THE RIGHT TO DIE: WHY NORTH DAKOTA SHOULD NOT HAVE DISMISSED HOUSE BILL 1415

ABSTRACT

In February 2021, the North Dakota House of Representatives voted 9-85 to reject a bill that would have given the terminally ill residents of North Dakota more freedom and control over the personal choice of how and when to end their life. House Bill 1415, which has been referred to as the "Death with Dignity" bill or "the Freedom Bill" would have provided an option for terminally ill patients to utilize physician-assisted suicide as an option for their end-of-life care. By rejecting the bill, North Dakota declined to follow the trend that eight other states and the District of Columbia have already set: that those with qualifying terminal diseases can take steps to work with their physician to end their life in a "humane and dignified manner." Life is precious and does need to be protected, however, when one is faced with the reality of being diagnosed with a terminal illness that makes death a certain, impending outcome instead of a distant thought, States should allow these residents, who are able to make such decisions, to have control of their final moments. Giving the terminally ill the option of ending their life in a safe, dignified way by going through their physicians will allow patients to have the privacy and control over their lives that they deserve. Physicians should not be placed in a position of prolonging an eligible patient's pain when the patient is capable of making the decision to end his or her life in a humane fashion. It is time for North Dakota to allow their terminally ill residents to have control over their lives. Unfortunately, not everyone is lucky enough to experience a long, healthy life which allows them to escape the worry of choosing how to die. For those North Dakota residents who are faced with a terminal illness that will inevitably take their life, they are still being denied the opportunity and the privacy of choosing to die in a safe, controlled, dignified way.

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I. INTRODUCTION

Life is precious. One of the greatest luxuries in life is the ability to be happy and healthy, and to live long enough to make and accomplish dreams, discover and explore passions, and meaningful enough to leave an impression on this world in one way or another. The harsh reality is there are many Americans that do not get to experience this luxury. There are many ways in which a life can end; some people experience their last moments on Earth knowing they are going to die, while others are taken unexpectedly, without warning. This note addresses the lack of end-of-life choices the terminally ill in North Dakota have. The terminally ill residents of North Dakota will not get the peace which comes with having control of one's end of life decisions. The terminally ill residents of North Dakota were not granted the ability to choose when and how to end their life by the North Dakota Legislature in 2021.[1]

1. *See* Jeremy Turley, *North Dakota House Rejects Bill to Allow Assisted Suicide*, THE DICKINSON PRESS (Feb. 16, 2021, 3:13 PM), https://www.thedickinsonpress.com/news/government-and-politics/6890097-North-Dakota-House-rejects-bill-to-allow-assisted-suicide.

II. HISTORY OF DEATH WITH DIGNITY LAWS

A law which allows a terminally ill patient to choose how to end their life with physician assistance is often referred to by its supporters as a Death with Dignity Law.[2] Death with dignity statutes are also referred to as "physician-assisted death" or "aid-in-dying" laws.[3] The idea surrounding the push to enact these laws in each state stems from the notion that the terminally ill, not the government, should have control of their own end-of-life decisions and should determine how much suffering they should bear.[4] In the United States, eight states and the District of Columbia have some form of death with dignity statutes already in place.[5] Montana does not have a death with dignity statute, but the Montana Supreme Court has ruled there is nothing in the state's law which would prohibit "a physician from honoring a terminally ill, mentally competent patient's request by prescribing medication to hasten the patient's death."[6]

Many countries around the world have already enacted some sort of death with dignity laws.[7] Some countries have further legalized euthanasia.[8] Physician-assisted suicide laws, which is another name for death with dignity laws, are not the same as laws that make euthanasia legal. Euthanasia is when a doctor administers a lethal dose of medication to a patient.[9] Therefore, when one chooses euthanasia, instead of physician-assisted suicide, a patient seeking death "assistance has someone else take the action that leads to their unnatural death" like injecting a lethal drug, while assisted suicide requires a patient to be "prescribed drugs that they take themselves in order to die."[10] The difference between the two forms of assistance has led to more countries legalizing physician-assisted suicide laws, or death with dignity laws, and

2. *Frequently Asked Questions*, DEATH WITH DIGNITY, https://deathwithdignity.org/resources/faqs/ (last visited Apr. 19, 2022).

3. *Id.*

4. *See id.*

5. *State Statute Navigator*, DEATH WITH DIGNITY, https://deathwithdignity.org/resources/state-statute-navigator/ (last visited Apr. 19, 2022) (U.S. jurisdictions with death with dignity statutes:" California, Colorado, District of Columbia, Hawaii, Maine, New Jersey, New Mexico, Oregon, Vermont, Washington).

6. *Montana*, DEATH WITH DIGNITY, https://deathwithdignity.org/states/montana/ (last visited Apr. 19, 2022).

7. *Euthanasia & Physician-Assisted Suicide (PAS) around the World*, BRITANNICA PROCON.ORG (Nov. 11, 2021), https://euthanasia.procon.org/euthanasia-physician-assisted-suicide-pas-around-the-world/ (including Austria, Belgium, Canada, Finland, Germany, Luxembourg, The Netherlands, New Zealand, Spain, Switzerland) [hereinafter *Euthanasia & PAS*].

8. *Id.* (including Belgium, Canada, Columbia, Luxembourg, The Netherlands, Spain).

9. *Id.*

10. *What is the Difference Between Euthanasia and Assisted Suicide?*, MAXIM INSTITUTE, https://www maxim.org nz/article/faq1-euthanasia-and-assisted-suicide/ (last visited Dec. 18, 2021).

less with enacted euthanasia laws.[11] Euthanasia is currently illegal in all fifty states in the United States.[12]

The movement to pass death with dignity laws is growing more popular in the United States each year, with New Mexico passing its death with dignity statute in 2021.[13] Many of the states that have passed death with dignity statutes have modeled their laws on Oregon's Death with Dignity Act, as Oregon was the first state to have passed such an act in 1994.[14] As more states begin to look at the ideas that death with dignity laws encompass, and decide whether or not to pass these laws in their own states, it is important to take a look at what the courts have said on the matter.

A. KAREN ANNE QUINLAN

The tragic story of Ms. Quinlan is a landmark case that began the right-to-die conversation in this country and started the debate on how much the government should intervene in these personal end of life decisions.[15] Karen Quinlan, a twenty-two-year-old New Jersey resident, for unknown reasons, stopped breathing for two fifteen-minute time spans.[16] Quinlan fell into a coma and required a respirator to breathe.[17] The doctors who examined Quinlan described her as "being in a 'chronic persistent vegetative state.'"[18] The expert witness at trial described this vegetative state as, "a 'subject who remains with the capacity to maintain vegetative parts of neurotological function but who. . . no longer has any cognitive function.'"[19] Therefore, Quinlan was determined to be incompetent, or unable to make sound decisions on her own behalf, so appointing a guardian was necessary.[20]

Joseph Quinlan, Karen's father, wished to be appointed guardianship and wanted to have the express power as Karen's guardian, "to authorize the discontinuance of all extraordinary medical procedures now allegedly sustaining Karen's vital processes and hence her life, since these measures, he

11. *Euthanasia & PAS, supra* note 7.

