

LIFE, LIBERTY, AND THE PURSUIT OF A DIGNIFIED DEATH: CONSIDERATIONS FOR PRESERVING ACCESS TO PHYSICIAN-ASSISTED SUICIDE

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INTRODUCTION

The guarantee of due process of law under the Fifth and Fourteenth Amendments is the paramount protection that upholds liberty and order in our society. Through these amendments, persons may not be abridged of their fundamental rights, those deeply rooted in tradition and history and implicit in the concept of ordered liberty, by the government. These fundamental rights include, among other things, the freedom of speech, the freedom of association, the right to privacy, the right to be free of cruel and unusual punishment, the right to make decisions concerning oneself and one's children, and others that have been deemed essential to liberty and justice. One right which the Supreme Court has mentioned, but never fully established as fundamental, is the right to a dignified death—essentially, the right to control the circumstances of one's own death to ensure a minimal amount of pain and suffering. This right, pivotal in personal autonomy, must be held as fundamental. Without it, the State has means to intrude on the most vulnerable and personal decision one can make in their lifetime, which is the case in the majority of states where physician-assisted suicide is prohibited and penalized. Access to physician-assisted suicide must be protected nationwide in order to ensure that the government cannot abridge the fundamental right to a dignified death.

The history of euthanasia and physician-assisted suicide is complex throughout the world and in the United States. There are many advocates around the globe that are fighting to establish the right to a dignified death as fundamental. To do this effectively, physician-assisted suicide must be a normalized, widely-accessible practice so people have the option to exercise their rights and die with dignity. There are many communities that see concern with the practice due to its moral implications and the detriment it could cause to society. It is important to recognize and consider these arguments to strike a practical balance when

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implementing legal safeguards and limiting application of physician-assisted suicide.¹

This Comment begins first by providing a historical overview of euthanasia, suicide, and Medical Aid In Dying (hereinafter MAID). Part I includes the evolution of the efforts to legalize MAID across the world and throughout the United States. Part II establishes the jurisprudence of fundamental rights and argues the right to a dignified death is fundamental. Finally, Part III asserts that to uphold this fundamental right to a dignified death, access to MAID must be preserved nationwide and considers some limitations in the practical aspects of implementing such legislation and judicial rule.

I. HISTORICAL OVERVIEW OF MEDICAL AID IN DYING

A. *History of Euthanasia and Suicide*

Euthanasia is the practice of a doctor causing an early and painless death in order to end severe or prolonged suffering in patients with terminal illnesses.² The concept of euthanasia, and the controversy that surrounds it, dates back to ancient Greece and Rome.³ While the general consensus did not oppose euthanasia initially, physicians eventually denounced the practice explicitly in the Hippocratic Oath, which led to criticism by the majority of society in between the twelfth and fifteenth centuries.⁴ Since then, opinions of euthanasia have ebbed and flowed across cultures and generations, leaving a controversy that has yet to be settled.⁵

In contrast to euthanasia, suicide is “a self-directed act that results in one’s own death.”⁶ This act does not necessarily involve contributing acts by a physician.⁷ The history of suicide is extensive, stretching back to primordial societies.⁸ As with euthanasia, suicide has been the subject of controversy across the world throughout time.⁹ Ancient Romans criminalized suicide in the fifth century, and the spread of Christianity with its condemning views of suicide brought this doctrine to common law England.¹⁰ By the end of the eighteenth century, the views towards suicide had softened; while it was still technically a

1. Due to the stigma associated with the terms “euthanasia” and “suicide,” I will be referring to the practice as “Medical Aid In Dying” or “MAID,” because it should be considered the preferable term in order to destigmatize the practice and decrease the negative connotations that have historically been associated with this convention.

2. Lacramioara Bălan, *Death with Dignity Under the AUPs of the Law*, 9 EUR. J.L. & PUB. ADMIN. 108, 109 (2022).

3. Ezekiel J. Emanuel, *Euthanasia: Historical, Ethical, and Empiric Perspectives*, 154 ARCHIVES OF INTERNAL MED. 1890, 1890 (1994).

4. *Id.* at 1891.

5. *See id.*

6. Helen Y. Chang, *A Brief History of Anglo-Western Suicide: From Legal Wrong to Civil Right*, 46 S.U. L. REV. 150, 150 (2018).

7. *See id.* at 151.

8. *Id.* at 150-51.

9. *See id.* at 154-55.

10. *Id.* at 160-61.

crime, many jurisdictions did not enforce punishment.¹¹ When the first American colonies were settled, the criminality of suicide varied by jurisdiction,¹² but eventually was abolished entirely.¹³

The long history of euthanasia and suicide across all cultures demonstrates the varying viewpoints of death, as well as the varying viewpoints of a person's legal capacity to cause their own death. For the majority of history until the present, there has been a substantial stigma surrounding these practices.¹⁴ This stigma against euthanasia has roots in moral philosophy. The unfortunate tragedies people have experienced, such as enslavement, eugenics, and human experimentation,¹⁵ have led society to undermine the values of being able to die painlessly and with dignity.¹⁶ Similarly with suicide, many religions condemn the act of killing oneself, as it is an affront to their respective deity or moral values.¹⁷ Even when suicide was no longer being criminally punished, courts generally excused it as being an act of insanity.¹⁸ The stigmas surrounding euthanasia and suicide play a large role in how medical aid in dying was—and still is—viewed.

B. *Distinguishing Medical Aid In Dying*

Medical aid in dying is also known as, “medical assistance in dying,” “voluntary assisted dying,” “physician-assisted suicide,” and “physician-assisted death.” The American Medical Association (AMA) defines MAID as occurring “when a physician facilitates a patient’s death by providing the necessary means and/or information to enable the patient to perform the life-ending act.”¹⁹ It can also be thought of as one person, usually a physician, contributing to the death of another, but the person who dies is considered to have taken their own life.²⁰ This has similar elements of euthanasia and suicide combined: a doctor facilitating death and a person causing death to themselves.

When discussing MAID, it is important to note the different manners in which it can be facilitated. First, there is a distinction between “voluntary” and “involuntary” MAID.²¹ Voluntary MAID is where a patient, who has the capacity

11. *See id.* at 165-66 (explaining attempted suicide was an enforceable crime until the twentieth century).

12. *Id.* at 169-70 (showing that Connecticut, New Jersey, New York, Maryland, Virginia, North Carolina, South Carolina, Georgia, and New Hampshire followed the English common law’s prohibition on suicide. Rhode Island and Massachusetts criminalized suicide through their own legislative enactments. Pennsylvania and Delaware expressly decriminalized suicide).

13. *Id.* at 174.

14. Chang, *supra* note 6, at 151; *see* Emanuel, *supra* note 3, at 1890.

15. *See Euthanasia Program and Aktion T4*, U.S. HOLOCAUST MEM’L MUSEUM: HOLOCAUST ENCYC. (Oct. 7, 2020), <https://encyclopedia.ushmm.org/content/en/article/euthanasia-program>.

16. *See* Emanuel, *supra* note 3, at 1891-92; Chang, *supra* note 6, at 177.

17. Chang, *supra* note 6, at 161-63.

18. *Id.* at 165.

19. CODE OF MED. ETHICS, Op. 5.7 (AM. MED. ASS’N 2016).

20. THE N.Y. STATE TASK FORCE ON LIFE & THE L., WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 83 (2d ed. 2000) [hereinafter N.Y. TASK FORCE] (incorporating the Task Force’s 1994 report and 1997 supplement).

21. *See id.* at 82-83.

to make their own medical decisions, deliberately requests and consents to the act.²² In contrast, involuntary MAID occurs when the patient lacks the capacity to make their own medical decisions and cannot request or provide meaningful consent to the act; therefore, a third party makes the decision to administer the treatment.²³ Second, there is a distinction between “active” and “passive” MAID.²⁴ Active MAID is when the patient and the aiding physician take affirmative steps, such as prescribing and administering lethal medication, to end the patient’s life.²⁵ In contrast, passive MAID is when necessary life-sustaining medical care is withdrawn to allow the patient’s life to cease naturally.²⁶ The focus of this comment is specifically about voluntary, active MAID.

C. *International Views of MAID*

MAID is currently legal²⁷ in nine European countries, three countries in South America, six states in Australia, and New Zealand.²⁸ In North America, Canada²⁹ and Cuba³⁰ have legalized MAID, as well as ten states plus the District of Columbia in the United States.³¹ Currently, France³² and the Federal Northern Territory of Australia³³ are considering administrative policies to do the same. Uruguay has been the most recent country, and the first country in Latin America, to have legalized MAID through parliamentary legislation, doing so in October

22. Bălan, *supra* note 2, at 109.

23. *Id.*

24. N.Y. TASK FORCE, *supra* note 20, at 82-83.

25. *See* Bălan, *supra* note 2, at 109.

26. *Id.*

27. “Legal” MAID includes where jurisdictions have amended it into their constitution, passed other legislation, or the court system has allowed great deference to a physician’s professional opinion.

