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Death with Dignity and Assistance: A Critique of the Self-Administration Requirement in California's *End of Life Option Act*

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In 2015, California passed the End of Life Option Act (“ELOA”).¹ This Act enables Californians to end their lives if they have less than six months to live, are not clinically depressed, and are able to self-administer a life-ending prescription.² This Note will specifically address the self-administration requirement of California's ELOA and explain how it unreasonably limits the options for Californians approaching the inevitable end of their lives. Not only does this requirement limit much needed access to life-ending medications, but also, in practice, the self-administration requirement is unnecessary because of its broad interpretation.

This Note comes at a time when one's right to choose the timing of his or her own death is being heavily debated in the United States.³ In 1994, Oregon voters passed the Death With Dignity⁴ ballot initiative, the first of its kind.⁵ Since then, three

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¹ It was originally passed as ABx2-15 (2015), but is now CAL. HEALTH & SAFETY CODE §§ 443.1–22 (West 2016). See 2015 Cal. Legis. Serv. 3045–58 (West). For information regarding the law's voting history, passage margins, and effective date, see *AB-15 End of Life*, LEGINFO (Oct. 5, 2015), https://leginfo.legislature.ca.gov/faces/billHistoryClient.xhtml?bill_id=201520162AB15 [<http://perma.cc/F2XF-GMX3>].

² Commonly prescribed end-of-life medications in Oregon are secobarbital and pentobarbital—medications that, when taken in small doses, help patients sleep. See OREGON DEATH WITH DIGNITY ACT: 2015 DATA SUMMARY, OREGON HEALTH AUTHORITY (Feb. 4, 2016), <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf> [<http://perma.cc/DWK9-P5JQ>].

³ See Taylor E. Purvis, *Debating Death: Religion, Politics, and The Oregon Death with Dignity Act*, 85 YALE J. BIO. MED. 271, 271–72 (2012) (discussing the ongoing public debate regarding Oregon's 1994 legislation). See generally SCOTT C. SHERSHOW, *DECONSTRUCTING DIGNITY: A CRITIQUE OF THE RIGHT-TO-DIE DEBATE* (2014).

⁴ When this Note refers to “right to die,” “death with dignity,” or “physician-assisted suicide,” it refers to a patient's choice to end his or her life through a legal physician-prescribed medication.

⁵ OR. REV. STAT. ANN. § 127.880 (West 1997). The Act was passed in 1994, but not enacted until 1997 due to a temporary injunction that was granted and then later lifted.

other states have followed suit.⁶ When California joined this movement, it included in its legislation the common requirement of self-administration.⁷ Simply put, self-administration requires a patient to administer the medication to him or herself.

While this requirement may silence some critics, and is said to protect a patient's right to self-determination, it excludes anyone who cannot physically self-administer medication from taking advantage of the rights granted by the ELOA.⁸ Many terminally ill patients with mobility issues may want to end their lives on their own terms and should not be excluded from this legislation.⁹

Looking at the practices of states with the self-administration requirement, it is evident that it is not strictly enforced and has been rendered essentially powerless; patients receive administration assistance, and their assistants have not been prosecuted.¹⁰ Knowing this, why do states continue to require self-administration? Is it not sufficient to require a patient's verbal and physical manifestation of assent and a desire to ingest the life-ending medication? Would assisted-administration really lead to the litany of societal ills suggested by its opponents?¹¹

This Note will address the aforementioned questions, and propose the removal of self-administration as a requirement from the ELOA. Part I addresses the history, development, and expansion of right-to-die legislation. Part II discusses the current state of

See *Lee v. Oregon*, 891 F. Supp. 1429, 1431, 1434 (D. Or. 1995) (identifying the arguments for and against Oregon's Death With Dignity Act).

⁶ *Death with Dignity Acts*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/learn/death-with-dignity-acts/> (reporting that although four states currently have similar legislation—Vermont, Washington, Oregon, and California—five overtly permit life-ending prescriptions; Montana is the fifth state law and its law came about through a 2009 state supreme court decision) [<http://perma.cc/5WXH-7KTU>].

⁷ CAL. HEALTH & SAFETY CODE § 443.1 (West 2016).

⁸ The Oregon law clarifies that self-administration of a life-ending medication is not to be considered suicide. OR. REV. STAT. § 127.880 (1997); see also JAMES ORLANDO, CONN. GEN. ASSEM. OFFICE OF LEGIS. RESEARCH, 2012-R-0477, RIGHT TO DIE LAWS (2012), <https://www.cga.ct.gov/2012/rpt/2012-R-0477.htm> (saying that patients are protected through the self-administration requirement) [<http://perma.cc/KAH6-AGLJ>].

⁹ Some of the most common conditions that are known to limit a patient's ability to move, yet cause bodily pain include: Parkinson's Disease, brain cancer, bone cancer, genetic disorders, and motor vehicle accidents. See, e.g., HOWARD BALL, AT LIBERTY TO DIE: THE BATTLE FOR DEATH WITH DIGNITY IN AMERICA 1–11 (2012) (discussing various illnesses and genetic disorders that cannot be effectively treated); Lisa Lezzoni et al., *Mobility Difficulties Are Not Only a Problem of Old Age*, 16 J. GEN. INTERN. MED. 235, 235–43 (2001) (describing various diseases and conditions that result in mobility limitations).

¹⁰ See *infra* note 88.

¹¹ See, e.g., Mary E. Harned, *The Dangers of Assisted Suicide: No Longer Theoretical*, in AM. UNITED FOR LIFE, DEFENDING LIFE 513, 514 (2012) (“[T]he dangers inherent in the legalization of physician-assisted suicide range from untreated depression to elder abuse to the slippery slope of outright euthanasia.”); Margaret K. Dore, “*Death With Dignity*”: A Recipe for Elder Abuse and Homicide (*Albeit Not By Name*), 11 MARQ. ELDER'S ADV. 387, 399 (2010) (discussing the likelihood of physician-assisted suicide leading to homicide and a decrease of patient choice).

right-to-die legislation, focusing primarily on California's recently passed End of Life Option Act. Part III analyzes the purpose and practice of self-administration requirements in the United States and Europe. It also notes that under California's current law, people will likely be able to obtain administration assistance, negating the self-administration requirement. Finally, Part IV proposes the removal of the self-administration requirement from California's ELOA legislation, essentially allowing a patient to access lethal medication if he or she meets all other requirements.

I. DEVELOPING ONE'S RIGHT TO CHOOSE LIFE OR DEATH

Over the last twenty years, the United States Supreme Court and various states have made significant strides regarding one's right to die with dignity.¹² Although the United States federal government remains hesitant to legalize a patient's right to die, states have begun to normalize the protection of a patient's right to a dignified death.¹³ The justification for such state legislation includes patient autonomy and self-determination, prevention of undignified and painful deaths, and advocacy efforts from residents of various states.¹⁴

States have long served as laboratories of democracy for the development of new and innovative laws.¹⁵ In serving as laboratories for experimentation, the states enact new legislation, test it on their residents, and then, if successful, inspire other states to follow suit. It is essential to note that the states are not acting entirely on their own; the Supreme Court has set a baseline standard regarding one's right to die.¹⁶ Many countries

¹² See Brian Hawkins, *The Glucksberg Renaissance: Substantive Due Process since Lawrence v. Texas*, 105 MICH. L. REV. 409, 410 (2006) (discussing the right to substantive due process as it was interpreted in *Lawrence* and *Glucksberg*); see also Lee v. Oregon, 891 F. Supp. 1429, 1434 (D. Or. 1995) (outlining the state's interest in death with dignity legislation, including: preventing people from painful suicide attempts, prolonged medical treatments, and preserving the right of mentally competent adults to make their own healthcare decisions).

¹³ See Thomas A. Eaton & Edward J. Larson, *Experimenting with the "Right to Die" in the Laboratory of the States*, 25 GA. L. REV. 1253, 1253 (1991) (discussing the view of the federal government that the right to die should be determined through the laboratories of the states rather than through the federal government).

¹⁴ Anjali Shastry, *Maryland State Senator Withdraws Right to Die Bill, Facing Defeat in Key Committee*, WASH. TIMES (Mar. 3, 2016), <http://www.washingtontimes.com/news/2016/mar/3/maryland-state-senator-withdraws-right-to-die-bill/> (quoting Massachusetts State Senator Young who said, "I think it's an individual choice and that's how it should be done.") [<http://perma.cc/JHB9-AJSC>]; Elizabeth Woods, *The Right to Die with Dignity with the Assistance of a Physician: An Anglo, American and Australian International Perspective*, 4 ILSA J. INT'L COMP. L. 817, 818–19 (1998); see Lee, 891 F. Supp. at 1434.

¹⁵ See *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting) ("It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.").

