 2022.

63. See Vincent J. Samar, *Is the Right to Die Dead?*, 50 DEPAUL L. REV. 221, 221 (2000).

64. *Id.*

65. *Id.*; see also *Washington v. Glucksberg*, 521 U.S. 702, 705–06 (1997).

66. *Vacco v. Quill*, 521 U.S. 793, 796–98 (1997).

67. *Id.* at 801.

68. *Right to Die with Assistance*, *supra* note 10, at 2025.

69. The court opined: “Presumably this right is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman's decision to terminate pregnancy under certain conditions.” *In re Quinlan*, 355 A.2d 647, 663 (N.J. 1976) (citing *Roe v. Wade*, 410 U.S. 113, 153 (1973)).

70. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278 (1990); see also Powell & Cohen, *supra* note 2, at 170–71.

71. See *Right to Die with Assistance*, *supra* note 10, at 2025.

discussing the right to die, are “also rooted in an ideal of individual autonomy. Privacy rights protect citizens from government interference [surrounding] fundamental personal decisions, including those that involve family relationships, education, and abortion.”⁷²

Opponents of physician-assisted suicide note that neither the Constitution nor its Amendments mention suicide.⁷³ In order for physician-assisted suicide to be considered a constitutional right under the American jurisprudence model,⁷⁴ the right must be so deeply rooted in American tradition and psyche to be considered fundamental.⁷⁵ Further, in the United States, suicide has been more condemned than accepted.⁷⁶ While a strict constructionist may find this argument appealing,⁷⁷ the case law surrounding physician-assisted suicide demonstrates that courts are, in some ways, using a more liberal approach while not explicitly condoning physician-assisted suicide.⁷⁸ In many instances, including in *Planned*

72. *Id.*

73. See CeloCruz, *supra* note 33, at 386.

74. G. Edward White, *The Path of American Jurisprudence*, 124 U. PA. L. REV. 1212, 1225–26 (1976) (explaining that American jurisprudence is unique in the fact that it requires common law to “continually reflect currently held social attitudes”).

75. See CeloCruz, *supra* note 33, at 387.

76. *Executive Summary: A Survey About Mental Health and Suicide in the United States*, AM. FOUND. FOR SUICIDE PREVENTION, <https://afsp.org/executive-summary-survey-mental-health-suicide-united-states/> [<http://perma.cc/ZLF4-NBSG>] (last visited Dec. 26, 2019).

77. See *Strict Constructionist*, MERRIAM-WEBSTER, <https://www.merriam-webster.com/dictionary/strict%20constructionist> [<http://perma.cc/PC5S-XSYF>] (last visited Dec. 26, 2019) (defining a strict constructionist as “one who favors giving a narrow conservative construction of a given document or instrument” and specifically as “one who favors a strict construction of the Constitution of the United States”).

78. See Powell & Cohen, *supra* note 2, at 170–71; see also *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992). In *Casey*, the Court addressed the idea of fundamental rights surrounding a person’s life and liberty by saying:

Our law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education. Our cases recognize “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.” Our precedents “have respected the private realm of family life which the state cannot enter.” These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment.

Casey, 505 U.S. at 851 (citations omitted).

Parenthood v. Casey, the Court relayed a strong belief in an individual's right to make their own choices related to personal dignity and autonomy.⁷⁹ This is evidenced by the Court's acknowledgment that "[a]t the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State."⁸⁰

C. Other Reasons for Opposition

1. Mistake

Many opponents of physician-assisted suicide challenge the action based on the fear of mistake, expressing concern that the person choosing physician-assisted suicide would have chosen differently if they had known of another way, or the possibility of a cure becoming available after physician-assisted suicide has been carried out.⁸¹ This argument is not very strong, however, as it would be rare for a person to choose death when other options have not been explored and rare for a physician to suggest death if all medical options had not been evaluated.⁸² Moreover, it would be an unusual situation for a person or physician to not be aware of near future medications or clinical trials that could potentially improve the patient's quality of life.⁸³ Further, clinical trials tend to have long waiting lists and can take years to get up and running.⁸⁴ Various safeguards can be put in place for those seeking physician-assisted suicide to prevent these kinds of mistakes, including requiring multiple physicians to diagnose the patient, making sure the patient is comfortable and therefore not making the decision while in pain, and other precautions that are currently in place for Do Not Resuscitate orders.⁸⁵

79. *Casey*, 505 U.S. at 851.