12. *Id.*

13. *New Mexico*, DEATH WITH DIGNITY, https://deathwithdignity.org/states/new-mexico/(last visited Apr. 19, 2022).

14. *Why Is Medical Aid in Dying a Safe Practice?*, COMPASSION & CHOICES MEDICAL AID IN DYING FACT SHEET, https://le.utah.gov/interim/2016/pdf/00002835.pdf; Jessica Gillespie, *Death with Dignity in North Dakota*, NOLO, https://www.nolo.com/legal-encyclopedia/death-with-dignity-north-dakota html (last visited Dec. 18, 2021); *Oregon*, DEATH WITH DIGNITY, https://deathwithdignity.org/states/oregon/ (last visited Apr. 19, 2022).

15. Annette E. Clark, *The Right to Die: The Broken Road from Quinlan to Schiavo*, 37 LOY. U. CHI. L.J. 383 (2006), https://www.luc.edu/media/lucedu/law/students/publications/llj/pdfs/clark.pdf.

16. *Matter of Quinlan*, 355 A.2d 647, 651, 653 (1976).

17. *Id*. at 654.

18. *Id.*

19. *Id.*

20. *Id.* at 651, 653.

asserted present no hope of her eventual recovery."[21] Further, during trial it was said that Karen has "firmly evinced her wish, in like circumstances, to not have her life prolonged by the otherwise futile use of extraordinary means."[22] Karen's father asserted several constitutional rights on behalf of Karen, such as the free exercise of religion, cruel and unusual punishment, and the right to privacy, that would allow her to have her respirator disconnected.[23] The Supreme Court of New Jersey focused on the right to privacy concerns, and dismissed the rest.[24]

The court determined, in the present case, "no external compelling interest of the State could compel Karen to endure the unendurable, only to vegetate a few measurable months with no realistic possibility of returning to any semblance of cognitive or sapient life."[25] The court reviewed the right to privacy jurisprudence in this country, and, while referencing Roe v. Wade[26] stated, "[p]resumably this right [to privacy] is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman's decision to terminate pregnancy under certain conditions."[27]

The claimed State interests, which were "the preservation and sanctity of human life and defense of the right of the physician to administer medical treatment according to his best judgment," were not strong enough for the State to prevail.[28] "We think that the State's interest . . . weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the State interest."[29] The court concluded that if Karen's family determines Karen would have made the choice to disconnect her respirator, then the guardian and the family's decision to act in accordance with Karen's wishes must be accepted.[30]

While this court did not address whether the same reasoning would apply to a terminally ill, competent person deciding to end their life with their physician's assistance, this case was important for several reasons in the right-to-die context. This case recognized that the constitutionally recognized right to privacy was broad enough to encompass one's decision to decline medical

21. *Id.* at 652.
22. *Id*. at 653.
23. *Id.* at 661-65.
24. *Id*. at 661-62.
25. *Id.* at 663.
26. 410 U.S. 113, 153 (1973).
27. *Quinlan*, 355 A.2d at 663.
28. *Id.* at 664.
29. *Id.*
30. *Id.*

treatment, even if the consequence to their decision is their death.[31] Further, the Supreme Court of New Jersey rejected the lower court's position that the decision to withdraw life-sustaining treatment must exclusively be left in the hands of physicians.[32] This court looked not only at Quinlan's chance for mere biological existence, but instead looked at the chances that Quinlan had to return to sapient life, which in this case, was realistically none.[33] This case, even though it was not heard by the United States Supreme Court, still played a major role in the right to die jurisprudence in this country.

B. CRUZAN V. DIRECTOR, MISSOURI DEPARTMENT OF HEALTH

In 1990, the United States Supreme Court heard Cruzan v. Dir. Mo. Dep't of Health,[34] which altered the way incompetent individuals were able to make their right to die decisions. Nancy Cruzan was deemed incompetent after she sustained severe injuries during an automobile accident.[35] After it was clear Nancy would not recover her cognitive faculties, Nancy's parents and co-guardians sought a court order that would allow them to withdraw Nancy's artificial feeding and hydration support.[36] The Supreme Court of Missouri required the parents to present clear evidence that Nancy would have desired to have the life-sustaining treatment withdrawn if she could make the decision herself.[37] Nancy's parents failed to meet this standard, so the Supreme Court of Missouri determined the parents lacked authority to have their request granted. However, Nancy's parents appealed, and the United States Supreme Court granted certiorari to consider, the question of whether Nancy "has a right that would require the hospital to withdraw life-sustaining treatment from her under these circumstances."[38]

"No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his person, free from all restraint or interference of others, unless by clear and unquestionability authority of law."[39] This notion is applicable to medical treatment as well and is illustrated by the informed consent requirement often needed to obtain medical assistance.[40] Most courts have based the right to refuse treatment on either the "common-law right to informed consent or on

31. *Id.* at 663.
32. *Id.* at 664.
33. *Id.* at 663.
34. 497 U.S. 261 (1990).
35. *Id.* at 265.
36. *Id.*
37. *Id.*
38. *Id.* at 265, 269.
39. *Id*. at 269 (quoting Union Pacific R. Co. v. Botsford, 141 U.S. 250, 251 (1891)).
40. *Id.* at 269.

both the common-law right and a constitutional privacy right."[41] The United States Supreme Court, however, chose to focus their attention only on the question of whether there is a right to die granted by the United States Constitution, not on the privacy right or the common law right to informed consent.[42]

The Court turned to the Fourteenth Amendment[43] and reaffirmed the "principal that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment . . . ."[44] However, the Court also stated, "determining that a person has a 'liberty interest' under the Due Process Clause does not end the inquiry; 'whether the respondent's constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests.'"[45] The Court, for the purposes of the case at hand, assumed "the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition."[46] However, the Court was not convinced that "an incompetent person should possess the same rights in this respect as is possessed by a competent person."[47]

An incompetent person's right to terminate life sustaining treatment is made on her behalf by a surrogate, and Missouri has recognized that there should be "procedural safeguards" to assure that the surrogate's actions conform as closely as possible with "the wishes expressed by the patient while competent."[48] Missouri requires a surrogate to present evidence of the incompetent's wishes to terminate treatment, and the evidence is measured through a clear and convincing standard.[49] Whether this clear and convincing standard violates the United States Constitution depends on the State interests, which in *Cruzan*, was the "protection and preservation of human life."[50] The court recognized the validity of this interest and stated, "the choice between life and death is a deeply personal decision of obvious and overwhelming finality. We believe Missouri may legitimately seek to safeguard the personal element of this choice through the imposition of heightened evidentiary requirements."[51]

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41. *Id.* at 271.
42. *Id.* at 277.
43. U.S. Const. amend. XIV § 1 ("No state shall . . . deprive any person of life, liberty, or property, without due process of law . . . .").
44. *Cruzan*, 497 U.S. at 278.
45. *Id.* at 279 (quoting Youngberg v. Romeo, 457 U.S. 307, 321, 102 S. Ct. 2452, 2461 (1982)).
46. *Id.*
47. *Id.*
48. *Id.* at 280.
49. *Id.*; *Evidence*, BLACK'S LAW DICTIONARY (11th ed. 2019) ("Evidence indicating that the thing to be proved is highly probable or reasonably certain.").
50. *Cruzan*, 497 U.S. at 280.
51. *Id.* at 281.

