
FROM KAREN ANN QUINLAN TO BRITTANY MAYNARD: ADVANCED HEALTH CARE DIRECTIVES AND THE ROAD TO AID-IN- DYING LEGISLATION IN IOWA

ABSTRACT

In October 2014, the aid-in-dying debate in the United States reignited following an online video post by Brittany Maynard, age 29, who had terminal brain cancer and moved to Oregon to utilize Oregon's Death with Dignity law. The aid-in-dying debate is nothing new to the United States. As medicine has advanced in the twentieth and twenty-first centuries, doctors are able to keep people alive longer, but at what cost? When is it no longer permissible or good to keep a person alive, and what rights do individuals have in refusing medical treatment and choosing to die?

This Note will address the advances and changes in end-of-life decisions: first focusing on the right to refuse medical treatment and the use of advance directives, then moving to the history of aid-in-dying legislation and how states have implemented this legislation, focusing on Oregon's Death with Dignity Act. Later, this Note addresses how Iowa law views the right to refuse medical treatment and aid in dying, briefly looking into the proposed Iowa Death with Dignity Act that entered the Iowa Legislature in January 2015. The time has come to have a discussion on death, how each individual wants to die, and what can be done to ensure the last chapters of life are lived in a way that accords with individuals' beliefs.

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I. INTRODUCTION

“I can’t even tell you the amount of relief that it provides me to know that I don’t have to die the way that it’s been described to me that my brain tumor would take me on its own.”¹

“Every human being of adult years and sound mind has a right to determine what shall be done with his own body. . . .”²

During the twentieth century, “beginning-of-life” issues involving

1. *Videos*, THE BRITTANY FUND, <http://www.thebrittanyfund.org/category/videos/> (last visited Dec. 29, 2015). Brittany Maynard spoke these words in a video put out by the organization Compassion & Choices that has been viewed over 11.5 million times and shared worldwide. See *The Brittany Maynard Fund*, YOUTUBE (Oct. 6, 2014), <https://www.youtube.com/watch?v=yPfe3rCcUeQ>. She posted the video in advocacy for Death with Dignity, probably not realizing that it would reignite a nationwide debate on whether aid in dying should be legalized. See Lindsey Bever, *How Brittany Maynard May Change the Right-to-Die Debate*, WASH. POST (Nov. 3, 2014), <https://www.washingtonpost.com/news/morning-mix/wp/2014/11/03/how-brittany-maynard-may-change-the-right-to-die-debate-after-death/> [hereinafter Bever, *Right-to-Die Debate*]. At the time, Brittany had been diagnosed with a terminal brain cancer known as glioblastoma, had a prognosis of less than six months to live, and moved to Oregon in order to access their Death with Dignity law. Lindsey Bever, *Brittany Maynard, As Promised, Ends Her Life at 29*, WASH. POST (Nov. 2, 2014), <https://www.washingtonpost.com/news/morning-mix/wp/2014/11/02/brittany-maynard-as-promised-ends-her-life-at-29/>. Brittany took the medication prescribed by her physician under Oregon’s Death with Dignity Act on November 1, 2014—ending her life on her own terms. *Id.*

2. *Schloendorff v. Soc’y of N.Y. Hosp.*, 211 N.Y. 125, 129 (1914).

childbirth, birth control, and abortion dominated the field of biomedical politics and the law.³ Today, the focus has shifted to the opposite side of the spectrum with end-of-life issues such as palliative care, advance health care directives, aid in dying, and euthanasia.⁴ Part of the reason for this shift is the aging baby boomer generation—the proponents of beginning-of-life issues who are now facing issues on the other end of the spectrum.⁵ Society turns away from issues involving mortality and death, and as a result, people are not aware of their rights regarding end-of-life care decisions.⁶ Many Americans do not have any basic estate planning documents, such as a will, a living will, or financial and medical powers of attorney, in place.⁷ Families are not having conversations regarding death—including whether they would want to be on a ventilator, what types of extraordinary medical treatments should be given, what happens to children if both parents die, or whether they want to be cremated or buried in a casket.⁸ Instead, families are forced to face these issues of mortality when confronted with a crisis.⁹ What most people do not realize is if they had been aware of their rights and had those important conversations about death, then there would be no question as to what decisions to make regarding health care and dying.¹⁰

In addition to understanding end-of-life decisions, there has been an increased movement involving aid-in-dying legislation.¹¹ Since beginning

3. See SUSAN M. BEHUNIAK & ARTHUR G. SVENSON, PHYSICIAN-ASSISTED SUICIDE: THE ANATOMY OF A CONSTITUTIONAL LAW ISSUE 1 (2003).

4. *Id.*

5. *Id.*

6. CENTERS FOR DISEASE CONTROL, ADVANCE CARE PLANNING: ENSURING YOUR WISHES ARE KNOWN AND HONORED IF YOU ARE UNABLE TO SPEAK FOR YOURSELF 1, 2–4, <http://www.cdc.gov/aging/pdf/advanced-care-planning-critical-issue-brief.pdf> (last visited Dec. 29, 2015) (stating that many American adults lack important end-of-life care documents due to lack of awareness, denial, confusion, and cultural differences).

7. Richard Eisenberg, *Americans' Ostrich Approach to Estate Planning*, FORBES (April 9, 2014) (citing a ROCKET LAWYER survey), <http://www.forbes.com/sites/nextavenue/2014/04/09/americans-ostrich-approach-to-estate-planning/>. As of 2014, “51% of Americans age 55 to 64 [did not] have wills. . . .” *Id.* In the 45 to 54 year age range, 62 percent did not have wills. *Id.* Overall, the study estimates that 64 percent of the public does not have a will. *Id.*

8. See CENTERS FOR DISEASE CONTROL, *supra* note 6, at 2–4.

9. See *id.*

10. See *id.* at 1–2.

11. See, e.g., *In Your State*, COMPASSION & CHOICES, <https://www.compassionandchoices.org/what-you-can-do/in-your-state/> (last visited Dec. 29, 2015).

work on this Note, 29-year-old Californian Brittany Maynard moved to Oregon to access Oregon's Death with Dignity Act and posted a video regarding her right to choose death through, the end-of-life choice organization, Compassion & Choices.¹² This video brought the nation's attention to aid in dying and whether or not it should be legalized.¹³ This implicitly deals with people's rights to make decisions regarding their own bodies.¹⁴ This right of autonomy has been apparent since the late 1800s when the Supreme Court held that "[n]o 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 own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."¹⁵

This Note serves the purpose of discussing death and the advances that have taken place regarding end-of-life decisions—starting with the right to refuse medical treatment, as seen in the New Jersey Supreme Court case *In re Quinlan* and the United States Supreme Court case *Cruzan v. Dir., Mo. Dept. of Health*.¹⁶ Then the Note will move on to further advances in end-of-life care, focusing on the progression of aid-in-dying legislation in the United States, calling for the state of Iowa to adopt aid-in-dying legislation, and looking briefly into Iowa House File 65, a bill introduced in the Iowa Legislature on January 21, 2015, that would create Iowa's own Death with Dignity law.¹⁷

II. THE RIGHT TO REFUSE MEDICAL TREATMENT AND ADVANCE HEALTH CARE DIRECTIVES

A. *Karen Ann Quinlan, Nancy Cruzan, and the Right to Refuse Medical Treatment*

One of the first cases to explore the concept of the right to refuse medical treatment and discontinue life support was *In re Quinlan*, a New Jersey

12. THE BRITTANY FUND, *supra* note 1. The Brittany Fund website is an initiative of Compassion & Choices to provide information on Maynard and her story, as well as the Compassion & Choices organization and Death with Dignity. *Id.*

13. See Bever, *Right-to-Die Debate*, *supra* note 1.

14. See *id.*

15. *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891).

