

PHYSICIAN-ASSISTED SUICIDE IN THE UNITED STATES: AN APPEAL TO ALLOW AN INDIVIDUAL SUFFERING FROM A CHRONIC PROGRESSIVE ILLNESS TO OPT FOR PHYSICIAN ASSISTED SUICIDE PRIOR TO THE SIX-MONTH TERMINAL ILLNESS REQUIREMENT

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INTRODUCTION

Suffering from a progressively debilitating disease, such as Amyotrophic Lateral Sclerosis¹, Multiple Sclerosis², Huntington's disease³, or Cystic Fibrosis⁴, results in an individual losing control over multiple body movements and functions and eventually becoming entirely incapacitated. These diseases may even lead to an individual's inability to ingest things, such as medications, on their own. With medical advances, the level of pain suffered is less than in the past, but individuals with these diseases suffer in various other ways, both physically and emotionally. Often individuals with these diseases have a strong desire to end their lives once they progress to a certain point, but under the physician-assisted suicide laws currently in place they are frequently unable to do so.

The six-month terminal illness requirement set forth in all current physician-assisted laws requires patients to self-administer the lethal dose of medication. These requirements arbitrarily exclude persons with incurable, but not imminently terminal, progressive illnesses such as ALS or MS, who may wish to end their lives in a dignified way through the use of physician-

¹ *See infra* Part III (a), notes 61–77.

² *See infra* Part III (b), notes 78–88.

³ *See infra* Part III (c), notes 89–105.

⁴ *See Infra* Part III (d), notes 106–117.

assisted suicide.⁵ This group of people, those with chronic progressive illnesses, deserve the options afforded under physician-assisted suicide laws in the United States. This article will discuss the implications of the current physician-assisted suicide laws for individuals suffering from chronic progressive illnesses and set forth a proposed exception to the six-month terminal illness requirement for this specific group of individuals. Part I of this article will lay out a brief background of the physician-assisted suicide laws as they presently exist in the United States, and will also discuss who physician-assisted suicide laws are intended to protect. Part II will discuss physician-assisted suicide laws in other countries. Part III will set forth an in-depth analysis of various chronic progressive illnesses and the effects they have on individuals suffering from the same. Part IV will discuss the problems an individual with a chronic progressive illness faces with physician-assisted suicide laws as they are currently written and why an exception to the six-month terminal illness requirement is necessary for this subset of individuals. Additionally, Part IV will set forth a proposed exception to the six-month terminal illness requirement for individuals suffering from a chronic progressive illness.

I. BACKGROUND OF PHYSICIAN-ASSISTED SUICIDE LAWS IN STATES WHERE PHYSICIAN-ASSISTED SUICIDE IS CURRENTLY LEGAL

First and foremost, it is essential to define physician-assisted suicide. Physician-assisted suicide occurs when an individual makes the decision to end his/her own life and his/her doctor assists in the termination of life, but the lethal drugs are self-administered by the patient.⁶

⁵ Martin Gunderson & David J. Mayo, *Restricting Physician-Assisted Death to the Terminally Ill*, 30 THE HASTINGS CENTER REP. no. 6, 2000, at, 18. (The argument is that it is unfair to limit physician-assisted suicide to individuals that are terminally ill since individuals that are not terminally ill have equally compelling reasons for wanting to end their lives and an equal claim to self-determination and therefore the laws are morally arbitrary).

⁶ Stephen Hoffman, *Euthanasia and Physician-Assisted Suicide: A Comparison of E.U. and U.S. Law*. 63 SYRACUSE L. REV. 383, 385 (2013); see also Margaret Otlowski, et al, *Physician-Assisted Death: Dying with Dignity?: Legal Issues of PAS*, 2 THE LANCET 637, 640 (2003) (Physician-assisted suicide differs from euthanasia. Euthanasia involves active participation by the doctor in bringing about the patient's death—for example through the administration of a lethal dose of drugs—and is punishable as murder. Physician-assisted suicide is

Currently, only five states allow physician-assisted suicide.⁷ Both Oregon and Washington have very similar laws authorizing the practice of physician-assisted suicide.⁸ Those laws were enacted via voter initiative and took effect in 1997 and 2009.⁹ In 2013, Vermont became the first state to enact such a law by the way of the legislative process.¹⁰ In Montana, a judicial decision handed down in *Baxter v. Montana*, authorized doctors to engage in the practice of physician-assisted suicide.¹¹ Most recently, in September of 2015, California passed a law allowing physician-assisted suicide via the legislative process.¹²

All five states require that an individual be terminally ill and capable of self-administering a lethal dose of medication to qualify for physician-assisted suicide. The first state to legalize physician-assisted suicide in the United States was Oregon. In 1997, by voter-initiative, the Death with Dignity Act (ODWDA) was passed.¹³ In pertinent part, ODWDA provides that:

An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purposes of ending his or her life in a humane and dignified manner.¹⁴

The ODWDA defines the term “terminal disease” as an “incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.”¹⁵

Following in Oregon’s footsteps, in March 2009, Washington

also distinct from the giving of drugs to relieve pain, which incidentally hasten death).

⁷ See LEGISLATIVE HISTORY, S. B. 128, 2015–2016 Leg. (Cal. 2015).

⁸ See LEGISLATIVE HISTORY, S. B. 128, 2015–2016 Leg. (Cal. 2015).

⁹ See LEGISLATIVE HISTORY, S. B. 128, 2015–2016 Leg. (Cal. 2015).

¹⁰ See LEGISLATIVE HISTORY, S. B. 128, 2015–2016 Leg. (Cal. 2015).

¹¹ See *Baxter v. State*, 224 P.3d 1211 (Mont. 2009).

¹² LEGISLATIVE HISTORY, Assem. B. 15, 2015–2016 Leg. (Cal. 2015).

¹³ Hoffman, *supra* note 6, at 393.

¹⁴ OR. REV. STAT. ANN. § 127.805(1) (2008).

¹⁵ OR. REV. STAT. ANN. at § 127.800(12).

became the second state to legalize physician-assisted suicide.¹⁶ A state measure, known as initiative 1000, passed, making it legal for doctors to prescribe a lethal dose of medication for patients with less than six months to live.¹⁷ Much like the ODWDA, the Washington Death With Dignity Act (WDWDA) provides that “An adult who is competent, a resident of Washington State, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication”.¹⁸

The patient then may self-administer the medication to end his or her life in a humane and dignified manner.¹⁹ “Terminal disease” as defined by the WDWDA is “an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.”²⁰

In December 2008, a Montana district court judge ruled that the state’s constitution includes the right to assisted suicide.²¹ In that case, a seventy-five year old, suffering from lymphocytic leukemia with diffuse lymphadenopathy, a terminal form of cancer, wanted the option of assisted death when his suffering became unbearable.²² The judge declared that the “Montana constitutional rights of individual privacy and human dignity, taken together encompass the right of a competent terminally ill patient to die with dignity.”²³ The judge’s decision allowed “[a] patient [to] use the assistance of his physician to obtain a prescription for a lethal dose of medication that the patient may take on his own if and when he decides to terminate his life.”²⁴

The Patient Choice and Control at End of Life Act (Act 39), signed into law on May 20, 2013, provides Vermont residents with a terminal disease the option to be prescribed a dose of

¹⁶ WASH. REV. CODE. ANN. § 70.245.020 (2008) (effective Mar. 5, 2009).