80. *Id.*

81. *See* Stone & Winslade, *supra* note 51, at 500–02.

82. *See id.* at 501–02. This idea also encompasses those who may not be terminally ill (technically), but who are trapped in their bodies, meaning their cognitive ability is completely intact but the individual has no physical capabilities. *See id.* at 503.

83. *See id.* at 501.

84. *See id.* at 501–02.

85. *See id.* at 502–03.

2. Inalienable Right to Life

The Declaration of Independence states that all humans are “endowed, by their Creator, with certain unalienable rights; that among these are life, liberty, and the pursuit of happiness.”⁸⁶ For a right to be considered inalienable, it must be impossible for that right to be waived or given away.⁸⁷ Based on this, right to die adversaries posit that to kill another person, even at their request, infringes on that person’s inalienable rights.⁸⁸ This argument, however, lacks muster due to the way in which courts have allowed the withdrawal of treatment.⁸⁹

There is no real distinction between a patient asking for her medical treatment to be removed resulting in her death, and a patient asking a physician to prescribe medication that will result in her death.⁹⁰ Allowing one and not the other simply creates an impossible distinction along an arbitrary line, dividing “refusing” and “receiving.”⁹¹ In essence, courts have carved out an exception to suicide by allowing a patient to withdraw medical treatment, which makes an extension of this exception for physician-assisted suicide within the bounds of the judicial system.⁹² When life-sustaining care is withdrawn, patients are essentially committing suicide with the help of their physicians.⁹³ “[T]his type of physician-assisted suicide has been legalized, [therefore] there is no objective reason why courts cannot create exceptions in similar cases that involve lethal injections and prescription drugs.”⁹⁴

3. Protecting State Interests and Medical Ethics

Because it is within the interest of the state to protect the lives of its citizens, many opponents of physician-assisted suicide consider the “slippery slope” dilemma: if a state allows someone to utilize physician-assisted suicide, what prevents the killing of patients who actually want to live?⁹⁵ Many of these concerns, however, are easily addressed through proper regulation of a physician-assisted suicide

86. THE DECLARATION OF INDEPENDENCE para. 2 (U.S. 1776).

87. See CeloCruz, *supra* note 33, at 387.

88. See *id.*

89. See *Right to Die with Assistance*, *supra* note 10, at 2024–25.

90. See *id.* at 2029.

91. *Id.*

92. *Id.*

93. *Id.* at 2030.

94. *Id.* at 2031.

95. *Id.* at 2034.

law.⁹⁶ Further, some opponents believe that it is the government's role to protect the morality of society and that allowing physician-assisted suicide is inherently evil.⁹⁷ However, these utilitarian concepts constitute a few of the many factors that a court would consider when determining the constitutionality of a physician-assisted suicide law.⁹⁸

Other opponents, mainly physicians, fear that allowing physician-assisted suicide taints the medical profession and goes against the Hippocratic Oath.⁹⁹ However, doctors used the same argument when a terminal patient's choice to withdraw medical care was legalized.¹⁰⁰ Medicine, and the perspective of medical practitioners, changes continuously, making it very possible that just as withdrawal of care became acceptable, so will physician-assisted suicide and maybe even active euthanasia.¹⁰¹

IV. A RIGHT TO DIE LAW IN MARYLAND

Currently, physician-assisted suicide is illegal in Maryland.¹⁰² A right to die law, however, is no stranger to the State.¹⁰³ In fact, a right to die bill was introduced for the sixth time during the 2019 legislative session.¹⁰⁴ While opposition remains within Maryland's

96. See Stone & Winslade, *supra* note 51, at 506.

97. See *Right to Die with Assistance*, *supra* note 10, at 2034.

98. *Id.*

99. See generally *id.* at 2035 (discussing the professional ethical dilemma of physician-assisted suicide).

100. See *id.*

101. See *id.*

102. MD. CODE ANN., CRIM. LAW § 3-102 (West 2019). The current law holds:

With the purpose of assisting another individual to commit or attempt to commit suicide, an individual may not: (1) by coercion, duress, or deception, knowingly cause another individual to commit suicide or attempt to commit suicide; (2) knowingly provide the physical means by which another individual commits or attempts to commit suicide with knowledge of that individual's intent to use the physical means to commit suicide; or (3) knowingly participate in a physical act by which another individual commits or attempts to commit suicide.