28. *Physician-Assisted Dying Legislation Around the World*, BRIT. MED. ASS’N, <https://www.bma.org.uk/media/6706/bma-where-is-pad-permitted-internationally.pdf> (last visited Dec. 18, 2025); *Europe*, CAMPAIGN FOR DIGNITY IN DYING, <https://www.dignityindying.org.uk/assisted-dying/assisted-dying-around-the-world/europe/> (last visited Dec. 18, 2025); Alexandra Valencia, *Ecuador Top Court Recognizes Right to Euthanasia*, REUTERS (Feb. 7, 2024), <https://www.reuters.com/world/americas/ecuador-top-court-recognizes-right-euthanasia-2024-02-07/>; Macarena Hermosilla, *Uruguay Passes Latin America’s First Law Regulating Euthanasia*, UNITED PRESS INT’L: WORLD NEWS (Oct. 16, 2025, at 12:08 ET), https://www.upi.com/Top_News/World-News/2025/10/16/uruguay-euthanasia-law-approval/3051760629902/.

29. *Physician-Assisted Dying Legislation Around the World*, *supra* note 28.

30. Marc Frank & Nelson Acosta, *Cuba Quietly Authorizes Euthanasia*, REUTERS (Dec. 22, 2023), <https://www.reuters.com/world/americas/cuba-quietly-authorizes-euthanasia-2023-12-22/>.

31. *In Your State*, DEATH WITH DIGNITY (Sep. 2, 2025), <https://deathwithdignity.org/states/>.

32. The French National Assembly recently adopted a bill to allow MAID for adults with incurable illnesses in clearly defined circumstances. As of the publication date of this Comment, the bill is being sent to the Senate for further debate and a final vote. *French Lawmakers Approve Assisted Dying Bill*, LE MONDE: FRENCH POL. (May 27, 2025, at 20:00 UTC), https://www.lemonde.fr/en/france/article/2025/05/27/french-lawmakers-approve-assisted-dying-bill_6741744_7.html.

33. *Voluntary Assisted Dying*, QUEENSL. UNIV. OF TECH.: END OF LIFE L. IN AUSTR. (Sep. 5, 2025), <https://end-of-life.qut.edu.au/assisteddying>.

2025.³⁴ Though Switzerland was the first country to legalize such a practice in 1942,³⁵ the administrative action for legalization that took place in the Netherlands in 2001 brought MAID to the forefront of the modern world.³⁶

In the Netherlands, the practice of MAID predated the monumental reforms in 2001.³⁷ In 1984, the Dutch Supreme Court made the country's first exception to the prohibition of assisted suicide.³⁸ This case involved the first instance in which a physician was not prosecuted for assisting the suicide of a terminally ill woman, rather the court carved out an approval of this type of practice if applied in narrow circumstances.³⁹ In 2001, the Dutch Parliament finally approved a bill permitting the practice of MAID with specific eligibility requirements.⁴⁰ MAID may be used where:

1. the physician holds the conviction that the request by the patient was voluntary and well-considered;
2. the physician holds the conviction that the patient's suffering was lasting and unbearable;
3. the physician has informed the patient about the situation and its prospects;
4. the patient held the conviction that there were no other reasonable solutions for their situation;
5. the patient has consulted with at least one other independent physician; and,
6. the physician has terminated a life or assisted a suicide with due care.⁴¹

This bill, the Termination of Life on Request and Assisted Suicide Act, gave physicians the authority to supply lethal drugs for patients to self-administer and to inject lethal drugs intravenously.⁴² Furthermore, it provided access to MAID for those who suffer from only psychiatric conditions, which is not the case in most other jurisdictions.⁴³ The Parliament did limit access by restricting eligibility to Dutch citizens above the age of twelve, and parental consent is required for a person between the ages of twelve and sixteen.⁴⁴ After the Netherlands officially

34. Hermosilla, *supra* note 28.

35. See *Physician-Assisted Dying Legislation Around the World*, *supra* note 28 (noting that MAID was legalized in 1942, which was prior to any other country legalizing the practice).

36. See NEIL M. GORSUCH, *THE FUTURE OF ASSISTED SUICIDE AND EUTHANASIA* 106 (2006) (explaining that the trend in discussing the legalization of MAID became more prevalent around the world after the Netherlands legalized it).

37. *Id.*

38. *Id.* at 104.

39. *Id.* at 104-05.

40. *Id.* at 106.

41. *Id.* (alternations made and alterations in original) (citation omitted).

42. *Physician-Assisted Dying Legislation Around the World*, *supra* note 28; Ana Worthington et al., *Efficacy and Safety of Drugs Used for 'Assisted Dying'*, 142 *BRIT. MED. BULL.* 15, 16 (2022).

43. GORSUCH, *supra* note 36, at 105. (discussing the Court held that for a request to be justified on necessity, "the patient's suffering need not be physical, the patient need not be terminally ill, and purely psychological suffering can qualify a patient for [MAID]"); *Physician-Assisted Dying Legislation Around the World*, *supra* note 28.

44. *Physician-Assisted Dying Legislation Around the World*, *supra* note 28.

carved out exceptions for MAID at the administrative level, other countries and states began to follow suit.⁴⁵

Between 2017 and 2023, all six Australian states legalized the practice of MAID.⁴⁶ The Northern Territory, under the regime of the federal Australian government, has had a back-and-forth struggle with attempting to legalize the practice since 1996.⁴⁷ While each state has its own legislative model, they have generally the same eligibility criteria and requirements for conducting the procedures of MAID.⁴⁸

Generally, a person is eligible for MAID in Australia if they are diagnosed with an advanced, progressive disease that causes suffering and is expected to cause death within six or twelve months, depending on the jurisdiction and the condition.⁴⁹ Half of states require the condition be incurable.⁵⁰ The patient must have decision-making capacity and must make the decision voluntarily and without coercion.⁵¹ All states limit MAID to those who are over the age of eighteen and are Australian citizens.⁵² Some states prohibit medical professionals from initiating discussions about MAID with their patients, while others allow a physician to start the conversation after informing the patient about their treatment options and likely outcome.⁵³ Patients who request MAID must do so at least three times and be assessed by at least two other independent medical practitioners.⁵⁴ Five states default to self-administration of the prescribed lethal drug, and third-party administration is available in circumstances where a patient is not able to self-administer.⁵⁵ The Australian model demonstrates an ethical and practical approach to MAID regulations.

Canada started legalizing MAID in 2014.⁵⁶ The Québec provincial government formed the Right to Die with Dignity committee to advocate the practice of MAID as being a legitimate option for end-of-life care.⁵⁷ Bill C-14 was passed in Québec even though the federal Canadian government⁵⁸ criminalized the

45. While not all countries legalized MAID at the administrative level, as the Netherlands had, the following decade brought legalization efforts throughout the rest of Europe and the United States. *See id.*

46. Katherine Waller et al., *Voluntary Assisted Dying in Australia: A Comparative and Critical Analysis of State Laws*, 46 U.N.S.W. L.J. 1421, 1422-23 (2023).

47. *Voluntary Assisted Dying*, *supra* note 33.

48. *See* Waller et al., *supra* note 46, at 1425-56, 1460-61.

49. *Id.* at 1425.

50. *Id.*

51. *Id.* at 1426.

52. *Id.* at 1427.

53. *Id.* at 1437.

54. *Id.* at 1438.

55. *Id.* at 1442-43.

56. Jocelyn Downie, *From Prohibition to Permission: The Winding Road of Medical Assistance in Dying in Canada*, 34 HEC F. 321, 326 (2022).

57. *See id.*

58. *See id.* at 325, 334-35 (In Canada, the federal government controls the criminal lawmaking while the administration of the justice system and delivery of health care services is left with the provinces and territories. The federal government can challenge a province's exercise of legislative

practice.⁵⁹ Then in 2015, in the landmark case *Carter v. Canada*,⁶⁰ the Supreme Court of Canada unanimously ruled the federal government's ban on MAID violated the Charter of Rights and Freedoms.⁶¹ The Court found that the law criminalizing MAID, established to protect vulnerable persons, was overbroad and limited others who were not within the legislation's objective to regulate.⁶² The Court held the prohibition deprived these nonvulnerable individuals of their fundamental rights to life, liberty, and security of their person.⁶³ Thereafter, the Canadian federal government officially passed numerous legislative acts between 2016 and 2021 to provide for the legal practice of MAID.⁶⁴

In Canada, a person is eligible for MAID if they have a "grievous and irremediable medical condition," which requires that the person have a serious condition in an advanced state of decline that cannot be reversed and that causes unbearable physical or mental suffering that cannot be relieved.⁶⁵ Canada previously limited access to only patients with physical conditions, but in 2023 individuals with mental illness as their only condition became eligible.⁶⁶ Patients who request MAID must have capacity, and must do so in writing, which is to be witnessed by an independent person, but Canada does not require the patient make multiple requests.⁶⁷ The government has limited MAID to those who are over the age of eighteen and Canadian citizens.⁶⁸ Canada also allows patients to self-administer the lethal drug or request a physician administer without the need to meet an exception, such as the inability to self-administer.⁶⁹ While Canada's legislative landscape in regards to MAID and the right to die with dignity is still developing, the work completed over the past decade has proved monumental for the international movement in legalizing the practice.⁷⁰

control in the federal court system, but where it declines to do so, the province is free to make laws that may be in conflict with the federal laws of the nation.)

59. *Id.* at 326.

60. *Id.* at 330.