16. See generally *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 268 (1990); *In re Quinlan*, 335 A.2d 647, 651 (N.J. 1976). See discussion *infra* Part II.A.

17. H.F. 65, 86th Gen. Assemb., Reg. Sess. (Iowa 2015); see discussion *infra* Part IV.E.

Supreme Court case.¹⁸ In April 1975, at the age of 21, Karen Ann Quinlan became unconscious following a party and lapsed into a persistent vegetative state.¹⁹ After spending months in a vegetative state, her father sought to be appointed guardian so that he could “authorize the discontinuance of all extraordinary medical procedures” that were keeping her alive, as there was no hope that she would ever recover.²⁰ The case raised questions relating to the definition and existence of death, the prolonging of life through artificial means, and the existence of a right to die.²¹

The court ruled that Karen’s father was able to assume the role of guardian and request to have all forms of life support removed.²² It ruled that she had a right to privacy that “included the decision to refuse extraordinary medical treatment and that her father as her surrogate could exercise that right on behalf of his incompetent daughter.”²³ Karen was removed from her ventilator, was able to breathe unassisted, and lived another nine years before dying of pneumonia in 1985.²⁴ *Quinlan* set the stage for the U.S. Supreme Court’s *Cruzan* case.

In 1990, the U.S. Supreme Court had its first foray into the right to refuse or discontinue medical treatment in the case of Nancy Cruzan.²⁵ Cruzan was a Missouri woman who was in a severe car accident in 1983 that rendered her in a persistent vegetative state.²⁶ Her parents “sought a court order directing the withdrawal of their daughter’s artificial feeding and hydration equipment after it became apparent that she had virtually no chance of recovering her cognitive faculties.”²⁷ The issue before the Court was whether Cruzan had a right under the Constitution, “which would require the hospital to withdraw life-sustaining treatment from her.”²⁸ The Court affirmed the Missouri Supreme Court’s prior ruling that there must be a focus on the patient’s expressed intent, and that there needed to be clear and convincing evidence of Cruzan’s desire to not be in a persistent vegetative

18. *In re Quinlan*, 355 A.2d at 651.

19. *Id.* at 653–54.

20. *Id.* at 651.

21. *Id.* at 652.

22. *Id.* at 671–72.

23. BEHUNIAK & SVENSON, *supra* note 3, at 15.

24. *Id.*

25. *Id.* at 44.

26. *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 266 (1990).

27. *Id.* at 265.

28. *Id.* at 269.

state.²⁹

The Court focused on the fact that “[t]he choice between life and death is a deeply personal decision of obvious and overwhelming finality” and that “Missouri may legitimately seek to safeguard the personal element of this choice through the imposition of heightened evidentiary requirements.”³⁰ The Court needed to see clear and convincing evidence of Cruzan’s desire to be removed from life support, and the facts before it at that time did not meet that standard.³¹

Justice Stevens wrote a powerful dissent in *Cruzan*, focusing on an individual’s liberty interest protected by the Due Process Clause of the Fourteenth Amendment.³² He spoke empathetically on the profound nature of a person’s choices, and those close to them, on deciding life and death, stating:

The meaning of respect for her personhood, and for that of others who are gravely ill and incapacitated, is, admittedly, not easily defined: Choices about life and death are profound ones, not susceptible of resolution by recourse to medical or legal rules. It may be that the best we can do is to ensure that these choices are made by those who will care enough about the patient to investigate his or her interest with particularity and caution.³³

After the Court ruled that Cruzan could not be removed from artificial feeding and hydration due to a lack of clear and convincing evidence of her wishes, the case went back to the Missouri court.³⁴ The family found further evidence based on Nancy’s statements prior to the accident that she would have wanted to be removed from life support, and won the court order.³⁵ Her quality of life in a persistent vegetative state for those seven years was minimal, as “her body was rigid and her feet and hands contracted and bent. She had occasional seizures and vomited, and while her eyes sometimes opened and moved, she showed no sign of recognizing her family.”³⁶ After spending eight years in a persistent vegetative state, Nancy Cruzan was removed from

29. *Id.* at 275.

30. *Id.* at 281.

31. *Id.* at 285.

32. *Id.* at 331 (Stevens, J., dissenting).

33. *Id.* at 354.

34. Tamar Lewin, *Nancy Cruzan Dies, Outlived by a Debate Over the Right to Die*, N.Y. TIMES (Dec. 27, 1990), <http://www.nytimes.com/1990/12/27/US/nancy-cruzan-dies-outlived-by-a-debate-over-the-right-to-die.html>.

35. *Id.*

36. *Id.*

artificial hydration and nutrition and died 12 days later.³⁷

Quinlan and *Cruzan* both demonstrate that there is a right to refuse medical treatment and not prolong continued suffering.³⁸ These cases show that clear evidence of an individual's desire to not have prolonged life-sustaining treatment needed in order to remove them from those treatments.³⁹ These cases raise the question of how to address end-of-life care wishes and concerns prior to a crisis occurring, and how society can respect and fulfill those wishes.⁴⁰

B. Patient Self-Determination Act of 1990

Following the ruling in *Cruzan*, which established there was a right to refuse medical treatment, Congress enacted the Patient Self-Determination Act of 1990 (PSDA).⁴¹ The Act requires that institutions provide patients with information of their "right to make decisions regarding their treatment, and the facility's, agency's, or plan's policies regarding their recognition of advance directives at the time of inpatient admission or enrollment."⁴² The Act requires:

- (1) at the time of admission, patients be given a written summary of healthcare decision-making rights specific to the state and the facility's policies with respect to recognizing advance directives, (2) patients be asked if they have an advance directive and that their response be documented, (3) hospitals make an effort to educate staff and the community about advance directives, and (4) no discrimination based on whether or not a patient has an advance directive, and (5) providers educate themselves, their staff, and the community on issues concerning advance directives.⁴³

The Act did not create any new rights, but empowered patients to know their

37. *Id.*

38. *See supra* Part II.A.

39. *See supra* Part II.A.

40. *See supra* Part II.A.

41. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, §§ 4206, 4751, 104 Stat. 1388-115-17, 1388-204-06 (1990) (codified at 42 U.S.C. §§ 1395cc, 1396a (2012)).

42. Katherine Hayes et al., *Providing Patient-Centered Care: An Examination of the Policy and Political Barriers and Proposed Option to Improve Care for Persons with Advanced Illness*, NAT'L ACAD. ELDER L. ATT'YS J., 1,7 (Spring 2014).