¹⁷ WASH. REV. CODE. ANN. § 70.245.020 (2008) (effective Mar. 5, 2009).

¹⁸ WASH. REV. CODE. ANN. § 70.245.020 (2008) (effective Mar. 5, 2009).

¹⁹ WASH. REV. CODE. ANN. § 70.245.020 (2008) (effective Mar. 5, 2009).

²⁰ WASH. REV. CODE. ANN. § 70.245.010(13) (2008) (effective Mar. 5, 2009).

²¹ See *Baxter v. State*, 224 P.3d 1211, 1213 (Mont. 2009); Cyndi Bollman, *A Dignified Death? Don't Forget About the Physically Disabled and Those Not Terminally Ill: An Analysis Of Physician-Assisted Suicide Laws*, 34 S. ILL. U. L.J. 395, 404–05 (2010).

²² Bollman, *supra* note 21, at 404.

²³ *Id.* at 405.

²⁴ *Id.*

medication to hasten the end of life.²⁵ This option requires the participation of a Vermont physician.²⁶ However, no patient, physician, or pharmacist may be required to participate in activities under Act 39, every step must be voluntary.²⁷ The law defines terminal as “an incurable and irreversible disease which would, within reasonable medical judgment, result in death within six months.”²⁸ For the next three years, physicians and patients must adhere to a process laid out by the Act.²⁹ In 2016, that process sunsets, but the law continues to provide immunity for patients and physicians who wish to take steps under the Act.³⁰

Most recently, California’s legislature passed a bill allowing competent, terminally ill, California residents over the age of eighteen, who meet certain criteria, to request medication to be self-administered by the individual for the purpose of ending his or her life.³¹ California’s bill was modeled largely upon Oregon and Washington’s laws.³² California’s legislative history specifies that the purpose behind its physician-assisted suicide statute is to provide terminally ill adults with control over their final days as well as the ability to ease their suffering.³³ The statute provides terminally ill patients, with a humane end-of-life option.³⁴ The law defines terminal disease as “an incurable and irreversible disease that has been medically confirmed and will, with reasonable medical judgment, result in death within six months.”³⁵ California’s legislature noted that “providing terminally ill patients with this humane choice is preferable to the desperate and covert self-help practices some patients are currently forced to employ.”³⁶ Significantly, “compassion for

²⁵ VT. DEP’T OF HEALTH, *Patient Choice and Control at End of Life*, <http://www.healthvermont.gov/systems/patient-choice-and-control-end-life> (last visited Apr. 20, 2017).

²⁶ *Id.*

²⁷ *Id.*

²⁸ VT. STAT. ANN. tit. 18, § 5281(10) (2017).

²⁹ *Patient Choice and Control at End of Life*, *supra* note 25.

³⁰ *Id.*

³¹ See LEGISLATIVE HISTORY, S. B. 128, 2015–2016 Leg. (Cal. 2015).

³² See LEGISLATIVE HISTORY, S. B. 128, 2015–2016 Leg. (Cal. 2015).

³³ LEGISLATIVE HISTORY, A.B. 374, 2007 Legis. (Cal. 2007).

³⁴ LEGISLATIVE HISTORY, A.B. 374, 2007 Legis. (Cal. 2007).

³⁵ A.B. 15, 2015 Leg. 2d Extraordinary Sess. (Cal. 2015).

³⁶ *End of Life: Hearing on S.B. 128 Before the S. Judiciary Comm.*, 2015 Leg., 2015–2016 Sess. (Cal. 2015) (“[I]t is inhumane to not be provided with a choice that would bring them peace”); see also *Bill Analysis: Assemb. Third Reading of A.B. 374 Before the Assemb. Floor*, 2007 Leg., 2007–2008 Sess. (Cal.

suffering and respect for patient's autonomy serve as the basis for the strongest arguments in favor of legalizing physician-assisted suicide."³⁷

Except in Montana, these laws leave out a group of dying patients who may need their provisions. Those with chronic progressive illnesses are not considered terminal until six months before their death when they will likely be unable to self-administer the medication as required by law. Commentators recognize that "a fraction of dying patients confront a dying process so prolonged and marked by such extreme suffering and deterioration that, even with excellent pain and symptom management, they determine that hastening impending death is the least bad alternative."³⁸ As such, physician-assisted suicide laws should be expanded to allow an individual with a chronic progressive illness that meets certain criteria to opt for physician assisted suicide before the six-month terminal illness requirement.

A. WHO PHYSICIAN-ASSISTED SUICIDE LAWS ARE INTENDED TO PROTECT

Physician-assisted suicide laws are intended to protect the autonomy of individuals faced with progressive loss of bodily function and personal integrity.³⁹ Physician-assisted suicide laws were drafted to provide individuals who wish for a peaceful end of life with an alternative to one marked by suffering, pain, and/or the loss of autonomy and dignity.⁴⁰ But notably, quality of life for

2007) ("Every day in California, suffering patients ask their doctors to hasten their death. These patients either stockpile and take medicines supplied by their doctor or resort to horrific and violent methods to end their suffering.").

³⁷ Bollman, *supra* note 21, at 411.

³⁸ Kathryn L. Tucker, *Choice at the End of Life: Lessons from Oregon*, AM. CONST. SOC'Y FOR L. & POL'Y, June 2008, at 1.

³⁹ *Vacco v. Quill*, 521 U.S. 793, 796 (1997) (This case was brought by three physicians challenging the constitutionality of New York statutes making it a crime to aid a person in committing suicide or attempting to commit suicide, as applied to physicians who wish to aid mentally competent, terminally ill adults wishing to avoid continued severe suffering. The Supreme Court ruled that a New York ban on physician-assisted suicide was constitutional, and preventing doctors from assisting their patients, even those terminally ill and/or in great pain, was a legitimate state interest that was well within the authority of the state to regulate. This case established that as a matter of law, there was no constitutional guarantee of a "right to die.").

⁴⁰ See LEGISLATIVE HISTORY, A.B. 374, *supra* note 33; *Morris v. Brandenburg*, 356 P.3d 564, 567 (N.M. Ct. App. 2015).

patients varies depending on the specific illness and its manifestations in the patient.⁴¹ Chronic progressive illnesses can also interfere with a patient's vital functions, such as eating and drinking, breathing, blood flow, and the basic functions of the brain.⁴² As such, individuals with chronic progressive illnesses should be afforded the option to end their lives under physician-assisted suicide laws.