61. *Guide to the Canadian Charter of Rights and Freedoms*, GOVT. OF CAN. (Aug. 2, 2024), <https://www.canada.ca/en/canadian-heritage/services/how-rights-protected/guide-canadian-charter-rights-freedoms.html#a3>; Constitution Act, 1982, *being* Schedule B to the Canada Act, 1982, c. 11, § 7 (U.K.) (The Canadian Charter of Rights and Freedoms is a part of the Canadian Constitution which protect many rights and freedoms, including the "right to life, liberty, and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.").

62. *Carter v. Canada*, [2015] S.C.R. 331, 376 (Can.).

63. *Id.* at 366-69.

64. Downie, *supra* note 56, at 334-40.

65. *Physician-Assisted Dying Legislation Around the World*, *supra* note 28.

66. *Id.*

67. *Id.*

68. *Id.*

69. *Id.*

70. *See generally* Downie, *supra* note 56, at 346-48 (explaining Québec's legalization of MAID as a model for other countries to learn from and follow in implementing their own legalization efforts).

D. MAID in the United States

As of the publication date of this Comment, MAID is currently legal in twelve states and Washington, D.C.⁷¹ Seven states are considering whether to legalize the practice within their jurisdiction.⁷² The federal government has not enacted any legislation to correspond with the world in the MAID movement, and “assisting a suicide” is a punishable act under general homicide laws.⁷³ The Supreme Court has encountered MAID in three notable cases: *Cruzan v. Missouri Department of Health*,⁷⁴ *Vacco v. Quill*,⁷⁵ and *Washington v. Glucksberg*.⁷⁶

In *Cruzan*, Nancy Cruzan was fixed in a persistent vegetative state after a tragic car accident.⁷⁷ Her husband and parents petitioned the Court to have the hospital withdraw life-sustaining treatment so that Nancy could die peacefully in accordance with her expressed, though not properly documented, wishes;⁷⁸ however, the Court ultimately held that while a person does have a right to refuse medical treatment, even life-saving treatment, a State can prohibit third parties from that decision for a patient absent clear and convincing evidence of the patient’s intentions.⁷⁹ The Court reasoned the State has a significant interest in protecting vulnerable persons from abuse and in preserving human life,⁸⁰ though the dissenters emphatically supported Nancy’s right to die with dignity as outweighing any such interest of the State.⁸¹

In *Glucksberg* and *Vacco*, multiple practicing physicians challenged their respective jurisdiction’s ban on MAID so they could provide treatment for their terminally ill and suffering patients.⁸² In both cases, the Court held the laws prohibiting MAID did not infringe on the Due Process Clause, reasoning that the State has an interest in preserving human life, upholding the integrity of the medical profession, and protecting vulnerable groups from abuse.⁸³ The U.S. Supreme Court has not issued a decision regarding MAID since these cases in 1997.

71. MAID: Medical Aid in Dying, BRITANNICA: PROCON (July 8, 2025), <https://euthanasia.procon.org/states-with-legal-physician-assisted-suicide/>.

72. *In Your State*, *supra* note 31 (Currently, Indiana, Massachusetts, Minnesota, New Hampshire, New York, North Carolina, and Pennsylvania are considering death with dignity.).

73. MAID: Medical Aid in Dying, *supra* note 71.

74. *Cruzan v. Mo. Dep’t of Health*, 497 U.S. 261, 269 (1990).

75. *Vacco v. Quill*, 521 U.S. 793, 797 (1997).

76. *Washington v. Glucksberg*, 521 U.S. 702, 707 (1997).

77. *Cruzan*, 497 U.S. at 266.

78. *Id.* at 267-68.

79. *See id.* at 284.

80. *Id.* at 280-82.

81. *Id.* at 301.

82. *Washington v. Glucksberg*, 521 U.S. 702, 707-08 (1997); *Vacco v. Quill*, 521 U.S. 793, 797-98 (1997).

83. *Glucksberg*, 521 U.S. at 728, 747-88; *Vacco*, 521 U.S. at 808-09.

The first state to legalize the practice of MAID was Oregon.⁸⁴ The Death with Dignity Act became law in 1994 by a slim voter majority of fifty-one percent.⁸⁵ After being delayed by a federal injunction, it became effective in 1997 by another statewide vote.⁸⁶ The statute provides that,

An adult who is capable, is a resident of Oregon,⁸⁷ 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 purpose of ending his or her life in a humane and dignified manner.⁸⁸

To be eligible the patient must have an incurable and irreversible disease that is likely to cause death within six months.⁸⁹ Individuals with only psychiatric conditions do not qualify.⁹⁰ The state limits access to MAID to those over the age of eighteen, and the statute is clear that an individual cannot qualify solely on the basis of age or disability.⁹¹ Oregon provides other safeguards for individuals who may be more vulnerable at the time of making life-or-death decisions; for instance, a patient must make three requests, one in writing, and a fifteen-day waiting period between the two oral requests.⁹²

A recent state to legalize MAID was Delaware.⁹³ House Bill 140, the Ron Silverio/Heather Block End of Life Options Law, was signed into law and became effective on May 20, 2025.⁹⁴ Ron Silverio and Heather Block were Delaware residents who avidly fought for the right to die with dignity in the face of their terminal cancer diagnoses.⁹⁵ Unfortunately, neither Silverio nor Block were able to personally benefit from their dedication to the cause, as they both passed away in 2018.⁹⁶ For a person to be eligible for MAID in Delaware under this law, they must be an adult resident, and their health-care provider must confirm the individual has a terminal illness with six months or less to live, is capable of

84. *MAID: Medical Aid in Dying*, *supra* note 71.

85. Bill Taylor, *Background Brief on Oregon Death with Dignity Act*, STATE OF OR.: LEGIS. COMM. SERVS. 1 (Nov. 2006), https://www.oregonlegislature.gov/citizen_engagement/Reports/2006/DeathWithDignityActF.pdf

86. *MAID: Medical Aid in Dying*, *supra* note 71; Taylor, *supra* note 85, at 1; OR. REV. STAT. § 127.805 (2023).

87. *MAID: Medical Aid in Dying*, *supra* note 71 (showing Oregon ended the requirement for residency in 2022).

88. § 127.805.

89. *MAID: Medical Aid in Dying*, *supra* note 71.

90. *Id.* (“[Patient’s] diagnosis must include a terminal illness.”).

91. § 127.805.

92. Steven B. Datlof, *Beyond Washington v. Glucksberg: Oregon’s Death with Dignity Act Analyzed from Medical and Constitutional Perspectives*, 14 J.L. & HEALTH 23, 26-27 (1999).

93. *See MAID: Medical Aid in Dying*, *supra* note 71.

94. DEL. CODE ANN. tit. 16, ch. 25C, §§ 2501C-2513C (2025).

95. *Ron Silverio*, COMPASSION & CHOICES, <https://compassionandchoices.org/stories/ron-silverio/> (last visited Dec. 18, 2025); *Heather Block*, COMPASSION & CHOICES, <https://compassionandchoices.org/stories/heather-block/> (last visited Dec. 18, 2025).

96. *Ron Silverio*, *supra* note 95; *Heather Block*, *supra* note 95.

making the voluntary request, and is able to self-administer the lethal medication.⁹⁷ The individual must make one written and two oral requests for the lethal medication, and they must be assessed by two physicians and a mental health professional prior to prescription of the medication.⁹⁸ The physician is required to discuss with the individual their medical diagnosis and prognosis, the potential risks and probable result of self-administering the lethal medication, the individual's option to not use it after it being prescribed, and what alternative treatment options are available for the individual to be able to make an informed decision.⁹⁹ Through the steps taken by Oregon, Delaware, and other states that have legalized the practice of MAID, it is apparent the practice can be implemented safely with the proper regulations.

II. THE RIGHT TO A DIGNIFIED DEATH IS A FUNDAMENTAL RIGHT

As a human, one has a right to a dignified death—that is, the right to control the aspects surrounding one's death to ensure it is as comfortable and painless as possible. Due to the nature of life, as recognized by the Supreme Court, not everyone may get the opportunity to exercise this right.¹⁰⁰ However, this does not displace its importance and need to be protected by the government so people may freely exercise it. This right to a dignified death is fundamental and entitled to protection under the Due Process Clauses of the Fifth and Fourteenth Amendments of the Constitution.

A. *What Is a Fundamental Right?*

The Fifth Amendment of the United States Constitution guarantees that “[n]o person shall...be deprived of life, liberty, or property, without due process of law.”¹⁰¹ The Fourteenth Amendment provides that “No State shall...deprive any person of life, liberty, or property, without due process of law.”¹⁰² This requires the government, before depriving someone of their life, liberty, or property, provide due process of law.¹⁰³ “The Clause also provides heightened protection against government interference with certain fundamental rights and liberty interests.”¹⁰⁴ Fundamental rights are those that are “the very essence of a scheme of ordered liberty” and “a ‘principle of justice so rooted in the traditions and conscience of our people.’”¹⁰⁵ These rights have also been considered natural rights, rights belonging to the citizens of all free governments and that may not

97. DEL. CODE ANN. tit. 16, §§ 2504C.

98. *Id.* § 2505C.

99. *Id.* § 2508C.

100. *Glossip v. Gross*, 576 U.S. 863, 869 (2015) (“After all, while most humans wish to die a painless death, many do not have that good fortune.”).