¹⁶ *Washington v. Glucksberg*, 521 U.S. 702, 705–07, 727–35 (1997).

throughout Europe have also passed laws legalizing one's right to die with dignity.¹⁷

A. The Supreme Court

In the 1997 case *Washington v. Glucksberg*, the Supreme Court assessed one's right to commit (assisted) suicide.¹⁸ In that case, the plaintiff was a physician who counselled patients on suicide and challenged the constitutionality of a Washington law¹⁹ that banned assisted suicide.²⁰ The Supreme Court held that one does not have a right to commit assisted suicide because the Court found that it was not a fundamental liberty interest.²¹ If this right had been deemed a fundamental liberty interest, assisted suicide would have been protected under the Fourteenth Amendment of the Constitution. The Court said that it was rational for a state to want to protect human life, and upholding a ban on assisted suicide would achieve the state's rational objective.²²

However, Justice O'Connor stated in a concurring opinion that if a patient were suffering from untreatable pain and on the verge of death, that patient may have the right to die on his or her own terms.²³ In fact, she stated that "[t]he parties and *amici* agree that in these States a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death."²⁴ Here, a Supreme Court Justice acknowledged that it may be appropriate for doctors to prescribe medication that would hasten the death of one of their patients, appealing to the interests of both the physicians and the State.²⁵

In the same year, a similar situation occurred in *Vacco v. Quill*, a Supreme Court case involving a group of New York physicians that brought an action challenging the constitutionality of a law that banned them from assisting someone in committing or attempting to commit suicide.²⁶ The Court held a state's prohibition of assisted suicide did not violate the Equal Protection Clause, adding however, that a doctor may provide a patient with palliative

¹⁷ *Where to Go to Die*, ECONOMIST (July 19, 2014), <http://www.economist.com/news/international/21607888-small-group-countries-helping-someone-die-not-crime-where-go-die> (discussing right-to-die laws in various European countries) [<http://perma.cc/8LZ4-LAPD>].

¹⁸ *Glucksberg*, 521 U.S. at 728.

¹⁹ WASH. REV. CODE § 9A.36.060(1) (1994).

²⁰ *Glucksberg*, 521 U.S. at 707–08.

²¹ *Id.* at 728.

²² *Id.* at 730.

²³ *Id.* at 736–38 (O'Connor, J., concurring).

²⁴ *Id.* at 736–37.

²⁵ *Id.*

²⁶ *Vacco v. Quill*, 521 U.S. 793, 797–98 (1997).

treatment that may result in a patient's hastened death.²⁷ The Court highlighted the difference between a physician actively killing someone and a physician letting someone die—the doctor's intent.²⁸ In her concurrence, Justice O'Connor said it should be up to the states to decide whether one has a right to die.²⁹

Seven years before the *Vacco* decision, the Supreme Court held that patients have the right to refuse treatment if they so desire; it is not for another person, nor the state, to make that decision for them.³⁰ Further, the Court held states can require clear and convincing evidence of one's desire to end life-sustaining treatment before actually ending such treatment.³¹ Although this is different than permitting assisted suicide, it is noteworthy because it reveals the Court's respect for a patient's choice regarding end-of-life options.

Through the aforementioned cases, the Court acknowledged the importance of one's right to choose his or her own destiny, centering around the continuance or discontinuance of medical treatment. As the Supreme Court has not yet directly ruled upon whether legislation permitting a doctor to prescribe life-ending treatment is constitutional, the States have taken to legislating the issue themselves.

B. The States

As the Supreme Court handed down these decisions, some states began to pass legislation to create and protect patients' right to die with dignity. In 1997, Oregon was the first state to legalize physician-assisted suicide through a voter initiative.³² Oregon's Death with Dignity Act allows terminally-ill residents to request life-ending medication from their doctors, and permits

²⁷ *Id.* at 802; *Glucksberg*, 521 U.S. at 737–38 (“There is no dispute that dying patients in Washington and New York can obtain palliative care, even when doing so would hasten their deaths.”).

²⁸ *Vacco*, 521 U.S. at 802 (commentators agree there is a stark difference between a doctor hastening a patient's death for a valid purpose, such as honoring the patient's wishes or decreasing a patient's persistent pain, and a doctor having the intent to commit homicide); see Frederick R. Parker, Jr., *Washington v. Glucksberg and Vacco v. Quill: An Analysis of the Amicus Curiae Briefs and the Supreme Court's Majority and Concurring Opinions*, 43 ST. LOUIS L.J. 469, 491 (1999) (clarifying that when a doctor prescribes a medication that would aid a patient in dying, the doctor does not necessarily have the intent to affirmatively bring about the death of a patient).

²⁹ *Glucksberg*, 521 U.S. at 737.

³⁰ See *Cruzan v. Dir. Mo. Dep't. of Health*, 497 U.S. 261, 280 (1990) (“We do not think a State is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death.”).

³¹ *Id.* at 280–82 (“In our view, Missouri has permissibly sought to advance these interests through the adoption of a ‘clear and convincing’ standard of proof to govern such proceedings.”).

³² See OR. REV. STAT. §§ 127.800–.897 (1999).

doctors to prescribe life-ending medications to their patients.³³ To ensure the utmost protection for patients, the Death With Dignity Act requires numerous steps for patients who want to end their lives.

Anyone applying for assistance under the Act must have Oregon residency.³⁴ The doctor and patient must have a candid conversation about the patient's status, which must include that the patient likely has less than six months to live.³⁵ The patient must also submit two requests—one written and one oral—to his or her doctor requesting the medication.³⁶ If the patient's doctor finds any indications that the patient may be suffering from a psychiatric illness, then the doctor must refer the patient to a counselor. The statute specifically states “[n]o medication to end a patient's life in a humane and dignified manner shall be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.”³⁷ Finally, the patient must be able to self-administer the medication.³⁸ There is no requirement to supervise a patient when he or she ingests the life-ending medication.³⁹

Oregon also mandates that state regulatory agencies provide annual reports reflecting Oregonians' use of this end-of-life

³³ *Id.* §§ 127.800–.815.

³⁴ *Id.* § 127.860.

³⁵ *Id.* § 127.815.

³⁶ *Id.* § 127.840.

³⁷ *Id.* § 127.825.

³⁸ DEP'T. HUMAN SERV., EIGHTH ANNUAL REPORT ON OREGON'S DEATH WITH DIGNITY ACT 7 (2006) (indicating that self-administration is a requirement of the Act).

³⁹ On January 1, 2014, twenty-nine-year-old Brittany Maynard was diagnosed with an inoperable brain tumor, and in her case, the self-administration requirement alone was coercive in convincing her to pass before she was fully ready. 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/> [<http://perma.cc/559X-M93W>]. Her brain tumor resulted in seizures, pain, and a fear of her inevitable death. Dan Diaz & Amanda Thyden, INTERVIEW WITH DAN DIAZ (2016). After doctors informed her that she had less than six months to live, she chose to move to Oregon and end her life using the Death With Dignity law. *Id.* She chose the day of her death, in large part because of Oregon's self-administration requirement; she felt that she needed to self-administer before she lost the physical capability. *Id.*; see also Stacey Kennelly, *Death With Dignity: Brittany Maynard's Husband Carried on the Right to Die Fight*, DIABLO MAG. (Oct. 5, 2015), <http://www.diablogmag.com/October-2015/Death-With-Dignity-Brittany-Maynards-husband-carries-on-the-right-to-die-fight/> [<http://perma.cc/FXR8-QHZW>]. She had experienced her most severe seizure a few days prior and knew that if she did not take the life-ending medication soon, she would not be able to fulfill Oregon's requirement that one self-administer any life-ending medication. See Jonathan LaPook, *Should the Terminally Ill Control How They Die?*, CBS NEWS (Mar. 13, 2016), <http://www.cbsnews.com/news/60-minutes-aid-in-dying-lapook/> (her husband reported to CBS that his wife's “[p]ain was just constant.”) [<http://perma.cc/9FRR-6QEL>]. Although she passed before the tumor killed her due to her own fear of losing the ability to self-administer, she passed before she was entirely ready. Dan Diaz & Amanda Thyden, INTERVIEW WITH DAN DIAZ (2016).

option.⁴⁰ Doctors must inform the State Registrar within seven days of prescribing the medication.⁴¹ Then, within ten days of the patient ingesting the medication and dying, or dying from natural causes, the physician must notify the Registrar and must complete the “Oregon Death with Dignity Act Attending Physician Interview” form.⁴² To ensure public awareness, all of this information is available on the Oregon Health Authority’s website.⁴³

The Oregon Health Authority maintains these forms, the records of all Oregonians who receive a prescription, and the personal information about all of the patients who die from ingesting the medication.⁴⁴ In 1998, the Death With Dignity Act’s first year, twenty-four people received the medication and sixteen ingested it, ending their lives.⁴⁵ Five years later, in 2003, sixty-eight people received the medication and forty-two ingested it.⁴⁶ From 2007 through 2010, the numbers increased slightly, but still, less than one-hundred people each year received the medication, while approximately sixty each year ingested it.⁴⁷ In 2015, as technology and awareness of this option have improved, and particularly after Brittany Maynard’s case made the national news, the numbers have increased but still remain low: 218 Oregonians received the medication, and 132 ingested it.⁴⁸

Following Oregon, two more states, Vermont and Washington, adopted legislation permitting physician-assisted suicide. Washington passed its Death With Dignity Act in 2008 through the voter initiative process,⁴⁹ and Vermont passed its Patient Choice at End of Life Act in 2013 through the legislature.⁵⁰ Both state laws essentially utilized the model Oregon adopted. Both require multiple requests within fifteen days of each other,⁵¹ residency in the state providing the medication,⁵² self-administration,⁵³ and physician reporting when the medication is prescribed to

40 OR. ADMIN. R. 333-009-0020 (2009) (requiring a Record Review and Annual Report).

41 *Id.* at 333-009-0010 (requiring various physician reporting requirements).

