

On a Path Toward International Recognition:
Physician-Assisted Suicide as an Emerging Human Rights Norm

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ABSTRACT

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Physician-assisted suicide is a form of end-of-life care wherein a doctor provides a lethal dose of medication for a patient to use of his or her own volition, which has become increasingly legalized since 1994. This trend in legalization, the convincing human rights-based arguments in favor of physician-assisted suicide, and the comportment of the practice with existing international human rights law and norms leads to two core claims. First, I argue that access to physician-assisted suicide is itself a right even though it is not codified in any treaty because it is an emerging norm. Second, based on an observed trend toward accelerated legalization in increasing numbers states, and because of trends in public opinion around this issue and related topics such as political and religious affiliation, I foresee that legalization will continue apace, and accelerate in the coming decades, solidifying physician-assisted suicide as an internationally-protected human right. The central contribution of this work is extending the existing human rights argument for physician-assisted to make the stronger claim that physician-assisted suicide is a right, and to predict the future of legalization and norm-creation around this form of end-of-life care.

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Introduction of Physician-Assisted Suicide

In 2006, Craig Colby Ewert, a vibrant man from Harrogate, England, was suffering from Amyotrophic Lateral Sclerosis, or ALS. His illness had robbed him of mobility, the ability to use his arms and hands, and a great deal of happiness. He and his family knew that soon he would become even less independent, and ALS would take his life.¹ Eventually, the muscle weakness, twitching, and atrophy that affected his limbs would likely stop him from being able to swallow or breathe on his own, and might paralyze internal organs.²

Rather than stealing himself for a slow and painful decline and death, Ewert and his wife, Mary, travel to Switzerland, where aids from the advocacy group Dignitas remind Ewert that the decision remains in his hands. The patient will have to take all of the medications and make all of the decisions himself, to absolve his wife and the Dignitas employees of legal wrongdoing.

Ewert takes the first step, to set a timer to turn off his breathing aid after forty-five minutes. Unable to use his hands, he takes the switch in his mouth and bites to set the clock ticking. Next, he drinks a mixture prepared by the Dignitas aides, of medication designed to coat the lining of his stomach and prepare it for the caustic drugs to come. About thirty minutes later, after a brief conversation and kiss from his wife, Ewert drinks a second cocktail of sodium pentobarbital. While the Dignitas aide holds the cup, he sips through a straw on his own power. Ewert cuts the bad taste of the drug with apple juice, finishes the drink. Within minutes, he is dead.³

¹ "The Suicide Tourist." *Frontline*. HDTV. 2 March 2010. *Youtube.com*. Tim Lee, 18 July 2014. Web. 14 Mar. 2017.

² Heller, Laura. "ALS - Amyotrophic Lateral Sclerosis." *Neurology and Neurosurgery*. October 05, 2015. Accessed March 15, 2017.

https://www.hopkinsmedicine.org/neurology_neurosurgery/centers_clinics/als/conditions/als_amyotrophic_lateral_sclerosis.html

³ "Suicide Tourist." *Frontline*. HDTV. 2 March 2010. *Youtube.com*. Tim Lee, 18 July 2014. Web. 14 Mar. 2017.

Ewert's story is representative of physician-assisted suicide. With legally obtained prescriptions, Ewert has ended his life prematurely. As medical advances allow people to live longer and healthier lives, the average lifespan has expanded, but so have the extraordinary measures people take to keep the hearts of their loved ones beating. With high-tech life support machines, people are able to sustain some basic minimum alive status long after they may naturally die, and, in many cases, long after their quality of life is physically, mentally, and emotionally tolerable. As illness takes hold, one's thought process may become blurred, and the end of life can bring pain, limited mobility, and an inability to take part in the quotidian activities that contribute to a meaningful life worth living.

Instead of extending life indefinitely with medical help, some want to end their lives legally, with the assistance of medical professionals who can make suicide less painful and more accessible to those physically unable to commit suicide in traditional ways. Physician-assisted suicide has become one way for patients to access life-ending treatments in some states and jurisdictions. In these states, patients who fit certain criteria can request a prescription for a lethal drug cocktail that will put them out of their misery.

Legalization of physician-assisted suicide has become increasingly common over the past quarter century. Six countries, seven American states, and Washington D.C. have made physician-assisted suicide legal and accessible to citizens. This trend towards legalization has accelerated in recent years, creating wider acceptance of the practice. Arguments over physician-assisted suicide have been thrust into the realm of human rights law and practice as more countries recognize the practice as a legitimate end-of-life option. Consequently the language and constructs of human rights norms have been adopted in discussions of the issue. Therefore, it is vital to understand the implications for the right of existing human rights law.

Considering existing trends in legalization and public opinion data, comportment with existing human rights laws, and the strength of human rights-based arguments, I argue that the right to die via physician-assisted suicide is an emerging international human rights norm. Though the number of states internationally which have legalized physician-assisted suicide to date is relatively small, shifts in attitude towards end-of-life care, religion, and political preferences indicate that the wave of legalization will continue apace. I predict that legalization will continue to accelerate internationally, and thus physician-assisted suicide will solidify as a human right through the norm-making process over the next few decades.

Because nations are sovereign, and respect for the sovereignty of states dictates that, in most circumstances, one state cannot infringe on the internal politics or legislation of another, it may not seem momentous that states are legalizing physician-assisted suicide one-by-one, but more and more quickly. However, the norm-making process involves an acceleration of recognition of the new right by more states, until a practice become ingrained in global culture, and begins to be expected by both states and their citizens. The fact that physician-assisted suicide is becoming increasingly recognized will beget more international recognition and respect for the right to the provision of this form of end-of-life care. As a newly legalized way to die, physician-assisted suicide changes how people understand health care and the right to life. Especially as the baby boomer generation ages, revolutionary ideas about end-of-life care are becoming more accepted, and more relevant to the intimate and personal decisions people makes with regards to the illness and dying of family and one's self.

Physician-assisted suicide falls along a spectrum of measures people take when confronting end-of-life care. In order to understand physician-assisted suicide as a human right, I will explore it in the context of a range of options— including euthanasia and palliative care.