43. Sigrid Fry-Revere, Thomas Reher & Matthew Rey, *Death: A New Legal Perspective*, 27 J. CONTEMP. HEALTH LAW & POL'Y 1, 19 (2010).

rights and options through better information and communication with their physicians.⁴⁴

Congress recognized that end-of-life care decisions are not often discussed prior to the time patients lose the capacity to make those decisions.⁴⁵ Congress wanted to prevent tragic situations like Quinlan's and Cruzan's from happening again.⁴⁶ The PSDA "continues the trend to have patients, doctors, and families communicate and develop decisions that preserve the well-being and dignity of the person, the integrity of the medical profession, and the laws of the State."⁴⁷

Overall, the PSDA's function was to strengthen individuals' ability to participate in their own health care decisions.⁴⁸ It brought awareness nationally to the importance of end-of-life issues and put the issue in the hands of the states to implement legislation that functioned alongside the PSDA.⁴⁹

C. Applied in Iowa: Iowa Code § 144A.3

Quinlan, *Cruzan*, and the PSDA increased the knowledge of advance health care directives and the right to refuse medical treatment.⁵⁰ The Iowa Life Sustaining Procedures Act⁵¹ was amended after the Court's decision in *Cruzan*.⁵² The Iowa Code now states that "[a] competent adult may execute a declaration at any time directing that life-sustaining procedures be withheld or withdrawn. The declaration shall be given operative effect only if the declarant's condition is determined to be terminal and the declarant is not

44. 136 CONG. REC. E943-01 (daily ed. Apr. 3, 1990) (statement of Rep. Levin).

45. See *id.*; see also *The Conversation Project National Survey 2013*, THE CONVERSATION PROJECT (Sept. 18, 2013), http://theconversationproject.org/wp-content/uploads/2013/09/TCP-Survey-Release_FINAL-9-18-13.pdf. The survey found that 90 percent of people believe that talking with their loved ones about end-of-life care is important, but only 30 percent have actually done so. *Id.* "The Conversation Project is dedicated to helping people talk about their wishes for end-of-life care." *About Us*, THE CONVERSATION PROJECT, <http://theconversationproject.org/about/> (last visited Dec. 19, 2015).

46. See, e.g., 136 CONG. REC. E943-01 (statement of Rep. Levin).

47. *Id.*

48. Jennifer Hoehne, Note, *Physician Responsibility and the Right to "Death Care": The Call for Physician-Assisted Suicide*, 42 DRAKE L. REV. 225, 237 (1993).

49. *Id.* at 237–38.

50. See *id.*

51. IOWA CODE § 144A.3 (2015).

52. See 1992 Iowa Acts 175–76; see also *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 280 (1990).

able to make treatment decisions.”⁵³ If a person chooses to forego life-sustaining treatment, the Act provides a standard declaration that will ensure these wishes are followed:

If I should have an incurable or irreversible condition that will result either in death within a relatively short period of time or a state of permanent unconsciousness from which, to a reasonable degree of medical certainty, there can be no recovery, it is my desire that my life not be prolonged by the administration of life-sustaining procedures. If I am unable to participate in my health care decisions, I direct my attending physician to withhold or withdraw life-sustaining procedures that merely prolong the dying process and are not necessary to my comfort or freedom from pain.⁵⁴

The Life-Sustaining Procedures Act is Iowa’s way of dealing with end-of-life care and refusing treatment, but creating advance directives and invoking a patient’s right to refuse medical treatment are not the only issues involving death. While *Cruzan* demonstrated that people have a right to refuse treatment,⁵⁵ later Supreme Court cases challenged a deeper question regarding death: whether or not there is a fundamental right to die.⁵⁶

III. CROSSING THE LINE FROM RIGHT TO REFUSE MEDICAL TREATMENT TO AID IN DYING

A. *An Introduction to Aid in Dying and Death with Dignity*

From the right to refuse medical treatment set out in *Cruzan*, the conversation turned to whether or not an individual should be able to choose their own death through the voluntary administration of a lethal prescription prescribed by physicians—a process commonly called aid in dying.⁵⁷ One of the first things to make clear is the choice of the phrase “aid in dying” over terms such as “physician-assisted suicide,” “euthanasia,” or “mercy killing.” Aid in dying is not physician-assisted suicide, euthanasia, or a form of mercy killing.⁵⁸ The term “assisted suicide” is offensive to patients and value

53. IOWA CODE § 144A.3(1).

54. *Id.* at § 144A.3(5).

55. See *Cruzan*, 497 U.S. at 278.

56. See *infra* Part III.

57. See COMPASSION & CHOICES, AID IN DYING: HISTORY & BACKGROUND FOR STUDENTS, ACTIVISTS AND PROFESSIONALS 10–19, <https://compassionandchoices.org/userfiles/Aid-in-Dying-History-and-Background.pdf> (last visited Dec. 29, 2015) (describing the timeline of the aid in dying movement).

58. Kathryn L. Tucker, *When Dying Takes too Long: Activism for Social Change*

laden.⁵⁹ There are profound psychological differences between suicide and aid in dying: “It is important to remember that the reasoning on which a terminally ill person (whose judgments are not impaired by mental disorders) bases a decision to end his or her life is fundamentally different from the reasoning a clinically depressed person uses to justify suicide.”⁶⁰ Using the word suicide casts a dark shadow on what the issue of aid in dying is about: allowing terminally ill people to have the chance to die with dignity.⁶¹ Additionally, the word euthanasia stems from “Greek words ‘eu,’ meaning well or good and ‘thanatos,’ meaning death.”⁶² Simply stated, euthanasia means “good death.”⁶³ The word euthanasia has strayed from its roots into a word with excessive negative connotations and history.⁶⁴ “Because euthanasia is regularly associated with genocide in Nazi concentration camps, the modern meaning imbues a much different picture than the humane death a person with a terminal illness seeks.”⁶⁵

Finally, states with aid-in-dying legislation in place do not recognize actions taken under the act as being assisted suicide or mercy killing.⁶⁶ The Oregon Death with Dignity Act, which regulates the practices of aid in dying, states: “Actions taken in accordance with [the Dignity Act] shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law.”⁶⁷ In Washington, the State Psychological Association issued a statement focusing on the use of accurate terminology, stating:

A person with a terminal illness is going to die even with, or despite, the best medical treatment available. The designation of suicide is disre-

to Protect and Expand Choice at the End of Life, 33 WHITTIER L. REV. 109, 154 (2011) [hereinafter Tucker, *Activism*].

59. *Id.*

60. *Id.* at 144–45 (quoting Rhea K. Farberman, *Terminal Illness and Hastened Death Requests: The Important Role of the Mental Health Professional*, 28 PROF. PSYCHOL. RES. & PRAC. 544, 544 (1997)).

61. *See id.*

62. Kathryn Tucker & Fred Steele, *Patient Choice at the End of Life: Getting the Language Right*, 28 J. LEGAL MED. 305, 312–13 (2007).

63. *Id.* at 312.

64. *Id.*

65. *Id.*

66. *See, e.g.,* The Oregon Death with Dignity Act, OR. REV. STAT. ANN. § 127.880 (West 2015) (“Nothing in [this Act] shall be constructed to authorize a physician or any other person to end a patient’s life by lethal injection, mercy killing or active euthanasia.”).

67. *Id.*

spectful to individuals with terminal illness who wish to have choice regarding death with dignity, and can be distressing and problematic emotionally, socially, psychologically, and financially, for family members and loved ones of dying individuals.⁶⁸

Therefore, for this Note, the phrase aid in dying will be used over physician-assisted suicide, euthanasia, or mercy killing out of respect for the patients and families who experience this issue, except when directly citing material that chooses to use those phrases.