"It cannot be disputed that the Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment."[52] However, the State has the power "to guard against potential abuses in such situations. Similarly, a State is entitled to consider that a judicial proceeding to make a determination regarding an incompetent's wishes may very well not be an adversarial one, with the added guarantee of accurate factfinding that the adversary process brings with it."[53] The Court determined that Missouri's clear and convincing standard of proof where guardians seeks to terminate life sustaining treatment to a person in a persistent vegetative state was permissible to advance its interest.[54] Further, the Court held the argument that "Missouri must accept the substituted judgment of close family members even in the absence of substantial proof that their views reflect the views of the patient" was not supported by case law.[55] The Due Process Clause allows states to require a clear and convincing standard of proof showing the patient's wishes and, further, allows the State to "choose to defer only to those wishes, rather than confide the decision to close family members."[56]

Cruzan does assume that competent individuals have a federal constitutionally protected right to refuse life sustaining treatment, however they rejected the notion that an incompetent person should have the same rights, in regard to a "right to die" claim, as a competent person.[57] *Cruzan* rejected several principals the *Quinlan* court based its decisions on. First, *Cruzan* did not perceive the right to refuse life-sustaining medical treatment as a fundamental privacy right, and further, the guardian or surrogate, will not get the final decision on whether to terminate life sustaining medical treatment.[58]

C. WASHINGTON V. GLUCKSBERG

The United States Supreme Court next discussed a right to die issue in *Washington v. Glucksberg*.[59] Washington's law made "prompting a suicide attempt" a felony and stated, "a person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide.'"[60] Doctors in the state of Washington along with terminally ill patients and a nonprofit organization, filed a suit against the State and its Attorney General claiming the law was unconstitutional because it infringes upon their

52. *Id.*
53. *Id.*
54. *Id*. at 282, 284.
55. *Id.* at 285-86.
56. *Id.* at 286-87.
57. *Id.* at 278-79.
58. Annette E. Clark, *The Right to Die: The Broken Road from Quinlan to Schiavo*, 37 LOY. U. CHI. L.J. 395-96 (2006).
59. 521 U.S. 702 (1997).
60. *Id.* at 707; WASH. REV. CODE § 9A.36.060(1) (1994).

liberty interests protected by the Due Process Clause, "which extends to a personal choice by a mentally competent, terminally ill adult to commit physician-assisted suicide."[61] The United States Supreme Court held Washington's law, which made it a felony to cause or aid a suicide, does not violate the Due Process Clause.[62]

The Court determined that the nation's history, practices, and traditions demonstrate that American common law has disapproved, and continues to punish the assisting of suicide, and, further, this notion is still supported today, evidenced by laws similar to Washington's in almost every State, and the Federal Assisted Suicide Funding Restriction Act of 1997, which bans use of federal funds to support physician-assisted suicide.[63] Through this analysis, the Court found no fundamental liberty interest in physician-assisted suicide protected by the Due Process Clause.[64]

Although the idea that physician-assisted suicide is inconsistent with American values has been demonstrated by voters and legislator's continued support for most States' prohibitions on assisting suicide, there has been some change.[65] The Court did discuss the Oregon Death with Dignity Act, which made physician-assisted suicide legal so long as the patient was a terminally ill and competent adult.[66] At the time of this case, Oregon was the only state to have such a bill passed.[67] However, despite Oregon's law, the Court concluded, "[o]ur laws have consistently condemned, and continue to prohibit, assisting suicide. Despite changes in medical technology and notwithstanding an increased emphasis on the importance of end-of-life decision-making, we have not retreated from this prohibition."[68] The Court stated, "to hold for respondents, we would have to reverse centuries of legal doctrine and practice, and strike down the considered policy choice of almost every State."[69] The Court did not find *Cruzan*[70] and *Casey*[71] persuasive to support respondent's proposition that physician-assisted suicide is a liberty

61. *Glucksberg*, 521 U.S. at 707-08; U.S. Const. amend. XIV § 1 ("No state shall . . . deprive any person of life, liberty, or property, without due process of law . . . .").

62. *Glucksberg*, 521 U.S. at 705-06.

63. *Id.* at 710-13.

64. *Id.* at 728.

65. *Id.* at 716.

66. *Id.* at 717; OR. REV. STAT. § 127.800 (1996).

67. *Glucksberg*, 521 U.S. at 717-18 ("Since the Oregon vote, many proposals to legalize assisted-suicide have been and continue to be introduced in the States' legislatures, but none have been enacted.").

68. *Id.* at 719.

69. *Id.* at 723.

70. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261 (1990).

71. Planned Parenthood v. Casey, 505 U.S. 833 (1992).

interest protected under the Due Process Clause.[72] The court noted that, in *Cruzan*:

> The decision to refuse unwanted medical treatment, our assumption was entirely consistent with this Nation's history and constitutional traditions. The decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection. Indeed, the two acts are widely and reasonably regarded as quite distinct.[73]

Further, respondents used *Casey*, which dealt with a woman's right to an abortion, to demonstrate the Court's precedent in finding fundamental rights and liberties that "involve[e] the most intimate and personal choices a person may make in a lifetime," and that the right to physician suicide is consistent with those rights.[74] The Court concluded that although "[m]any of the rights and liberties protected by the Due Process Clause sound in personal autonomy does not warrant the sweeping conclusion that any and all important, intimate, and personal decisions are so protected . . . ."[75] Taking this into account, the court held the asserted right to physician-assisted suicide is not fundamental, and is not protected by the Fourteenth Amendment Due Process Clause.[76] After determining the right to physician-assisted suicide was not a fundamental right, the Court weighed Washington's interest and looked at the statute's relation to those interests, to ultimately conclude the Washington statute did not violate the Due Process Clause of the Fourteenth Amendment.[77]

This case was a landmark case in this country's right to die jurisprudence. The case reaffirmed that a competent person has the protected right to refuse unwanted medical treatment, but also recognized that there is no fundamental right for physician-assisted suicide.[78] The same day as *Washington v. Glucksberg* was decided, the United States Supreme Court decided *Vacco v, Quill*,[79] another right to die case.[80]

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72. *See Glucksberg,* 521 U.S. at 723-74.

73. *Id.* at 725.

74. *Id.* at 726 (quoting *Casey*, 505 U.S. at 851 "This Court's substantive-due-process tradition [is to] interpret[] the Due Process Clause to protect certain fundamental rights and 'personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education,' and noted that many of those rights and liberties 'involve[e] the most intimate and personal choices a person may make in a lifetime.'").

75. *Glucksberg*, 521 U.S. at 727.

76. *Id.* at 728.

77. *Id*. at 728-35.

78. *Id.* at 725-26.

79. 521 U.S. 793 (1997).

80. *Cases - Right to Die*, OYEZ, https://www.oyez.org/issues/426 (last visited Dec. 18, 2021).