After clarifying these terms, I will discuss the sources of international human rights law, and describe how physician-assisted suicide comports with established human rights law. Then, I will establish the process by which a practice becomes a human rights norm. By contextualizing the rise of physician-assisted suicide as a human right within the history of other norms which have emerged through this process, such as the prohibition of the death penalty, and by describing the extent to which the right to physician-assisted suicide comports with existing law, I hope to illustrate that physician-assisted suicide has strong precedent both on its merits and as an emerging norm. I will then situate physician-assisted suicide politically, and address human rights, ethical, and religious arguments opponents to legalization. Subsequently, I will also discuss the public opinion-driven political context of physician-assisted suicide. Political will to legalize the process is salient in determining its fate, and so gauging public support for physician-assisted suicide is relevant to understanding its status as an emerging norm. Finally, it is vital to recognize the difficulty of implementing this right and defining who should have access to this type of medical care.

Definitions and Context

The terms “physician-assisted suicide,” “euthanasia” and “palliative care” may be clearly distinct to some readers, they require differentiation. Both advocates and opponents to physician-assisted suicide often conflate the methods in order to twist data and strengthen their arguments. I argue that physician-assisted suicide is a right, in part because its use rests in the hands of the patient himself. This is not always the case with either euthanasia or palliative care, as defined below. Therefore, legally, and in terms of the human rights framework, physician-assisted suicide must be considered separately from these other important topics. Physician-assisted suicide is unique, because it involves the patient’s personal and physical involvement in most cases.

The European Association for Palliative Care, an NGO recognized by the European Union, defines physician-assisted suicide as “a physician intentionally helping a person to terminate his or her life by providing drugs for self-administration, at that person’s voluntary and competent request.”⁴ This definition comports with those given by others as well. Derek Humphry, one of the leading advocates for legalization in the United States, founded the Hemlock Society, an early pro-physician-assisted suicide group in this country. Humphry elaborates on the definition, saying that physician-assisted suicide occurs when “a physician conversant with your case [writes a prescription for] a lethal overdose which is taken orally by you as and when you wish. Sometimes, the prescribing doctor is present, more often not...”⁵ Unlike other forms of end-of-

⁴ Radbruch, Lukas, Carlo Leget, Patrick Bahr, Christof Müller-Busch, John Ellershaw, Franco De Conno, and Paul Vanden Berghe. "Euthanasia and Physician-Assisted Suicide: A White Paper From the European Association for Palliative Care." *Palliative Medicine*, 2015, 6. Accessed April 9, 2017. doi:10.1177/0269216315616524.

⁵ Humphry, Derek. *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying*. Digital Edition (KE 2011) ed. Eugene, OR: Hemlock Society, 1991. Location 348-358.

life care which are often confused with this act, physician-assisted suicide does not always involve the health care providers' direct involvement in the final moments of life. The medications prescribed by a doctor for the purpose of dying are taken home with the patient, and may be taken whenever the individual is ready, often without a doctor present. People may gather with loved ones and perform the task in a less medical setting. For instance, in his final moments, Roger Sagner, one of the subjects of the Sundance Film Festival award-winning documentary "How to Die in Oregon," gathers his family, thanks the people of Oregon for allowing him to take this step, and emotionally intones the lyrics of the mournful classic "Old Black Joe." Sagner's family surrounds him and comforts both him and themselves with final words and affectionate touches.⁶

One other form of care often confused with physician-assisted suicide is euthanasia. Unlike physician-assisted suicide, where the patient is responsible for repeatedly and explicitly requesting a prescription for a lethal dose, and administering the drugs independently, euthanasia is an option more often used in more acute circumstances, where the conditions of a patient's illness suddenly or irrevocably make active participation impossible. This is used most often when a patient is unconscious, in excruciating pain, or, sometimes, when mental incapacitation (such as in the case of Alzheimer's or traumatic brain injury) leaves the patient unable to make the decision without assistance. In these circumstances, euthanasia is usually performed with the consent of the patient obtained prior to the illness or incapacitation, or, more controversially,

⁶ Richardson, Peter. Film. USA: Clearcut Productions, 2011. October 30, 2014. Accessed April 09, 2017. https://www.youtube.com/watch?v=VN3ObOK_ccs. Excerpt from "How to Die in Oregon." The clip is titled "How to Die in Oregon - Goodbye Roger."

with the request of a family member or next of kin. In places where euthanasia is legal, it is performed by a doctor at the explicit request of the patient.

Physician-assisted suicide is most starkly contrasted with euthanasia in that in cases of physician-assisted suicide, the patient must physically take the drugs himself. In cases of euthanasia, the doctor administers the medication, and thus is seen as more personally involved in the death. According to the European Association for Palliative Care's Ethics Task Force, "Euthanasia is killing on request, and is defined as a doctor intentionally killing a patient by the administration of drugs, at the person's voluntary and competent request."⁷

Most of the end-of-life decisions people face personally or when caring for a loved one do not qualify as assisted suicide. It is not uncommon for people who are dying to choose to forego remaining treatment options in favor of being able to reduce their physical pain in their final days, and spend time with loved ones, rather than confined in a hospital. "Withholding futile treatment... withdrawing futile treatment [and] terminal sedation (the use of sedative medication to relieve intolerable suffering [during] the last days of life" is not euthanasia or physician-assisted suicide.⁸ Rather, they fall into the category of palliative care.

This form of end-of-life care aims to "[improve] the quality of life of patients and their families facing [issues] associated with life-threatening illness, through the prevention and relief of suffering..."⁹ While care providers don't intend to cure an illness, or even delay death,

⁷ Materstvedt, Lars Johan, David Clark, John Ellershaw, Reidun Førde, Anne-Marie Boeck Gravgaard, Hans-Christof Müller-Busch, Josep Porta I Sales, and Charles-Henri Rapin. "Euthanasia and Physician-Assisted Suicide: A View from an EAPC Ethics Task Force." *Zeitschrift für Palliativmedizin* 5, no. 4 (2004): 98. doi:10.1055/s-2004-834590.

⁸ Ibid.