42 *Id.*

43 OR. HEALTH AUTH., *Oregon Revised Statute*, <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ors.aspx> [<http://perma.cc/2QTH-5ALL>].

44 *Oregon Death with Dignity Act: 2015 Data Summary*, *supra* note 2, at 2–4.

45 *Id.* at 2.

46 *Id.*

47 *Id.*

48 *Id.*

49 WASH. REV. CODE. § 70.245.903 (2009).

50 VT. STAT. ANN. tit. 18, § 5281 (2013).

51 VT. STAT. ANN. tit. 18, § 5283 (2015); WASH. REV. CODE. § 70.245.110 (2009).

52 VT. STAT. ANN. tit. 18, § 5281 (2013); WASH. REV. CODE. § 70.245.010 (2009).

53 VT. STAT. ANN. tit. 18, § 5283 (2015); WASH. REV. CODE. § 70.245.020 (2009).

patients, so that the relevant statistical information regarding use of the end-of-life option remains available to the public.⁵⁴

Taking a different approach, Montana's highest court authorized the use of physician-assisted suicide in 2009 in the landmark case, *Baxter v. State*.⁵⁵ That case involved a terminally-ill man with lymphocytic leukemia who argued that patients in Montana should have the right to commit suicide under the state's Constitution.⁵⁶ The Montana Supreme Court said:

[A] physician who aids a terminally ill patient in dying is not directly involved in the final decision *or* the final act. He or she only provides a means by which a terminally ill patient *himself* can give effect to his life-ending decision, or not, as the case may be. Each stage of the physician-patient interaction is private, civil, and compassionate. The physician and terminally ill patient work together to create a means by which the patient can be in control of his own mortality.⁵⁷

The court held that physician-assisted suicide was protected by the Montana Constitution and was not contrary to public policy.

C. Europe

End-of-life options like those mentioned above, are not unique to the United States; European countries including the Netherlands,⁵⁸ Belgium,⁵⁹ and Switzerland⁶⁰ all permit physician-assisted suicide.⁶¹ In fact, in Switzerland, an organization known as EXIT allows employees and volunteers to assist people in pursuing their right to a self-determined life and death.⁶²

⁵⁴ VT. STAT. ANN. tit. 18, § 5283 (2013); WASH. REV. CODE. § 70.245.150 (2009).

⁵⁵ *Baxter v. State*, 224 P.3d 1211, 1222 (Mont. 2009).

⁵⁶ *Id.* at 1214.

⁵⁷ *Id.* at 1217 (emphasis added).

⁵⁸ *Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding* [Termination of Life on Request and Assisted Suicide (Review Procedures) Act], Wet van 1 apr. 2002, Stb. 2002.

⁵⁹ *Wet betreffende de euthanasie* [A Belgian Act on Euthanasia] of May 28, 2002, MONITEUR BELGE [M.B.] [Official Gazette of Belgium], June 22, 2002, 28515. For one patient's experience with the Belgian legislation, see *The Right to Die: An Inside Look at the World's Most Liberal Euthanasia Law*, PBS (Jan. 17, 2015, 11:30 AM), <http://www.pbs.org/newshour/bb/right-die-belgium-inside-worlds-liberal-euthanasia-laws-2/> [<http://perma.cc/A9GC-F6XV>].

⁶⁰ VERLEITUNG UND BEIHILFE ZUM SELBSTMORD [Inciting and Assisting Someone to Commit Suicide] [STGB] [CRIMINAL CODE] Jan. 1, 1942, SR 311.0, art. 115 (Switz).

⁶¹ Additional countries that permit physician-assisted suicide include Colombia, Luxembourg, England, Wales, Quebec, and most recently Canada, but the specific details of Canada's law are to be determined. *Assisted Suicide Law Reform*, ASSISTED SUICIDE (Oct. 15, 2015), http://www.assistedsuicide.org/suicide_laws.html [<http://perma.cc/S3Q8-6X3U>]. For a discussion of assisted suicide laws in Switzerland, the Netherlands, and Oregon, see Georg Bosshardt et al., *Open Regulation and Practice in Assisted Dying: How Switzerland Compares with the Netherlands and Oregon*, SWISS MED. WKLY. 123, 527–534 (2002).

⁶² *EXIT—Self-Determined Living and Dying*, EXIT, <https://www.exit.ch/en/en/> (explaining how EXIT permits volunteers to assist in the coordination of patients' life-ending medications) [<http://perma.cc/S3Q8-6X3U>].

EXIT has been in existence since 1982 and not only helps Swiss citizens with physician-assisted suicide, but also with living wills and public education regarding end-of-life options.⁶³ EXIT works in conjunction with its foundation, Palliatura, which aims to improve patient treatment and coordinate palliative care.⁶⁴ This organization highlights an important distinction between palliative care and physician-assisted suicide. If a patient does not wish to take advantage of the country's assisted suicide law, then he or she can work with Palliatura and receive palliative care to make his or her last months or years as comfortable as possible. The organization emphasizes a key phrase: self-determined. Those who utilize physician-assisted suicide may ask for assistance from EXIT employees or volunteers, but the decision remains in the patient's hands regarding whether to follow through with ingesting the medication. It is worth noting that from 1998 through 2009, the number of assisted suicide cases in Switzerland did not exceed 300.⁶⁵

The Netherlands has taken its law one step further, permitting physicians to administer life-ending medications.⁶⁶ Patients have an option of either euthanasia, where a doctor performs the final act, or physician-assisted suicide, where a patient may perform the final act him or herself.⁶⁷ The Netherlands, like Switzerland, has an organization, NVVE, which educates the public about the law and helps those who opt to die on their own terms.⁶⁸ The organization's motto is "[a] dignified life, deserves a dignified death."⁶⁹ Its website explains that "it is not an offence for physicians to perform euthanasia, provided they comply with the due care criteria" and "the

⁶³ *Who is EXIT?*, EXIT, <https://www.exit.ch/en/en/who-is-exit/> [<http://perma.cc/4K6W-K5KW>]. Like Oregon, California, and other state laws, Switzerland requires a person to administer the medications to him or herself, saying "[u]p to this point, the person wishing to die may abort the process any time." *FAQ*, EXIT, <https://www.exit.ch/en/en/faq/> [<http://perma.cc/7VSS-NCX3>].

⁶⁴ *Our Commitment*, EXIT, <https://www.exit.ch/en/en/what-exit-fights-for/our-commitment/> [<http://perma.cc/K55E-RKF6>].

⁶⁵ *Cause of Death Statistics 2009: Assisted Suicide and Suicide in Switzerland*, NEUCHÂTEL (Mar. 2012), <https://www.bfs.admin.ch/bfs/en/home/statistics/catalogues-databases/publications.assetdetail.345104.html>.

⁶⁶ *Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding* [Termination of Life on Request and Assisted Suicide (Review Procedures) Act], Wet van 1 apr. 2002, Stb. 2002.

⁶⁷ For more information on the development, rationale, and success of the Dutch law, see *Euthanasia, Assisted Suicide, and Non-resuscitation on Request*, GOVERNMENT OF THE NETHERLANDS, <https://www.government.nl/topics/euthanasia/contents/euthanasia-assisted-suicide-and-non-resuscitation-on-request> [<http://perma.cc/ES9T-JFLU>].

⁶⁸ NVVE stands for "Nederlandse Vereniging voor een Vrijwillig Levensende," which means "Dutch Association for a Voluntary End of Life." *About NVVE*, NVVE, <https://www.nvve.nl/about-nvve> (describing the goal of NVVE and providing an explanation about the euthanasia/right to die law) [<http://perma.cc/9TY5-6VX5>].

⁶⁹ *Id.*

physician must, among other things, be satisfied that the patient's request for euthanasia is voluntary and well-considered.⁷⁰

Finally, Belgium's law on euthanasia is the most liberal in the world and allows physicians to euthanize terminally ill patients, depressed citizens, and terminally ill children.⁷¹ This is by far the most extreme law when it comes to right-to-die legislation worldwide; it is likely that few in the United States would not support such extreme legislation.

Since these laws have become more well-known, and as assisted suicide has become accepted throughout Europe, it does not have the same stigma, nor does it spark the same controversy that it does in the U.S.⁷² As legalization of one's right to die with dignity continues to spread throughout the United States, it will likely continue to gain acceptance.

II. THE PROBLEM WITH SELF-ADMINISTRATION IN CALIFORNIA'S END OF LIFE OPTION ACT

Following the acceptance of the right-to-die movement in Oregon, Vermont, Washington, and Montana, California passed its own End of Life Option Act.⁷³ This Act mirrors those passed in Oregon, Vermont, and Washington. It requires Californians to request the life-ending medication verbally or in writing twice, at least fifteen days apart, to ensure that they have the opportunity to reflect on the decision they have made to end their lives.⁷⁴ It also requires a physician to refer a patient to a counselor if the physician believes that the patient may require a psychological evaluation.⁷⁵ Finally, it requires that a patient have the capacity to self-administer.⁷⁶ This requirement puts the final act of medication consumption in the hands of the patient.