101. U.S. CONST. amend. V.

102. U.S. CONST. amend. XIV.

103. *Dep’t of State v. Muñoz*, 602 U.S. 899, 909-10 (2024).

104. *Washington v. Glucksberg*, 521 U.S. 702, 720 (1997).

105. *Palko v. Connecticut*, 302 U.S. 319, 325 (1937) (quoting *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934)).

necessarily be enumerated in the Constitution.¹⁰⁶ In general, the natural rights broadly provide protection by the government, the enjoyment of life and liberty, the ability to acquire and possess property, and the ability to pursue and obtain happiness and safety.¹⁰⁷

Where the government attempts to infringe on a person's fundamental rights, its action must survive judicial review under strict scrutiny.¹⁰⁸ Under strict scrutiny, the court must decide whether the government's act is narrowly drawn to a compelling interest.¹⁰⁹ If an act's purpose is not found to be appropriate and legitimate, or if its means are not narrowly drawn to their end, the act cannot stand on constitutional grounds.¹¹⁰ Where the court finds the right being infringed upon is not actually fundamental, it is subject to rational basis review.¹¹¹ Under rational basis review, the court grants great deference to the legislature, and an act cannot be struck down unless "it is of such a character as to preclude the assumption that it rests upon some rational basis within the knowledge and experience of the legislators."¹¹² Essentially, an act of the government will survive rational basis review if it is rationally related to a legitimate government interest.¹¹³ However, acts that infringe upon someone's fundamental rights are subject to the heightened strict scrutiny.¹¹⁴

B. *The Right to MAID*

Case law precedent has established the right to MAID is not fundamental.¹¹⁵ However, the Supreme Court has yet to frame the issue of MAID as one that falls under the right to a dignified death or the right to die with dignity.¹¹⁶ The Court has conducted more specific analyses, not focused on the broad liberty to choose how and when to die, but rather the right to MAID in and of itself.¹¹⁷ If brought under the framework of fundamental rights, it would be clear that having access to MAID is an essential part of the right to a dignified death. Thus, any government efforts to restrict a person's right to die with dignity would need to survive strict scrutiny.

106. *Corfield v. Coryell*, 6 F. Cas. 546, 551 (E.D. Pa. 1823).

107. *Id.* at 551-52.

108. *See Lochner v. New York*, 198 U.S. 45, 57-58 (1905).

109. *Id.* ("The act must have a more direct relation, as means to an end, and the end itself must be appropriate and legitimate, before an act can be held to be valid which interferes with the general right of an individual to be free in his person.")

110. *Id.*

111. *United States v. Carolene Prods. Co.*, 304 U.S. 144, 152 (1938).

112. *Id.*

113. *See id.*

114. *See Lochner*, 198 U.S. at 57-58.

115. *Washington v. Glucksberg*, 521 U.S. 702, 705-06 (1997); *Cruzan v. Mo. Dep't of Health*, 497 U.S. 261, 280 (1990); *Vacco v. Quill*, 521 U.S. 793, 797 (1997).

116. *See Glucksberg*, 521 U.S. at 705-06; *Cruzan*, 497 U.S. at 280; *Vacco*, 521 U.S. at 797.

117. *See Thomas Halper, Lear's Daughters? Unenumerated Fundamental Rights and the Constitution*, 13 BRIT. J. AM. LEGAL STUD. 199, 228 (2024).

It has been recognized that “our legal tradition may provide greater support” if analyzed under a different formulation, such as the fundamental right to a dignified death.¹¹⁸ At the core of this right lies “personal control over the manner of death, professional medical assistance, and the avoidance of unnecessary and severe physical suffering,”¹¹⁹ which is more akin to the other natural rights already established by the Court.¹²⁰ “Choices about death touch the core of liberty.”¹²¹ It is difficult to say that the freedom to live does not implicitly come with the freedom to cease living, for they are interdependent. Furthermore,

Our duty, and the concomitant freedom, to come to terms with the conditions of our own mortality are undoubtedly “so rooted in the traditions and conscience of our people as to be ranked fundamental,” and indeed are essential incidents of the unalienable rights to life and liberty endowed us by our Creator.¹²²

The right to a dignified death being fundamental also finds support from other established rights that the Court has emphasized as fundamental. These rights include the right of personal autonomy; the right of privacy; the right to be free of cruel and unusual punishment; and the right of patients to make informed medical decisions, including to refuse treatment. Each of these established rights will be discussed in turn.

C. *The Right of Personal Autonomy*

“The only part of the conduct of any one, for which he is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.”¹²³ The right of personal autonomy has been a point of controversy mainly in cases related to abortion¹²⁴ or contraception as in *Planned Parenthood of Southeastern Pennsylvania v. Casey*;¹²⁵ though, the Supreme Court has discussed its application in other cases regarding the freedom to marry,¹²⁶ the freedom to procreate,¹²⁷ and the freedom to raise children.¹²⁸ While this right is stronger against the government’s influence in some areas than in others, it is

118. *Glucksberg*, 521 U.S. at 790 (Breyer, J., concurring).

119. *Id.*

120. *Corfield v. Coryell*, 6 F. Cas. 456, 551-52 (E.D. Pa. 1823).

121. *Cruzan*, 497 U.S. at 343 (Stevens, J., dissenting).

122. *Id.* (quoting *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934)).

123. JOHN STUART MILL, ON LIBERTY AND OTHER ESSAYS 13 (1926).

124. *See Roe v. Wade*, 410 U.S. 113, 129 (1973); *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 846-47 (1992); *Dobbs v. Jackson Women’s Health Org.*, 597 U.S. 215, 235 (2022).

125. *See Planned Parenthood*, 505 U.S. at 846-47; *Griswold v. Connecticut*, 381 U.S. 479, 482 (1965).

126. *See Loving v. Virginia*, 388 U.S. 1, 2 (1967); *Obergefell v. Hodges*, 576 U.S. 644, 656-57 (2015).

127. *See Stanley v. Illinois*, 405 U.S. 645, 647 (1972).

128. *See Meyer v. Nebraska*, 262 U.S. 390, 399 (1923); *Pierce v. Society of Sisters*, 268 U.S. 510, 534-35 (1925).

undoubtedly essential to the general liberty interest of the People. In *Casey*, the Court emphasized that these matters, “involving the most intimate and personal choices a person may make in a lifetime, choices about *personal dignity and autonomy*, are central to the liberty protected by the [Due Process Clause].”¹²⁹

The most recent decisions from the Supreme Court have held that the government may have a substantial interest in protecting “potential” human life, which leads to the conclusion that not all regulations on a person’s ability to interfere with potential life must be deemed unconstitutional.¹³⁰ Indeed, purposeful termination of potential human life is not a fundamental right protected by the Constitution.¹³¹ However, it is important to recognize in cases where patients are seeking MAID, the potential for human life to prosper is evidently diminished. The circumstances surrounding a patient who is terminally ill and seeking a permanent and effective treatment to end their pain and suffering are not akin to a person who would like to rid themselves of pregnancy. “Potential life” for a person suffering in such a way is a falsity.

To have the freedom to die with dignity is central to personal autonomy. To take away a person’s freedom—in making one of the most impactful and personal decisions they could make in a lifetime—would be to make that decision for them and destroy the notion that individuals have any right to personal autonomy. The Court in *Casey* further acknowledged, “[a]t the heart of liberty is the right to define one’s own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.”¹³² The recognition of personal autonomy as fundamental to the freedoms protected in the Constitution demonstrates the right to a dignified death must also be recognized as fundamental and require the same protection.

D. *The Right of Privacy*

One of the most important unenumerated rights that has been recognized by the Supreme Court as fundamental is the right to privacy. While the Constitution does not explicitly guarantee this right, it has been held as implicit due to its importance of keeping the government from intruding on people when intimate issues are at stake.¹³³ The Court has expressed the right of privacy “is the right of the *individual*...to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person.”¹³⁴ This “right includes the privilege of an individual to plan his own affairs, for, ‘outside areas of plainly harmful conduct, every American is left to shape his own life as he thinks best, do what he pleases,

129. *Planned Parenthood*, 505 U.S. at 851 (emphasis added).

130. *See id.* at 870; *Dobbs v. Jackson Women’s Health Org.*, 597 U.S. 215, 256 (2022).

131. *Dobbs*, 597 U.S. at 231.

132. *Planned Parenthood*, 505 U.S. at 851.

133. *Griswold v. Connecticut*, 381 U.S. 479, 485-86 (1965).

134. *Doe v. Bolton*, 410 U.S. 179, 213 (1973) (emphasis in original) (quoting *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972)).

go where he pleases.”¹³⁵ Government acts that infringe on a person’s right to privacy under the Due Process Clauses are generally held to be unconstitutional.¹³⁶

Some courts have expressly extended this right of privacy to patients or families of patients who are called upon to make life-altering healthcare decisions.¹³⁷ Though the right of patients to make informed medical decisions is discussed in Part F, it is important to recognize that the right of privacy is one of the overarching principles that supports patients’ rights, as the right of privacy is so fundamental in the ability to confront such intimate matters. In regard to healthcare decisions, the right to privacy is conceived as “an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life.”¹³⁸ Furthermore, courts have held that “[p]ersonal dignity is a part of one’s right to privacy.”¹³⁹ Allowing the government to intrude where people are making such vital decisions concerning their life and death could risk abuse to those people it claims an interest in protecting. This fundamental right of privacy in healthcare settings further supports the right to a dignified death as also being fundamental.