⁹ Ibid., Quoting Sepúlveda, C., A. Marlin, and A. Ulrich. "Palliative Care: The World Health Organization's Global Perspective." *Journal of Pain and Symptom Management* 24, no. 2 (2002): 91-96, and World Health Organization. *Cancer Pain Relief and Palliative Care*. 1990. Technical Report Series 804, Geneva.

palliative care “provides relief from pain and other distressing symptoms... affirms life[,] and regards dying as a normal process....”¹⁰ In other words “Palliative care is an all-encompassing

term that refers to caring for patients who are no longer responsive to curative treatment.”¹¹

Palliative care is significantly less controversial than either physician-assisted suicide or euthanasia, because it does not involve the doctor actively setting out to end the life of his or her patient.

These three end-of-life treatments are at the heart of broad arguments about the right to die. While often grouped together in human rights literature, the nuances become critical when determining rights and laws. For example, while physician-assisted suicide can be considered an emerging norm, euthanasia has not yet reached that same status; euthanasia is legal in fewer places, and is not supported as strongly by existing human rights law.

¹⁰ Materstvedt, Lars Johan, David Clark, John Ellershaw, Reidun Førde, Anne-Marie Boeck Gravgaard, Hans-Christof Müller-Busch, Josep Porta I Sales, and Charles-Henri Rapin. "Euthanasia and Physician-Assisted Suicide: A View from an EAPC Ethics Task Force." *Zeitschrift für Palliativmedizin* 5, no. 4 (2004): 98. doi:10.1055/s-2004-834590.

¹¹ Burdette, Amy M., Terrence D. Hill, and Benjamin E. Moulton. "Religion and Attitudes toward Physician-Assisted Suicide and Terminal Palliative Care." *Journal for the Scientific Study of Religion* 44, no. 1 (March 2005): 80. Accessed April 2, 2017. <http://www.jstor.org/stable/3590520>.

Comportment with Existing Law

Physician-assisted suicide is not currently endorsed by a treaty, charter, or other form of codified international human rights law. Nonetheless, I argue that because the practice does not explicitly violate any treaty provision or law, existing precedent does not prohibit the emergence of physician-assisted suicide as a norm, which may be codified and made more obligatory at some point in the future. In fact, there are many components of established human rights law that implicitly support physician-assisted suicide.

Some of the core theoretical assumptions of human rights law which have informed the codification of law since the founding charter of the United Nations was drawn in 1945 rest on ethical norms which found their footing hundreds, if not thousands, of years ago. Some of the ethical presumptions and principles supported by other, codified, human rights which extend to support the right to physician-assisted suicide are laid out quite bluntly by Lawrence Gostin in his article "The Constitutional Right to Die: Ethical Considerations." Gostin argues that the physician-assisted suicide should be legal because each person should be respected as an individual and given the option to control his or her own life. He says "everyone who is competent has an autonomy interest in deciding what will happen with their lives..."¹² Furthermore, the principle of beneficence, or the physician's obligation to help a patient, calls for

¹² Gostin, Lawrence O. "The Constitutional Right to Die: Ethical Considerations." *St. John's Journal of Legal Commentary* 12 (1997): 600. Accessed April 13, 2017. <http://scholarship.law.georgetown.edu/cgi/viewcontent.cgi?article=1749&context=facpub>. Citing *Cruzan v. Missouri Department of Health* (June 25, 1990).

legalization of physician-assisted suicide, because “it [provides] the comfort that... at the moment of our death, our physician will not turn his or her back on us.”¹³

In *Final Exit*, Derek Humphry reiterates the importance of the principle of autonomy by advocating that access to physician-assisted suicide provides the ability for terminally ill or painfully deteriorating people to create their own “good death,” or one which is “quick, peaceful, [and] surrounded by love...”¹⁴ Humphry argues that “careful planning is essential for smooth and gracious self-deliverance.”¹⁵ Rather than forcing patients to endure slow, painful dying processes, access to physician-assisted suicide allows patients to die peacefully when they feel ready. They have the opportunity to speak with loved ones one last time, to settle their affairs, and to die in a non-institutionalized setting. Physician-assisted suicide allows people to avoid suffering, and to make the most of their final days.

While activists in favor of physician-assisted suicide have articulated ethical issues such as autonomy, beneficence, and the nebulous desire to aid in a good death, specific human rights must also comport with, or not reject, the right to physician-assisted suicide. Some argue that the provision of this relatively newly respected end-of-life option explicitly violates the right to life. Ryan T. Anderson of the Heritage Foundation argues, “physician-assisted suicide ‘is, in fact, the state’s abdication of its duty to protect innocent life and its abandonment of the old, the weak, and the poor.’”¹⁶

¹³ Gostin, Lawrence O. "The Constitutional Right to Die: Ethical Considerations." *St. John's Journal of Legal Commentary* 12 (1997): 600. Accessed April 13, 2017.

<http://scholarship.law.georgetown.edu/cgi/viewcontent.cgi?article=1749&context=facpub>.

¹⁴ Humphry, Derek. *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying*. Digital Edition (KE 2011) ed. Eugene, OR: Hemlock Society, 1991. Location 129.

¹⁵ *Ibid.*, Location 1557.

¹⁶ Anderson, Ryan T. "Always Care, Never Kill: How Physician-Assisted Suicide endangers the weak, Corrupts Medicine, Compromises the Family, and Violates Human Dignity and Equality." *Backgrounder*, 2015, 1-22. March 24, 2015. Accessed March 27, 2017.

This right is validated and reaffirmed again and again, in existing human rights law and norms, including in the Universal Declaration of Human Rights (UDHR), which states, “Everyone has the right to life, liberty and security of person.”¹⁷ Similarly, the International Covenant on Civil and Political Rights (ICCPR), which solidifies that “every human being has the inherent right to life, supports it. This right shall be protected by law. No one shall be arbitrarily deprived of his life,” and the Convention on the Rights of Persons with Disabilities, which states that “States Parties reaffirm that every human being has the inherent right to life and shall take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others.”¹⁸ This is perhaps the most foundational of all human rights.

I contend, though, that physician-assisted suicide is not a right to life issue, because states are the primary duty-bearers of public international law. As such, it is the state’s responsibility to protect its citizens’ right to life by not arbitrarily executing individuals and by protecting individuals from non-consensual killing both by other citizens and by agents of the states. However, provision of physician-assisted suicide does not jeopardize or diminish the right to life, because the state is neither forcing nor encouraging anyone to die. Because physician-assisted suicide is voluntary, neither the state nor its agent, the doctor, is responsible for the death.