Id.

103. See *Maryland*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/states/maryland/> [<http://perma.cc/8E4E-GYT7>] (last visited Dec. 26, 2019).

104. *Id.* Maryland considered physician-assisted suicide legislation in 1995 with HB 933, in 1996 with HB 474, in 2015 with HB 1021, in 2016 with HB 0404, and again in 2017 with HB 370. *Id.* All attempts have been unsuccessful. *Id.*

state legislature (and that of most other states),¹⁰⁵ roughly seventy percent of Americans believe in an individual's right to physician-assisted suicide.¹⁰⁶ As explained earlier, however, the opposition to this type of legislation rests on unfounded reasoning.¹⁰⁷ Courts have developed a comprehensive balancing approach to determine whether an individual may withdraw medical treatment, considering "the preservation of life, the protection of third parties, and the protection of medical ethics. The patient can have treatment legally withheld or withdrawn if the competing state interests do not outweigh the patient's right to die."¹⁰⁸ This same balancing approach can also be applied to cases of physician-assisted suicide.¹⁰⁹ By first determining whether the patient has a right to die with assistance, courts would recognize that patients have an interest in self-determination and deserve judicial protection regardless of the method and then would use the same balancing approach employed to determine the right to withdraw medical treatment.¹¹⁰

The approach mentioned above has been utilized in each of the nine states and the District of Columbia which permit physician-assisted suicide, with all but one jurisdiction implementing similar laws.¹¹¹ Oregon's Death with Dignity Act, the trailblazer of physician-assisted suicide laws, legalizes physician-assisted suicide but prohibits euthanasia outright.¹¹² Oregon's Death with Dignity Act also allows terminally ill Oregonian patients to receive a prescription that is intended to end their life.¹¹³ While there is a lack

105. *See id.*; *see also States with Legal Physician-Assisted Suicide*, *supra* note 21.

106. *See Maryland*, *supra* note 103; *see also CeloCruz*, *supra* note 33, at 377 ("Presently, no state or federal statute punishes an individual who commits or attempts suicide. However, thirty states and two territories currently have laws imposing criminal sanctions for aiding, assisting, causing, or promoting suicide. An additional five states impose such criminal penalties under case law.").

107. *See supra* notes 73–101 and accompanying text.

108. *Right to Die with Assistance*, *supra* note 10, at 2033.

109. *See id.*

110. *See id.*

111. *See States with Legal Physician-Assisted Suicide*, *supra* note 21.

112. *See* Sandra Norman-Eady, *Oregon's Assisted Suicide Law*, CONN. GEN. ASSEMBLY: OFF. LEGIS. RES. (Jan. 22, 2002), <https://www.cga.ct.gov/2002/rpt/2002-R-0077.htm> [<http://perma.cc/Z353-LCKC>].

113. Cohen-Almagor & Hartman, *supra* note 44, at 271; *see also* Sandra Norman-Eady, *supra* note 112. To receive the prescription, the Death with Dignity Act requires that: "[A] patient voluntarily express his wish to die and be: 1. an adult (age 18 or older), 2. an Oregon resident, 3. capable (able to make and communicate health care decisions), and 4. diagnosed with a terminal illness (incurable and irreversible) that will lead to death within six months." Norman-Eady, *supra* note 112. Once a

of significant empirical data showing abuse of the legislation, “[t]he most common reasons that patients chose assisted suicide were a loss of autonomy (89%), ability to do pleasurable activities (87%), and dignity (82%); the least common are financial reasons (3%) and inadequate treatment of pain (27%).”¹¹⁴ These reasons support the finding that people simply want to “control the manner of their death.”¹¹⁵ For these reasons, Maryland should implement a law permitting physician-assisted suicide.¹¹⁶