D. VACCO V. QUILL

Aiding another person to either commit or attempt suicide is a crime, but it is also established law that patients may refuse lifesaving medical treatment.[81] In Vacco, a lawsuit was brought to determine whether New York's statute criminalizing assisting suicide violates the Equal Protection Clause found in the Fourteenth Amendment.[82] Respondents, three New York physicians, sued the state's Attorney General and argued that, "because New York permits a competent person to refuse life-sustaining medical treatment, and because the refusal of such treatment is 'essentially the same thing' as physician-assisted suicide, New York's assisted-suicide ban violates the Equal Protection Clause."[83]

The Equal Protection Clause requires States to "treat like cases alike but may treat unlike cases accordingly."[84] The United States Supreme Court held that neither the New York "ban on assisting suicide nor its statutes permitting patients to refuse medical treatment treat anyone differently from anyone else or draw any distinctions between persons. *Everyone*, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; *no one* is permitted to assist a suicide."[85] Because everyone was treated the same, the New York law was not in violation of the Equal Protection Clause.[86]

The argument that terminally ill patients on life support are treated differently from those terminally ill patients not on life support, because the former may "hasten death" by choosing to end their treatment, but the latter may not, because physician-assisted suicide is not available to them, was not persuasive to the court.[87] The court noted the difference between the two: "[f]irst, when a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication."[88] Further, the court focused on the physicians intent.[89] A physician who withdrawals, or does not begin due to the patient's request, life sustaining treatment intends to respect the "patient's wishes and 'to cease doing . . . futile or degrading things to the patient when [the patient] no longer stands to benefit from [the

81. *Vacco*, 521 U.S. at 796-97.

82. *Id.*; U.S. Const. amend. XIV § 1 ("[N]or [shall any state] deny to any person within its jurisdiction the equal protection of the laws.").

83. *Vacco*, 521 U.S. at 798 (referencing Quill v. Koppell, 870 F.Supp. 78, 84-85 (S.D.N.Y. 1994)).

84. *Id.* at 799 (referencing Plyler v. Doe, 457 U.S. 202, 216 (1982)).

85. *Id.* at 800.

86. *See id.*

87. *Id.* at 800-01.

88. *Id.* at 801.

89. *Id.* at 801-02.

treatment]."[90] Physicians who provide aggressive care may quicken a patient's death but, the physician's intent is to ease the patient's pain.[91] A physician who assists a terminally ill patient with suicide, however, must intend the patient end up dead.[92]

Many States, like New York, have "reaffirmed the line between 'killing' and 'letting die.'"[93] The Court emphasized that they previously recognized "the distinction between letting a patient die and making that patient die."[94] The *Cruzan* decision that assumed a competent person has a constitutionally protected right to refuse treatment[95] was not based on the idea "patients have a general and abstract 'right to hasten death,' but on well-established, traditional rights to bodily integrity and freedom from unwanted touching."[96]

E. GONZALEZ V. OREGON

The most recent case heard by the United States Supreme Court dealing with an individual's "right to die" is *Gonzales v. Oregon*.[97] The issue presented in this case was "whether the Controlled Substances Act allows the United States Attorney General to prohibit doctors from prescribing regulated drugs for use in physician-assisted suicide, notwithstanding a state law permitting the procedure."[98] The Oregon Death With Dignity Act (ODWDA) was passed in 1994, making Oregon the first state to legalize physician-assisted suicide.[99] The bill exempts physicians from any liability who, "in compliance with the specific safeguards in ODWDA, dispense or prescribe a lethal dose of drugs upon the request of a terminally ill patient."[100] The drugs used are regulated by the federal Controlled Substances Act ("CSA"), which requires a registered physician to write a prescription for the drugs before patients can access the medication.[101] The US Attorney General determined "that using controlled substances to assist suicide is not a legitimate medical practice," therefore, dispensing them for this purpose is a violation of CSA, which could cause the prescribing physician to lose their registration and subsequently, their ability to legally prescribe medication.[102]

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90. *Id.* at 801.
91. *Id.* at 802.
92. *Id.*
93. *Id.* at 806 (internal references omitted).
94. *Id.* at 807; *Cruzan*, 497 U.S. at 278.
95. *Vacco*, 521 U.S. at 807 (discussing *Cruzan*, 497 U.S. at 278).
96. *Id.* at 807 (discussing *Cruzan*, 497 U.S. at 778-79).
97. 546 U.S. 243 (2006).
98. *Gonzales*, 546 U.S. at 248-49.
99. *Id.* at 249.
100. *Id.*
101. *Id.*; 21 U.S.C. § 801.
102. *Gonzales*, 546 U.S. at 249, 254.

CSA requires physicians obtain a registration from the US Attorney General in order for them to issue lawful prescriptions.[103] The US Attorney General has the ability to "deny, suspend, or revoke this registration if, as relevant here, the physician's registration would be 'inconsistent with the public interest."[104] With the US Attorney General's interpretation of CSA leaving the ODWDA ineffective, the State of Oregon, along with a physician, pharmacist, and several terminally ill patients challenged the interpretation.[105] The Court stated:

> The Attorney General has rulemaking power to fulfill his duties under [CSA]. The specific respects in which he is authorized to make rules, however, instruct us that he is not authorized to make a rule declaring illegitimate a medical standard for care and treatment of patients that is specifically authorized under state law.[106]

The Court concluded that the US Attorney General did not have the authority to interpret CSA in a way which, in essence, prohibited physician-assisted suicide.[107] Further, the Court concluded the statute "support[s] the conclusion that Congress regulates medical practice insofar as it bars doctors from using their prescription-writing powers as a means to engage in illicit drug dealing and trafficking as conventionally understood. Beyond this, however, the statute manifests no intent to regulate the practice of medicine generally."[108] In looking at the text of CSA, the court concluded Congress did not have the intent to alter the federal-state balance of defining standards of medical practice, and therefore, the US Attorney General did not have the authority to substantially disrupt the Oregon Death with Dignity Act through the interpretation asserted.[109]

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103. *Id.* at 250-51.

104. *Id*. at 251 (referencing 21 U.S.C. § 824(a)(4); 21 U.S.C. § 822(a)(2)); 21 U.S.C. § 823(f)) ("In determining the public interest, the following factors shall be considered: (1) The recommendation of the appropriate State licensing board or professional disciplinary authority. (2) The applicant's experience in dispensing or conducting research with respect to controlled substances. (3) The applicant's conviction record under Federal or State laws relating to the manufacture, distribution, or dispensing of controlled substances. (4) Compliance with applicable State, Federal, or local laws relating to controlled substances. (5) Such other conduct which may threaten the public health and safety.").

105. *Id.* at 254.

106. *Id.* at 258.

107. *Id.* at 275.

108. *Id.* at 269-70.

109. *Id.* at 255, 275.

III. DEATH WITH DIGNITY IN THE UNITED STATES

Ten jurisdictions within the United States and a growing number of foreign countries have some form of legalized physician-assisted suicide.[110] The movement toward legalizing these laws continue to grow, as the majority of the United States jurisdiction that have passed physician-assisted suicide laws have done so within the last ten years.[111] Oregon, being the first state to pass a death with dignity law,[112] has been a model for many of the other bills, including the proposed North Dakota bill.[113] Reviewing the proposed North Dakota bill and how death with dignity laws in other states are working, will provide helpful insight into what the Death with Dignity bills are really about, and what they are really asking for from the legislature.