E. *The Right to Be Free of Cruel and Unusual Punishment*

The Eighth Amendment provides that cruel and unusual punishments shall not be inflicted.¹⁴⁰ Since the ratification of the Bill of Rights in 1791, “cruel and unusual punishment” has not been understood to include execution via capital punishment.¹⁴¹ While execution may not violate the Eighth Amendment, or the Due Process Clauses, it may nevertheless be deemed unconstitutional where the method of execution causes the offender to suffer death in a cruel and unusual way.¹⁴² Where the issue of capital punishment methods is raised, essentially, courts are called to consider the right to a dignified death in conjunction with Eighth Amendment rights.¹⁴³ This is because, fundamentally, “the amendment stands to safeguard ‘nothing less than the dignity of man.’”¹⁴⁴ This right under the Eighth Amendment presumes that all people, even criminal offenders, have a right to a dignified death that must be protected by the State.¹⁴⁵

The Supreme Court has held that cruel methods of execution are punishments that are “incompatible with the ‘evolving standards of decency that mark the

135. *Id.* (quoting *Kent v. Dulles*, 357 U.S. 116, 126).

136. *See Griswold*, 381 U.S. at 486; *Eisenstadt v. Baird* 405 U.S. 438, 443 (1972); *Lawrence v. Texas*, 539 U.S. 558, 578-79 (2003).

137. *See Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 427 (Mass. 1977); *Bouvia v. Superior Ct.*, 225 Cal. Rptr. 297, 303 (Cal. Ct. App. 1986).

138. *Saikewicz*, 370 N.E.2d at 426.

139. *Bouvia*, 225 Cal. Rptr. at 306.

140. U.S. CONST. amend. VIII.

141. *See Gregg v. Georgia*, 428 U.S. 153, 169 (1976); *Baze v. Rees*, 553 U.S. 35, 41 (2008).

142. *See Baze*, 553 U.S. at 47.

143. *See Fierro v. Gomez*, 865 F. Supp. 1387, 1409 (N.D. Cal. 1994).

144. *Fierro*, 965 F. Supp. at 1409 (quoting *Trop v. Dulles*, 356 U.S. 86, 100 (1958)).

145. *See id.*

progress of a maturing society.”¹⁴⁶ The Court has not expressly defined “unusual” punishment; but in *Baze v. Rees*, it defined “cruel,” in regard to capital punishment, as when the execution “involve[s] torture or a lingering death.”¹⁴⁷ In *Baze*, it further affirmed that “‘punishments of torture, ...and all others in the same line of unnecessary cruelty, are forbidden’ by the Eighth Amendment.”¹⁴⁸ These unnecessarily cruel and torturous punishments include, but are not limited to, disembowelment, beheading, quartering, public dissection, and being burned alive.¹⁴⁹ When a method of execution is challenged, courts consider how much pain the inmate suffers and the risk of pain.¹⁵⁰ Quicker deaths are found to be more constitutional, as are deaths that are less likely to be prolonged and agonizing.¹⁵¹

The interest in preserving one’s right to a dignified death is further exhibited in the long history of advancements aimed to make death sentences and carrying out capital punishment more humane. After all, “[a]s the concepts of dignity and civility evolve, so too do the limits of what is considered cruel and unusual.”¹⁵² In 2025, twenty-seven states still authorize the death penalty, as well as the federal government and United States military.¹⁵³ In seventeen states, lethal injection is the sole method due to determinations that other execution methods are cruel and unusual or otherwise unconstitutional.¹⁵⁴ Nine states allow offenders to choose their method of execution, and if the offender waives their right to choose, lethal injection is the default method in eight of those states.¹⁵⁵

Since the first use of lethal injection in 1982,¹⁵⁶ the protocol typically involves a one, two, or three drug method that varies by jurisdiction.¹⁵⁷ The drugs used include an anesthetic or sedative, a paralytic agent, and a cardiotoxic agent to stop the heart, which are very similar to the drugs used for a patient receiving MAID.¹⁵⁸ The Supreme Court has upheld the constitutionality of the lethal injection and denied it being cruel and unusual punishment because of its low risk of pain and suffering on the part of the offender.¹⁵⁹

146. *Gomez v. U.S. Dist. Ct. for the N. Dist. of Cal.*, 503 U.S. 653, 658 (1992) (quoting *Estelle v. Gamble*, 429 U.S. 97, 102 (1976) (citation omitted)).

147. *Baze*, 553 U.S. at 49 (quoting *In re Kemmler*, 136 U.S. 436, 447 (1890)).

148. *Id.* at 48 (omission in original) (quoting *Wilkerson v. Utah*, 99 U.S. 130, 136 (1879)).

149. *Id.* (quoting *Wilkerson v. Utah*, 99 U.S. 130, 135 (1879)).

150. *Fierro*, 865 F. Supp. at 1410-11 (citing *Campbell v. Wood*, 18 F.3d 662, 687 (1994)).

151. *Id.* (citing *Campbell v. Wood*, 18 F.3d 662, 687 (1994)).

152. *Id.* at 1409.

153. *Facts About the Death Penalty*, DEATH PENALTY INFO. CTR. (Aug. 29, 2025), <https://dpic-cdn.org/production/documents/pdf/FactSheet.pdf>.

154. *Methods of Execution Authorized Methods by State*, DEATH PENALTY INFO. CTR., <https://deathpenaltyinfo.org/executions/methods-of-execution/authorized-methods-by-state> (last visited Dec. 18, 2025).

155. *Id.*

156. *The History of the Death Penalty: A Timeline*, DEATH PENALTY INFO. CTR., <https://deathpenaltyinfo.org/stories/history-of-the-death-penalty-timeline> (last visited Dec. 18, 2025).

157. *Methods of Execution, Lethal Injection*, DEATH PENALTY INFO. CTR., <https://deathpenaltyinfo.org/executions/lethal-injection> (last visited Dec. 18, 2025).

158. *Id.*; Worthington et al., *supra* note 42, at 17.

159. *See Baze v. Rees*, 553 U.S. 35, 53-54 (2008); *Glossip v. Gross*, 576 U.S. 863, 867 (2015); *Bucklew v. Precythe*, 587 U.S. 119, 131-32 (2019); *Barr v. Lee*, 591 U.S. 979, 980-81 (2020).

The Court's acknowledgment that no person, not even a criminal, deserves to die a prolonged and painful death implies its support for a person's right to die with dignity. In continued upholding of the death penalty itself, the government "thereby has concluded that the sanctity of human life does not require that it always be preserved."¹⁶⁰ Protecting life is not the goal of the Eighth Amendment, nor should it be the goal of restricting a person's access to MAID. The objective is to spare people of painful and agonizing deaths where there is a legitimate interest in hastening it.¹⁶¹ To allow criminal offenders the basic right to die with dignity, but to deny that same right to innocent persons who have a definite chance of experiencing an excruciating and prolonged death, is cruel and unusual and cannot be upheld.

F. *The Right of Patients to Make Informed Medical Decisions, Including to Refuse Life-Sustaining Treatment*

Patients' rights are a large product of a person's right to privacy and personal autonomy. Courts have consistently held that a person's right to make their own medical decisions is protected by the Due Process Clauses.¹⁶² The Supreme Court has expressly stated, "[t]he right to seek advice on one's health and the right to place reliance on the physician of one's choice are basic to Fourteenth Amendment values."¹⁶³ Whether or not this right extends to a person's ability to refuse medical treatment, especially in life-threatening cases, has been the subject of controversy for decades.¹⁶⁴ The Supreme Court clarified the long history of medical decision-making case law has established "a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment."¹⁶⁵ This is even so when a person makes the choice to refuse life-saving treatment,¹⁶⁶ because that "is a moral and philosophical decision that, being a competent adult, is [the individual's] alone."¹⁶⁷ State courts have continued to ensure patients are free to exercise this constitutional right.¹⁶⁸

The argument has been made to extend this right of patients to refuse life-saving treatment to also include a patient's medical decision to utilize MAID, but

160. *Washington v. Glucksberg*, 521 U.S. 702, 741-42 (1997).

161. *See id.*

162. *See Doe v. Bolton*, 410 U.S. 179, 198 (1973); *Cruzan v. Mo. Dep't of Health*, 497 U.S. 261, 269-70 (1990); *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 427 (Mass. 1977); *Bartling v. Superior Ct.*, 163 Cal. App. 3d 186, 193-95 (1984); *Bouvia v. Superior Ct.*, 179 Cal. App. 3d 1127, 1137-38 (1986); *In re Guardianship of Browning*, 568 So. 2d 4, 9-10 (Fla. 1990).

163. *Doe*, 410 U.S. at 219-20.

164. *See Cruzan*, 497 U.S. at 269-73.

165. *See id.* at 278.

166. *Id.* at 279.

167. *Bouvia*, 179 Cal. App. 3d at 1143.