Although physician-assisted suicide is not an explicitly protected right in any treaty, there are some codified rights that may be interpreted as supporting the right to physician-assisted

<http://report.heritage.org/bg3004>. Citing Kass, Leon R. "Dehumanization Triumphant." *First Things*, August 1996.

¹⁷ General Assembly of the United Nations. *Universal Declaration of Human Rights*. December 10, 1948. United Nations, New York. Art. 3.

¹⁸ General Assembly of the United Nations. *International Covenant on Civil and Political Rights*. December 16, 1966. United Nations, New York. Art. 6.1; General Assembly of the United Nations. *International Covenant on Civil and Political Rights*. December 16, 1966. United Nations, New York. Art. 10.

suicide implicitly. For instance, the right to health care supports legalization of physician-assisted suicide, because, as articulated by the World Health Organization, “[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”¹⁹ The right to health care is provided for in several treaties and conventions. The non-binding but standard-setting UDHR specifies that “Everyone has the right to... medical care...”²⁰ This right is further solidified by the International Covenant on Economic, Social, and Cultural Rights (ICESCR), which specifies that in order to guarantee the right to “the highest attainable standard of physical and mental health,” States Parties must provide for “the creation of conditions which would assure to all medical service and medical attention in the event of sickness.”²¹

Since prescribing lethal doses of medication for the purpose of suicide is a medical act, proponents argue that physician-assisted suicide falls under the proviso of adequate medical care; especially because many people use physician-assisted suicide when options like hospice care (a type of palliative care) are not adequate for subduing pain in one’s final days. For example, Sandy Trunzer, a 49 year old woman diagnosed desires to turn off her pacemaker and use palliative sedation to end her own life with assistance, so that she will not be in pain. She has Erdheim-Chester Disease, a condition characterized by the overproduction of histiocytes, which then go on to attack bones and organs.²² Though turning off a pacemaker is not the typical form

¹⁹ International Health Conference. *Constitution of the World Health Organization*. July 22, 1946. New York. Preamble.

²⁰ General Assembly of the United Nations. *Universal Declaration of Human Rights*. December 10, 1948. United Nations, New York. Art. 25.1.

²¹ United Nations General Assembly. *International Covenant on Economic, Social, and Cultural Rights*. December 16, 1966. United Nations, New York. Art. 12.

²² Histiocytosis Association. "Erdheim-Chester Disease." Erdheim-Chester Disease . Accessed April 11, 2017. <https://www.histio.org/page.aspx?pid=403#.WOzhGRTLQ1g>; "Assisted Suicide - Sandy Trunzer's Story - Last Right Series ." In *The National*. Canadian Broadcast Corporation. November 25, 2013. Accessed March 14, 2017. <https://www.youtube.com/watch?v=X6y975Xm3II>.

of aid one thinks of as physician-assisted suicide, hospice providers were uncomfortable helping her with palliative sedation if it was needed as a result of a medical procedure to stop a life-sustaining medical implant. Trunzer explains "...the hospice staff were not comfortable with the idea of having the pacemaker turned off at the hospice, and receiving comfort care. I'm doing my best to work within the confines of Canadian law that it is my right to have the pacemaker turned off and it is also my right to have palliative care... trying to make the two fit together is proving to be quite the challenge."²³

Physician-assisted suicide was not legal where Trunzer was in Canada at the time, so instead she was trying to access the appropriate care through hospices, "feeling like [she had] been stonewalled."²⁴ Because the hospices refused to provide her with the health care options which could alleviate Trunzer's terminal pain, her final days, before she was able to find a doctor to help her, were spent battling with bureaucracy, rather than spending time with her daughter, who had taken time off of her education to be with her mother in her final months.²⁵

Another core human right that implicitly supports the right to physician-assisted suicide is the recognition of the inherent dignity of the person. The UDHR, the ICCPR, the ICESCR, and the Convention on the Rights of Persons with Disabilities state that "recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world," in their respective preambles.²⁶ Human

²³ "Assisted Suicide - Sandy Trunzer's Story - Last Right Series ." In *The National*. Canadian Broadcast Corporation. November 25, 2013. Accessed March 14, 2017.

<https://www.youtube.com/watch?v=X6y975Xm3ll>. (0:26-0:58).

²⁴ *Ibid.*, (8:36-8:42)

²⁵ "Assisted Suicide - Sandy Trunzer's Story - Last Right Series ." In *The National*. Canadian Broadcast Corporation. November 25, 2013. Accessed March 14, 2017.

<https://www.youtube.com/watch?v=X6y975Xm3ll>.

²⁶ General Assembly of the United Nations. *Universal Declaration of Human Rights*. December 10, 1948. United Nations, New York. Preamble; General Assembly of the United Nations. *International Covenant on Civil and Political Rights*. December 16, 1966. United Nations, New York . Preamble;

dignity is the basis of all other rights. For example the right to education, which is widely and explicitly protected, aims at enhancing and preserving the respect for the unique dignity of each person; “education shall be directed to the full development of the human personality and the sense of its dignity, and shall strengthen the respect for human rights and fundamental freedoms.”²⁷

It is possible to live and die with dignity without physician-assisted suicide in most cases. However, for some people, the debilitating features of an illness may cause them to lose their sense of dignity; for many patients, limited mobility, reliance on others, and pain and suffering can contribute to losing the respect of self and others, and one’s sense of dignity. Though disability rights advocates correctly point out that loss of mobility, reliance on others, and disability do not diminish the inherent dignity of all people, these factors can make them feel as though their dignity is not respected or validated. Furthermore, losing the autonomy to make medical decisions for oneself itself can cause loss of dignity. Just because one has a disability does not mean they lose their dignity or right to privacy in medical decision-making; therefore, they should be able to make this decision.²⁸ Although Ryan Anderson argues that legalization of physician-assisted suicide “[betrays] human dignity,” I argue that dignity is not respected by its prohibition, because prohibition on physician-assisted suicide does not respect the individuality, personhood, and dignity, of the patient.²⁹

United Nations General Assembly. *International Covenant on Economic, Social, and Cultural Rights*. December 16, 1966. United Nations, New York. Preamble.

²⁷ United Nations General Assembly. *International Covenant on Economic, Social, and Cultural Rights*. December 16, 1966. United Nations, New York. Art. 13.