In 1996, two cases involving aid in dying filed for certiorari with the U.S. Supreme Court: *Vacco v. Quill*, from the Second Circuit Court of Appeals,⁶⁹ and *Washington v. Glucksberg*, from the Ninth Circuit Court of Appeals.⁷⁰ These were the first two cases dealing with aid in dying to come before the Court.⁷¹ The legalization of aid in dying was a prevailing issue with an increased focus on patients' rights at the end of life.⁷² Even as states recognized the importance of protecting patients' dignity at the end of life following *Cruzan* and the establishment of the PSDA, New York and Washington remained opposed to aid in dying.⁷³ These two cases challenged whether there was a fundamental right to die and whether physicians should be allowed to provide medication to patients to help them die.⁷⁴ "These cases asserted that liberty and equality guaranteed by the Fourteenth Amendment . . . protected the right of an individual to choose aid in dying."⁷⁵ Though later reversed by the Supreme Court, these circuit courts held that

68. JUDITH R. GORDON, WASH. ST. PSYCHOL. ASS'N, NEW WSPA POLICY ON VALUE-NEUTRAL LANGUAGE REGARDING END-OF-LIFE CHOICES 1 (2007), <http://www.wapsych.org/search/all.asp?bst=Value+neutral+language+regarding+end+of+life+choic>.

69. Petition for Writ of Certiorari at i, *Vacco v. Quill*, 521 U.S. 793 (1997) (No. 95-1858), 1996 WL 3341377, at *i; see also BEHUNIAK & SVENSON, *supra* note 3, at 88.

70. Petition for Writ of Certiorari at i, *Washington v. Glucksberg*, 521 U.S. 702 (1997) (No. 96-110), 1996 WL 33414068, at *i; see also BEHUNIAK & SVENSON, *supra* note 3, at 88.

71. See *Glucksberg*, 521 U.S. at 720 (quoting *Collins v. Harker Heights*, 503 U.S. 115, 125 (1992) (citing *Moore v. E. Cleveland*, 431 U.S. 494, 502 (1977) (plurality opinion)) ("We must therefore 'exercise the utmost care whenever we are asked to break new ground in this field,' lest the liberty protected by the Due Process Clause be subtly transformed into the policy preferences of the Members of this Court." (internal citations omitted))).

72. See, e.g., *id.* at 722-23 (citations omitted); *Vacco*, 521 U.S. at 805-07 (citations omitted).

73. *Vacco*, 521 U.S. at 805-06.

74. *Glucksberg*, 521 U.S. at 723; *Vacco*, 521 U.S. at 807.

75. Tucker, *Activism*, *supra* note 58, at 136.

the statutes in New York and Washington—preventing patients from choosing aid in dying—were unconstitutional.⁷⁶ Plaintiffs in these cases wanted the Court to expand on the views set forth in *Cruzan*’s dissenting opinions that “[d]ying is personal. And it is profound. For many, the thought of an ignoble end, steeped in decay, is abhorrent. A quiet, proud death, bodily integrity intact, is a matter of extreme consequence.”⁷⁷

B. Before the Supreme Court: *Vacco v. Quill*

Vacco was brought before the Court challenging New York’s prohibition on assisting suicide and whether it violated the Equal Protection Clause of the Fourteenth Amendment.⁷⁸ At the time, the law stated it was a crime to aid another to commit or attempt suicide, but patients may refuse lifesaving treatment.⁷⁹ The challengers of the law were three New York physicians and three gravely ill patients who died prior to the Court granting *certiorari*.⁸⁰ The challengers believed that refusing medical treatment was the equivalent of aid in dying.⁸¹

This case raised the question of what the difference was between refusing treatment and taking medication to help someone die.⁸² The Court held that the distinction deals with the principles of causation and intent.⁸³ In regard to causation, the Court ruled, “[w]hen a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology.”⁸⁴ However, when a patient takes lethal medication, he is killed by the medication, regardless of whether the underlying illness would have also resulted in death.⁸⁵

When looking at intent, the Court determined that one must consider the patient’s death in regard to the administering of medication.⁸⁶ Terminally ill people often suffer excruciating pain, and doctors prescribe painkilling

76. *Id.*

77. *Cruzan v. Dir., Miss. Dep’t of Health*, 497 U.S. 261, 310–11 (Brennan, J., dissenting).

78. *Vacco*, 521 U.S. at 797.

79. *Id.* at 796–97.

80. *Id.* at 797.

81. *Id.* at 798.

82. *Id.*

83. *Id.* at 801.

84. *Id.*

85. *Id.*

86. *Id.*

drugs to help ease their pain.⁸⁷ Often, these painkillers may hasten a patient's death; however, the Court claimed this was different from aid in dying in that the physician's purpose in administering the painkillers was only to ease the patient's pain.⁸⁸ The Court stated that a doctor who prescribes a lethal medication "must necessarily and indubitably, intend primarily that the patient be made dead."⁸⁹ New York's law used "actors' intent or purpose to distinguish between two acts that may have the same result."⁹⁰ The Court found that the New York law's criminalization of assisted suicide did not violate the Equal Protection Clause and that there was a distinct difference between refusing treatment and taking medication to help someone die.⁹¹

C. *Before the Supreme Court: Washington v. Glucksberg*

The question presented in *Glucksberg* was "whether Washington's prohibition against 'caus[ing]' or 'aid[ing]' a suicide offends the Fourteenth Amendment to the United States Constitution."⁹² Similar to *Vacco*, four doctors, who attested they would assist terminally ill patients in ending their lives if not for Washington's ban, and three terminally ill patients who died prior to the Court granting certiorari, brought this suit.⁹³ The Ninth Circuit Court of Appeals held that the ban "was unconstitutional 'as applied to terminally ill competent adults who wish to hasten their deaths with medication prescribed by their physicians.'"⁹⁴ The Ninth Circuit found that persuasive evidence existed that "the Constitution encompasses a due process liberty interest in controlling the time and manner of one's death—that there is, in short, a constitutionally recognized 'right to die.'"⁹⁵

The Supreme Court reversed the Ninth Circuit's decision and found

87. *Id.* at 802.

88. *Id.*

89. *Id.* (quoting *Assisted Suicide in the United States: Hearing Before the Subcomm. on the Constitution of the H. Comm. on the Judiciary*, 104th Cong. 367 (1996)).

90. *Id.* at 803 (quoting *U.S. v. Bailey*, 444 U.S. 394, 403–06 (1980) ("The . . . common law of homicide often distinguishes . . . between a person who knows that another person will be killed as the result of his conduct and a person who acts with the specific purpose of taking another's life.")).

91. *Vacco*, 521 U.S. at 807–09.

92. *Washington v. Glucksberg*, 521 U.S. 702, 705–06 (1997) (alterations in original).

93. Compare *id.* at 707, with *Vacco*, 521 U.S. at 797.

94. *Glucksberg*, 521 U.S. at 709 (quoting *Compassion in Dying v. Washington*, 79 F.3d 790, 836–37 (9th Cir.1996)).

95. *Compassion in Dying*, 79 F.3d at 816.

that access to physician-assisted suicide is not a fundamental right.⁹⁶ In coming to this ruling, the Court relied heavily on the country's history, tradition, and adversity to legalizing any form of suicide.⁹⁷

The Court found:

The history of the law's treatment of assisted suicide in this country has been and continues to be one of the rejection of nearly all efforts to permit it. That being the case, our decisions lead us to conclude that the asserted "right" to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause. The Constitution also requires, however, that Washington's assisted-suicide ban be rationally related to legitimate government interests.⁹⁸

Chief Justice Rehnquist ended the majority opinion, stating: "Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society."⁹⁹

While the rulings in *Vacco* and *Glucksberg* upheld the bans on aid in dying in New York and Washington, the door was left open for states to make the decision for themselves.¹⁰⁰

D. Aid-in-Dying Law in Iowa: Iowa Code § 707A

Iowa criminalized aid in dying just prior to the Court's rulings in *Vacco* and *Glucksberg*.¹⁰¹ In 1996, the legislature passed Iowa Code § 707A.¹⁰² The Code states, "A person commits a class 'C' felony if the person intentionally or knowingly assists, solicits, or incites another person to commit or attempt to commit suicide, or participates in a physical act by which another person

96. *Glucksberg*, 521 U.S. at 728.