168. *See id.* at 1145-46 (holding that patients have a right to refuse medical treatment, even treatment that may save or prolong life); *Bartling v. Superior Ct.*, 163 Cal. App. 3d 186, 197-98 (1984) (holding that the right to discontinue life-sustaining medical treatment is not limited to comatose or terminally ill patients); *In re Guardianship of Browning*, 568 So. 2d 4, 17 (Fla. 1990) (holding that a competent person has the constitutional right to choose or refuse medical treatment in all relevant decisions concerning one's health).

it has yet to be settled.¹⁶⁹ The dissenters of the *Cruzan* Court firmly believed patients are “entitled to choose to die with dignity,” as this choice clearly is protected by the Due Process Clauses, which supports a patient’s ability to refuse life-sustaining treatment.¹⁷⁰ To deprive a competent patient of the right to make their own medical decisions would be, essentially, to make the decision for them. This is contradictory to the fundamental purpose of due process and equal protection. The rights of a patient to make their own informed medical decisions only support the proposition that MAID should be a decision that also receives constitutional protection. An individual must be given the choice to have a dignified death to ensure their rights to personal autonomy, to privacy, to be free of cruel and unusual punishment, and to medical decision making are not infringed upon by the government.

III. TO UPHOLD THE FUNDAMENTAL RIGHT TO A DIGNIFIED DEATH, ACCESS TO MAID MUST BE SECURED NATIONWIDE

With the right to a dignified death being established as fundamental, the government is limited in what legislation it can pass to ensure this right is not infringed upon.¹⁷¹ Under the other rights to privacy, personal autonomy, and patient decision-making, the state is imposed with a duty to protect and respect a person’s wishes regarding their medical treatment.¹⁷² This duty “serves to protect the rights of the individual from intrusion...unless the state has a compelling interest great enough to override this constitutional right.”¹⁷³ Thus, for the government to carry out any compelling interest, its means “must be narrowly tailored in the least intrusive manner possible to safeguard the rights of the individual.”¹⁷⁴

A. Considerations Against MAID

States have come up with a variety of “compelling interests” they believe are enough to outweigh the constitutional rights of individuals in these end-of-life situations, such as preserving human life, preventing suicide, ensuring the ethical integrity of the medical profession, protecting third-party interests, general public policy, and economic interests.¹⁷⁵ Each of these interests will be discussed in turn.

169. See *Cruzan*, 497 U.S. at 340-43.

170. *Id.* at 302 (Brennan, J., dissenting).

171. *Washington v. Glucksberg*, 521 U.S. 702, 720 (1997).

172. *Browning*, 568 So. 2d at 13-14.

173. *Id.* at 14.

174. *Id.*

175. See *Glucksberg*, 521 U.S. at 741; *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 425 (Mass. 1977).

1. *Protecting Human Life*

“The state’s interest in the preservation of life generally is considered the most significant state interest.”¹⁷⁶ Indeed, the landmark Supreme Court cases regarding the constitutional implications of MAID held this “unqualified interest in the preservation of human life” is so compelling that an individual’s rights is unlikely to outweigh it.¹⁷⁷ The Court further discussed that states have an interest in protecting vulnerable groups, such as the poor, the elderly, and disabled persons, from abuse, neglect, and mistakes that may arise in delicate end-of-life situations.¹⁷⁸ It noted that after legalization of MAID in the Netherlands, there were still concerns of vulnerable people, specifically those who are disabled, being subject to abuse in this practice.¹⁷⁹ In the eyes of the Court, the risk of harm to one’s life in such sensitive situations is something the state ought to have the authority mitigate.¹⁸⁰

Though the Supreme Court has established protecting human life is so compelling, lower courts, such as the Massachusetts Supreme Court in *Superintendent of Belchertown State School v. Saikewicz*, have acknowledged this interest may not always be sufficient in overcoming an individual’s constitutionally protected rights.¹⁸¹ In *Saikewicz*, the Court noted that recognition of this interest “does not necessarily resolve the problem where the affliction or disease clearly indicates that life will soon, and inevitably, be extinguished.”¹⁸² The weighing of the state’s interest in protecting an individual’s life should be rebalanced when the outcome of that individual is predetermined.¹⁸³ It is difficult to say the state has an interest in protecting life when that life faces an imminent end, and any “protection” would therefore be futile. The Massachusetts Supreme Court held the “interest of the State in prolonging a life must be reconciled with the interest of an individual to reject the traumatic cost of that prolongation.”¹⁸⁴ Where the state seeks to protect human life at the expense of an individual’s right to die with dignity in the face of imminent death, that individual’s fundamental

176. *Browning*, 568 So. 2d at 14.

177. *See Cruzan v. Mo. Dep’t of Health*, 497 U.S. 261, 280 (1990) (“As a general matter, the States—indeed, all civilized nations—demonstrate their commitment to life by treating homicide as a serious crime.... 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.”); *Glucksberg*, 521 U.S. at 746 (Stevens, J., concurring) (“That [unqualified interest in the preservation of human life] not only justifies—it commands—maximum protection of every individual’s interest in remaining alive, which in turn commands the same protection for decisions about whether to commence or terminate life-support systems or to administer pain medication that may hasten death.”).

178. *Glucksberg*, 521 U.S. at 731-32.

179. *See id.* at 734.

180. *See Cruzan*, 497 U.S. at 282; *Glucksberg*, 521 U.S. at 746.

181. *Glucksberg*, 521 U.S. at 752; *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 425 (Mass. 1977).

182. *Saikewicz*, 370 N.E.2d at 425.

183. *Id.* at 425-26 (“There is a substantial distinction in the State’s insistence that human life be saved where the affliction is curable, as opposed to the State interest where...the issue is not whether, but when, for how long, and at what cost to the individual that life may be briefly extended.”).

184. *Id.* at 425.

right should supersede to ensure their suffering is minimized and their death is dignified.¹⁸⁵

2. *Preventing Suicide*

Corresponding to the interest of protecting life, states also have an interest in preventing suicide. Suicide or intentional self-harm is ranked eleventh on causes of death in the United States and accounts for 14.8 deaths per 100,000 people.¹⁸⁶ It is understandable states strive to minimize and prevent deaths by suicide whenever possible. In 2001, the United States saw its first administrative action to combat the suicide crisis with the National Strategy for Suicide Prevention (NSSP).¹⁸⁷ The Department of Health and Human Services has since published two new NSSPs, one in 2012 and one in 2024, to continue its objectives in promoting awareness, reducing the stigma, developing community-based prevention programs, increasing access to services, facilitating research, and more.¹⁸⁸

The NSSP has stated the risk of suicide is much higher in people who have been diagnosed with mental disorders.¹⁸⁹ The Supreme Court has also acknowledged this increased risk.¹⁹⁰ The Court reasoned because of this risk factor, physicians may have a harder time responding to their patient's needs due to the difficulty in diagnosis for many mental disorders.¹⁹¹ It then follows that "legal physician-assisted suicide could make it more difficult for the State to protect depressed or mentally ill persons, or those who are suffering from untreated pain, from suicidal impulses."¹⁹² However, this reasoning is mainly relevant to the issues of legalizing MAID without sufficient regulations to safeguard individuals and physicians or in the context of MAID being used for individuals whose only medical challenge is a mental disorder and not a terminal illness.

Generally, the choice to go through MAID is not made on an impulse. Per Oregon's and Delaware's statutes regarding MAID, a patient who makes the request must submit to screening by the physician to determine eligibility, there is required reporting paperwork to complete, and there is a waiting period between

185. *Glucksberg*, 521 U.S. at 752 (Stevens, J., concurring) ("[I]t is clear that the so-called 'unqualified interest in the preservation of human life,' is not itself sufficient to outweigh the interest in liberty that may justify the only possible means of preserving a dying patient's dignity an alleviating her intolerable suffering.") (quoting *Cruzan v. Mo. Dep't of Health*, 497 U.S. 261, 282 (1990)).

186. *Suicide and Self-Harm Injury*, CDC: NAT'L CTR. FOR HEALTH STAT. (July 21, 2025), <https://www.cdc.gov/nchs/fastats/suicide.htm>.

187. See *National Strategy for Suicide Prevention: Goals and Objectives for Action*, U.S. DEP'T OF HEALTH AND HUM. SERVS. 1 (2001), https://www.ncbi.nlm.nih.gov/books/NBK44281/pdf/Bookshelf_NBK44281.pdf.

188. *Id.* at 15-16; *National Strategy for Suicide Prevention 2024*, U.S. DEP'T OF HEALTH AND HUM. SERVS. x-xi (Apr. 17, 2024), <https://www.hhs.gov/sites/default/files/national-strategy-suicide-prevention.pdf>.

189. *National Strategy for Suicide Prevention 2024*, *supra* note 188, at 6-7.

190. *Glucksberg*, 521 U.S. at 730 ("Those who attempt suicide—terminally ill or not—often suffer from depression or other mental disorders.")

191. *Id.* at 731.

192. *Id.*

the time a person requests MAID and completes the eligibility requirements and the moment when the lethal medication may actually be prescribed and given to the patient to self-administer.¹⁹³ This allows ample time for a patient to reconsider their decision, even if the initial request for MAID was made on an impulse. If a state aims to reduce suicide rates because of the difficulties medical professionals may face in ensuring their patients are in fact suffering from a terminal illness, rather than solely a mental disorder, then the state should be more focused on supporting medical professionals in achieving definite diagnoses for patients and implementing proper community resources to combat the suicide crisis. These means are more tailored in justifying the state's interest in reducing suicide rather than a broad prohibition on MAID. Such an approach would be able to achieve many ends without unreasonably infringing on a patient's right to die with dignity.