²⁸ General Assembly of the United Nations. *Universal Declaration of Human Rights*. December 10, 1948. United Nations, New York. Art. 12; Paust, Jordan J. "The Human Right to Die With Dignity: A Policy-Oriented Essay." *Human Rights Quarterly* 17, no. 3 (1995): 478. doi:10.1353/hrq.1995.0030.

²⁹ Anderson, Ryan T. "Always Care, Never Kill: How Physician-Assisted Suicide endangers the weak, Corrupts Medicine, Compromises the Family, and Violates Human Dignity and Equality."

The right to the recognition of one's dignity dovetails with the guarantee of the autonomy of the individual. The right to autonomy is central to almost every pro-legalization activist's argument for approving physician-assisted suicide. Though very few people are advocating for physician-assisted suicide on an international level, the right to autonomy is almost always mentioned in state-level political arguments for legalization.

“An essential part of contemporary human rights is the concept of personal autonomy. Every person has to have autonomy so that he/she can feel free to make decisions. A person who feels free to make decisions will feel secure and happy. The human being is understood to be an essentially independent and individually developing entity.”³⁰

Just as respecting the dignity of all people is central to the role of the state in protecting human rights law, so is recognizing and ensuring the right to autonomy. Key to autonomy is the ability to make decisions for one's self. This right extends to everyone, including the dying. “One's status as a dying patient or terminally ill person is not a proper basis for the denial or deprivation of basic human rights.”³¹ Legalizing physician-assisted suicide is one way for the state to protect and extend autonomy to people who may otherwise be stripped of their choices and their ability to control their own body by the circumstances of illness. Rather than infringing on any existing right, legalizing physician-assisted suicide extends respect and individualism to some of the most forgotten people in society – the ill and dying.

Backgrounder(2015): 1. *The Heritage Foundation*. The Heritage Foundation, 24 Mar. 2015. Web. 27 Mar. 2017.

³⁰ Gumbis, Jaunius, Vytaute Bacianskaite, and Jurgita Randakeviciute. *Do Human Rights Guarantee Autonomy?* Publication. University of Vilnius. Vol. 62/63. Cuadernos Constitucionales de la Cátedra Fadrique Furió Ceriol. 77. Accessed April 11, 2017. <https://dialnet.unirioja.es/descarga/articulo/3684807.pdf>.

³¹ Paust, Jordan J. "The Human Right to Die With Dignity: A Policy-Oriented Essay." *Human Rights Quarterly* 17, no. 3 (1995): 478. doi:10.1353/hrq.1995.0030.

What is a Norm?

Just as there is a spectrum of definitions for end-of-life options, there are also gradations in the range of human rights law. Short of codification in international treaty, there are human rights norms that carry weight in human rights courts such as the International Court of Justice. While there are extensive *de jure* international human rights laws now, until the drafting of the ICCPR and the ICESCR in 1966, human rights creation was largely normative.³² Since the beginning of codification at the UN and in other international organizations, existing norms have been formalized extensively through treaties, including the Universal Declaration of Human Rights, The Convention on the Elimination of all forms of Racial Discrimination, the European Convention on Human Rights, and the American Declaration on the Rights and Duties of Man, among other texts. The existence and continued process of codification of unwritten norms continues to this day.³³

In areas not discussed in treaty, human rights are often accepted by the community of nations through the process of norm building. Unlike the components of human rights expectations that have been codified into treaty, human rights norms generally are not explicitly stated. Rather, a norm “a standard of appropriate behavior for actors with a given identity.”³⁴ The term “norm,” as used by political scientists, is often used interchangeably with “institution,” as used by sociologists. The delineation between a norm and an institution in this case is that an institution is “a collection of practices and rules,” rather than just the individual rule, as implied

³² Buergethal, Thomas. "The Normative and Institutional Evolution of International Human Rights." *Human Rights Quarterly* 19, no. 4 (1997): 705. Accessed March 11, 2017. doi:10.1353/hrq.1997.0033.

³³ *Ibid.*

³⁴ Finnemore, Martha, and Kathryn Sikkink. "International Norm Dynamics and Political Change." *International Organization* 52, no. 4 (Autumn 1998): 891. Accessed March 14, 2017. doi:10.1162/002081898550789..

by “norm.”³⁵ For clarity’s sake, in this paper, I will use the word norm to encompass both individual rules and practices and groups of rules and practices.

Norm development is a useful step in the process of regularizing newly recognized human rights norms. Over the last quarter century, rights have been extended to more categories of people than ever, and the breadth of the rights states are expected to protect has grown quickly. In order to accommodate the expanding expectations of the public and human rights activists and scholars, many new rights are initiated through norm creation, rather than treaty drafting. When new rights are developed as norms, a trend of recognition can begin outside of states where a new right which may be culturally or politically inappropriate for the moment.

This process is often the way that international business practices are regulated in the human rights arena. Norms, rather than explicit law, are often used when violators of human rights are non-state actors, because only states can be held to public international law. Businesses that violate the human rights of the workers cannot explicitly be held to human rights law, but normative standards have developed over recent decades. Through corporate policy, companies define their own best practices, and, due to publicity and the changing trends of industry, increasing numbers companies have signed on to protecting the rights of workers. Though norms in the business world are rarely binding, but they are still created because there is growing “international awareness regarding the corporate responsibility toward human rights.”³⁶ The process of norm creation among nations can be seen through the lens of policy-making on the smaller scale corporate level.

³⁵ Ibid. Citing Jepperson, Ronald L. *The New Institutionalism in Organizational Analysis*. Edited by Walter W. Powell and Paul J. DiMaggio. Chicago, IL: University of Chicago Press, 1991. "Institutions, Institutional Effects, and Institutionalism" 143-163.

³⁶ Mantilla, Giovanni. "Emerging International Human Rights Norms for Transnational Corporations." *Global Governance* 15, no. 2 (April-June 2009): 279-280. Accessed March 11, 2017. JStor.