97. *Id.* at 710–19.

98. *Id.* at 728 (citations omitted). A discussion on the governmental interests will follow in Part IV.B.

99. *Glucksberg*, 521 U.S. at 735.

100. Melvin I. Urofsky, *Leaving the Door Ajar: The Supreme Court and Assisted Suicide*, 32 U. RICH. L. REV. 313, 313 (1998) ("[W]hile a federal right [to assisted suicide] does not exist, the Court made it clear that the states had ample leeway in which to fashion law on this issue . . .").

101. *Glucksberg*, 521 U.S. at 717–18 ("And just last year, Iowa and Rhode Island joined the overwhelming majority of States explicitly prohibiting assisted suicide.").

102. 1996 Iowa Acts ch. 1002, § 2.

commits or attempts to commit suicide.”¹⁰³ Prior to 1996, Iowa had no law expressly prohibiting aid in dying.¹⁰⁴ The issue of aid in dying was prevalent in the 1990s with the cases before the U.S. Supreme Court and media sensationalism involving the protagonists in some of those cases.¹⁰⁵ People were familiar with the stories of Nancy Cruzan, Terri Schiavo, and Dr. Jack Kevorkian—a.k.a. Dr. Death.¹⁰⁶ Iowa was following the guidance of other states by criminalizing aid in dying.¹⁰⁷

The Iowa Code takes a distinct approach in the criminalization of aid in dying by taking the time to distinguish it from the right to refuse medical treatment, stating:

1. A licensed health care professional who administers, prescribes, or dispenses medications or who performs or prescribes procedures to relieve another person’s pain or discomfort, even if the medication or procedure may hasten or increase the risk of death, does not violate section 707A.2 unless the medications or procedures are intentionally or knowingly administered, prescribed, or dispensed with the *primary intention* of causing death.

2. A licensed health care professional who withholds or withdraws a life-sustaining procedure in compliance with chapter 144A or 144B does not violate section 707A.2.¹⁰⁸

Iowa law currently maintains that all forms of aid in dying are illegal and punishable.¹⁰⁹ While this is the sentiment of a majority of states, Iowa has separated itself from the majority in the past on other issues involving individual rights, including slavery, desegregation, equal rights for men and

103. IOWA CODE § 707A.2 (2015).

104. See *Glucksberg*, 521 U.S. at 717–18.

105. See Ross Douthat, *The Last Right: Why America is Moving Slowly on Assisted Suicide*, N.Y. TIMES, Oct. 12, 2014, at SR12 (“Polls in the 1990s consistently showed more support—majority support, depending on the framing—for physician-assisted suicide than for what then seemed like the eccentric cause of same-sex marriage.”).

106. See *id.*; Sarah Childress, *The Evolution of America’s Right-to-Die Movement*, PBS (Nov. 13, 2012), <http://www.pbs.org/wgbh/frontline/article/the-evolution-of-america-right-to-die-movement/>; Kate Pickert, *A Brief History of Assisted Suicide*, TIME (Mar. 3, 2009), <http://content.time.com/time/nation/article/0,8599,1882684,00.html>.

107. *Glucksberg*, 521 U.S. at 717–18.

108. IOWA CODE § 707A.3 (2015) (emphasis added). Iowa Code chapter 144A is Iowa’s Life-Sustaining Procedures Act. See IOWA CODE § 144A.1 (2015). Iowa Code chapter 144B deals with durable power of attorney for healthcare. See IOWA CODE § 144B.12(1)–(4) (2015).

109. *Id.* § 707A.2.

women, and same-sex marriage.¹¹⁰ A brief discussion on Iowa legalizing aid in dying and the state's forward thinking in regard to individual civil rights will follow in Part IV.C.

IV. MOVING FORWARD IN THE LEGALIZATION OF DEATH WITH DIGNITY

As the United States Supreme Court has held, there is no absolute right to aid in dying, but "*Cruzan* makes it clear that some individuals who no longer have the option of deciding whether to live or to die because they are already on the threshold of death have a constitutionally protected interest that may outweigh the State's interest in preserving life at all costs."¹¹¹ States have the power to allow and regulate aid in dying or to prohibit it.¹¹² Currently, five states have legalized aid in dying: Oregon,¹¹³ Washington,¹¹⁴ Vermont,¹¹⁵ Montana,¹¹⁶ and California.¹¹⁷

A. *The Original Aid-in-Dying Act: Oregon's Death with Dignity*

Oregon was the first state to legalize aid in dying when it enacted the Death with Dignity Act in 1994.¹¹⁸ Oregonians voted to approve the ballot initiative 51 percent to 49 percent.¹¹⁹ The Act was met with criticism, and the Oregon legislature, feeling the Act was fatally flawed, tried to repeal Death with Dignity in another ballot initiative, which the voters defeated by 20 percent.¹²⁰ During the time in which the Act was challenged, Oregonians were

110. See *In re Ralph*, 1 Morris 1, 6 (Iowa 1839) (abolishing slavery in Iowa); *Clark v. Bd. of Sch. Dirs.*, 24 Iowa 266, 276–77 (1868) (desegregating Iowa public schools); *Coger v. Nw. Union Packet Co.*, 37 Iowa 145, 153–54 (1873) (ruling against racial discrimination in public accommodations); *Varnum v. Brien*, 763 N.W.2d 862, 906 (Iowa 2009) (finding that an Iowa statute limiting civil marriage to a union between a man and a woman violated the Equal Protection Clause of the state constitution).

111. *Glucksberg*, 521 U.S. at 745 (Stevens, J., concurring).

112. *Id.* at 735.

113. The Oregon Death with Dignity Act, OR. REV. STAT. ANN. §§ 127.800–.897 (West 2015).

114. WASH. REV. CODE ANN. §§ 70.245.010–.904 (West 2015).

115. VT. STAT. ANN. tit. 18, §§ 5281–93 (West 2015).

116. *Baxter v. State*, 224 P.3d 1211, 1215 (Mont. 2009); see also MONT. CODE ANN. § 50-9-101 to -111 (West 2015).

117. CAL. HEALTH AND SAFETY CODE § 433 (WEST 2015). California Governor Jerry Brown signed the controversial "End of Life Option Act" on October 5, 2015. Greg Botelho, *California governor signs 'right to die' bill*, CNN (Oct. 6, 2015, 5:20 AM), <http://www.cnn.com/2015/10/05/us/california-assisted-dying-legislation/>.

118. 1995 Or. Laws Ch. 3; BEHUNIAK & SVENSON, *supra* note 3, at 28.