⁷⁰ *Id.*

⁷¹ Wet betreffende de euthanasie [A Belgian Act on Euthanasia] of May 28, 2002, MONITEUR BELGE [M.B.] [Official Gazette of Belgium], June 22, 2002. For an example of the permissibility of depressed patients to die under Belgian law, see Eilish O'Gara, *Physically Healthy 24-year-old Granted Right to Die in Belgium*, NEWSWEEK (June 29, 2015, 7:17 PM), <http://europe.newsweek.com/healthy-24-year-old-granted-right-die-belgium-329504> [<http://perma.cc/N7BE-TCVK>].

⁷² Joachim Cohen et. al., *European Public Acceptance of Euthanasia: Socio-demographic and Cultural Factors Associated with the Acceptance of Euthanasia in 33 European Countries*, 63 SOC. SCI. MED. 744, 747 (Aug. 2006) (discussing a greater rate of acceptance of euthanasia in Western Europe).

⁷³ 2015 Cal. Legis. Serv. 3045 (West).

⁷⁴ CAL. HEALTH & SAFETY CODE § 443.3 (West 2016).

⁷⁵ *Id.* § 443.5.

⁷⁶ *Id.* § 443.1.

Legislators' purpose in passing the ELOA was to prevent Californians from having to suffer miserable deaths.⁷⁷ The objective was to provide Californians with an option at the end of their lives: they now may choose to die naturally or on their own time.

A notable requirement of the ELOA, and the requirement upon which this Note is centered, is that a person who receives any death-inducing prescription must be able to self-administer said medication.⁷⁸ The ELOA defines self-administration as "a qualified individual's affirmative, conscious, and physical act of administering and ingesting the aid-in-dying drug to bring about his or her own death."⁷⁹ It was introduced into the ELOA, as well as other right-to-die legislative initiatives to prevent murder, mercy killings, and euthanasia.⁸⁰ If a patient is required to administer his or her own life-ending medication, then another person cannot be blamed for the patient's resulting death. The predominant factor in any self-administration requirement is that a patient must manifest his or her own desire to die through *ingesting* the life-ending medication.⁸¹ Beyond requiring a patient to ingest the medication on his or her own, clarification regarding the exact parameters of "self-administration" has not yet been provided by the California legislature.

The only commentary regarding assistance came through the introduction of the ELOA, which says that it grants "immunity from civil or criminal liability solely because the person was present when the qualified individual self-administered the drug, or the person *assisted* the qualified individual *by preparing the aid-in-dying drug* so long as the person did not assist with the ingestion of the drug"⁸² However, by permitting assistance in preparation of the drug, lingering questions remain: How far does "preparation" extend? Does it include mixing the medication into a food or liquid? Putting a straw in a patient's drink? Helping a patient drink from a glass filled with the medication? Spoon-feeding the medication to the patient? When has an assistant gone too far? The inherent ambiguity in the language of the statute and a lack of oversight in the administration process,

⁷⁷ See Rob Bonta, Chair, ABx2-15, Assemb. Public Health and Developmental Servs., cmt. 1 (Sept. 1, 2015), https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201520162AB15.

⁷⁸ CAL. HEALTH & SAFETY CODE § 443.1 (West 2016).

⁷⁹ *Id.* Although self-administration as a term is defined, other terms used in the definition are not further defined. Thus far, there are no further definitions of "administering" and "ingesting."

⁸⁰ See Bonta, *supra* note 77, at 6.

⁸¹ See CAL. HEALTH & SAFETY CODE § 443.1(i)(4) (West 2016).

⁸² 2015 Cal. Legis. Serv. Ch. 1 3046 (West) (emphasis added).

make the administration requirement nearly unenforceable; there is no bright-line rule to indicate when an assistant may have crossed the line.⁸³

III. THE IMPRACTICAL AND UNNECESSARY REQUIREMENT OF SELF-ADMINISTRATION

Legislators and healthcare scholars have said that the goal of self-administration is to ensure that patients are not coerced into taking the medication if they change their minds as their end-of-life reality nears.⁸⁴ State legislatures that have enacted right-to-die legislation empower qualified patients with the ability to maintain control over their lives and end them with dignity.⁸⁵ By permitting people to pass when they are ready, they are not forced to endure the pain and suffering that is often associated with many types of death. They can choose the date, time, and location of their death, and ensure that their support system is present to help them die with ease and love.

In addition to promoting patient autonomy, self-administration prevents loved ones from having to endure the emotional torment that may follow after assisting in the suicide of someone they know.⁸⁶ It could be understandably traumatic to administer medication to a loved one that resulted in their death. However, even if states were to permit assistance, this Note is not advocating for forced assistance. A patient applying for a life-ending prescription is making a choice; agreeing to assist someone in administration is no different.

Although these may be some of the goals of self-administration, to understand how it has been interpreted thus far, and how it will likely be interpreted in California, one must look to other states in which similar statutes have been enacted. In Oregon, for example, 991 patients have died by ingesting doctor-prescribed

⁸³ Due to a lack of clarification regarding the meaning of self-administration and a lack of oversight in the actual act of administration of the medication, the self-administration requirement achieves no actual objective. See CAL. HEALTH & SAFETY CODE §§ 443.1–.22 (West 2016) (mentioning no regulatory agency that will check to make sure that there is no evidence of assistance in the medication administration).

⁸⁴ See Kathryn L. Tucker, *In the Laboratory of the States: The Progress of Glucksberg's Invitation to States to Address End-of-Life Choice*, 106 MICH. L. REV. 1593 (2008) (discussing that scholars have found no evidence of coercion due to key safeguards in aid in dying legislation).

⁸⁵ "Dignity" and "dignified" are mentioned five times in the two documents that patients are required to complete pursuant to California's End of Life Option Act. CAL. HEALTH & SAFETY CODE § 443.11 (West 2016). In Washington's Death With Dignity Act, "dignified" is mentioned twenty-four times. WASH. REV. CODE. § 70.245 (2008).

⁸⁶ See generally Woods, *supra* note 14 (discussing how right-to-die legislation forces the government to weigh society's desire to prolong life against a patient's right to self-determination).

life-ending medications.⁸⁷ Oregon's law broadly interprets self-administration to apparently permit third-parties to hand a patient's pills, mix the prescribed drugs into a liquid, insert a straw into that liquid, and even put the life-ending medication into a patient's gastrointestinal tube to be ingested.⁸⁸ The only clear requirement under the Oregon law is that the patient has to conduct the last overt act of ingesting the medication.⁸⁹

No cases have yet been brought forward charging an assistant with murder in Oregon despite its requirement for self-administration.⁹⁰ All indications show that California intends to follow Oregon's interpretation of self-administration.⁹¹ However, with no realistic enforcement mechanism and no negative repercussions from third-party assistance, the requirement serves no purpose. Furthermore, as there has been minimal analysis of the self-administration requirement by legal and medical professionals alike, it would seem that the requirement has been included in California's ELOA simply because it was included by Oregon, Vermont, and Washington.

⁸⁷ This statistic reflects the total number of patients from the time legislation was passed in 1997 to 2015. See OREGON DEATH WITH DIGNITY ACT: 2015 DATA SUMMARY, *supra* note 2, at 2.

⁸⁸ See Jennifer Frey, *A Death in Oregon: One Doctor's Story*, WASH. POST (Nov. 3, 1999), <https://www.washingtonpost.com/archive/lifestyle/1999/11/03/a-death-in-oregon-one-doctors-story/eb7ab050-f6af-482a-9d20-3eff99d0baa6/> (detailing how Barbara Houck's son spoon-fed her the prescribed life-ending medication, while under the supervision of her doctor) [<http://perma.cc/ZWK2-Z8ZP>]; HARRY S. MARGOLIS, *Health Care Decision Making in an Elder Law Practice*, in ELDER LAW PORTFOLIO (Aspen 1995) (discussing the "help" that Joe Hayes provided to his brother, Patrick Matheny, when it came time to administer the medication, but was not prosecuted); Elizabeth Landau, *Choosing Death Can Be Like a 'Birth,' Advocates Say*, CNN (Aug. 30, 2011, 2:24 PM), <http://www.cnn.com/2011/HEALTH/08/30/assisted.suicide.oregon/> (referring to aid-in-dying volunteer, Katy Powell, "[s]he knows how to mix the medication so the family of the person who is hastening doesn't have to.") [<http://perma.cc/268V-SLF4>]; DEMETRA M. PAPPAS, THE EUTHANASIA/ASSISTED-SUICIDE DEBATE 129–30 (Greenwood eds., 2012) (mentioning a volunteer who helped mix a patient's end-of-life medications and confirmed with him that he was ready to die before giving it to him); see also Rita Marker, *Euthanasia, Assisted Suicide & Health Care Decisions: Protecting Yourself & Your Family*, PATIENT RTS. COUNCIL, <http://www.patientsrights.council.org/site/euthanasia-assisted-suicide-health-care-decisions/> ("[P]atients who cannot swallow would need to have an NG tube or G tube placement.") [<http://perma.cc/LFU4-Z7BR>].

⁸⁹ PAPPAS, *supra* note 88, at 130.