3. *Protecting the Ethical Integrity of the Medical Profession*

The Supreme Court has also supported the state's interest in protecting the medical profession's ethics and integrity,¹⁹⁴ suggesting that if MAID were legalized, it could "undermine the trust that is essential to the doctor-patient relationship by blurring the time-honored line between healing and harming."¹⁹⁵ The American Medical Association (AMA) has also argued providing physicians the opportunity to engage in MAID would cause more harm than good.¹⁹⁶ Although it recognizes those suffering from terminal, painful, and debilitating illnesses are in extreme duress, it contends MAID is "fundamentally incompatible with the physician's role as a healer," it would be "difficult or impossible to control," and it would "pose serious societal risks."¹⁹⁷ The AMA guides physicians to "aggressively respond to the needs of patients at the end of life" by continuing care, respecting autonomy, providing good communication and emotional support, and providing appropriate comfort and pain control, instead of engaging in MAID.¹⁹⁸ MAID is not specifically mentioned in the Uniform Health-Care Decisions Act, but it states a health-care provider may decline to comply with an individual's instruction or health-care decision if that provider believes the instruction or decision is contrary to a policy of its health-care institution expressly based on reasons of conscience.¹⁹⁹ This protects medical providers and institutions from administering MAID if they believe it would go against the ethical standards or integrity of their profession.

While the argument is made that the state has a compelling interest in preserving the ethics and integrity of the medical profession, courts have found a disconnect between the ethical demands in the medical profession and ethical

193. Or. Admin. R. 333-099-0010 (2023); DEL. CODE ANN. tit. 16, § 2507C (2025).

194. *Glucksberg*, 521 U.S. at 731.

195. *Id.*

196. CODE OF MED. ETHICS, Op. 5.7 (AM. MED. ASS'N 2016).

197. *Id.*

198. *Id.*

199. UNIF. HEALTH-CARE DECISIONS ACT § 21(f)(1)-(3) (UNIF. L. COMM'N 2023).

medical practice.²⁰⁰ In contrast to the AMA's view of ethics in the medical profession, "[p]revailing medical ethical practice does not, without exception, demand that all efforts toward life prolongation be made in all circumstances."²⁰¹ The practice of healing patients via end-of-life treatment would not threaten the integrity of the medical profession, the physician's role in caring for patients, or the state's interest in protecting the same.²⁰² Furthermore, if patient's rights are founded in the fundamental rights of privacy, autonomy, and bodily integrity, then those rights are far superior to the institutional interests of doctors, hospitals, and the medical profession as a whole.²⁰³

4. *Protecting Third-Party Interests*

Courts recognize another interest of the state in protecting innocent third parties who may be impacted by a patient's decision to seek MAID.²⁰⁴ Of potential parties who may be negatively affected, minor children of the patient and persons who assist with the administration of MAID are the most notable.²⁰⁵ Courts have attested "the possible impact on minor children would be a factor which might have a critical effect on the outcome of the [interest] balancing process."²⁰⁶ Other courts have also declined to "expand the nature of [the patient's] right of privacy to provide a protective shield for third persons who end his life."²⁰⁷ Although the recognition of third-party interests is a factor to consider when weighing a person's rights, it should not be decisive nor compelling.

Other third parties at issue in the MAID debate are the American health insurance companies. While the Court has not directly addressed the issue of the implications raised when a patient choosing MAID intends to use their health insurance to cover the costs, it is apparent the parties' differing interests would be likely to conflict. There are multiple federal statutes in place that impose a duty on health insurance companies to act in the best interests of their consumers,²⁰⁸ but insurance companies frequently deny claims for basic life-sustaining medical needs. In an effort to keep revenue rolling in, it would not seem strange for an insurance company to deny a patient's rightful claim for MAID medications. People who die do not pay the continued medical expenses that would have been necessary to keep them alive, and this can cost medical insurance companies

200. *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 426 (Mass. 1977) ("The force and impact of this interest is lessened by the prevailing medical ethical standards.").

201. *Id.*

202. *See id.* at 426-27.

203. *Id.* at 427.

204. *See id.* at 426; *Washington v. Glucksberg*, 521 U.S. 702, 729 (1997); *Cruzan v. Mo. Dep't of Health*, 497 U.S. 261, 281 (1990).

205. *See Saikewicz*, 370 N.E.2d at 426-27; *Donaldson v. Lungren*, 2 Cal. App. 4th 1614, 1620 (1992).

206. *Saikewicz*, 370 N.E.2d at 426 (citing *Holmes v. Silver Cross Hosp.*, 340 F. Supp. 125 (D. Ill. 1972)).

207. *Donaldson*, 2 Cal. App. 4th at 1662.

208. *See e.g.*, 29 U.S.C. § 1185e (2024) (imposing a duty of good faith on insurance companies in multiple stages of an insurance transaction).

almost \$18,000 per month in hospice care bills.²⁰⁹ States have an important interest in protecting the people subject to its jurisdiction. A state cannot do this if it allows insurance companies to continue operating with profits being prioritized over people and their constitutional rights.

5. *Public Policy and Economic Interests*

States have argued they have a significant interest in “preserving the lives of those who can still contribute to society and have the potential to enjoy life.”²¹⁰ The Supreme Court, though not expressly affirming this interest to be compelling, has supported this notion by expressly permitting states to not make judgments about the quality of life a person may live where life can be prolonged artificially.²¹¹ This further supports the principle that a state has an interest in protecting human life in order to preserve and foster the benefits of the community to which every human can contribute.²¹² Thus, the policy interests suggest a person who is experiencing pain and suffering, and whose material contributions to society would be minimal due to this suffering, must continue to suffer in order to foster the exchange of ideas, expressions of affection, shared memories, and humorous incidents, which the state finds to be more valuable than a person’s right to be free from such anguish and to die with dignity.

This proposition is deeply troubling. It forgoes a person’s constitutional rights to further the benefits to a society from which that person is unlikely to benefit. If anything, this contravenes public policy because it fails to consider the positive impacts on society that could be had if people had access to MAID and were not forced to suffer. The world cannot be viewed through the lens of the trolley problem. The fulfillment of one goal does not necessarily come at the expense of another. Other countries and states have determined that permitting MAID does not go against public policy, and those jurisdictions have yet to see the dissolution of their communities.²¹³ To deny a person the right to a dignified death on the ground of furthering public policy would be a great injustice that would in fact achieve the contrary.

209. Joan Myers Bondareff, *The Cost of Dying in the U.S.*, AM. BAR ASS’N: SENIOR LAW. DIV. (July 20, 2025), https://www.americanbar.org/groups/senior_lawyers/resources/voice-of-experience/2024-april/the-cost-of-dying-in-the-us/.

210. *Washington v. Glucksberg*, 521 U.S. 702, 729 (1997) (citation omitted).

211. *Cruzan v. Mo. Dep’t of Health*, 497 U.S. 261, 282 (1990) (“We think a State may properly decline to make judgments about the ‘quality’ of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual.”).

212. *Glucksberg*, 521 U.S. at 741 (Stevens, J., concurring) (“The State has an interest in preserving and fostering the benefits that every human being may provide to the community—a community that thrives on the exchange of ideas, expressions of affection, shared memories, and humorous incidents, as well as on the material contributions that its members create and support.”).

213. *See Baxter v. State*, 224 P.3d 1211, 1220 (Mont. 2009); *see also Carter v. Canada*, [2015] S.C.R. 331, 379-88 (Can.) (affirming that a person’s right to life under the Canadian Constitution does not go against societal or general public policy interests).

B. *Potential Limitations*

After analyzing the arguments against the practice of MAID, it is important to next discuss the limitations that should be considered if MAID were to be made legal across the nation. While the right to a dignified death is fundamental and the government cannot infringe this right, there still must be regulations to ensure the practice is executed safely and ethically. The largest issues legislators and courts have run into with regard to MAID is whether it is administered actively or passively and whether the decision to pursue MAID is made voluntarily or involuntarily.²¹⁴ The previous sections of this article advocate for MAID specifically in the context where it is both voluntary and active, but the following sections will review the controversies of applying MAID in situations where it is passive or involuntary.

1. *The Passive vs. Active Dichotomy*

Active MAID occurs where the patient takes affirmative actions to end their life, such as taking a lethal medication.²¹⁵ In contrast, passive MAID is where the patient's life is ended by discontinuing life-supporting medical treatment, such as a feeding tube or a ventilator.²¹⁶ Many courts have made the distinction between “the right to refuse treatment and the right to commit physician-assisted suicide through self-administration of a lethal dose of medication.”²¹⁷ The right to refuse medical treatment—even life-saving treatment—is well founded, but courts are more reluctant to say it follows that a person has the right to affirmatively take steps to end their life.²¹⁸

The Supreme Court has expressed a competent person, regardless of their physical condition, is entitled to refuse unwanted lifesaving medical care, but no one is permitted to assist a suicide.²¹⁹ The reasoning supporting this proposition is based in the “fundamental legal principles of causation and intent.”²²⁰ The Court discusses a patient who refuses life-sustaining medical treatment is going to die from their terminal illness, but a patient who requests MAID will die from the lethal medication that is prescribed and administered.²²¹ Similarly, a physician who does not provide or ceases to provide life-saving treatment does so with the intent to respect the patient's right to refuse treatment, rather than an intent to cause death.²²² In contrast, a doctor who assists a patient with MAID, being directed by the patient who has the specific intent to end their own life, must also primarily

214. *See Cruzan*, 497 U.S. at 277 (1990); *Glucksberg*, 521 U.S. at 729; *Vacco v. Quill*, 521 U.S. 793, 800-01 (1997).