The laws are intended to allow an individual to avoid unnecessary pain and suffering, preserve and enhance the right of competent adults to make their own critical health care decisions, and avoid tragic cases of attempted or successful suicides in a less humane and dignified manner.⁴³ Significantly, "a proper [physician-assisted] suicide statute must strike a balance between protecting vulnerable patients and populations while simultaneously providing patients with the choice of a dignified death in their final days."⁴⁴ The current physician-assisted suicide laws fail to provide patients with chronic progressive illnesses, which can be debilitating to the point where they cannot self-administer the medications once they are considered terminal, with the same options as terminally ill patients, even though the purpose of physician-assisted suicide statutes may apply equally to these patients. For example,

[u]nder the physician-assisted suicide statutes of Oregon and Washington, a person who suffers from a physically debilitating ailment is unable to be assisted by her physician in committing suicide because she does not have the capacity to ingest the lethal prescription herself. Because she is unable to take the medication herself, she will be forced to live out her days in a hospital bed with no chance of ever living a normal life again.⁴⁵

The laws are essentially limited to the terminally ill and despite the fact that many patients suffer from long-lasting

⁴¹ *Morris*, 356 P.3d at 568.

⁴² *Id.*

⁴³ *Id.* at 605.

⁴⁴ Emily R. Mason, Note, *Ignoring It Will Not Make It Go Away: Guidelines For Statutory Regulation of Physician-Assisted Death*, 45 NEW ENG. L. REV. 139, 161 (2010).

⁴⁵ Bollman, *supra* note 21, at 396.

painful diseases, which progressively become more and more unbearable, i.e. chronic progressive illnesses, they are disqualified from being permitted to die with the assistance of their physician, due to the debilitating nature of their disease.⁴⁶

II. PHYSICIAN ASSISTED SUICIDE LAWS IN OTHER COUNTRIES

Some foreign countries have also legalized physician-assisted suicide. Two countries where physician-assisted suicide is allowed are the Netherlands and Switzerland. Physician-assisted suicide laws in these countries are broader than in the United States.

In the Netherlands, physician-assisted suicide and euthanasia both became legal in 2001.⁴⁷ Physician-assisted suicide occurs when an individual makes the decision to end his/her own life and his/her doctor assists in the termination of life, but the final casual act, the administration of lethal drugs, is performed by the patient. On the other hand, euthanasia involves a physician, or someone else, intentionally administering medication to cause a patient's death.⁴⁸

Although the Netherlands sets forth strict requirements individuals must meet in order to opt for physician-assisted suicide, individuals with a chronic progressive illness are permitted to opt for physician-assisted suicide.⁴⁹ Additionally, because the Netherlands allows euthanasia, an individual with a chronic progressive illness can choose to live longer and still retain the option of choosing the time of death because they do not have to self-administer the lethal medication.

If a patient in the Netherlands is experiencing “lasting and

⁴⁶ *Id.*

⁴⁷ *Holland's Euthanasia Law*, PATIENTSRIGHTSCOUNCIL.ORG, <http://www.patientsrightscouncil.org/site/hollands-euthanasia-law/> (last visited Apr. 7, 2017).

⁴⁸ Stephen Hoffman, *Jurisprudence and the Body: Taking the Pulse of Health Law*, 63 SYRACUSE L. REV. 383, 385 (2013); Otlowski et al., *supra* note 6, at 640. *See also Euthanasia*, BLACK'S LAW DICTIONARY (9th ed. 2009) (defining “euthanasia” as “the act or practice of killing or bringing about the death of a person who suffers from an incurable disease or condition, especially a painful one, for reasons of mercy”).

⁴⁹ *Background about Euthanasia in the Netherlands*, PATIENTSRIGHTSCOUNCIL.ORG, <http://www.patientsrightscouncil.org/site/holland-background/> (last visited Apr. 7, 2017) (In the United States, individuals with chronic progressive illnesses are unable to opt for physician-assisted suicide until they are considered “terminal” which often is too late for them to be able to self-administer the medications).

unbearable pain and suffering,” and has no prospect for improvement, the patient qualifies for physician-assisted suicide.⁵⁰ Under this standard, patients who are suffering from a neurodegenerative disease, such as Huntington’s, can opt for physician-assisted suicide.⁵¹ Significantly, the law in the Netherlands does not impose a six-month terminal illness requirement nor does it require that the suffering to be physical in nature.⁵² Many patients in the Netherlands consider euthanasia or physician-assisted suicide, but few choose to die that way.⁵³

Switzerland has also decriminalized the act of physician-assisted suicide.⁵⁴ Significantly, in Switzerland, a patient need

⁵⁰ See Steve P. Calandrillo, *Corralling Kevorkian: Regulating Physician-Assisted Suicide in America*, 7 VA. J. SOC. POL’Y & L. 41, 87 (1999) ([T]he patient must have a clear understanding of the available alternatives. This is a substantially different requirement than merely presenting the patient with her options, and one that would do well to be added to American P.A.S. policy. Third, the decision must be voluntary. . . . Next, there must be no other reasonable alternative for the patient to pursue. I believe this condition to be a bit strong and potentially problematic with respect to who should be the party interpreting what is a ‘reasonable alternative.’ For example, the decision to opt for P.A.S. in the first place is certainly not one which all reasonable people are likely to agree with. Finally, the Dutch system requires that ‘the manner of death must not cause unavoidable misery to others.’); *Holland’s Euthanasia Law*, PATIENTS RIGHTS COUNCIL, <http://www.patientsrightscouncil.org/site/holland-euthanasia-law/>. (last visited Apr. 11, 2017) (“There is no requirement that suffering be physical or that the patient be terminally ill.”); see also *Is Euthanasia Allowed?*, GOV’T OF THE NETHERLANDS, <https://www.government.nl/topics/euthanasia/contents/is-euthanasia-allowed> (last visited Apr. 7, 2017).

⁵¹ Suzanne J. Booi et al., *Perhaps the Subject of the Questionnaire was too Sensitive: Do We Expect too Much too Soon? Wishes for the end of life in Huntington’s Disease- The perspective of European physicians*, J. OF HUNTINGTON’S DISEASE 3, 229, 229 (2014).

⁵² *Background about Euthanasia in the Netherlands*, PATIENTS RIGHTS COUNCIL, <http://www.patientsrightscouncil.org/site/holland-background/>. (last visited Apr. 7, 2017).

⁵³ 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 THE ELDER L. J. 333, 356 (2008) (“Patients are about three times more likely to be interested in the possibility of euthanasia or assisted suicide at some future time, rather than at a specific time”).