119. BEHUNIAK & SVENSON, *supra* note 3, at 28.

120. *Id.* at 28, 151.

not able to utilize the provisions of the Act.¹²¹ With the passing of the second ballot initiative, Oregon enacted the Death with Dignity Act on October 27, 1997.¹²² The Death with Dignity Act “allows terminally-ill Oregonians to end their lives through the voluntary self-administration of lethal medications, expressly prescribed by a physician for that purpose.”¹²³

1. Criteria for Being Eligible for Death with Dignity

The Act is very detailed regarding the responsibilities and procedures a patient must go through to obtain Death with Dignity under the Act. The law states:

(1) An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner¹²⁴

The first criterion of the Act is that it only applies to adults, meaning individuals over the age of 18, who are residents of Oregon.¹²⁵ There is no minimum residency requirement—patients must only prove that they are a current, bona fide resident of the state, typically shown through state-issued identification or documents demonstrating that the individual rents or owns property in the state.¹²⁶ The second criterion of the Act is that it is only available to patients with a terminal disease, defined as “an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.”¹²⁷ Two separate physicians must confirm the terminal diagnosis.¹²⁸

To receive a prescription that will end one’s life in a dignified and humane manner, a qualified patient must make “an oral request and a written request, and reiterate the oral request to his or her attending physician no

121. *Id.* at 83.

122. *Death with Dignity Act*, OREGON HEALTH AUTH., <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/index.aspx> (last visited Jan. 30, 2014).

123. *Id.*

124. OR. REV. STAT. ANN. 127.805 § 2.01 (West 2015).

125. OR. REV. STAT. ANN. 127.800 § 1.01(1), (11).

126. OR. REV. STAT. ANN. 127.860 § 3.10.

127. OR. REV. STAT. ANN. 127.800 § 1.01(12).

128. *Id.* § 1.01(8).

less than fifteen (15) days after making the initial oral request.”¹²⁹ Deeming that a patient is capable to make the request is also crucial to the process of receiving a prescription through the Death with Dignity Act. The statute says, “‘Capable’ means that in the opinion of a court or in the opinion of the patient’s attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers.”¹³⁰ This is a very thorough process to ensure the patient is a qualified candidate to receive a prescription.¹³¹

2. Responsibilities of the Physician

Beyond the criteria that a patient must meet to be considered for the Death with Dignity Act, physicians also have a long list of responsibilities they must follow. These responsibilities are in place to ensure the ethical integrity of the medical profession.¹³² The Act states:

- (1) The attending physician shall:
 - (a) Make the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily;
 - (b) Request that the patient demonstrate Oregon residency pursuant to ORS 127.860;
 - (c) To ensure that the patient is making an informed decision, inform the patient of:
 - (A) His or her medical diagnosis;
 - (B) His or her prognosis;
 - (C) The potential risks associated with taking the medication to be prescribed;
 - (D) The probable result of taking the medication to be prescribed; and
 - (E) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control;

129. OR. REV. STAT. ANN. 127.840 § 3.06.

130. OR. REV. STAT. ANN. 127.800 § 1.01(3).

131. Raphael Cohen-Alagor & Monica G. Hartman, *The Oregon Death With Dignity Act: Review and Proposals for Improvement*, 27 J. LEGIS. 269, 271 (2001).

132. Helene Bradowski & Marybeth Malloy, *Suffering Against Their Will: The Terminally Ill and Physician Assisted Suicide—A Constitutional Analysis*, 12 ST. JOHN’S J. LEGAL COMMENT. 171, 201–02 (1996) (noting the State’s interest in maintaining ethical integrity of the medical profession).

- (d) Refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily;
- (e) Refer the patient for counseling if appropriate pursuant to ORS 127.825;
- (f) Recommend that the patient notify next of kin;
- (g) Counsel the patient about the importance of having another person present when the patient takes the medication prescribed pursuant to ORS 127.800 to 127.897 and of not taking the medication in a public place;
- (h) Inform that patient that he or she has an opportunity rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the end of the 15-day waiting period pursuant to ORS 127.840;
- (i) Verify, immediately prior to writing the prescription for medication under ORS 127.800 to 127.897, that the patient is making an informed decision;
- (j) Fulfill the medical record documentation requirements of ORS 127.855;
- (k) Ensure that all appropriate steps are carried out in accordance with ORS 127.800 to 127.897 prior to writing a prescription for medication to enable a qualified patient to end his or her life in a humane and dignified manner.¹³³

The Act places stringent requirements on both patients and physicians. Physicians who follow the requirements are able to prescribe the lethal medication without the fear of losing licensures or having criminal culpability in deaths.¹³⁴ Patients go through strict testing to ensure they are of sound mind with their decision.¹³⁵ The Act also includes a declaration for patients to use when making the written request to end their life in a humane and dignified manner.¹³⁶ Furthermore, all action is directed by and through patients, giving them autonomy and control in their health care and end-of-life care decisions.¹³⁷

133. OR. REV. STAT. ANN. 127.815 § 3.01.

134. OR. REV. STAT. ANN. 127.885 § 4.01.

135. OR. REV. STAT. ANN. 127.825 § 3.03, 127.830 § 3.04.

136. OR. REV. STAT. ANN. 127.897 § 6.01.

137. OR. REV. STAT. ANN. 127.800 § 1.01, 127.830 § 3.04.

3. Results of Oregon's Death with Dignity Act

"[T]he Oregon Health Authority (OHA) is required to annually review a sample of records, which reflect current statistics on various [Death with Dignity Act] factors, including how many people obtained life-ending medication, who actually used the medication, and a consensus of who is electing to take the medication."¹³⁸ As of 2014, "1,327 people have had [Death With Dignity] prescriptions written and 859 patients" have chosen to go forward with ending their lives by ingesting the medications prescribed.¹³⁹ In 2014, 155 patients received prescriptions.¹⁴⁰ There were 105 patients who ingested the medication and died in 2014: 94 who received the medication in 2014 and 11 patients who received medication in previous years.¹⁴¹ There were 37 patients who received the medications in 2014 but did not take it, and subsequently died of other causes.¹⁴²

In addition to calculating statistics regarding how many prescriptions were used and how many patients used them, the Oregon Health Authority also researches patients' end-of-life concerns, insurance, circumstances regarding death, and ages and genders of patients.¹⁴³ Of the 105 Death with Dignity Act deaths during 2014, 67.6 percent were age 65 or older, with a median age of 72.¹⁴⁴ Over 90 percent of all patients were enrolled in hospice care at the time the prescription was written or at the time of death.¹⁴⁵ The three most frequently mentioned end-of-life concerns for 2013 were: (1) "loss of autonomy," (2) "decreasing ability to participate in activities that made life enjoyable," and (3) "loss of dignity."¹⁴⁶

4. Opinion Regarding Oregon's Death with Dignity Act

As demonstrated above, Oregon's law for Death with Dignity has

138. Lindsay Reynolds, Note, *Losing the Quality of Life: The Move Toward Society's Understanding and Acceptance of Physician Aid-in-Dying and the Death with Dignity Act*, 48 New Eng. L. Rev. 343, 350 (2014).

139. OR. PUB. HEALTH DIV., OREGON'S DEATH WITH DIGNITY ACT—2014, 2 (2015) <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf>.

140. *Id.*

141. *Id.*

142. *Id.*

143. *Id.* at 2, 4–5.

144. *Id.* at 2.