A. HOUSE BILL 1415

In February 2021, the North Dakota House of Representatives did not pass House Bill 1415, which would have created chapter 23-06.7 of the North Dakota Century Code, and would have given terminally ill North Dakota residents a chance to choose physician-assisted suicide, 9-85.[114] The bill begins with identifying pertinent definitions.[115] The next section, "Qualifications for written requests for medication" described the heart of the bill:

> A patient who is capable and has been determined by the attending physician and consulting physician to have a terminal disease and who voluntarily expresses the wish to die, may make a written request to the attending physician for medication prescribed under this chapter to end the patient's life in a humane and dignified manner in accordance with this chapter.[116]

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110. *In Your State*, DEATH WITH DIGNITY, (Apr. 18, 2022) https://deathwithdignity.org/states/ (These U.S. jurisdictions have death with dignity enacted laws: California, Colorado, District of Columbia, Hawaii, Maine, New Jersey, New Mexico, Oregon, Vermont, Washington); *Euthanasia & (PAS), supra* note 7 (The following countries have some forms of physician-assisted suicide legalized: Austria, Belgium, Canada, Finland, Germany, Luxembourg, The Netherlands, New Zealand, Spain, Switzerland.).

111. *Our History,* DEATH WITH DIGNITY, https://deathwithdignity.org/history/ (last visited Apr. 19, 2022) (2013: Vermont is the third state to enact a death with dignity law. 2015: California, the fourth state, passes End of Life Option Act, a Death with Dignity law. 2016: D.C. and Colorado pass Death with Dignity laws. 2018: Hawaii becomes the 7th jurisdiction to enact an assisted dying law. 2019: New Jersey and Main become the eighth and ninth jurisdiction to enact assisted dying laws. 2021: New Mexico becomes the tenth jurisdiction to enact an assisted dying law.).

112. *Id.*

113. Tris Anderson, *House Bill 1415 Fails in House 9-85*, WAHPETON DAILY NEWS (Feb 23, 2021), https://www.wahpetondailynews.com/news_monitor/news/house-bill-1415-fails-in-house-9-85/article_4eefb50a-7612-11eb-8584-53f9d52053a0 html.

114. *Id.*

115. H.B. 1415, 67th Legis. Assemb. (N.D. 2021).

116. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-02(1)).

This section contains several notable words found in the "definition" section of the bill. Some of the more pertinent definitions include, "patient" which is defined as "an adult resident of the state under the care of a physician."[117] The patient must be "capable," meaning either by opinion of a court or of either a patient's attending or consulting physician, "a patient has the ability to make and communicate a health care decision to a health care provider, including communication through an individual familiar with the patient's manner of communicating if the individual is available."[118] The patient must be diagnosed by a North Dakota licensed physician[119] to have a terminal disease, which means, "a medically confirmed incurable and irreversible disease which, within reasonable medical judgment, will produce death within six months."[120]

Section 23-06.7-02 further clarifies that an individual cannot qualify under this bill simply because of one's age or disability.[121] The section ends with ways an individual can prove residency,[122] which is necessary in order to be a "patient" under the statute.[123] The following section, "23-06.7-03 Requirements for written and oral requests - Right to rescind" requires a patient seeking to request medication to end their life in a humane manner to first "make an oral request to the attending physician."[124] Second, the patient must "[m]ake a second oral request at least fifteen days after the patient's initial oral request; and [third] [s]ubmit a written request, signed and dated by the patient, to the attending physician at least forty-eight hours before medication may be prescribed or dispensed."[125] The written request for medication must be in accordance with a specific form provided at the end of the bill.[126] A

117. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-01(11)).

118. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-01(3)).

119. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-01(12)).

120. *Id*. (at what would have been N.D. CENT. CODE § 23-06.7-01(14)).

121. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-02(2)).

122. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-02(3)) ("An individual may demonstrate North Dakota residency by offering: a. The individual's North Dakota driver's license; b. Evidence the individual owns or leases property in the state; or c. The filing of a North Dakota individual tax return for the most recent tax year.").

123. *Id*. (at what would have been N.D. CENT. CODE § 23-06.7-01(11)).

124. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-03(1)(a)).

125. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-03(1)(b)-(c)).

126. *Id*. (at what would have been N.D. CENT. CODE §§ 23-06.7-03(2)(a)) (stating the form must be "witnessed by at least two individuals who, in the presence of the patient, attest to the best of each individual's knowledge and belief, the patient is capable, acting voluntarily, and is not being coerced to sign the request." One of the witnesses must not be a relative to the patient, or "entitled to any portion of the estate of the patient upon death under any will or by operation of law, or [] [a]n owner, operator, or employee of a health care facility at which the patient is receiving medical treatment or is a resident."), -03(2)(b) ("[i]f the patient is a resident of a long-term care facility at the time the written request is made, one of the witnesses must be . . . designated by the facility."), -03(2)(c) (patient's attending physician cannot be a witness.).

patient has the right to rescind their request "at any time and in any manner without regard to the patient's mental state."[127]

The next section, "Attending physician responsibilities," requires the attending physician who receives a written request for life ending medication to take several steps before prescribing the medication.[128] The attending physician must determine that the patient is a North Dakota resident that has a terminal illness and is both capable of making the request to receive life ending medication, and "has made the request voluntarily".[129] The attending physician must also "[i]nform the patient of: (1) The patient's medical diagnosis; (2) The patient's prognosis; (3) Potential risks associated with taking the mediation to be prescribed; (4) The probable result of taking the medication to be prescribed; and (5) Feasible alternatives, including comfort care, hospice care, and pain control[.]"[130] Further, the attending physician must "[r]efer the patient to a consulting physician for medical confirmation of the diagnosis and a determination the patient is capable and acting voluntarily" and must also "[r]efer the patient for counseling, if appropriate".[131]

The attending physician must also recommend the patient contact their next of kin to tell them about the decision to request life-ending medication,[132] must "[c]ounsel the patient about the importance of having another individual present" while taking the medication and not take "medication in a public place,"[133] and must inform the patient of their ability "to rescind the request at any time and in any manner."[134] Finally, the attending physician must verify the "patient is making an informed decision"[135] and "[e]nsure all appropriate steps are carried out in accordance with this chapter before prescribing the medication to enable a qualified patient to end the patient's life in a humane and dignified manner."[136] The attending physician must follow each step before writing the prescription, and the bill states "the attending physician may sign the patient's death certificate."[137]

The next section, "23-06.7-05 Consulting physician confirmation," requires a consulting physician to first, "examine the patient and . . . [their] relevant medical records and confirm, in writing," the attending physician's

127. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-03(3)).
128. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-04(1)).
129. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-04(1)(a)-(b)).
130. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-04(1)(c)).
131. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-04(1)(d)-(e)).
132. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-04(1)(f)).
133. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-04(1)(g)).
134. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-04(1)(h)).
135. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-04(1)(i)).
136. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-04(1)(k)) (including the verification requirements of medication record documentations set out in 23-06.7-09).
137. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-04(2)).

diagnosis that the patient has a terminal illness,[138] and second, confirm, in writing, that the patient is both capable of making this decision, and is voluntarily making the decision to accept medication to end their life.[139] Finally, the consulting physician must recommend counseling to the patient and refer them if so required by 23-06.7-06.[140]