In the case of international human rights law, the actors bound by expectations are states. As with all public international law, states are the key obligation-bearing bodies. These standards of appropriate behavior emerge through the continued practice of many states, and the belief of a state that the right it is granting is necessary and expected. In their piece in *International Organization*, “International Norm Dynamics and Political Change,” scholars Martha Finnemore and Kathryn Sikkink, preeminent in the field of international norm establishment, explain that human rights law began to be established and enforced normatively rather than through explicit treaty during the Cold War. As the Soviet Union and the United States clashed ideologically and became geopolitical foes, it became increasingly important for each superpower to express its might by influencing the cultures and social norms of states within their respective spheres of influence. By promulgating Soviet and American social expectations, and becoming culturally hegemonic in less wealthy and politically influential states, each could extend its power and rise in status. During the 1970s, norms of political behavior became a way for powerful states to show their ideological influence on other states.³⁷

“According to Finnemore and Sikkink, a norm follows a “lifecycle” consisting of three stages: norm emergence, norm cascade, and norm internalization. In the stage of norm emergence... so-called ‘norm entrepreneurs attempt to convince a critical mass of states to embrace new norms.’”³⁸ In this way, states can, through shared ongoing practice, bring new

³⁷ Finnemore, Martha, and Kathryn Sikkink. "International Norm Dynamics and Political Change." *International Organization* 52, no. 4 (Autumn 1998): 888. Accessed March 14, 2017. doi:10.1162/002081898550789. Citing Keohane, Robert O., and Joseph S. Nye, Jr. "Transnational Relations and World Politics: An Introduction." *Transnational Relations and World Politics* 25 (1971): 329-52.

³⁸ Mantilla, Giovanni. "Emerging International Human Rights Norms for Transnational Corporations." *Global Governance* 15, no. 2 (April-June 2009): 279-80. Accessed March 11, 2017. JStor. Citing Peter Katzenstein, cited in Finnemore, Martha, and Kathryn Sikkink. "International Norm Dynamics

norms into existence. This constitutes the first stage of the life cycle “norm emergence.” When enough states have been convinced to embrace a new rule or standard practice, there is a critical juncture at which a “norm cascade” begins. This is the second stage of norm realization.

Finally, when many key states have explicitly or implicitly signed on to the new standard of behavior, the norm may become internalized.³⁹ In the context of human rights law, internalization may appear in the form of official codification or enshrinement in treaty, or it may appear as the elevation of a right to peremptory norm status. As will be demonstrated, at this time, physician-assisted suicide is an emerging norm, with legalization on the cusp of becoming so prevalent that the act qualifies as part of a norm cascade. Norm creation takes time, because one factor of states’ recognition of new rights is consistency of practice over time.

and Political Change." *International Organization* 52, no. 4 (1998): 887-917.
doi:10.1162/002081898550789.

³⁹ Finnemore, Martha, and Kathryn Sikkink. "International Norm Dynamics and Political Change." *International Organization* 52, no. 4 (Autumn 1998): 895. Accessed March 14, 2017.
doi:10.1162/002081898550789.

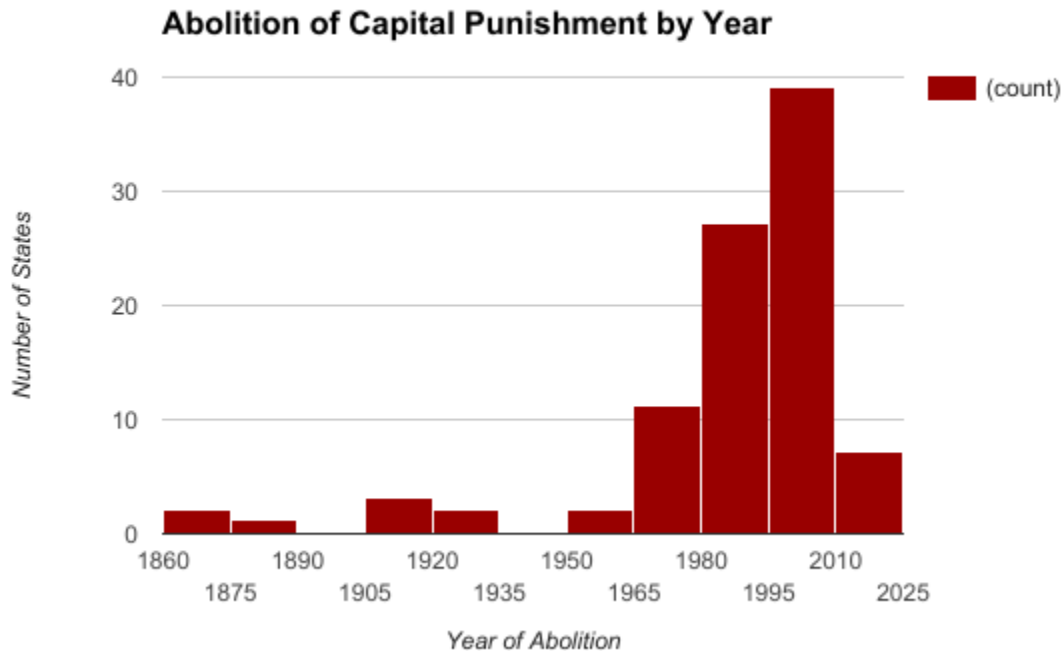
What Makes Physician-Assisted Suicide an Emerging Norm?

While physician-assisted suicide comports with human rights principles and law espoused in existing human rights law, as discussed, the right to die and physician-assisted suicide are not explicitly enumerated in any treaty. Nonetheless, I argue that in recent years, physician-assisted suicide has begun the process of becoming a norm, through increased rapidity of legalization, widespread ethical and political acceptance, and increased discussion of the subject in key international organization, including the United Nations. Though physician-assisted suicide is still a nascent right, the historical example of the worldwide abolition of the death penalty can be seen as an example of the trajectory I foresee legalization of physician-assisted suicide taking to become a norm.

Over the past 50 years, the abolition of the death penalty has spread over the globe, and has been a prime example of a relatively newly understood right gaining momentum, and consequently being accepted by exponentially more states and jurisdictions each year. As illustrated by the following graph, the number of states abolishing the death penalty each year has accelerated by the year since the 1970s. This pattern indicates growing widespread support for abolition, and represents the “cascade” stage of norm development.⁴⁰ In fact, “in the past decade [2006-2016], an average of over three countries a year have abolished the death penalty in law or, having done so for ordinary offences, have gone on to abolish it for all offences.”⁴¹

⁴⁰ Data: Amnesty International. *Abolitionist and Retentionist Countries as of 19 December 2016*. December 2016. Report. Graph: Schmitz, Lucy. "Abolition of Capital Punishment by Year." Digital image. Spring 2017.