145. *Id.*

146. *Id.*

many safeguards and requirements to ensure the safety of all patients, families, and citizens.¹⁴⁷ Over the past 16 years since Death with Dignity became legal in Oregon, the state has been the model for other states considering legalizing aid in dying.¹⁴⁸ The format and structure of the law have proven to be successful in dealing with a very sensitive subject.¹⁴⁹ The Death with Dignity Act is focused on ending suffering in patients and respecting the patient's autonomous choice to end their own lives.¹⁵⁰

B. Balancing the State's Countervailing Interests

There are six key interests that the state has in prohibiting aid in dying: (1) "preserving life;" (2) "preventing suicide;" (3) "avoiding the involvement of third parties and use of arbitrary, unfair, or undue influence;" (4) "protecting family members and loved ones;" (5) "protecting the integrity of the medical profession;" and (6) avoiding future movement toward euthanasia and other abuses.¹⁵¹ The most discussed interest is the "unqualified interest in the preservation of human life."¹⁵² Some people argue that all human life is sacred and that it is wrong to take any human life, whether it be your own or another's.¹⁵³ "[T]he State has a real interest in preserving the lives of those who can still contribute to society and enjoy life,"¹⁵⁴ but what about those individuals who are at the end of their lives? *Cruzan* ruled that states "may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy."¹⁵⁵ The states' interest in preserving the sanctity of life is questioned when it involves patients that are in their final chapter of life.

Suicide is "a serious public-health problem, especially among persons in otherwise vulnerable groups."¹⁵⁶ However, Death with Dignity prevents

147. See *supra* Part IV.A.1, IV.A.2.

148. See, e.g., Charity Nebbe & Emily Woodbury, *The Complexities of Aid In Dying, Physician-Assisted Suicide*, IOWA PUBLIC RADIO (Sept. 29, 2014), <http://iowapublicradio.org/post/complexities-aid-dying-physician-assisted-suicide#stream/0>.

149. *Id.*

150. Reynolds, *supra* note 138, at 363–64.

151. *Compassion in Dying v. Washington*, 79 F.3d 790, 816–17 (9th Cir. 1996), *reversed by Washington v. Glucksberg*, 521 U.S. 702 (1997).

152. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 282 (1990).

153. See, e.g., KEVIN YUILL, *ASSISTED SUICIDE: THE LIBERAL, HUMANIST CASE AGAINST LEGALIZATION* 30 (2013).

154. See *Glucksberg*, 521 U.S. at 729–730 (quoting Brief of Respondents at 35 n. 23, *Washington v. Glucksberg*, 521 U.S. 702 (1997) (no. 96–110)).

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

156. *Glucksberg*, 521 U.S. at 730.

some evils of suicide because it allows terminally ill persons an “option without taking matters into their own hands—where the patient’s decision to end their own life will most likely be unregulated, performed in a dangerous manner, and potentially cloaked with guilt and shame.”¹⁵⁷ The states’ interest in preventing suicide is usually considered along with the interest of avoiding the involvement of third parties and use of arbitrary, unfair, or undue influence.¹⁵⁸ The Oregon statute prevents issues of undue influence from arising through the protective safeguards in place before a person can receive a prescription.¹⁵⁹

The other state interest that is often considered is the preservation of the integrity of the medical profession.¹⁶⁰ States fear that “permitting physicians to assist in suicide is inconsistent with the perception that they serve their patients solely as healers.”¹⁶¹ It is argued that allowing aid in dying would “undermine the trust that is essential to the doctor-patient relationship by blurring the time-honored line between healing and harming.”¹⁶² The argument against this state interest is

physicians are already involved in making decisions that hasten the death of terminally ill patients—through termination of life support, withholding of medical treatment, and terminal sedation—there is in fact significant tension between the traditional view of the physician’s role and the actual practice in a growing number of cases.¹⁶³

In *Glucksberg*, the Court held that these state interests were sufficient to support Washington’s general public policy against assisted suicide.¹⁶⁴

C. When Individual Interests Overcome State Interests

But the question remains, at what point should the individual’s interest overcome the state’s? The New Jersey Supreme Court ruled in the case of *In re Quinlan* “that the State’s interest *contra* 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

157. Reynolds, *supra* note 138 at 363.

158. *Glucksberg*, 521 U.S. at 747 (Stevens, J., concurring).

159. See OR. REV. STAT. ANN. 127.800–.897 (West 2015).

160. See, e.g., *Compassion in Dying v. Washington*, 79 F.3d 790, 816–17 (9th Cir. 1996), *reversed by Glucksberg*, 521 U.S. at 748.

161. *Glucksberg*, 521 U.S. at 748 (Stevens, J., concurring).

162. *Id.* at 731.

163. *Id.* at 748–49 (Stevens, J., concurring).

164. *Id.* at 735–36.

rights overcome the State interest.”¹⁶⁵

In *Glucksberg*, Justice Stevens wrote in his concurrence that “[a]voiding intolerable pain and the indignity of living one’s final days incapacitated and in agony is certainly ‘[a]t the heart of [the] liberty . . . to define one’s own concept of existence, of meaning, of the universe, and of the mystery of human life.’”¹⁶⁶

The Supreme Court has not heard a case where it was an individual’s liberty interest that was considered in regard to a law prohibiting aid in dying.¹⁶⁷ The current opinions on the issue of aid in dying hint that an individual’s interest can overcome the state’s interest, but the Court would need to review a case with those requirements to making a ruling on the existence of an individual’s liberty interest in regard to aid in dying.¹⁶⁸

D. Legalizing Aid in Dying in Iowa

The time has come for Iowa to strongly consider passing legislation that would legalize aid in dying. The nation is slowly moving toward acceptance.¹⁶⁹ Since November, when Brittany Maynard died, 15 states and the District of Columbia “have introduced bills to authorize the medical option of aid in dying.”¹⁷⁰ “All of the bills were introduced during a seven-week period between Jan. 8 and Feb. 24,” 2015.¹⁷¹ In addition to Washington D.C., the states are Missouri, California, Iowa, Montana, Wyoming, Colorado, Hawaii, Kansas, Oklahoma, Maryland, Alaska, Wisconsin, Rhode Island, New York, and Utah.¹⁷²

It is now Iowa’s turn to bring legislation that would legalize aid in dying

165. *In re Quinlan*, 355 A.2d 647, 664 (N.J. 1976).

166. *Glucksberg*, 521 U.S. at 745 (Stevens, J., concurring) (quoting *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 851 (1992) (alteration in original)).

167. See, e.g., *id.* at 735 n.24.

168. See, e.g., *id.*; see also, e.g., *id.* at 745 (Stevens, J., concurring).

169. See, e.g., Ian Richards, *Gallup: Americans Support Death With Dignity Even if Question Wording is Biased*, COMPASSION & CHOICES (June 24, 2014), <https://www.compassionandchoices.org/2014/06/24/gallup-americans-support-death-with-dignity-even-if-question-wording-is-biased/>.

170. *Brittany Maynard Family, Compassion & Choices Making End-of-Life Care Progress*, COMPASSION & CHOICES (Mar. 10, 2015), <https://www.compassionandchoices.org/2015/03/10/brittany-maynard-family-compassion-choices-making-end-of-life-care-progress/>.