⁹⁰ In 2004, Dr. Kristina Hedberg, an epidemiologist who was instrumental in the implementation and supervision of the Oregon Death With Dignity Act, said, "we were not given the resources to investigate . . . when we have talked to our lawyers and others, not only do we not have the resources to do it but we do not have any legal authority to insert ourselves." SELECT COMMITTEE ON THE ASSISTED DYING FOR THE TERMINALLY ILL BILL, VOL. II: EVIDENCE, 2004-5, HL PAPER 86-II, at 266 (UK), <http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/86ii.pdf> [<http://perma.cc/2ZK9-6BSJ>]; see LaPook *supra* note 39 ("Ninety percent of the time here in Oregon there's no doctor present. So there's really a shroud of secrecy under this whole thing.")

⁹¹ Niraj Chokshi & Fenit Nirappil, *California Adopts 'Right-to-Die' Law Allowing Assisted Suicide for Terminally Ill Patients*, WASH. POST (Oct. 5, 2015), <https://www.washingtonpost.com/news/post-nation/wp/2015/10/05/california-adopts-right-to-die-law-allowing-assisted-suicide-for-terminally-ill-patients/> ("California's law is modeled off Oregon's assisted suicide system, which was first approved by voters in 1994.") [<http://perma.cc/4RA5-9Q2V>].

In looking to these other states, none have yet clarified the exact meaning of “self-administration” when it comes to right-to-die laws. The general definition, although indicative of the necessity for a physical manifestation of a patient’s desire to ingest the life-ending medication, does not in fact dictate any type of administration requirements, nor does it disallow any particular administration methods.⁹² Whether or not a patient can ingest the life-ending medication entirely on his or her own appears to be irrelevant in practice, rendering the self-administration requirement essentially moot. Further, with the current lack of enforcement mechanisms, self-administration has become nearly unenforceable. Although the goals of self-administration may be noble, they do not actually serve the purpose for which they were intended if they are not enforced by any regulatory authority.

If California follows Oregon’s lead, then self-administration will likely include the delivery of the medication by a third party.⁹³ Third party administration should be (and has been) permitted as long as the clear intent of the patient is to take the medication to end his or her life. Numerous diseases and disorders result in patients’ immobility, and therefore inability to self-administer medications.⁹⁴ There are already sufficient requirements in the ELOA ensuring that a patient wants to die, and as long as those aspects of the law are rigorously applied, it will remain clear that a patient is not being coerced or manipulated.

As the States, including California, are serving properly in their roles as laboratories of democracy, it is now incumbent upon the public as observers and participants in the legal process to determine the success or failure of the ELOA and bills like it.⁹⁵ As there are serious inconsistencies between the definition and implementation of self-administration, it should be removed as a requirement, but left as an option. One should be able to self-administer if desired, or delegate the administration of the medication to a person of their choosing.

⁹² CAL. HEALTH & SAFETY CODE § 443.1(p) (West 2016).

⁹³ See Frey, *supra* note 88; MARGOLIS, *supra* note 88; see also Landau, *supra* note 88.

⁹⁴ See generally BALL, *supra* note 9; Lezzoni, *supra* note 9.

⁹⁵ California’s End of Life Option Act is currently facing challenges in the courts from physicians who do not believe it should have become law. See, e.g., Transcript, AHN v. Hestrin, No. RIC 1607135 (Aug. 26, 2016), <https://www.compassionandchoices.org/wp-content/uploads/2016/08/AHN-vs-HESTRIN-8-26-16.pdf> (finding that the physicians in this case did not have standing to challenge the new law, thus it was not decided on the merits) [<http://perma.cc/LN4V-PULL>]. Although this law may continue to be challenged in the court system, the California Attorney General has agreed to defend the law as it currently stands. *Id.* (listing the California Department of Justice, Office of the Attorney General, for the State of California).

IV. EXPLICITLY ALLOWING ASSISTED-ADMINISTRATION MOVING FORWARD

If one has not been diagnosed with depression, is capable of making his or her own decisions, and is going to die within the next six months, then a third party should be able to help in the administration of a prescribed life-ending medication. As right-to-die laws currently stand, in Oregon in particular, residents have been implicitly permitted to receive assistance in self-administration because the requirement is not rigorously enforced and no criminal prosecutions have resulted against those who have provided assistance. Questions to ask ourselves about the reality of this situation include: What difference exists between a patient accepting a cup from a loved one and putting it to his or her own lips, versus a family member bringing the cup to the patient's lips for them to drink? Why require patients to administer when they can give a loved one permission to administer instead? If patients have been receiving assistance, and it has worked thus far, why continue with current laws that disallow assistance?

A. Allowing Assisted-Administration

It is critical to understand that what this Note calls "assisted-administration" is already practiced in Oregon without any resulting negative repercussions. Because assisted-administration is already the practice, explicitly requiring self-administration is no longer necessary nor relevant. The idea behind physician-assisted suicide, right-to-die, and death with dignity movements is to provide patients with autonomy and choice. Electing to have someone assist in the *preparation* of medication is currently a part of a patient's choice, but how much the person may assist remains unclear. The law says that one must self-administer, yet provides such a broad definition of self-administration that it leaves the door open for interpretation regarding its actual meaning.

Because this concept lacks clarification, California should seek to simplify and normalize it. There is no clear rule regarding how much help is *too much help* in the preparatory process of medication administration. A simple set of requirements should continue to include, at a minimum: (1) a patient's written or verbal desire to die through the use of physician-prescribed medication, heard or read by a physician; (2) documentation by a physician that the patient does not have depression or a similar diagnosis that would impair the patient's ability to make an informed and rational decision regarding death; and (3) a diagnosis estimating that the patient has less than six months to live.

Regarding medication administration specifically, supervision at the time of ingestion is currently not required so it cannot be said that no one will assist; the legislature chose not to require supervision.⁹⁶ Without required supervision in Oregon, the law has survived and people have continued to successfully obtain and ingest the medication without issue; the murder rate has not changed and in fact remains far lower than many other states'.⁹⁷ If states received claims that people were misusing the drugs to terminate the lives of those who did not want to die, this would need to be addressed in the legislation, but that is simply not the case. The current system is successful, despite no supervision requirement. Those who have ingested the drug have done so voluntarily and their families are not suing for the voluntary deaths. Similar statistics have been obtained throughout the European Union, where death with dignity is gaining acceptance.⁹⁸ In fact, in the Netherlands, where euthanasia and assisted administration are permitted, the murder rate has remained one of the lowest in the world; people have accepted that someone who faces an impending death should be able to choose their own death at their own time.⁹⁹ There, assisted administration has not resulted in a diminution in the value of life. Further, as discussed *infra*, even when there is assistance, the only repercussions are deaths that were desired by the decedents. As such, there is no demonstrable need for the self-administration requirement.

It cannot be said that the murder rate has lowered because death with dignity laws have permitted a type of murder. Murder requires intent to take the life of another in a manner

⁹⁶ Upon reading California and Oregon's laws, noticeably missing from both is a requirement for physician supervision over one's administration of the life-ending medication. If there is no supervision, then there is currently no realistic way to assure that one is not obtaining assistance in the administration. See CAL. HEALTH & SAFETY CODE §§ 443.1–.2 (West 2016).

⁹⁷ For more information about nationwide crime statistics, which show no indication that states with Death With Dignity laws have increased murder rates, see *Crime in the United States*, FBI: UNIFORM CRIME REPORTING (2012), https://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2012/crime-in-the-u.s.2012/tables/5tabledatadecpdf/table_5_crime_in_the_united_states_by_state_2012.xls (providing comparative crime reports for all fifty states through 2012) [<http://perma.cc/X2L7-QAAW>]. For more detailed information on Oregon's crime rates from 1995 through 2014, see *Oregon Annual Uniform Crime Reports*, OREGON.GOV, https://www.oregon.gov/osp/CJIS/Pages/annual_reports.aspx [<http://perma.cc/3MTQ-KUFP>].

⁹⁸ For additional information on European crime statistics, see *Eurostat Crime Statistics*, EUROPA (Jan. 2014), http://ec.europa.eu/eurostat/statistics-explained/index.php/Crime_statistics [<http://perma.cc/U3FM-UEK2>].

⁹⁹ *Murder Rate: Countries Compared*, NATIONMASTER, <http://www.nationmaster.com/country-info/stats/Crime/Murder-rate> [<http://perma.cc/BA73-CZBV>].

that is not otherwise legally allowed.¹⁰⁰ Suicides permitted under right-to-die legislation, even when achieved with assistance, are done with the patient as the driving force of the application for the life-ending medication.

One assertion as to why patients should have to self-administer is that assistance may lead to murders of those who do not have capacity over their bodies.¹⁰¹ However, as discussed prior, even as it stands now, there is no mechanism through which to confirm that someone actually self-administered. Current laws act as a blank check of sorts where a patient receives a prescription, and society is then supposed to believe that the patient is going to administer with no assistance. However, we already know that patients obtain assistance in preparing, mixing, and delivering the medication. The medical screenings, psychological exams, and general processes set in place provide a level of proactive screening and reporting to prevent any medication from getting into the wrong hands.