⁵⁴ See Lindsay Reynolds, *Losing The Quality of Life: The Move Toward Society’s Understanding and Acceptance of Physician Aid-in-Dying and the Death with Dignity Act*, 48 NEW. ENG. L. REV. 343, 355 (2014) (“For nearly a century, the Swiss distinguished between selfish and altruistic motives to assist others with their deaths. A person could face up to five years in prison if caught helping an individual commit suicide for selfish reasons. By contrast, if individuals ‘help a friend to die for altruistic reasons,’ they face no legal consequences.”); *Legal Basis*, DIGNITAS, <http://www.dignitas.ch/index.php?o>

not receive a second medical opinion regarding their illness, as is required in the Netherlands.⁵⁵ In Switzerland, a patient also does not need to be dying of a terminal illness to request assisted suicide.⁵⁶

A well-known company in Switzerland, Dignitas, helps foreign nationals who travel to Zurich end their lives via physician-assisted suicide.⁵⁷ Dignitas uses very broad language to define the requirements individuals must satisfy to avail themselves of Dignitas's services. "Anyone suffering from an illness which will lead inevitably to death, or anyone with an unendurable disability, who wants voluntarily to put an end to their life and suffering can, as a member of Dignitas, request the association to help them with the accompanied suicide."⁵⁸ Dignitas allows individuals with diseases such as incurable bipolar disease or even schizophrenia to travel to Zurich for physician-assisted suicide.⁵⁹ Ludwig Minelli, the founder of Dignitas, claims that, in his experience, many individuals wish to have the option of assisted suicide, but few actually take advantage of it.⁶⁰

The United States should model its physician-assisted suicide laws on the laws of both Switzerland and the Netherlands and expand its laws to allow individuals with a chronic progressive illness to opt for physician-assisted suicide prior to the six-month terminal illness requirement. A proposed exception will be set forth below.

III. INDIVIDUALS WITH ALS, MS, HUNTINGTON'S DISEASE AND CYSTIC FIBROSIS MAY BE UNABLE TO OPT FOR PHYSICIAN-

ption=com_content&view=article&id=12&Itemid=53&lang=en. (last visited Apr. 7, 2017).

⁵⁵ Lindsay Pfeffer, Note, *A Final Plea for "Death with Dignity": A Proposal for the Modification and Approval of Assisted Dying for the Terminally Ill Bill in the United Kingdom*, 15 *CARDOZO J. INT'L & COMP. L.* 497, 509; see also *Legal Basis*, *supra* note 54 ("in the case of medically diagnosed hopeless or incurable illnesses, unbearable pain or unendurable disabilities, DIGNITAS offers its members the option of an accompanied suicide").

⁵⁶ Pfeffer, *supra* note 55, at 509.

⁵⁷ Hoffman, *supra* note 6, at 391.

⁵⁸ *Id.*; see also *Objectives and purposes of Dignitas*, DIGNITAS, 2, available at <http://www.dignitas.ch/images/stories/pdf/informations-broschuere-dignitas-e.pdf>.

⁵⁹ *Objectives and purposes of Dignitas*, *supra* note 58, at 6.

⁶⁰ Pfeffer, *supra* note 55, at 511–12. See *Objectives and purposes of Dignitas*, *supra* note 58, at 3 ("DIGNITAS's experience shows that only a very few people who enroll as members take advantage of the service for assistance with suicide").

ASSISTED SUICIDE UNDER THE CURRENT LAWS IN THE UNITED STATES

A. AMYOTROPHIC LATERAL SCLEROSIS

Amyotrophic lateral sclerosis (hereinafter ALS), also known as Lou Gehrig's disease, has been "considered by some to be a 'fate worse than death', particularly at the end stage" of the disease.⁶¹ ALS is a neuromuscular disease that causes gradual paralysis, respiratory failure, and death usually within three to five years after it has been diagnosed.⁶² It is one of the most devastating disorders a human can be diagnosed with and has no known cure.⁶³

In the early stages of the disease, an individual with ALS begins experiencing muscle weakness.⁶⁴ Muscle cramping and twitching can also occur, as well as muscular atrophy.⁶⁵ At the beginning of the disease, an individual may also experience fatigue, poor balance, slurred speech, a weak grip, tripping when walking, as well as other minor symptoms.⁶⁶

With the progression of the disease, symptoms become more widespread.⁶⁷ The disease results in weakness of the muscles used for swallowing, which may cause choking, difficulty eating,

⁶¹ Debjani Mukherjee, *Recognizing Psychological Diversity in People with End-Stage Amyotrophic Lateral Sclerosis*, 17 AM. MED. ASS'N. J. OF ETHICS, no. 6, June 2015, at 530.

⁶² Linda Ganzini, et al., *Attitudes of Patients with Amyotrophic Lateral Sclerosis and their Care Givers Toward Assisted Suicide*, 339 NEW ENG. J. MED. 967, 967 (1998); see also EVELYN B. KELLY, ENCYCLOPEDIA OF HUMAN GENETICS AND DISEASE 79–80 (2013) (ALS affects nerve cells in the brain and the spinal cord, specifically the motor neurons, which control the voluntary movement of muscles.).

⁶³ Anderson, et al., *Genetics of ALS: an overview at 223*; See also Mukherjee, *supra* note 61, at 530.

⁶⁴ *Assistance in Stages of ALS*, MDA.ORG, <http://www.mda.org/disease/amyotrophic-lateral-sclerosis/medical-management/assistance-stages-of-als> (last visited on Apr. 3, 2016) [hereinafter "*Assistance in Stages of ALS*"].

⁶⁵ *Id.* (Sometimes this stage occurs before a diagnosis is made). See also, Medline Plus, Medical Encyclopedia, *Muscle atrophy*, U.S. NAT'L LIBRARY OF MEDICINE, <https://www.nlm.nih.gov/medlineplus/ency/article/003188.htm> ("Muscle atrophy is defined as the wasting or loss of muscle tissue.").

⁶⁶ *Assistance in Stages of ALS*, *supra* note 64; see also *Facts You Should Know*, ALS ASS'N, <http://www.alsa.org/about-als/facts-you-should-know.html> (Typically, ALS progresses by first limiting one's ability to walk, dress and even write).

⁶⁷ *Assistance in Stages of ALS*, *supra* note 64.

and difficulty managing one's own saliva.⁶⁸ One's breathing muscles also begin to weaken, causing respiratory insufficiency, especially when lying down.⁶⁹ Unused muscles may cause contractures, in which the joints become rigid, painful and sometimes deformed.⁷⁰

In the final stage of ALS, most voluntary muscles are paralyzed.⁷¹ The individual's ability to move air in and out of his or her lungs is severely compromised.⁷² Not only does an individual's mobility become extremely limited, but at this stage of the disease an individual is also unable to care for his or her own needs.⁷³ Speech may no longer be possible and both eating and drinking using one's mouth is not possible.⁷⁴ Eventually, the disease progresses to the point where an individual loses his/her ability to both swallow and breathe.⁷⁵ The disease eventually affects all muscles in one's body.⁷⁶

Having control over one's death may be especially important for persons with ALS, as loss of the ability to engage in pleasurable activities, care for oneself, communicate, swallow and breathe may make life insufferable.⁷⁷

B. MULTIPLE SCLEROSIS

Multiple sclerosis, one of the major disorders affecting the central nervous system, is also a progressive disease with no known cure.⁷⁸ The effects of multiple sclerosis vary widely from

⁶⁸ *Id.*

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ *Id.*

⁷² *Id.*

⁷³ *Assistance in Stages of ALS*, *supra* note 64.