Section 23-06.7-06 requires that if either the attending or consulting physician believes the patient requesting medication suffers from a "psychiatric or psychological disorder or depression causing impaired judgment, the physician shall refer the patient to counseling."[141] "The attending physician may not prescribe medication" until the individual conducting the counseling determines there is no disorder or depression impairing the patient's judgment.[142] The following section, "Family notification" does not allow a patient's request for medication to be denied just because the patient does not, or cannot, notify their next of kin.[143]

After ensuring the above requirements have been satisfied, section 23-06.7-08 states the attending physician may "[p]rovide the medication directly to the patient,"[144] or get the patient's written consent to "[c]ontact a pharmacist and inform the pharmacist of the prescription; and [d]eliver the written prescription to the pharmacist to dispense the medication to the patient, the attending physician, or an expressly identified agent of the patient."[145] This section also provides further instructions for pharmacists.[146] The patient's medication records must contain documentation which reflects compliance with all the requirements stated in the bill.[147] Further, the state department of health must annually review "dispensing records received under this chapter"

138. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-05(1)).
139. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-05(2)).
140. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-05(3)).
141. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-06(1)).
142. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-06(2)).
143. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-07).
144. *Id.* (at what would have been N.D. CENT. CODE §§ 23-06.7-08(2), (2)(a)).
145. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-08(2)(b)(1)-(2)).
146. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-08(3)) ("Upon dispensing medication under this chapter, a pharmacist shall file a copy of the de-identified dispensing record with the department.").
147. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-09) ("1. All oral and written requests made by the patient for medication prescribed under this chapter; 2. The attending physician's diagnosis, prognosis, and determination the patient is capable, acting voluntarily, and has made an informed decision; 3. The consulting physician's diagnosis, prognosis, and verification the patient is capable, acting voluntarily, and has made an informed decision; 4. A report of the outcome and determination made during counseling, if performed; 5. The attending physician's offer to the patient to rescind the patient's request at the time of the patient's second oral request pursuant to section 23-06.7.03; and 6. A note by the attending physician indicating all requirements of this chapter are met and the steps taken to carry out the request, including a notation of the medication prescribed.").

and publish an annual report of information collected.[148] The bill addresses several other issues, such as how the bill would effect wills, contracts, insurance, and annuity policies; however, these provisions do not address requirements the patient or physicians must meet in order to obtain or prescribe the kind of medication in question.[149]

The two sections, "Immunities – Basis for prohibiting health care provider from participation - Notification – Permissible sanctions" and "Liabilities – Penalties" cover, along with more information, liabilities to physicians in relation to this bill.[150] Section 23-06.7-14 starts with addressing liability: "A person who acts in good faith compliance with this chapter is not subject to civil or criminal liability or professional discipline for those acts."[151] Section 23-06.7-14(3) provides some protection for patients as well.[152] This bill supports allowing terminally ill patients to have the option to choose medication that would allow them to end their lives in a dignified way,[153] however, the bill does make clear that:

> A health care provider is not under any duty, whether by contract, statute, or any other legal requirement, to participate in the provision to a qualified patient of medication prescribed under this chapter. If a health care provider is unable or unwilling to carry out a patient's request under this chapter, and the patient transfers the patient's care to a new health care provider, the prior health care provider shall transfer, upon the patient's request, a copy of the patient's relevant medical records to the new health care provider."[154]

The bill does go into further discussion on how a health care provider may prohibit an employed physician from participation in this chapter.[155]

Section 23-06.7-17 describes when conduct will lead to a felony:[156]

> 1. It is a class A felony for a person:
>
> a. Without the authorization of the patient, to willfully alter or forge a request for medication under this chapter or to conceal or

148. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-10(1)).

149. *Id.* (at what would have been N.D. CENT. CODE §§ 23-06.7-11 to -12).

150. *Id.* (at what would have been N.D. CENT. CODE §§ 23-06.7-14, -17).

151. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-14(1)).

152. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-14(3)) ("A request by a patient for, or provision by an attending physician of, medication in good faith compliance with this chapter does not constitute neglect for any purpose of law or provide the sole basis for the appointment of a guardian or conservator.").

153. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-02(1)).

154. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-14(4)).

155. *Id.* (at what would have been N.D. CENT. CODE § 23-06.7-14(5)).

156. *Id.* (at what would have been N.D. CENT. CODE § 23.06.7-17(1)).

> destroy a rescission of that request with the intent or effect of causing the patient's death.
>
> b. To coerce or exert undue influence on a patient to request medication under this chapter, or to destroy a rescission of such a request.
>
> c. Without authorization of the principal, to willfully alter, forge, conceal, or destroy an instrument, the reinstatement or revocation of an instrument, or any other evidence or document reflecting the principal's desires and interests with the intent and effect of causing a withholding or withdrawal of life-sustaining procedures or of artificially administered nutrition and hydration that hastens the death of the principal.[157]

Further, the section states that one is guilty of a class A misdemeanor when "a person, without authorization of the principal . . . willfully alter[s], forge[s], conceal[s], or destroy[s] an instrument, the reinstatement or revocation of an instrument, or any other evidence or document reflecting the principal's desires and interests with the intent or effect of affecting a health care decision."[158] This chapter also will "not limit further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person."[159]

B. OTHER STATES RECOGNIZE THE IMPORTANCE OF THE BILL

As previously mentioned, the North Dakota bill was modeled after the Oregon Death with Dignity Act.[160] After comparing the North Dakota Bill and the Oregon Death with Dignity Act, the two documents are nearly identical, with the only notable differences being the Oregon Death with Dignity Act requires the initial patient request for medication to end their life in a humane manner be made both in an oral and written request, while House Bill 1415 only requires an initial oral request.[161] The Oregon Death with Dignity Act also, unlike the North Dakota bill, allows physicians to prescribe the medication to patients early when it is determined that the patient will die before the time requirements laid out in the statute.[162]

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157. *Id.*

158. *Id.* (at what would have been N.D. CENT. CODE § 23.06.7-17(2)).

159. *Id.* (at what would have been N.D. CENT. CODE § 23.06.7-17(3)).

160. Anderson, *supra* note 113.

161. OR. REV. STAT. § 127.840 (2021); H.B. 1415, 67th Legis. Assemb. (N.D. 2021).

162. OR. REV. STAT. § 127.850 (2021) ("[I]f the qualified patient's attending physician has medically confirmed that the qualified patient will, within reasonable medical judgment, die before the expiration of at least one of the waiting periods . . . the prescription for medication . . . may be written at any time following the later of the qualified patient's written request or second oral request . . . .").