171. *Id.*

172. *Id.*

in the state. Historically, Iowa has been the nation's leader in civil rights issues such as slavery, segregation of schools, same sex marriage, and women's rights, starting when Iowa was only a territory of the United States.¹⁷³

Back in 1839, the first case to come before the Supreme Court of the Territory of Iowa involved a black man and whether or not he was a fugitive slave.¹⁷⁴ The court held that slavery was not allowed in the territory, and rejected all forms of slavery.¹⁷⁵ This was 26 years before the end of the Civil War.¹⁷⁶

Another case where Iowa led the way in establishing civil rights was *Clark v. Board of School Directors*.¹⁷⁷ This decision ruled that racially segregated schools had no place in Iowa, a ruling that occurred 85 years before the United States Supreme Court reached that same decision in *Brown v. Board of Education*.¹⁷⁸ A few years later, in 1873, the Iowa Supreme Court ruled against racial discrimination in public accommodations in *Coger v. Northwestern Union Packet Co.*¹⁷⁹

In the areas of gender and sexual discrimination, Iowa was also a leader in establishing civil rights. Iowa became the first state to admit women to the practice of law when they admitted Arabella Mansfield in 1869.¹⁸⁰ In a more recent decision, in the 2009 case of *Varnum v. Brien* the unanimous court held that an Iowa statute limiting civil marriage to a union between a man and a woman violated the Equal Protection Clause of the Iowa Constitution.¹⁸¹ This ruling gave same-sex couples the right to marry under state law.¹⁸² Iowa was the first in the Midwest to make that decision.¹⁸³

These cases all demonstrate Iowa's history as a leader in establishing

173. See *supra* note 110 and accompanying text; *infra* notes 174–85 and accompanying text.

174. *In re the Matter of Ralph*, 1 Morris 1, 5 (Iowa 1839).

175. *Id.* at 6–7.

176. See *Lee Surrendered*, AMERICA'S LIBRARY, http://www.americaslibrary.gov/jb/civil/jb_civil_surrender_1.html (last visited Dec. 30, 2015).

177. *Clark v. Bd. of Sch. Dirs.*, 24 Iowa 266 (1868).

178. *Id.* at 276–77; see also *Brown v. Bd. of Ed. of Topeka*, 347 U.S. 483, 495 (1954).

179. *Coger v. Nw. Union Packet Co.*, 37 Iowa 145, 157 (1873).

180. *Arabella Mansfield*, IOWA DEP'T OF HUM. RTS., <https://human-rights.iowa.gov/arabella-mansfield> (last visited Dec. 30, 2015).

181. *Varnum v. Brien*, 763 N.W.2d 862, 906–07 (Iowa 2009).

182. See *id.*

183. *Iowa Supreme Court Legalizes Gay Marriage*, NBC NEWS (Apr. 3, 2009), http://www.nbcnews.com/id/30027685/ns/politics-more_politics/t/iowa-supreme-court-legalizes-gay-marriage/#.VkpF16Pnabg.

civil rights. The time has come for Iowa to legalize aid in dying through a ballot initiative, similar to what was done in Oregon, Washington, and Vermont. Iowa's population is growing older, and they need to have an option to utilize aid in dying. If not, Iowans wanting to utilize a Death with Dignity Act will have to be like Brittany Maynard and leave their native state to have the right to take control of their own bodies, their own lives, and choose death.¹⁸⁴

E. House File 65 – A Start Toward Legalizing Aid in Dying in Iowa

On January 21, 2015, nine Iowa legislators introduced House File 65, known as the Iowa Death with Dignity Act.¹⁸⁵ The nine sponsors are comprised of nine Democrats, seven of which are female.¹⁸⁶ The bill is drafted after Oregon's Death with Dignity Act and is almost identical, as Oregon has proven to be the standard.¹⁸⁷ The bill is currently in subcommittee, and there has been little news or discussion in the media of the bill's introduction.¹⁸⁸

Time will tell whether the bill will move forward through the Iowa legislature; but, it is not likely to pass this legislative session with a Republican controlled House of Representatives and a Republican governor.¹⁸⁹ For the bill to gain support, there needs to be increased discussion on aid in dying in Iowa.¹⁹⁰ The introduction of this bill is the first step in legalizing aid in dying in Iowa—with increased awareness and publicity of the issue, Iowa could follow its strong history as a leader in individual civil rights and become a

184. See *About*, THE BRITTANY MAYNARD FUND, <http://thebrittanyfund.org/about/> (last visited Dec. 30, 2015).

185. H.F. 65, 86th Gen. Assemb., Reg. Sess. (Iowa 2015).

186. *Id.* The sponsors include: Rep. Brian Meyer [D], Rep. Dennis Cohoon [D], Rep. Cindy Winckler [D], Rep. Sally Stutsman [D], Rep. Mary Mascher [D], Rep. Timi Brown-Powers [D], Rep. Mary Wolfe [D], Rep. Mari Anderson [D], and Rep. Beth Wessel-Kroeschell [D]. *Id.*

187. Compare *id.*, with OR. REV. STAT. ANN. § 127.800–897 (West 2015).

188. *Bill History for HF 65*, THE IOWA LEGISLATURE, <http://coolice.legis.iowa.gov/cool-ICE/default.asp?Category=BillInfo&Service=DspHistory&var=HF&key=0079C&ya=86>.

189. See William Petroski, *Iowa Senate OKs Medical Marijuana, But Likely Dead in House*, THE DES MOINES REGISTER (Apr. 15, 2015), www.desmoinesregister.com/story/news/politics/2015/04/15/iowa-senate-medical-marijuana/258218331/.

190. *Iowans Deserve Choice, 'Death With Dignity'*, Editorial, DES MOINES REGISTER (Apr. 24, 2015), <http://www.desmoinesregister.com/story/opinion/editorials/2015/04/23/editorial-iowans-deserve-choice-death-dignity/26275179/>.

state that allows its citizens to die on their terms, in a humane and dignified manner.¹⁹¹

V. CONCLUSION

It is time for Americans to accept and confront their own deaths.¹⁹² It is time to recognize their rights at the end of life.¹⁹³ The right to refuse medical treatment through advance directives and living wills is alive and well, but fewer than 40 percent of people in the United States have either document.¹⁹⁴ As medical treatment becomes more advanced and people live longer, the time has come to recognize that there are situations in which allowing individuals to take their own life and die with dignity permissible and within their own rights as a human being. While the Supreme Court has held that there is no fundamental right to assisted suicide, the actual legalization of aid in dying rests in the hands of the states.¹⁹⁵ The states must decide whether it is in their best interests to allow their constituents to die with dignity or to force them to live out deaths with intolerable pain and suffering.¹⁹⁶ Iowa has made a step in the right direction with the introduction of House File 65, and in the coming months, we will see if the bill survives.¹⁹⁷

Justice Stevens's dissent in *Cruzan* truly captured the importance of rights involving death when he stated, "Choices about death touch the core of liberty. 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 as fundamental.'"¹⁹⁸

Brittany Maynard strongly believed in an individual's right to have the option and choose death with dignity, believing that it is truly an important, autonomous choice.¹⁹⁹ Before her death, she wrote,

I would not tell anyone else that he or she should choose death with dignity. My question is: Who has the right to tell me that I don't deserve this choice? That I deserve to suffer for weeks or months in tremendous

191. See *supra* notes 174–84.

192. See *supra* notes 6–10 and accompanying text.

193. See *supra* notes 6–10 and accompanying text.

194. Eisenberg, *supra* note 7.

195. See *Washington v. Glucksberg*, 521 U.S. 753, 728, 735 (1997).

196. See *id.* at 735.

197. See *supra* Part IV.E.

198. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 343 (1990) (Stevens, J., dissenting) (quoting *Snyder v. Mass.*, 291 U.S. 97, 105 (1934)).

199. See THE BRITTANY FUND, *supra* note 1.

amounts of physical and emotional pain? Why should anyone have the right to make that choice for me?²⁰⁰

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200. Brittany Maynard, *My Right to Death with Dignity at 29*, CNN (Nov. 2, 2014), <http://www.cnn.com/2014/10/07/opinion/maynard-assisted-suicide-cancer-dignity/>.

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