⁴¹ Amnesty International. "Abolitionist and Retentionist Countries." Amnesty International. December 19, 2016. Accessed March 16, 2017. <https://www.amnesty.org/en/documents/act50/3831/2016/en/>.



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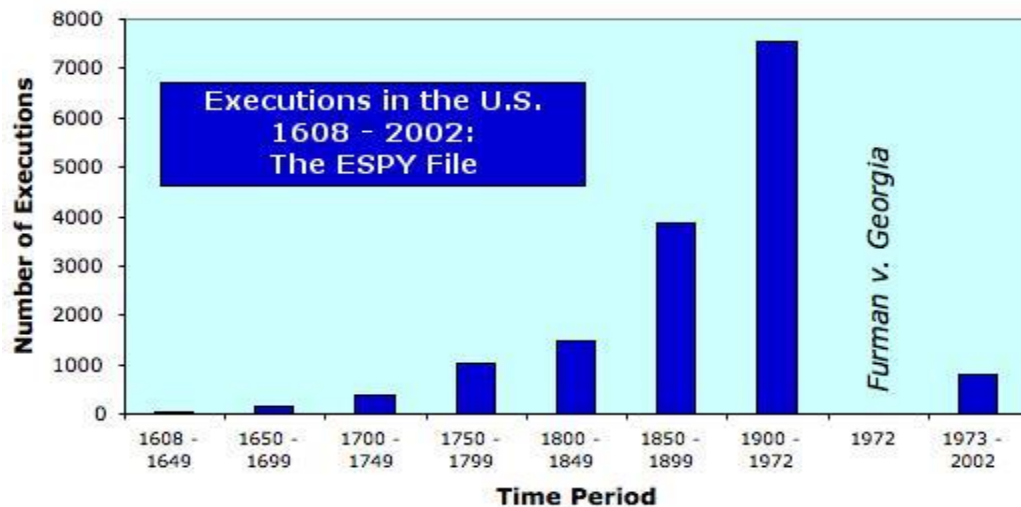
Chart 1: Abolition of Capital Punishment by Year

The movement for abolition has had support in individual states and internationally for decades, and ongoing efforts of human rights activists and international organizations, but some of the early components of the movement for abolition can be seen reflected in the fight around physician-assisted suicide today. There have been more explicit legal prohibitions of capital punishment than of physician-assisted suicide, but I argue that physician-assisted suicide has just not reached the critical mass of international scorn that promotes the multiple codifications of prohibition of the death penalty.

The legal wave of abolition of the death penalty began in the 1950s, when many western European, American-allied countries began to abolish the death penalty, and public opinion

⁴² Data: Amnesty International. *Abolitionist and Retentionist Countries as of 19 December 2016*. December 2016. Report. Graph: Schmitz, Lucy. "Abolition of Capital Punishment by Year." Digital image. Spring 2017.

began to turn against capital punishment. Even the United States prohibited the use of the death penalty for a short period, between 1972 and 1976.⁴³ Since then, as is demonstrated in Chart 2, the use of the death penalty declined significantly.⁴⁴



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Chart 2: Executions in the U.S. 1608 - 2002: The ESPY File

As of 2016, the prohibition of the death penalty is almost universally accepted on human rights grounds. “More than two-thirds of the countries in the world have now abolished the death penalty in law or practice.”⁴⁶ Now, there are only 57 countries that are “retentionist,” meaning they both have the death penalty on the books for “ordinary crimes,” or crimes that are not military related or committed in exceptional circumstances, and continue to employ capital

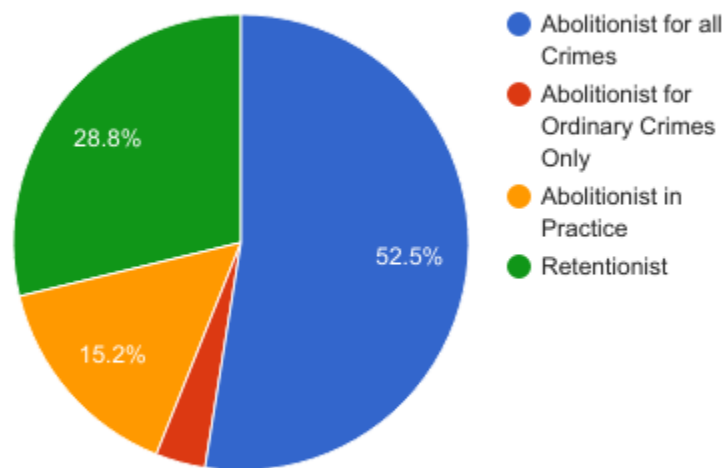
⁴³ *Furman v. Georgia* (June 29, 1972).

⁴⁴ Death Penalty Information Center. “Part I: History of the Death Penalty -The Abolitionist Movement.” Death Penalty Information Center. Accessed March 16, 2017. <http://www.deathpenaltyinfo.org/history-death-penalty>.

⁴⁵ Espy, M. Watt, and John Ortiz Smykla. “Executions in the U.S.1608-2002: the ESPY File.” Chart. In *Executions in the U.S.1608-2002: the ESPY File*. Ann Arbor, MI: Inter-University Consortium for Political and Social Research, 2016. Accessed March 16, 2017. <http://www.deathpenaltyinfo.org/history-death-penalty>.

⁴⁶ Amnesty International. *Abolitionist and Retentionist Countries as of 19 December 2016*. December 2016. Report

punishment.⁴⁷ Only 28.8% of states remain retentionist of capital punishment for all crimes, while “more than 160 Members States of the United Nations with a variety of legal systems, traditions, cultures and religious backgrounds, have either abolished the death penalty or do not practice it.”⁴⁸



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Chart 3: The Death Penalty: Abolitionist v. Retentionist States by Proportion

⁴⁷ Amnesty International . *Abolitionist and Retentionist Countries as of 19 December 2016*. December 2016. Report; Death Penalty Information Center. "Abolitionist and Retentionist Countries." Abolitionist and Retentionist Countries. Accessed March 16, 2017. <http://www.deathpenaltyinfo.org/abolitionist-and-retentionist-countries>.