The Oregon Death with Dignity Act "works exactly as intended and exactly for whom it was intended, clearing a path for other states to follow."[163] Through the required reports that must be annually released showing the statistics from the Oregon Death with Dignity Act,[164] the reports show that since the Oregon Death with Dignity Act passed, "a total of 2,518 people have received prescriptions under the DWDA [Death with Dignity Act] and 1,657 people (66%) have died from ingesting the medications."[165] In 2019, 290 prescriptions were written by physicians to dying Oregonians who qualified under the Oregon Death with Dignity Act.[166] 188 Oregonians died using the medication obtained in accordance with the Oregon Death with Dignity Act.[167] Most of these patients had cancer and were sixty-five years old or older.[168] The report also shows that "the three most frequently reported end-of-life concerns were ability to participate in activities that made life enjoyable (90%), loss of autonomy (87%) and loss of dignity (72%)."[169] This data is consistent with past Oregon reports.[170]

Comparing these numbers with California, another state who has more recently enacted a death with dignity law, the "California End of Life Option Act 2019 Data Report" demonstrates that these laws are being utilized by qualified patients.[171] In 2019, 618 individuals were prescribed "aid-in-dying drugs."[172] 378 individuals, of the 618 who were prescribed the medication, died upon ingesting the aid-in-dying medication prescribed pursuant to California's law.[173] Also in 2019, 27 individuals with prescriptions from prior years died after ingesting the drugs, resulting in a total of 405 individuals who died in 2019 using the aid-in-dying medication.[174] Most of the

163. *Oregon,* DEATH WITH DIGNITY, https://deathwithdignity.org/states/oregon/ (last visited Apr. 19, 2022).

164. OR. REV. STAT. § 127.865 (2021).

165. *Oregon Death with Dignity Act 2019 Data Summary,* OR. HEALTH AUTH. PUB. HEATH DIV., 5 (2019) https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf.

166. *Id.* at 7.

167. *Id.* at 3.

168. *Id.* ("[S]imilar to those in previous years: most patients were aged 65 years or over (75%) and most had cancer (68%).").

169. *Id.* at 6.

170. *Id.*

171. *California End of Life Option and 2019 Data Report*, CAL. DEP'T OF PUB. HEALTH, (July 2020), https://www.cdph.ca.gov/Programs/CHSI/ (click "End of Life Option Act"; then scroll to "Annual Reports" and select "California End of Life Option Act 2019 Data Report"). California's End of Life Option Act (EOLA) became effective on June 9, 2016. The Act allows terminally ill adults living in California to obtain and self-administer aid-in-dying drugs.

172. *Id.* at 3.

173. *Id.*

174. *Id.* at 4.

individuals who died were within 60-89 years of age.[175] Further, the most common terminal illness of the 405 people who died, had cancer.[176]

Comparing all the data reports from the states which have enacted death with dignity laws, the data shows the law is being used, and the number of cases generally grow from year to year in each state.[177] Allowing qualified patients to choose when to end their lives gives patients "dignity, control, and peace of mind during their final days with family and loved ones."[178] The reports from the jurisdictions that do give qualified patients this option shows the world that these laws are important and useful as we continue to see the number of people who decide to utilize aid in dying medication grow.[179] The North Dakota Legislature, if they would have passed House Bill 1415, would not be forcing someone to partake in aid-in-dying end of life decisions, instead, enacting the bill would have simply given qualified North Dakotans the respect and dignity to choose to end their life in a certain way.[180] By not passing the bill, the legislature required terminally ill individuals to suffer through their disease, which could be a painful, scary way to spend the end of your life.

People should have another choice other than to suffer through their illness or take their life in a different, less dignified way. When a disease takes over one's life, they should be granted the respect to choose how they want to spend their final days in this world, and the manner they want to leave this world. Some people wish to die on their own terms, before they are so riddled with disease that their old way of life becomes unrecognizable. This personal decision should be respected, not taken away by a government.

IV. HOUSE BILL 1415 CONCERNS

House Bill 1415 drew strong opposition from lawmakers and religious groups.[181] The executive director of the North Dakota Catholic Conference was "pleased to see [the bill] fail" because the bill "furthers the culture of

175. *Id.* ("Of the 405 individuals who died pursuant to EOLA during 2019, 11.4 percent were under 60 years of age, 74.5 percent were 60-89 years of age, and 14.1 percent were 90 years of age and older. The median age was 76 years.").

176. *Id.* at 5.

177. *State Report Navigator*, DEATH WITH DIGNITY, https://deathwithdignity.org/state-report-navigator/ (last visited Apr. 19, 2022) (examples include Washington wrote 63 prescriptions in 2009 with 36 deaths utilizing the prescription; these numbers grew and in 2018 Washington wrote 251 prescriptions with 203 patient deaths; Hawaii wrote 8 prescriptions in 2018 with 2 patient deaths, this number grew in 2020 with 37 prescriptions written and 25 patient deaths).

178. *Death with Dignity Laws*, TRIAGE CANCER, https://triagecancer.org/deathwithdignity (last visited Dec. 18, 2021).

179. *See State Report Navigator*, DEATH WITH DIGNITY, https://deathwithdignity.org/state-report-navigator/ (last visited Apr. 19, 2022).

180. H.B. 1415, 67th Legis. Assemb. (N.D. 2021).

181. Anderson, *supra* note 113.

death."[182] A supporter of the bill, a former Democratic-NPL chairman, gave a speech and provided a prospective of someone diagnosed with a terminal illness.[183] During his speech he stated,"[t]he end game, which is inevitable, presents me and those like me with the prospect of deterioration and the certain loss of physical and mental functions that will render me an empty shadow of my former self. The quality of life then: impossible."[184]

The two main concerns reported as to why the House did not pass this bill were: 1) the bill "undermines efforts to fight suicide and every life is worthy of protection" and 2) legalizing this bill would just be a slippery slope to legalizing end of life medication to healthy people, or legalizing euthanasia.[185]

A. DO DEATH WITH DIGNITY LAWS "UNDERMINE EFFORTS TO FIGHT SUICIDE" AND SUPPORT A NOTION THAT LIFE IS NOT WORTHY OF PROTECTION?

Most people can agree, life is precious. However, what House Bill 1415 was trying to do is further the value one can have in their lives by giving qualified patients the option to have control in their end-of-life decisions. "People are not afraid of dying, rather they're afraid of losing their autonomy, dignity and mental and physical faculties."[186] There is a legal definition of "life," which explains that life is "[t]he state of being alive as a human; an individual person's existence."[187] It seems that many who oppose the bill believe that so long as one is breathing, that person has a life that should be continued. This idea that those who support death with dignity laws do not value life seems to be a very "black and white"[188] argument, however, very few issues in this world are so straightforward.