⁷⁴ *Id.*

⁷⁵ *Facts You Should Know*, *supra* note 66.

⁷⁶ *Amyotrophic Lateral Sclerosis (ALS) Fact Sheet*, NAT'L INST. NEUROLOGICAL DISORDERS AND STROKE, http://www.ninds.nih.gov/disorders/amyotrophiclateralsclerosis/detail_ALS.htm.

⁷⁷ Ganzini, et al., *supra* note 62, at 971 ("A majority of the study participants with ALS said they would consider assisted suicide, and 44 percent said they would request a prescription for a lethal dose of medication from a physician if it became a legal option. Only one patient, however, would take the medicine immediately; most of the patients would reserve it for future use. These findings support the notion that some seriously ill persons gain psychological comfort from knowing that taking a lethal dose of medication is an option.").

⁷⁸ MARCELLA ZALESKI DAVIS, *LIVING WITH MULTIPLE SCLEROSIS: A SOCIAL PSYCHOLOGICAL ANALYSIS* 5 (1973) ("An estimated 500,000 persons in the United

individual to individual.⁷⁹ As Davis states, “Unlike cancer and heart disease, multiple sclerosis rarely is the cause of death, rather its distinction among serious illnesses derives from its slowly physically disabling nature, occurring most frequently in the ‘prime of life.’”⁸⁰

Significantly, multiple sclerosis has a very unpredictable course, and therefore, when the diagnosis is made, which could be anywhere from weeks, months or even years after the initial onset of symptoms, the patient will only know generally what symptoms he/she may experience in the future from the illness.⁸¹ Although there are multiple and variable symptoms with multiple sclerosis, most patients will experience increasing spasticity, immobility, respiratory and/or urinary infection, and death.⁸²

Symptoms of multiple sclerosis range from mild to severe.⁸³ Symptoms include, but are not limited to, weakness, tingling, numbness or impaired sensation, poor coordination, fatigue, problems with balance, tremors, spasticity or muscle stiffness, problems with speech or swallowing, bowel or bladder problems, unstable walking, increased susceptibility to clinical depression, and problems with memory, judgment, or reasoning.⁸⁴ In severe cases, multiple sclerosis can cause partial or complete paralysis.⁸⁵

“The existing evidence suggests that the interest in physician-assisted death is high among persons with multiple sclerosis.”⁸⁶ Unfortunately, the laws currently in place for physician-assisted

States are afflicted with multiple sclerosis . . . The highest incidence of onset is among young adults between the ages of 20–40 years.”). See Charles R. Smith & Labe Scheinberg, *Symptomatic Treatment and Rehabilitation in Multiple Sclerosis*, in HANDBOOK OF MULTIPLE SCLEROSIS 397, 397–98 (Stuart D. Cook, ed., 2d ed. 1996) (“Multiple Sclerosis (MS) is one of the most common diseases capable of producing severe disability in the young adult population.”); see also *Definition of MS*, NAT’L. MULTIPLE SCLEROSIS SOC’Y, <http://www.nationalmssociety.org/What-is-MS/Definition-of-MS> (stating MS has been shown to have four disease courses: relapsing-remitting MS (RRMS), primary-progressive MS (PPMS), secondary-progressive MS (SPMS), and progressive-relapsing MS. Each of these disease courses might be mild, moderate or severe).

⁷⁹ DAVIS, *supra* note 78 at 6.

⁸⁰ *Id.* at 10.

⁸¹ *Id.* at 9.

⁸² *Id.* at 6–7.

⁸³ *Definition of MS*, *supra* note 78.

⁸⁴ See *MS Symptoms*, NAT’L. MULTIPLE SCLEROSIS SOC’Y, <http://www.nationalmssociety.org/Symptoms-Diagnosis/MS-Symptoms>.

⁸⁵ DAVIS, *supra* note 78 at 6.

⁸⁶ Cathy S. Berkman, et al., *Attitudes Toward Physician-Assisted Suicide among Persons with Multiple Sclerosis*, 2 J. PALLIATIVE MED. 51, 52 (1999).

suicide in the United States may preclude individuals with multiple sclerosis from opting for physician- assisted suicide, as the illness may not satisfy the six-month terminal illness requirement set forth in the law until the individual is too disabled to self-administer the medications. The devastating nature of the disease in addition to its debilitating effects, result in individuals with MS facing a lowered quality of life as well as loss of autonomy.⁸⁷ As explained in the *Journal of Palliative Medicine*:

[M]any persons with multiple sclerosis (MS) share characteristics with cancer and AIDS patients in the often degenerative and incurable nature of the illness and the concomitant physical, social, and emotion distress, there are important differences among these groups. The course of MS may extend over several decades, and persons with MS may face more disability over a very protracted period than persons suffering from other terminal or chronic diseases. .”⁸⁸

As a result, it is necessary that physician-assisted suicide laws protect this subset of individuals.

C. HUNTINGTON’S DISEASE

Huntington’s disease is a devastating, inherited, neurodegenerative disease characterized by progressive motor, cognitive, and psychiatric symptoms that progress over the course of 15-20 years.⁸⁹ Like ALS and MS, Huntington’s disease has no known cure.⁹⁰

⁸⁷ Laura Kolaczowski, *Late-Stage Multiple Sclerosis*, MULTIPLESCLEROSIS.NET (Jul. 2, 2015), <http://multiplesclerosis.net/living-with-ms/late-stage/> (according to MS foundation, they point out that MS affects the quality of life but not the quantity).

⁸⁸ Berkman, et al., *supra* note 86, at 52.

⁸⁹ Marianne J. U. Novak & Sarah J. Tabrizi, *Huntington’s Disease*, 341 BRIT. MED. J., July 2010, at 34. See Amara Rose & Douglas Russell, *Huntington’s Disease: Symptoms, Treatment, and Hope*, HELP-ADVICE.COM, <http://www.help-advice.com/articles/alzheimers-dementia/huntingtons-disease.htm> (Huntington’s produces physical, mental and emotional changes with a typical life expectancy of around twenty years following the onset of visible symptoms).