V. CONCLUSION

The majority of states continue to criminalize physician-assisted suicide for many reasons, most of which can be condensed into two main motives: the sacredness of human life and the equal value of all human life.¹¹⁷ Proponents of these principles believe that regardless of the condition the human life is in, it ought to be equally valued as compared to all other lives.¹¹⁸ Sanford Kadish, an outspoken critic of physician-assisted suicide, believes that all lives are inviolable and that physician-assisted suicide should be proscribed to reflect the “sanctity-of-life principle in its strongest sense: the ‘good and simple

patient qualifies for the prescription, they “are eligible to request a prescription for lethal medication from a licensed Oregon physician.” *Id.* To then receive the prescription for lethal medication, the patient must fulfill the following steps:

1. the patient must make two oral requests to his physician, separated by at least 15 days;
2. the patient must provide a written, witnessed request to his physician (two witnesses);
3. the prescribing physician and a consulting physician must confirm the diagnosis and prognosis;
4. the prescribing physician and a consulting physician must determine whether the patient is capable;
5. if either physician believes the patient’s judgment is impaired by a psychiatric or psychological disorder, he must refer the patient for a psychological examination;
6. the prescribing physician must inform the patient of feasible alternatives to assisted suicide, including comfort care, hospice care, and pain control; and
7. the prescribing physician must request, but may not require, the patient to notify his next-of-kin of the prescription request. To comply with the law, physicians must report to Oregon Health Services (OHS) all prescriptions for lethal medications.

Id.

114. Pickett, *supra* note 8, at 362.

115. *Id.*

116. *See supra* notes 102–15 and accompanying text.

117. *See* Matthew P. Previn, *Assisted Suicide and Religion: Conflicting Conceptions of the Sanctity of Human Life*, 84 *GEO. L.J.* 589, 592–93 (1996).

118. *See id.*

moral principle that human life is sacred,' either because it is the gift of God or because of some more general religious commitment, and that it therefore may never be taken by man."¹¹⁹ If this way of thinking pervades most legislatures throughout the country, then the question becomes: at what point does the state allow an individual to make their own choices about how their life will end? Suicide has been decriminalized for decades,¹²⁰ yet the nation is slow to allow terminally ill patients to end their pain and suffering in a humane way on their own terms.¹²¹ While it is widely recognized that the state has an important interest in preserving the sanctity of life amongst its citizens, the right to determine how and when a person dies is fundamental to that individual—a liberty interest so strong that it rivals the right to marry, procreate, educate children, or choose to have an abortion.¹²² Eight states and the District of Columbia have passed legislation that allows physician-assisted suicide through laws that heavily regulate the practice to ensure it is not abused.¹²³ There is no reason to believe that other states, including Maryland, could not implement a law similar to Oregon¹²⁴ or the eight other jurisdictions that permit physician-assisted suicide by statute.¹²⁵

If, however, states still feel as though physician-assisted suicide is outside legal justification and only permitted in extraordinary circumstances, such as withdrawal of care, then perhaps ethical rather than legal standards should be used to assess if, when, and how physician-assisted suicide should take place.¹²⁶

119. *Id.* at 593.

120. See Justin Fenton, *Attempting Suicide Is Not a Crime Under Maryland Law. But an Eastern Shore Man Was Convicted of It*, BALT. SUN (Feb. 23, 2018, 1:05 PM), <https://www.baltimoresun.com/news/crime/bs-md-suicide-criminal-charge-20180222-story.html> [<http://perma.cc/K326-R5CM>].

121. See CeloCruz, *supra* note 33, at 377–78.

122. See Stone & Winslade, *supra* note 51, at 489.

123. See *States with Legal Physician-Assisted Suicide*, *supra* note 21.

124. See *supra* Part IV.

125. See *States with Legal Physician-Assisted Suicide*, *supra* note 21.

126. See Stone & Winslade, *supra* note 51, at 506.