To many, valuing life means so much more than one's body having the ability to function; valuing life encompasses the idea that people can make their life their own by enjoying passions, chasing dreams, and at the very least, having the capacity to have control of their body. One can place value in, and understand the importance of, life while still understanding that someone who has been diagnosed with a terminal illness may not want to have their last moments on Earth riddled with pain, suffering, and surrounded by

182. *Id.*
183. *Id.*
184. *Id.*
185. *Id.*
186. *Id.*
187. *Life*, BLACK'S LAW DICTIONARY (11th ed. 2019).
188. Jonathan Maloney, *Black & White Thinking*, INTELLIGENT SPECULATION: THINK CRITICALLY (Jan. 20, 2020), https://www.intelligentspeculation.com/blog/black-or-white-thinking (defining Black & White Thinking as "An informal fallacy where two options are an 'either/or' situation is presented when more possibilities exist.").

fading reminders of what their life used to be. Deborah Dempsey from Massachusetts stated, "I am an educated, professional woman, and I wish to die in a way that exemplifies how I have lived my life."[189] This statement did not come from a woman who had no value for her life, but quite the opposite. This statement came from an "educated, professional woman" who saw her younger sister suffer and beg to be relieved from her pain that accompanied pancreatic cancer nine years before Deborah herself was diagnosed with the same disease.[190]

Deborah did not want to watch herself deteriorate from her disease like her sister had years before.[191] Deborah's statement was not a message that life is not worthy of protection; instead, Deborah, like many terminally ill patients, did not want to experience, nor have their families and friends watch them fall victim to a disease that had taken control of their life. An individual that falls victim to a terminal illness strips that person from the reality of a normal life. Qualified individuals who seek medication under this act do not believe life is not worth protecting. Many fear that the life that strangers in their capital buildings are trying to "protect" no longer will be meaningful, and the terminally ill just want the respect to die in a dignified manner that would allow them to leave this world behind while being themselves, not a shelled body riddled with a disease that has taken over.[192]

Further, the argument that passing this bill will undermine efforts to prevent suicide also is not so "black and white." Death with dignity laws takes these personal decisions out of the hands of governments, politicians, and religious workers, and provides a choice to the terminally ill and their families about easing their pain and suffering.[193] Suicide is an act that one commits when he or she wants to die.[194] This bill lays out many requirements that one must meet before they are able to access the medication, the sole requirement is not simply just wanting to die.[195]

The people that would be utilizing this bill are already dying. These people must have a diagnosis of a terminal illness that will kill them within six months, along with a confirmation from a separate doctor, and must not suffer from depression or other disorders that can impair their judgment.[196] Those

189. *Deborah Dempsey: A Meaningful Journey*, DEATH WITH DIGNITY, https://deathwithdignity.org/stories/deborah-dempesy-meaningful-journey/ (last visited Apr. 19, 2022).

190. *Id.*

191. *Id.*

192. *About Us: Our Core Values*, DEATH WITH DIGNITY, https://deathwithdignity.org/about/ (last visited Apr. 19, 2022).

193. *See id.*

194. *Facts About Suicide,* CTRS. FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/suicide/facts/index html (last visited Apr. 19, 2022).

195. H.B. 1415, 67th Legis. Assemb. (N.D. 2021).

196. *Id.*

who would have utilized the bill are not killing themselves in the same way that those who commit the traditional act of suicide are because these individuals are already dying. These terminally ill patients have a confirmed estimate of time tagged onto their lives. This bill would have given these individuals control of how much time they would be forced to live with a disease bound to affect every part of their lives.

B. SLIPPERY SLOPE ARGUMENT

Skeptics of the bill argued that legalizing this bill will just be a slippery slope to legalizing end of life medication to healthy people, or legalizing euthanasia.[197] This argument is common, and is usually centered around the fear that these death with dignity laws will become more relaxed and resemble end of life laws found in countries like the Netherlands.[198] The Netherlands have euthanasia and assisted suicide laws which extends to people who are not suffering from terminal illnesses, and even allows children, from as young as age twelve, to request euthanasia.[199] The popular argument that enacting death with dignity laws will cause rational pressures that will force States down a slippery slope looks like this:

> [W]hatever justifications are presented in favor of PAS [physician-assisted suicide] apply equally to voluntary active euthanasia, or to euthanasia with surrogate decision making, or even to the involuntary killing of the mildly disabled. If, therefore, we permit PAS, we shall be rationally compelled to permit these further practices. Therefore, we had better not permit PAS [at all].[200]

These arguments are often made out of fear that enacting death with dignity laws, because it is agreed that these laws are based on justifiable considerations, will inevitably lead to unjustified end-of-life practices.[201] It is easy to make slippery slope arguments, these types of arguments are made all the time for numerous matters, however, if this fear was the reason behind House Bill 1415 failing to even get double digits "yes" votes, the true purpose of the bill could not have been truly considered.

Death with dignity laws protect privacy, personal autonomy and are grounded in belief that people should have the choice to die in a dignified

197. Anderson, *supra* note 113.

198. *Euthanasia, Assisted Suicide and Non-resuscitation on Request*, GOV'T OF THE NETHERLANDS, https://www.government nl/topics/euthanasia/euthanasia-assisted-suicide-and-non-resuscitation-on-request (last visited Mar. 29, 2022).

199. *Id.*

200. Neil Levy, GIVING DEATH A HELPING HAND: PHYSICIAN-ASSISTED SUICIDE AND PUBLIC POLICY. AN INTERNATIONAL PERSPECTIVE, 11, 12 (Dieter Birnbacher & Edgar Dahl eds., 2008).

201. *See id*.

way.[202] Laws enacted in North Dakota should reflect the beliefs of the people, and those who presented the bill during the North Dakota legislative session believe end of life decisions are a private matter.[203] If the argument is that what House Bill 1415 stood for was justified, but the fear that accepting it would lead to later unjustifiable practices, this fear puts the duty back on North Dakota Congress members to remember where House Bill 1415 came from and what the core values of the bill really are. Amendments to the statues that would make up the bill should only be passed to the extent necessary to continue these values of the original bill. This bill stands for self-autonomy and retaining dignity in making choices before a terminal illness can eat away at all parts of one's life. So, if the worry that the next discussion will include assisted suicide for healthy people, then the House members missed the entire point of the bill.

The bill is not an easy way out for those who just do not wish to live any longer. This bill requires a lot of action on behalf of multiple individuals before a prescription can even be written. This bill was presented with hopes North Dakota will recognize that for some, living with a terminal illness is not living at all, and they would prefer to leave this world behind in a state that they can at least recognize. If the House is worried about House Bill 1415 leading North Dakota down a slippery slope that would include allowing healthy people to access similar treatment in the future, then the House is not paying attention to the pleas of the terminally ill who are providing legitimate reasons to pass the bill. This bill is not for the healthy. This bill is for the dying, the terminally ill patients in North Dakota who are past being treated, and just want to die in a peaceful, dignified way.

V. CONCLUSION

The bill the North Dakota legislature did not pass was not for those who have a long, healthy life to live.[204] This bill was for those who are terminally ill that have hope to preserve the memories of their time on Earth when disease was not taking control over their lives.[205] Passing a death with dignity bill does not mean North Dakota does not value human life. The bill preserves human life by allowing qualified patients to opt out of experiencing the hardships that accompany a terminal illness that can overpower their last moments on Earth. When one's life is ending because of a terminal illness, no one but the individuals themselves can understand the feelings and choices that come with that reality, not even those on the legislative floor. This bill

202. *About Us: Our Core Values*, *supra* note 192.
203. Anderson, *supra* note 113.
204. H.B. 1415, 67th Legis. Assemb. (N.D. 2021).
205. *Id.*

requires qualified patients and their physicians to take numerous steps. These requirements are set in place to ensure the decision is an informed one.[206] The idea of a death with dignity law in North Dakota will likely not end with House Bill 1415. Hopefully, the next time the opportunity to give qualifying terminally ill patients the freedom to choose to die in a dignified way is presented to the North Dakota legislature, they will decide to support those individuals' end of life choices.

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206. *Id.*

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