⁹⁰ *What is Huntington’s Disease?*, HUNTINGTON’S NSW.ORG, <http://www.huntingtonsnsw.org.au/information/hd-facts/what-huntingtons-disease;> Kimberly

The progression of Huntington's disease subsequent to an individual's diagnosis is typically divided into five stages.⁹¹ In the early stages of the disease, the individual can function fully both at home and work.⁹² As the disease progresses, an individual is usually able to manage daily affairs but with some difficulties.⁹³ However, the disease will soon hit a point where the individual can "no longer work and/or manage basic household responsibilities."⁹⁴ As the disease progresses, the individual will experience unsteadiness, trouble holding onto things, trouble walking, changes in sleeping patterns, delusions and hallucinations, intellectual decline, and memory loss.⁹⁵

Once the disease hits the early advanced stage, the individual will no longer be independent and during the advanced stages of Huntington's disease, the individual will require complete support and professional nursing care is usually needed.⁹⁶ With the approach of late-stage Huntington's, affected individuals begin to experience speech difficulties and weight loss.⁹⁷ In the late stage, patients also lose bowel and bladder control.⁹⁸

By the time individuals with Huntington's are close to the end of the disease, they are profoundly disabled, communication may be severely limited and muteness is common.⁹⁹ When a person with Huntington's dies, it is typically from complications of the disease, such as choking or infection and not from the disease itself.¹⁰⁰

A 35-year-old mother who, in 1997 tested positive for Huntington's disease, discussed what happened to her

Holland and Diana K. Wells, *Multiple Sclerosis Vs. ALS: Similarities and Differences*, HEALTHLINE (Dec. 21, 2016), <http://www.healthline.com/health/multiple-sclerosis/ms-vs-als#treatment7>.

⁹¹ *How Does Huntington's Progress?*, HUNTINGTON'S NSW.ORG, <http://www.huntingtonsnsw.org.au/information/hd-facts/how-does-huntingtons-disease-progress>.

⁹² *Id.*

⁹³ *Id.*

⁹⁴ *Id.*

⁹⁵ Sandra Close Kirkwood et al., *Progression of Symptoms in the Early and Middle Stages of Huntington Disease*, 58 ARCHIVES OF NEUROLOGY 273, 275 (Feb. 2001).

⁹⁶ *How Does Huntington's Disease Progress?*, *supra* note 91.

⁹⁷ Kirkwood et.al., *supra* note 95, at 275.

⁹⁸ *Id.*

⁹⁹ Novak & Tabrizi, *supra* note 89, at 35.

¹⁰⁰ *What is Huntington's Disease?*, HUNTINGTON'S DISEASE SOC'Y OF AM., <http://hdsa.org/what-is-hd/>.

grandmother who also had Huntington's.¹⁰¹ Although this individual was free of symptoms at the time, she had grown up in a family where she had seen "many people endure a long and slow decline to a lingering death" from Huntington's.¹⁰² She laid out the horrific effects Huntington's had on her grandmother, noting that she was unable to control her own saliva and muscles and unable to feed herself. A tube had to be inserted so she could be fed and kept alive.¹⁰³ The woman describing Huntington's made clear that the "degradation" and "indignity" imposed on her grandmother by the disease was of a greater concern to her than death itself.¹⁰⁴ She noted that when you are dealing with a terminal illness, which has only one outcome, control becomes very important.¹⁰⁵

Evidenced by the symptoms and progression of the disease, individuals suffering from Huntington's disease fall into the subset of individuals that physician-assisted suicide laws should be aimed to protect.

D. CYSTIC FIBROSIS

Cystic fibrosis is a chronic illness that affects the "digestive and respiratory tracts resulting in generalized malnutrition and chronic respiratory infections."¹⁰⁶ More specifically, cystic fibrosis is an "inherited autosomal recessive disease that disrupts ion transport in epithelial-lined organs, including pulmonary airways, sweat ducts, pancreatic ducts, and the intestine."¹⁰⁷

¹⁰¹ Peter Reagan et al., *Physician-Assisted Death: Death with Dignity?*, 2 THE LANCET NEUROLOGY 637, 638 (2003).

¹⁰² *Id.*

¹⁰³ *Id.* at 638–39 ("By the time I was a teenager, she was no longer able to come and visit us because she could neither walk nor get in and out of the car. On her last visit to us she had declined so much that she spent most of the mealtime having spasms and sending food flying around the room. She was bedridden for her last 3 years, tube and drip fed, and doubly incontinent. She was lonely because friends stopped visiting over the years and the home she once cared for so much permanently smelt of stale urine. She wasted away to a skeletal, incoherent shadow of her former self and eventually died after several weeks of severe breathing difficulties and many extremely distressing episodes of choking on her own saliva.").

¹⁰⁴ *Id.* at 639.

¹⁰⁵ *Id.*

¹⁰⁶ H. Yu et al., *Innate Lung Defenses and Compromised Pseudomonas Aeruginosa Clearance in the Malnourished Mouse Model of Respiratory Infections in Cystic Fibrosis*, 68 INFECTION & IMMUNITY 2142, 2142 (2000).

¹⁰⁷ M. Jackson Stutts & Richard C. Boucher, *Cystic Fibrosis Gene and*

Moreover, cystic fibrosis is a life-threatening disease that causes a greater risk of persistent lung infections and progressively limits one's ability to breathe.¹⁰⁸ Like the aforementioned chronic progressive illnesses, cystic fibrosis has no cure and can result in a poor quality of life for individuals diagnosed with the disease.¹⁰⁹

Individuals with cystic fibrosis can experience a variety of symptoms affecting their respiratory, digestive, and reproductive systems as well as various other complications.¹¹⁰ Respiratory symptoms include decreased pulmonary function, coughing, production of thick sputum, congestion, and shortness of breath.¹¹¹ Mucus build-up makes oxygenation of the blood problematic, placing extra strain on the heart and other organs and often leading to a clubbing of the fingers and toes.¹¹² Many cystic fibrosis fatalities ultimately result from opportunistic infections.¹¹³ Over time, cystic fibrosis can result in the thinning of airway walls resulting in the coughing up of blood.¹¹⁴ Cystic fibrosis is one of the leading causes of bronchiectasis, a condition that damages the airways, making it harder to move air in and out of the lungs and clear mucus from the airways.¹¹⁵

People with cystic fibrosis experience a slow deterioration of lung function coupled with numerous disease complications, which may continue for many years.¹¹⁶ Obstruction of pulmonary airways is the cause of death of more than 90% of patients with cystic fibrosis.¹¹⁷

Functions of CFTR: Implications of Dysfunctional Ion Transport for Pulmonary Pathogenesis, in *CYSTIC FIBROSIS IN ADULTS 3* (James R. Yankaskas & Michael R. Knowles eds., Lippincott-Raven Publishers 1999).; *see also About Cystic Fibrosis*, CYSTIC FIBROSIS FOUND., <https://www.cff.org/What-is-CF/About-Cystic-Fibrosis/> ("In people with CF, a defective gene causes a thick buildup of mucus in the lungs, pancreas and other organs.").

¹⁰⁸ *About Cystic Fibrosis*, *supra* note 107.