Along a similar line, proponents of self-administration claim that by requiring a patient to commit the final act, the patient has full control up until the last moment and can choose not to lift the glass or drink from the straw.¹⁰² However, self-reporting is the only manner in which a breach would be discovered under the current laws. By permitting assisted administration, it is not likely that the crime rate would increase because each patient would still be required to request the medication, visit doctors, and go to any psychological referrals that may be deemed necessary.

Self-administration, although well-intended to protect terminally ill patients from murder, in fact removes many patients' right to autonomy.¹⁰³ A California court has held that a physician could permit a woman to stop all medical treatment and starve herself even when she could have lived another fifteen or twenty years—demonstrating a respect for choice.¹⁰⁴ The same court also said that “[n]o criminal or

¹⁰⁰ Oregon's statute criminalizing murder requires an intentional killing of another. OR. REV. STAT. § 163.115 (1997).

¹⁰¹ See Zara Aziz, *We Need Better Palliative Care, Not Assisted Dying*, GUARDIAN (Sept. 9, 2015 10:00 PM), <http://www.theguardian.com/society/2015/sep/09/better-palliative-care-not-assisted-dying> (“There is the real possibility of coercion – whether implied or expressed – by friends, family and even health professionals when patients are seen to be a burden.”) [<http://perma.cc/3Z72-JZJC>]; see also Dore, *supra* note 11.

¹⁰² Benjamin Schechtman, *Freedom and Compassion for All: The Physically Incapacitated Have a Right to Assisted Death*, 24 TEMP. INT'L & COMP. L.J. 507, 526 (2010).

¹⁰³ Jodi B. Gabel, *Release from Terminal Suffering?: The Impact of AIDS on Medically Assisted Suicide Legislation*, 22 FLA. ST. U. L. REV. 369, 421–30 (1994) (discussing proposed legislation in which a doctor would be permitted to assist patients suffering from AIDS in the administration of medications).

¹⁰⁴ *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 1143–45 (1986) (“Here, if force fed, petitioner faces 15 to 20 years of a painful existence, endurable only by the constant administrations of morphine. Her condition is irreversible.”).

civil liability attaches to honoring a competent, informed patient's refusal of medical service"—demonstrating a respect for autonomy.¹⁰⁵ If a patient cannot move, yet remains in an uncontrollable amount of pain, then under the current law, it would appear that she must remain in that amount of pain until she dies while her mobile counterpart—someone with the physical capability of self-administering—may take advantage of California's ELOA to end her life on her own terms. This does not make sense as it does not protect a patient with a disease or disorder that has caused the loss of motor function who should have an equal right to die with dignity, and thus should be changed.

B. Palliative Care is Not Enough

Commentators have proposed various alternatives to a patient killing him or herself including more rigorous use and promotion of palliative care, pain management, and palliative sedation.¹⁰⁶ However, none of these options result in the autonomy, humanity, and choice that would result if assisted-administration of medication was adopted as an option for patients at the end of their lives.

The World Health Organization says that “[p]alliative care improves the quality of life of patients and families who face life-threatening illness, by providing pain and symptom relief, spiritual and psychosocial support to from diagnosis to the end of life and bereavement.”¹⁰⁷ Though this may be the goal of palliative care, there is a misperception in modern society that palliative care and strong pain relief drugs can resolve nearly any pain a patient may suffer.¹⁰⁸ There is also an underlying fear among those against right-to-die legislation who claim that palliative care will falter if right-to-die legislation is implemented.¹⁰⁹ However, the contrary has been found; palliative care and pain management discussions improve after the

¹⁰⁵ *Id.*

¹⁰⁶ These options could be used if a patient is not able to qualify under death with dignity acts because they are not able to self-administer. See David A. Pratt, *Too Many Physicians: Physician-Assisted Suicide after Glucksberg/Quill*, 9 ALB. L.J. SCI. & TECH. 161, 166 (1999) (mentioning critics' concerns regarding death with dignity legislation thwarting palliative care options).

¹⁰⁷ *Palliative Care*, WHO, <http://www.who.int/cancer/palliative/definition/en/> [http://perma.cc/6F93-HRDZ].

¹⁰⁸ See Pratt, *supra* note 106, at 205–07 (“Palliative care experts believe that the number of patients with unavoidable and intolerable pain is very small.”).

¹⁰⁹ But, as the medical industry is currently regulated, it is already difficult to obtain the necessary pain medication for many patients. See generally Amy J. Dilcher, *Damned If They Do, Damned If They Don't: The Need for a Comprehensive Public Policy to Address the Inadequate Management of Pain*, 13 ANNALS HEALTH L. 81 (2004).

implementation of right-to-die measures.¹¹⁰ This is true in both the United States and Europe; “Belgium and Holland have some of the best palliative care in Europe,” and both countries permit doctor-assisted suicide.¹¹¹

The reality of pain is that some patients are forced to suffer through immeasurable pain because of the illnesses they have, and modern medication cannot provide relief.¹¹² This is one of the key reasons California passed the ELOA.¹¹³ Some painful diseases may eventually prevent patients from being able to bring water to their mouths, prevent them from being able to swallow, or prevent them from being able to load their own gastrointestinal tubes with medication. These patients are no less deserving of the right to die with dignity than any other person with a painful and life-threatening disease. Whether from multiple sclerosis,¹¹⁴ brain cancer,¹¹⁵ spinal cord injuries,¹¹⁶ phantom pain due to a nerve injury,¹¹⁷ or the unremitting pain associated with Parkinson’s disease,¹¹⁸ countless people in our

¹¹⁰ See U.S. GOV. ACCT. OFF., REP. TO HON. RON WYDEN, U.S. SENATE, END-OF-LIFE CARE: KEY COMPONENTS PROVIDED BY PROGRAMS IN FOUR STATES 14 (2007), <http://www.gao.gov/new.items/d0866.pdf> (“Representatives of a palliative care program operated by a health care system we interviewed stated that passage of [Oregon’s Death With Dignity] act helped create an environment in Oregon where end-of-life issues are discussed more openly.”) [<http://perma.cc/4EYG-TQTH>].

¹¹¹ *The Right to Die*, ECONOMIST (June 27, 2015), <http://www.economist.com/news/leaders/21656182-doctors-should-be-allowed-help-suffering-and-terminally-ill-die-when-they-choose> [<http://perma.cc/LLY5-LPDJ>].

¹¹² See Michael Cohn, PhD, et. al., *Transitions in Care for Patients with Brain Tumors: Palliative and Hospice Care*, UCSF MED. CTR. (Regents of Univ. of Cal. 2014), https://www.ucshealth.org/pdf/transition_of_care_handbook.pdf (describing the stages of brain cancer, including uncontrollable pain and loss of motor skills) [<http://perma.cc/5NKB-LQXM>]; Brian L. Schmidt et al., *Mechanism of Cancer Pain*, 10 MOLECULAR INTERVENTIONS 3, 164–68 (2010) (explaining the untreatable pain that often comes with cancer of any kind); see also Dilcher, *supra* note 109 (describing the difficulties that many doctors go through to get patients the opioid pain medication they need).

¹¹³ See Bonta, *supra* note 77, cmt. 2(d) (“While palliative care is generally agreed to be the standard of care for the dying, in some cases some patients who are very ill do not respond to pain medications or may be suffering in other ways that make comfort impossible.”).

¹¹⁴ See, e.g., Nicola Slawson, *MS Sufferer Should be Allowed to Die, Says Judge in Landmark Ruling*, GUARDIAN (Nov. 19, 2015), <http://www.theguardian.com/society/2015/nov/19/ms-sufferer-should-be-allowed-to-die-judge-landmark-ruling-multiple-sclerosis> [<http://perma.cc/UC7Q-LQ9U>].

¹¹⁵ Maynard, *supra* note 39.

¹¹⁶ Jeanine M. Rundquist, *The Right to Die—Ethical Dilemmas in Persons with Spinal Cord Injury*, 19 SCI NURSING 7, 7–8 (2002) (discussing the ethical issues posed regarding patients who have suffered spinal cord injuries).

¹¹⁷ See A. Kovindha, *The Right to Die of a High Quadriplegic in a Developing Country: Case Report*, 28 PARAPLEGIA 272, 272 (1990) (detailing the story of a young paraplegic man who had to endure assisted respiration even though he wanted to die).

¹¹⁸ See Michael S. Rosenwald, *NPR Host Diane Rehm Emerges as a Key Force in the Right to Die Debate*, WASH. POST (Feb. 14, 2015), https://www.washingtonpost.com/local/npr-host-diane-rehm-emerges-as-a-key-force-in-the-right-to-die-debate/2015/02/14/12b72230-ad50-11e4-9c91-e9d2f9fde644_story.html (describing Diane Rehm’s husband’s pain from

society are suffering from untreatable diseases and deserve the option of relief in their last months. Even palliative sedation, a procedure in which a doctor puts a patient in a comatose state in an attempt to prevent pain, is not always painless.¹¹⁹

With all of this in mind, California's legislators have reasoned that Californians near the end of their lives should not have to endure unnecessary and untreatable pain, but have not included clear options for those who require assistance in taking their medication.¹²⁰ Based upon polls of Americans, specifically Californians, discussed *infra*, it is likely that a broadening of the ELOA would be supported.¹²¹ California should create additional methods to make physician-assisted suicide available to those who want to pass on their own terms, but do not have the luxury of mobility.