215. Bălan, *supra* note 2, at 109.

216. *Id.*

217. *Krischer v. McIver*, 697 So.2d 97, 102 (Fla. 1997); *see Cruzan*, 497 U.S. at 277; *Glucksberg*, 521 U.S. at 729; *Vacco*, 521 U.S. at 800-01.

218. *See Cruzan*, 497 U.S. at 279.

219. *Vacco*, 521 U.S. at 800.

220. *Id.* at 801.

221. *Id.*

222. *Id.*

intend the patient dies from affirmative acts of care.²²³ A patient who decides to refuse life support, however, may not necessarily have the intent to die, but instead have the intent to be free of unwanted medical treatment.²²⁴

Because it is established a patient has the right to refuse or withdraw life-sustaining medical treatment, it follows that the same person should have the right to hasten their death in a more comfortable and dignified way. Both means of achieving death are by active choice of the patient, and the intent of the physician is irrelevant. In either case, the physician would be providing medical treatment at the wishes of the patient, rather than with the specific intent to kill or prolong life. The crux of the issue is the patient's intent. While death is practically certain to result from either choice, withdrawing life-sustaining treatment or utilizing MAID, the patient is not necessarily acting with the intent to cause death. Death is imminent at this point—it is not a choice in which the patient can opt in or out of. In either scenario, the patient makes the choice with the intent to reduce suffering and preserve dignity up to the point of death. Any effort to regulate this type of choice would be an infringement of a person's fundamental rights.

2. *The Involuntary vs. Voluntary Dichotomy*

Voluntary MAID is where the patient, who has the capacity to act for themselves, makes the decision to end their life.²²⁵ Involuntary MAID is where a third party, such as a parent or spouse, would make the decision in the event that the patient is unable to act for themselves in this capacity.²²⁶ Under the Uniform Health-Care Decisions Act (UHCDA), “capacity” means an individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and the ability to make and communicate health-care decisions.²²⁷ A patient could lack capacity for a number of reasons, such as being unconscious or having a mental disability that makes it difficult to understand and communicate health-care decisions.²²⁸ A “health-care decision” under the UHCDA is defined as “a decision made by an individual or the individual's [agent, guardian, or] surrogate, regarding the individual's health care.”²²⁹ These decisions can include: (i) selection and discharge of health-care providers and institutions; (ii) approval or disapproval of diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; and (iii) directions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care.²³⁰ While the voluntary decision

223. *Id.* at 802.

224. *Id.*

225. Bălan, *supra* note 2, at 109.

226. *Id.*

227. UNIF. HEALTH-CARE DECISIONS ACT § 3(a)(1)-(2) (UNIF. L. COMM'N 2023).

228. *See id.* § 3 cmt.

229. *Id.* § 2(11).

230. *Id.* § 2(11)(A)-(C).

to undergo MAID is slightly more—though still not very—favorable by the courts,²³¹ involuntary MAID remains much more highly contested.²³²

The Supreme Court has noted a person who lacks capacity “is not able to make an informed and voluntary choice to exercise a hypothetical right to refuse treatment or any other right.”²³³ Where such circumstances exist, a surrogate must step in to make decisions on behalf of the patient, and the state has an interest in protecting vulnerable patients whose surrogates may not act in accordance with the patient’s best interests.²³⁴ Even where a person may seem to be making a voluntary decision, regardless of their capacity, the Court believes a state could require higher evidentiary safeguards to protect the patient’s interest in life.²³⁵ Thus, the risk involved in determining capacity for a person to make a life-ending decision is too great to allow untethered access to MAID.²³⁶

As with any constitutional right, even those that are deemed fundamental, they are not absolute.²³⁷ A restriction on the right to die with dignity as applied to MAID may be permissible if it is narrowly tailored to a compelling state interest.²³⁸ The Court has clearly expressed a state’s interest in preventing the abuse of incompetent persons may be compelling.²³⁹ And a narrowly tailored restriction may be permissible where the eligibility requirements for MAID involve the patient having full capacity to make their own medical decisions, while patients who lack the capacity to voluntarily request MAID are ineligible.²⁴⁰ This type of limitation on MAID is utilized in many international jurisdictions, as well as some states that have legalized MAID.²⁴¹ Such a constitutional regulation on the practice could remedy the issue for courts to decide whether an incapable person can request MAID and instead leave courts with the familiar role of making factual determinations of a person’s mental capacity.

C. *Ensuring Medically Safe and Ethical End-of-Life Care*

Aside from upholding the right to a dignified death, it is imperative that access to MAID be preserved and properly regulated to ensure end-of-life care is medically safe and ethical. One of the fundamental goals of MAID is to ensure a person’s death happens in a humane and peaceful way. Forcing patients to suffer

231. *See* *Vacco v. Quill*, 521 U.S. 793, 801 (1997); *Washington v. Glucksberg*, 521 U.S. 702, 720 (1997).

232. *See* *Cruzan v. Mo. Dep’t of Health*, 497 U.S. 261, 280 (1990); *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 435 (Mass. 1977).

233. *Cruzan*, 497 U.S. at 280.

234. *Id.* at 280-81.

235. *Id.*

236. *See* *Glucksberg*, 521 U.S. at 738 (O’Connor, J., concurring) (“[T]he risk that a dying patient’s request for assistance in ending his or her life might not be truly voluntary justifies the prohibitions on assisted suicide we uphold here.”).

237. *Gitlow v. New York*, 268 U.S. 652, 666-67 (1925).

238. *See* *Lochner v. New York*, 198 U.S. 45, 57-58 (1905).

239. *See* *Cruzan*, 497 U.S. at 280; *Glucksberg*, 521 U.S. at 732-35.

240. *See* *Cruzan*, 497 U.S. at 280; *Glucksberg*, 521 U.S. at 732-35.

241. *See* *MAID: Medical Aid in Dying*, *supra* note 71.

long and painful deaths could lead to an increase in self-inflicted injury suicides. Firearms are the most common method used in suicides, followed by suffocation and poisoning.²⁴² Is a gun to your head going to hurt as much as losing the fight against cancer? But why should it hurt at all? Medications utilized with MAID are intended to have a high level of efficacy, bringing about death quickly, with a high degree of safety, and without distressing or adverse effects.²⁴³ Preserving access to these medications would ensure that patients, who are already suffering painful terminal illnesses, do not have to suffer a painful and gruesome death.

The Supreme Court has expressed “a State may properly decline to make judgments about the ‘quality’ of life...and simply assert an unqualified interest in the preservation of human life.”²⁴⁴ There is no such interest that would prevail over a person’s fundamental right to die in a dignified manner. “The government has a legitimate interest in protecting terminal patients from great pain and unnecessary suffering.”²⁴⁵ It seems to attach undue importance to the amount of time and fails to give more consideration to the quality of the life during that period.²⁴⁶ Further, this very sensitive decision patients are making whether to opt for MAID is not a place where the government should intrude. It is not a medical decision for a physician to make. It is not a legal question whose soundness is to be resolved by lawyers or judges. Neither is it a conditional right subject to the approval of courts of law or ethics committees. It is a moral and philosophical decision that is a competent individual’s alone.²⁴⁷ No state interest could outweigh this right of the individual.²⁴⁸ People are entitled to choose to die with dignity.²⁴⁹

CONCLUSION

The outlook for legalizing MAID has been improving immensely over the past few decades. While there is still significant resistance to the practice and its implications, it is becoming increasingly recognized as a crucial part of the fundamental right to a dignified death. The U.S. Supreme Court has made clear there are fundamental rights to privacy, to personal autonomy, to be free of cruel and unusual punishment, and to make personal medical decisions. All of these rights are at the heart of the right to die with dignity. The government may not infringe on any of these rights. Establishing nationwide access to MAID will

242. *Suicide and Self-Harm Injury*, *supra* note 186.

243. *See* Worthington et al., *supra* note 42, at 16-17.

244. *Cruzan*, 497 U.S. at 282.

245. *Datlof*, *supra* note 92, at 39.

246. *Bouvia v. Superior Ct.*, 179 Cal. App. 3d 1127, 1142 (1986) (“[T]he trial court mistakenly attached undue importance to the *amount of time* possibly available to petitioner, and failed to give equal weight and consideration for the *quality* of that life; an equal, if not more significant, consideration.”) (emphasis in original); *Cruzan*, 497 U.S. at 313 (Brennan, J., dissenting) (“[T]he State has no legitimate general interest in someone’s life, completely abstracted from the interest of the person living that life, that could outweigh the person’s choice to avoid medical treatment.”).

247. *Bouvia*, 179 Cal. App. 3d at 1143.

248. *Cruzan*, 497 U.S. at 312.

249. *Id.* at 302.

secure the right to a dignified death and provide people with a choice to enforce that right.