¹⁰⁹ *Id.* *See Cystic Fibrosis Symptoms and Causes*, MAYO CLINIC (Oct. 13, 2016), <http://www.mayoclinic.org/diseases-conditions/cystic-fibrosis/symptoms-causes/dxc-20211893>.

¹¹⁰ *Cystic Fibrosis Symptoms and Causes*, *supra* note 109.

¹¹¹ *Id.*

¹¹² YANKASKAS, *supra* note 107; Stutts & Boucher, *supra* note 107, at 3.

¹¹³ J. Daniel Schubert and Margaret Murphy, *The Struggle to Breathe: Living at Life Expectancy with Cystic Fibrosis*, 32 THE ORAL HISTORY REVIEW 35, 42 (Winter-Spring 2005).

¹¹⁴ *Id.*

¹¹⁵ *Cystic Fibrosis Symptoms and Causes*, *supra* note 109.

¹¹⁶ Dorota Sands et al., *End of Life Care for Patients with Cystic Fibrosis*, 10 J. CYSTIC FIBROSIS S37, S37 (2011).

¹¹⁷ YANKASKAS, *supra* note 107; Stutts & Boucher, *supra* note 107, at 3.

IV. THE LAWS IN PLACE IN THE UNITED STATES FOR PHYSICIAN-ASSISTED SUICIDE POSE A SIGNIFICANT PROBLEM FOR AN INDIVIDUAL SUFFERING FROM A CHRONIC PROGRESSIVE ILLNESS DUE TO THE SIX-MONTH TERMINAL ILLNESS REQUIREMENT

Physician-assisted suicide laws as they are currently written may not allow individuals with chronic progressive illnesses the option to die rather than endure years of pain and anguish.¹¹⁸ The existing physician-assisted suicide laws preclude an individual who is not expected to die within six months from enlisting his/her physicians to aid in his/her death.¹¹⁹ The stringent standard of requiring an individual to have a terminal illness means that individuals with chronic illnesses may have to endure years of pain and anguish.¹²⁰ Notably, the statutory language of physician-assisted suicide laws restricts not only individuals who are physically incapable of ingesting the medication on their own, but also those who are also not expected to die within six months, which is why an exception allowing this subset of individuals, those with a chronic progressive illness, to opt for physician-assisted suicide is crucial.¹²¹

The laws, as presently written, exclude all patients suffering from non-terminal diseases, such as multiple sclerosis and Parkinson's disease, or other medical conditions even if those conditions cause extreme pain, indignity, and loss of autonomy, if they are not expected to die within six-months or if they cannot self-administer the medication once they reach the six-month terminal illness requirement.¹²² Notably, many who suffer from chronic progressive illnesses are unable to opt for physician-assisted suicide because, by the time they become eligible for physician-assisted suicide, i.e. terminal, their disease has likely progressed to a point where they are unable to self-administer the lethal dose of medication. As section III of this article points

¹¹⁸ Bollman, *supra* note 21, at 406.

¹¹⁹ *Id.* at 406.

¹²⁰ *Id.* at 410.

¹²¹ *Id.*

¹²² *Morris v. Brandenburg*, 356 P.3d 564, 582 (N.M. Ct. App. 2015). (“recognizing that a fundamental right to aid in dying may not be exercised by people who are incapable of picking up . . . and/or swallowing the pills [by] themselves[,]” or by those “. . . inflicted with a wasting disease[,]” and noting that such patients “[may] be in a far worse position than those with terminal illness, e.g. six months or a year to live” because “[t]he suffering of nonterminal patients can go on and on, while, for the terminally ill, the end is in sight.”).

out, many chronic progressive illnesses result in individuals becoming incapacitated much before the six-month terminal illness requirement set forth in physician-assisted suicide laws.

Individuals with chronic progressive illnesses fit perfectly into the category of individuals these laws are intended to protect. Chronic progressive illnesses not only result in pain and suffering but can also result in the loss of independence, therefore, it seems only proper for these individuals to be afforded the same opportunity to be able to opt for physician-assisted suicide as those with a terminal illness.

Individuals suffering from chronic progressive illnesses, such as MS, ALS, Huntington's disease or cystic fibrosis, fall into the category of individuals that physician-assisted suicide laws are intended cover. As discussed above, the laws are intended to assist those with progressive loss of bodily function who wish for a peaceful end of life rather than one marked by suffering, pain, and/or the loss of autonomy and dignity. As such, individuals with chronic progressive illnesses should be allowed the option of physician-assisted suicide because similar to those with a terminal illness, an individual with a chronic progressive illness faces pain and suffering, loss of independence and a diminished quality of life due to deterioration from the disease. "Critics of the terminal illness requirement [recognize] that similar conditions apply equally to persons who are likely to live with and suffer from [a] debilitating disease for years to come," meaning that individuals with chronic progressive illness suffer in the same ways as those that are terminal ill.¹²³

Chronic progressive illnesses progress very similarly to diseases that are considered terminal, yet individuals with chronic progressive illnesses, those who may lose all bodily function prior to being considered terminal, are often precluded from opting for physician-assisted suicide due to the effects the disease has on their bodies and their inability to self-administer the lethal medication. Significantly, if it "[is] permissible, and compassionate, to help a dying person avoid a final few days or

¹²³ Bollman, *supra* note 21, at 411–12. (There is reliable evidence that people who have sought physician-assisted suicide have been motivated by mental deterioration more than by physical pain. Terminally ill patients often fear the disintegration not only of their bodies but their minds and their overall happiness during the remainder of their lives) (A patient facing the terrifying prospect of year after year of pain and inability to control her bodily functions and movements should be granted the same opportunities as individuals facing shorter periods of suffering.)

weeks of suffering, it would seem that it is much more compassionate to accommodate a similar request from a patient whose anticipated suffering is measured in years," as is often expected for individuals suffering from a chronic progressive illness.¹²⁴

To remedy this, legislatures need to amend the currently enacted physician-assisted suicide laws by adding an exception allowing individuals with chronic progressive illnesses to be able to opt for physician-assisted suicide before the six-month terminal illness requirement. One way to do so is to amend the statutory language relating to terminal disease or illness to include diseases or conditions that have been medically confirmed as irreversible and which, within reasonable medical judgment, will produce death.¹²⁵ Further, the law should specify that death does not have to be within six months, but rather, that death will likely be caused either directly or indirectly by the irreversible disease.¹²⁶ Additionally, individuals who are diagnosed with a chronic progressive illness should undergo counseling before being able to decide whether they want to opt for physician-assisted suicide. Lastly, the laws should further specify that an individual with a chronic progressive illness must have lasting unbearable physical and/or emotional suffering that cannot be cured to be able to opt for physician-assisted suicide to prevent otherwise healthy individuals from terminating their lives too soon.

This expansion of the statute provides an opportunity for individuals who will suffer tremendously and who are likely to succumb to the disease, its complications, or another incurable ailment as a result of the original disease, to terminate their lives with the help of a physician.¹²⁷ Under this proposed expansion of the laws, individuals would still be required to self-administer the lethal medication, but individuals with chronic progressive illnesses would be able to opt for physician-assisted suicide and before the six-month terminal illness requirement.