C. The Polls Support an Individual's Right to Choose Death

National polls indicate overwhelming support of right-to-die legislation. In a recent 2015 Gallup poll, nearly 68% of Americans supported going one step further than doctor-assisted suicide and supported euthanasia.¹²² Although there may be more dangers if euthanasia is legalized, this statistic shows that Americans are in favor of patient autonomy and self-determination in deciding the course of their lives.

Following Brittany Maynard's decision to utilize Oregon's Death With Dignity law, the Harris Poll found that 74% of

Parkinson's as "Parkinson's had ravaged his body and exhausted his desire to live.") [<http://perma.cc/C254-5BW3>].

¹¹⁹ On *60 Minutes*, the family of Jennifer Glass discussed the pain and torture that she went through while under palliative sedation: foaming at the mouth, gurgling on fluids, suffering a slow death, all while her family helplessly watched. LaPook, *supra* note 39; *see also* Bonta, *supra* note 77, at 11 ("[Death] may not happen for days or weeks . . . patients reject [terminal sedation] because they believe their dignity would be violated if they have to be unconscious for a prolonged period before they die, or that their families suffer unnecessarily while waiting for them to die.").

¹²⁰ *See* Bonta, *supra* note 77, at 9; *see also* Greg Botelho, *California Governor Signs Right to Die Bill*, CNN (Oct. 6, 2015, 5:20 AM), <http://www.cnn.com/2015/10/05/us/california-assisted-dying-legislation/> (quoting Governor Jerry Brown as saying, "I am certain, however, that it would be a comfort to be able to consider the options afforded by this bill And I wouldn't deny that right to others.") [<http://perma.cc/H9R4-Y4J7>].

¹²¹ *See* Maclay *infra* note 126.

¹²² Andrew Dugan, *In U.S., Support Up for Doctor-Assisted Suicide*, GALLUP (May 27, 2015), http://www.gallup.com/poll/183425/support-doctor-assisted-suicide.aspx?utm_source=Politics&utm_medium=newsfeed&utm_campaign=tiles [<http://perma.cc/K42S-GQUF>]. The question asked during the poll was, "When a person has a disease that cannot be cured and is living in severe pain, do you think doctors should or should not be allowed to assist the patient to commit suicide if the patient requests it?" *Id.* In this poll, "euthanasia" was defined as "ending a patient's life by some painless means." *Id.* One notable reference missing from this question is whether the person has six months left to live, indicating that people may sympathize with those who are in untreatable pain, despite their life expectancy.

Americans supported the right-to-die movement.¹²³ Only 15% of those polled opposed physician-assisted suicide.¹²⁴ When the polls are broken down, “[s]upport for the right-to-die movement cut[s] across all generations and educational groups, both genders, and even political affiliation”¹²⁵ In California alone, the Institute of California Statistics found that 75.5% of Californians supported legislation promoting life-ending medication.¹²⁶ The same poll found bipartisan support for California’s ELOA, with 70% of democrats and 55% of republicans supporting the legislation.¹²⁷

This is not to say that this movement does not have very strong opponents. The Catholic Church has spoken out vehemently against right-to-die legislation. In fact, Los Angeles Archbishop Jose Gomez has said, “[i]n a for-profit health care system driven by financial concerns, doctor-assisted suicide will not be a ‘choice’ for minorities, the poor and those without health care. It will become their only ‘option.’”¹²⁸ While Catholic leadership may have this view, the fact remains that over 60% of Catholics are generally in favor of death with dignity legislation, including California’s Jesuit governor, Jerry Brown.¹²⁹ In California, 55% of Catholics supported the ELOA.¹³⁰

Support for physician-assisted suicide is growing and its opposition is quickly shrinking. From these numbers, it is likely that explicit allowance of assisted-administration would also receive overwhelming support.

D. Safeguards to Prevent Euthanasia

There is a distinction to be made between euthanasia and what this Note proposes when it describes “assisted-administration.” Assisted-administration requires patients to request medication

¹²³ Dennis Thompson, *Most Americans Agree with Right-to-Die Movement*, HARRIS POLL (Dec. 5, 2014, 12:00 AM), http://www.theharrispoll.com/health-and-life/Most_Americans_Agree_With_Right-to-Die_Movement.html [<http://perma.cc/3W74-D3DW>].

¹²⁴ *Id.*

¹²⁵ *Id.*

¹²⁶ Kathleen Maclayl, *IGS Poll: Californians Support Medical Aid in Dying for Terminally Ill*, IGS (Sept. 3, 2015), <https://igs.berkeley.edu/news/igs-poll-californians-support-medical-aid-in-dying-for-terminally-ill> [<http://perma.cc/Q4PA-QT5Y>]; see Mark DiCamillo, *Strong Voter Support for the “End of Life Option Act,”* FIELD (Oct. 16, 2015), <http://field.com/fieldpollonline/subscribers/Rls2512.pdf> [<http://perma.cc/7TQR-DBRE>].

¹²⁷ *Id.*

¹²⁸ Alejandro Lazo, *California Senate Passes Right-to-Die Legislation*, WALL ST. J. (Sept. 11, 2015, 10:13 PM), <http://www.wsj.com/articles/california-senate-passes-right-to-die-legislation-1442013579>.

¹²⁹ Goodwin Simon Strategic Research & Probosky Research, *Significant Majority of California Voters Support End-Of-Life Option Act Allowing Terminally Ill People to Legally Access Medical Aid-in-Dying*, COMPASSION AND CHOICES (June 22, 2015), <https://www.compassionandchoices.org/wp-content/uploads/2014/10/PUBLIC-MEMO-EOL-OPTIONS-ACT-JUNE-2015.pdf> [<http://perma.cc/63KD-LBDN>].

¹³⁰ DiCamillo, *supra* note 126.

from their physicians, go through mental and physical exams, be fully competent, and perhaps most importantly, requires them to ingest the medication voluntarily. Unlike assisted-administration, which leaves the choice in the hands of the patient, through euthanasia “*the individual loses control of the decision*” and the decision is left to the healthcare provider.¹³¹ Additionally, euthanasia is outlawed in forty-four states¹³² and cannot be funded by federal dollars.¹³³

In honoring physicians’ self-identified roles in society as those who cure and treat illnesses,¹³⁴ this Note does not advocate for physician-assisted administration or euthanasia; physicians resoundingly do not want to actively aid a person in dying.¹³⁵ It is

¹³¹ Robin Marantz Henig, *Despite Sweeping Death With Dignity Law, Few Will Have That Option*, NPR (Oct. 7, 2015, 5:48 PM) (emphasis added), <http://www.npr.org/sections/health-shots/2015/10/07/446631786/despite-sweeping-death-with-dignity-law-few-will-have-that-option> [<http://perma.cc/88PN-VSYX>].

¹³² Alabama: ALA. CODE § 22-8A-10 (1997); Alaska: ALASKA STAT. § 11.41.120 (2001); Arizona: ARIZ. REV. STAT. ANN. § 13-1103 (1993); Arkansas: ARK. CODE ANN. § 5-10-104 (1987); Colorado: C.R.S. § 18-3-104 (2006); Connecticut: CONN. GEN. STAT. §§ 53a–56 (1969); Delaware: DEL. CODE ANN. § 632 (1995); Florida: FLA. STAT. § 782.08 (1992); Georgia: GA. CODE ANN. § 16-5-5 (1996); Hawaii: HAW. REV. STAT. § 707-702 (1993); Idaho: IDAHO CODE § 18-4017 (2011); Illinois: ILL. COMP. STAT. 12-34-5 (1961); Indiana: IND. CODE § 35-42-1-2 (1996); Ind. Code § 35-42-1-2.5 (1996); Iowa: IOWA CODE § 707A.2 (2011); Kansas: KAN. STAT. ANN. § 21-5407 (1995); Kentucky: KY. REV. STAT. ANN. § 216.302 (1994); Louisiana: LA. STAT. ANN. § 32.12 (1997); Maine: ME. STAT. ANN. § 204 (1983); Maryland: MD. CODE ANN., Assisting Another to Commit or Attempt Suicide, § 3-102 (2005); Massachusetts: MASS. GEN. LAWS § 201D-12 (2012); Michigan: MICH. COMP. LAWS § 750.329a (1997); Minnesota: MINN. STAT. § 609.215 (2012); Mississippi: MISS. CODE ANN. § 97-3-49 (1972); Missouri: MO. REV. STAT. § 55.023.1 (2000); Nebraska: NEB. REV. STAT. § 28-307 (1995); Nevada: NEV. REV. STAT. § 449.670 (1995); New Hampshire: N.H. REV. STAT. ANN. § 630:4 (1996); New Jersey: N.J. STAT. ANN. § 2C:11-6 (1995); New Mexico: N.M. STAT. ANN. § 30-2-4 (1996); New York: N.Y. PENAL § 125.15 (1967); North Carolina: N.C. GEN. STAT. §§ 14–17.1 (1973) (it is unclear as to whether suicide, as it has been abolished, includes assisted-suicide); North Dakota: N.D. CENT. CODE § 12.1-16-04 (1991); Ohio: OHIO REV. CODE ANN. § 3795.01–.03 (2013); Oklahoma: OKLA. STAT. § 21-817 (2014), § 21-818 (2014), § 63-3141.1 (2014); Pennsylvania: Causing or Aiding Suicide, PA. STAT. ANN. § 2505 (1983); Rhode Island: R.I. GEN. LAWS § 11-60-3 (1996); South Carolina: S.C. CODE ANN. § 16-3-1090 (1998); South Dakota: S.D. CODIFIED LAWS § 22-16-37 (2005); Tennessee: TENN. CODE ANN. § 39-13-216 (1993); Texas: TEX. PENAL CODE ANN. § 22.08 (1994); Utah: UTAH CODE ANN. § 75-2a-122 (2007); Virginia: VA. CODE ANN. § 8.01-622.1 (1998); West Virginia: W. VA. CODE R. § 16-30-14 (2015); Wisconsin: WIS. STAT. ANN. § 940.12 (1977); Wyoming: WYO. STAT. ANN. § 6-1-201 (1982).