Although physician assisted suicide laws need to be expanded to allow individuals with chronic progressive illnesses to opt for physician-assisted suicide, limitations of eligibility must still be in place. An individual must be diagnosed with a chronic

¹²⁴ Gunderson & Mayo, *supra* note 5, at 18.

¹²⁵ Bollman, *supra* note 21, at 414–15.

¹²⁶ *Id.*

¹²⁷ *Id.*

progressive illness and there must be a finding of lasting and unbearable suffering with no prospect for improvement and who wants to voluntarily put an end to their life and suffering. All other requirements set forth under the physician-assisted suicide laws must still be satisfied, the only change would be that the laws would be expanded to allow individuals with chronic progressive illnesses to opt for physician-assisted suicide prior to the current six-month terminal illness requirement.

Even though the above-proposed statutes would help individuals with chronic progressive illness that wish to end their lives via physician-assisted suicide, disability is still at the heart of the assisted suicide debate. Proponents argue that essentially society would be quantifying disabled individuals lives as “not worth it” or “better dead than disabled” if they were allowed to opt for physician-assisted suicide.¹²⁸ The disability activist group *Not Dead Yet* opposes physician-assisted suicide, as they believe it is a form of discrimination.¹²⁹

Not Dead Yet believes advocates of legalized assisted suicide are willing to treat disabled lives ended through assisted suicide as “acceptable losses”.¹³⁰ They argue that legalized assisted suicide sets up a double standard: some people get suicide prevention while others get suicide assistance, and the difference between the two groups is the health status of the individual. This, they contend, is blatant discrimination, a violation of the Americans with Disabilities Act, and will lead to a devaluation of the lives of the disabled in the minds of the public.¹³¹ Legalized assisted suicide has a disproportionate impact on disabled people. While everyone else receives suicide prevention, people with disabilities and certain illnesses will receive a fast pass to death

¹²⁸ *Rights Group: Assisted Suicide is Discriminatory, a Violation of Americans with Disabilities Act*, THE COLORADO INDEPENDENT (Feb. 6, 2015) <http://www.coloradoindependent.com/151598/rights-group-assisted-suicide-is-discriminatory-a-violation-of-americans-with-disabilities-act>.

¹²⁹ *Who We Are*, NOTDEADYET.ORG, <http://www.notdeadyet.org/about> (Not Dead Yet is a national, grassroots disability rights group that opposes legalization of assisted suicide and euthanasia as deadly forms of discrimination against old, ill and disabled people. Not Dead Yet helps organize and articulate opposition to these practices based on secular social justice arguments. Not Dead Yet demands the equal protection of the law for the targets of so called “mercy killing” whose lives are in their view, seen as worth-less.)

¹³⁰ *Id.*

¹³¹ *Not Dead Yet Disability Activists Oppose Assisted Suicide as a Deadly Form of Discrimination*, NOTDEADYET.ORG, <http://www.notdeadyet.org/assisted-suicide-talking-points>.

because their lives are viewed as less worthy.¹³² *Not Dead Yet* states,

in a society that prizes physical ability and stigmatizes impairments, it's no surprise that previously able-bodied people may tend to equate disability with loss of dignity. This reflects the prevalent but insulting societal judgment that people who deal with incontinence and other losses in bodily function are lacking dignity. People with disabilities are concerned that these psycho-social disability-related factors have become widely accepted as sufficient justification for assisted suicide.¹³³

Although *Not Dead Yet* sets out a compelling argument against physician-assisted suicide laws, it is important to keep in mind that some individuals suffering from chronic progressive illnesses would choose physician-assisted suicide voluntarily. More importantly, these individuals face many problems toward the end of life that are similar to those the terminally ill face. Physician assisted suicide does not negate the principle that a person's life is valuable.¹³⁴ Instead, 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 death should be given precedence.¹³⁵ Additionally, only the individual can determine the suffering he or she can endure. In that sense, individuals who are diagnosed with a chronic progressive illness should undergo counseling before being able to decide whether they want to opt for physician assisted suicide.

V. CONCLUSION

Physician-assisted suicide laws are intended to provide

¹³² Stephanie Woodward, *Why disabled people like me fear medically assisted suicide*, SYRACUSE.COM (Nov. 6, 2015), http://www.syracuse.com/opinion/index.ssf/2015/11/why_disabled_people_like_me_fear_medically_assisted_suicide_commentary.html.

¹³³ *Not Dead Yet Disability Activists Oppose Assisted Suicide as a Deadly Form of Discrimination*, *supra* note 131.

¹³⁴ Raphael Cohen-Almagor, & Monica G. Hartman, *The Oregon Death With Dignity Act: Review and Proposals for Improvement*, 27 J. LEGIS. 269, 272 (2001).

¹³⁵ *Id.*

individuals faced with progressive loss of bodily function the option of a peaceful end of life rather than an alternative to one marked by suffering, pain, and/or the loss of autonomy and dignity.¹³⁶ Individuals suffering from chronic progressive illnesses should be afforded the same option as those who are classified as terminally ill when it comes to physician-assisted suicide. Significantly,

in support of the practice [of physician-assisted suicide] lies the fundamental principle of mercy--the idea that some killing is justified if it is to relieve the brutal and inhumane suffering that many chronic illnesses cause at the end of life. Coupled with this notion is the fact that many marginally effective treatments aimed at prolonging life fail to serve the patient's best interests because they have little chance of real success and instead only exacerbate patient suffering and quality of life.¹³⁷

For those with a chronic progressive illness, “[physician-assisted suicide] is not a problem, it’s a solution. [It is] a solution for those whose quality of life- for one reason or another has diminished to a point where it is unbearable to continue living and the will to die dominates.”¹³⁸ “As an illness begins to seriously compromise the quality of a person’s life, few issues could be more profound and personal for that individual than determining the point at which his or her life is no longer worth living.”¹³⁹ As such, physician-assisted suicide laws in the United States should be expanded to allow individuals with chronic progressive illnesses who are experiencing lasting and unbearable pain to opt for physician-assisted suicide before the current six-month terminal illness requirement.

¹³⁶ See *Quill v. Koppell*, 870 F.Supp. 78 (S.D.N.Y. 1994), *rev'd*, F.3d 716 (2d Cir. 1996), *rev'd* 521 U.S. 793 (1997); see also, LEGISLATIVE HISTORY, A.B. 374, *supra* note 33; see also *Morris v. Brandenburg*, 356 P.3d 564, 612 (N.M. Ct. App. 2015) (J. Vanzi, dissenting).

¹³⁷ Calandrillo, *supra* note 50, at 60.

¹³⁸ Reynolds, *supra* note 54, at 370.

¹³⁹ Bollman, *supra* note 21, at 412–13.