¹³³ Assisted Suicide Funding Restriction Act, 111 Stat. 23 (1997) (outlawing federal funding for euthanasia, mercy killings, and assisted suicide).

¹³⁴ DEREK HUMPHREY & MARY CLEMENT, FREEDOM TO DIE: PEOPLE, POLITICS, AND THE RIGHT-TO-DIE MOVEMENT 60 (2000) (“Medical schools are organized to prepare students ‘to treat disease, to cure, to stave off death.’”). See generally Transcript, *AHN v. Hestrin*, No. RIC 1607135 (Aug. 26, 2016), <https://www.compassionandchoices.org/wp-content/uploads/2016/08/AHN-vs-HESTRIN-8-26-16.pdf> (California physicians challenging the End of Life Option Act) [<http://perma.cc/LN4V-PULL>].

¹³⁵ See Diane E. Meier, MD, et. al., *A National Survey of Physician-Assisted Suicide and Euthanasia in the United States*, 338 NEW ENG. J. MED. 1193 (1998) (indicating that a great minority of physicians do not support physician-assisted suicide, even if it were to be made legal); see also Steven Reinberg, *Most Doctors Oppose Physician-Assisted Suicide, Poll Finds*, US NEWS: HEALTH (Sept. 11, 2013, 5:00 PM),

argued that “[t]ermination of treatment, which thereby allows a patient to die, is vastly different from providing a lethal drug to enable a patient to kill himself.”¹³⁶ The argument is that a healthy patient will not die if taken off of a respirator, and since a doctor cannot know with 100% certainty that someone will die when taken off of a respirator, it is different than actively causing their death.¹³⁷ However, realistically, a doctor may still know with 90% certainty that someone will die when taken off of a respirator, yet that remains acceptable. There is no concrete percentage of certainty at which a doctor becomes criminally liable. Presumably, this is how doctors are able to emotionally distance themselves from the situation when taking someone off of a respirator. Similarly, when prescribing a life-ending medication, a doctor cannot know with 100% certainty that the patient will take it, therefore doctors should not be held liable.

To the contrary, if a doctor were to administer the medication, then he or she would know with certainty that the patient would die, which could alter the primary perception of doctors as healers. This could further expose doctors to malpractice claims and lawsuits.¹³⁸ To quell the concerns of physicians that assisted-administration may lead to physician-administered euthanasia, California, as well as other states, should enact safeguards to prevent just that. California could require documentation, reported to the state, regarding who has been granted permission to provide assistance with administration. Additionally, the assistant could be required to call or in some way notify a doctor before the actual administration to ensure transparency in the process. Requiring a form with two witnesses’ signatures could demonstrate that a patient ingested medication voluntarily. Although this may appear insensitive given the emotionally-charged nature of suicide, a measure like this may be necessary to ensure proper legal standards are followed. California could further require that any assistant go through a

news/news/articles/2013/09/11/most-doctors-oppose-physician-assisted-suicide-poll-finds (reporting that “[s]ome [physicians] said assisting a suicide violates a physician's oath to do no harm . . .”) [http://perma.cc/88QT-ADTW]; Dr. Kevin Fitzpatrick, *Euthanasia: We Can Live Without It . . .*, CNN (Nov. 27, 2013, 12:29 PM), <http://www.cnn.com/2013/11/27/opinion/opinion-anti-euthanasia-kevin-fitzpatrick/> (“Killing someone by lethal injection is not an act of medicine: it comes when medicine apparently has nothing left to offer.”) [http://perma.cc/V5EJ-Y2A6]. There are websites for doctors to reach out and connect with other anti-physician-assisted suicide doctors. See e.g., *Doctors as Healers*, LIFE, <http://www.life.org.nz/euthanasia/euthanasiamedicalkeyissues/doctors-as-healers/> [http://perma.cc/6XDQ-4J56].

¹³⁶ Susan R. Martyn & Henry J. Bourguignon, *Physician-Assisted Suicide: The Lethal Flaws of the Ninth and Second Circuit Decisions*, 85 CAL. L. REV. 371, 386 (1997).

¹³⁷ *Id.*

¹³⁸ See CAL. PENAL CODE §§ 187, 189, 192 (West 1872) (defining the various degrees of murder and manslaughter); CAL. CIV. CODE § 3333.1 (West 1975) (allowing patients to sue healthcare providers for negligent care).

class and/or discussion with the prescribing physician. In such a class, the physician could explain how to administer and verify that the patient is voluntarily going to ingest the medication. Finally, if a patient chose to receive assistance, California could require the supervision of a doctor to ensure proper procedures are followed without requiring doctors to actually administer.

Although doctors are thought to be healers and fixers, people must accept that many patients cannot be “fixed” by medicine. For Brittany Maynard, whose brain cancer was irreversible and immeasurably painful, the most viable option was to relieve her of a life that was too agonizing to endure. By requiring self-administration, patients like Brittany are not only required to rely on physicians’ calculations of when they have less than six months to live, but are also forced to estimate on their own when they may lose the ability to self-administer. This takes away potential quality time patients have left with their families. It should not be on the patient to determine when the time may come that they will lose the ability to self-administer. Patients should be able to delegate the physical act of administration to a person of their choosing.

In the case of Barbara Houck, a terminally-ill Oregonian suffering during the terminal stages of ALS, her son mixed her prescribed life-ending medications into a bowl of pudding and spoon-fed it to her as per her request.¹³⁹ She had the right to tell him not to give her the medications, but they had been prescribed, and she made the conscious choice to die on her own terms.¹⁴⁰ He was merely a vessel that aided her in her wish to die through legal means. He did not inject her with anything; he did not insert anything into her. He merely carried forth her wishes to pass on her own terms. His actions were no different and no more deserving of punishment than any other family member who has been permitted to mix the life-ending medication into a liquid, but does not actually assist in the delivery of the food or drink to the patient’s mouth. The intent of a loved one when offering assistance is to honor the desire of the patient, much in the same manner that a doctor who prescribes the medication does so out of empathy and compassion.¹⁴¹ Brittany Maynard’s doctor said it

¹³⁹ Frey, *supra* note 88.

¹⁴⁰ *Id.*

¹⁴¹ LaPook, *supra* note 39 (statement of the son of a woman who plans to end her life in Oregon) (“There isn’t a day where I won’t wish that there would be more time. But there will very easily be a day where I wish there was less suffering.”). See generally Howard Brody, *Physician-Assisted Suicide: Family Issues*, 1 MICH. FAM. REV. 19 (1995) (clarifying that ultimately the choice to die is left to a patient and not a family member).

best: “Shouldn’t I be able to help [patients] when they’re suffering, and the burden of living becomes intolerable to them?”¹⁴²

V. CONCLUSION

If California’s End of Life Option Act follows the precedent that its predecessor, Oregon, has established, then the self-administration requirement that is currently written into the law will serve no real purpose. This requirement should be removed for a lack of realistic enforceability. There is no practical way to legally enforce the self-administration requirement unless a third party captures on video camera or photograph illegal assisted-administration or through self-reporting mechanisms. There is documentation of patients receiving assistance in the administration of their life-ending medications, yet there have been no instances of criminal charges. The self-administration requirement has become nothing more than a line in a bill to silence critics who fear improbable outcomes, including murder and coercion.

In no way does this Note intend to imply that euthanasia is the answer. The simple solution is this: make it explicitly legal for a patient to receive assistance in mixing, ingesting, and ultimately, administering prescribed life-ending medications, and implement realistic safeguards to protect patients. There are people who do not want to die, but are dying, some of whom cannot self-administer.¹⁴³ Mobile or not, those in untreatable pain with only months left to live deserve the right to a dignified and humane end-of-life option. Providing patients with an option to receive help may allow them peace of mind in their final days, knowing that when the time is right, someone will be there to help them pass in peace.

¹⁴² LaPook, *supra* note 39. Doctor Walsh also gave descriptive insight into how to categorize the emotions that go along with prescribing a life-ending medication to a patient: “You know, we categorize tears into a single adjective. Tears of joy, tears of sorrow, tears of regret. But actually in the physician aid-in-dying these are tears that contain all of those adjectives.” *Id.*

¹⁴³ “I do not want to die. But I am dying.” Maynard, *supra* note 39.