⁴⁸ Office of the High Commissioner for Human Rights. "Death Penalty." Death Penalty. Accessed April 12, 2017. <http://www.ohchr.org/EN/Issues/DeathPenalty/Pages/DPIndex.aspx>.

⁴⁹ Data: Amnesty International . *Abolitionist and Retentionist States as of 19 December 2016*. December 2016. Report. Graph: Schmitz, Lucy. *The Death Penalty: Abolitionist v. Retentionist States by Proportion*. March 16, 2017. Graph.

After the first decades of accelerated abolition, international organizations and boards that have sway over human rights norm creation on the interstate level began to make comments and take stands which institutionalized and finalized the trend toward abolition. “The Council of Europe... prioritized abolition of the death penalty in 1997, calling for universal abolition, preliminarily stating that it believes the death penalty can no longer be regarded as an acceptable form of punishment from a human rights perspective.”⁵⁰ This statement precipitated the Treaty of Amsterdam, which entered into force in 1999, and “effectively abolishes the death penalty in all EU states.”⁵¹ That year, the European Union “declared that respect for human rights and fundamental freedoms will be a condition for admission.”⁵²

Similarly, the United Nations began to take a principled stand against the death penalty. Though states began to ban capital punishment in 1860, and the cascade of prohibition began in the 1950s, the United Nations only firmly condemned capital punishment with the Second Optional Protocol of the ICCPR in 1989, which states “No one within the jurisdiction of a State Party to the present Protocol shall be executed.”⁵³ Prior to 1989, Article 6 of the ICCPR allowed for capital punishment in some circumstances, though it was more broadly condemned.⁵⁴The

⁵⁰ Koenig, Dorean Marguerite. "International Reaction to Death Penalty Practices in the United States." *Human Rights Quarterly* 28, no. 3 (Summer 2001): 14. <http://www.jstor.org/stable/27880271>.

⁵¹ Ibid.

⁵² Ibid.

⁵³ General Assembly of the United Nations. *Second Optional Protocol to the International Covenant on Civil and Political Rights, aiming at the abolition of the death penalty*. December 15, 1989. United Nations, New York. Art. 1; Office of the High Commissioner for Human Rights. "Death Penalty." Death Penalty. Accessed April 12, 2017. <http://www.ohchr.org/EN/Issues/DeathPenalty/Pages/DPIIndex.aspx>.

⁵⁴ General Assembly of the United Nations. *International Covenant on Civil and Political Rights*. December 16, 1966. United Nations, New York. Art. 6.2; Office of the High Commissioner for Human Rights. "Death Penalty." Death Penalty. Accessed April 12, 2017. <http://www.ohchr.org/EN/Issues/DeathPenalty/Pages/DPIIndex.aspx>.

death penalty has now been officially prohibited in the Second Optional Protocol to the International Covenant on Civil and Political Rights.⁵⁵

Finally, another key component of human rights norm creation is the rejection of outliers who dismiss an emerging right by the community of nations. The United States is one of the few major world powers that still regularly employs the death penalty, and “without doubt, death penalty practices in the United States have damaged its international standing.”⁵⁶ This disapproval by the international community has been reflected in statements by key human rights organs of the United Nations and the attitudes and actions of other states towards the United States. For instance, some states refuse to honor their extradition treaties with the United States in cases where the death penalty could be implemented. “On February 15, 2001, the Canadian Supreme Court issued a unanimous decision holding that it would no longer permit extraditions to the United States in cases in which capital punishment was possible, thus disallowing extradition even where it is unclear whether the death penalty would be sought.”⁵⁷

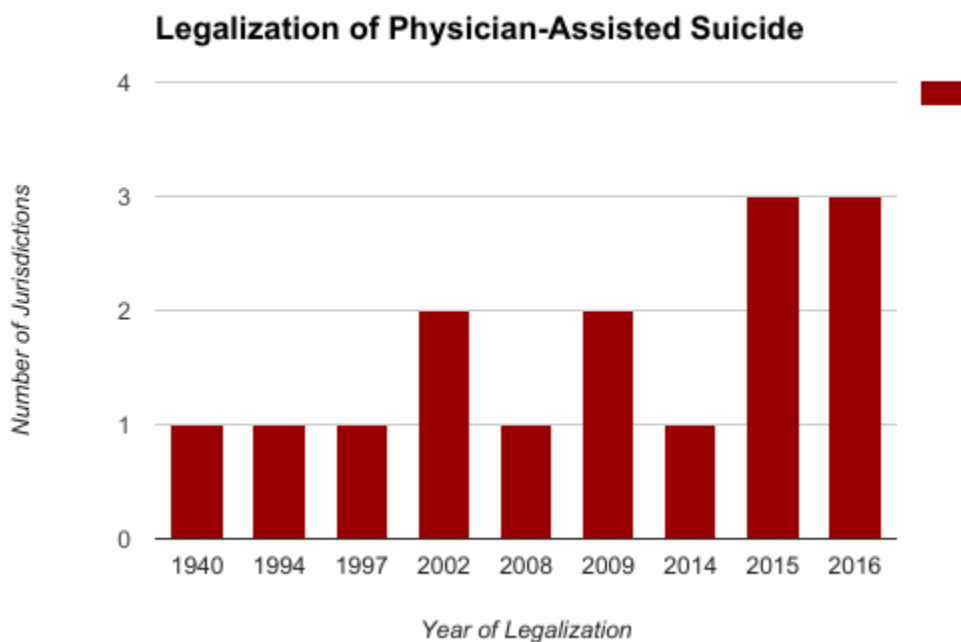
Around the world, six countries and seven American states have legalized physician-assisted suicide. This may not initially seem like very many jurisdictions, but the number of jurisdictions considering legalization is ever-growing, and states are legalizing physician-assisted suicide at an accelerating rate, as is reflected in Chart 4. As an example of the increasing number of jurisdictions considering the issue, “in 2015, 18 [American] states were considering laws to

⁵⁵ General Assembly of the United Nations. *Second Optional Protocol to the International Covenant on Civil and Political Rights, aiming at the abolition of the death penalty*. December 15, 1989. United Nations, New York.

⁵⁶ Koenig, Doreen Marguerite. "International Reaction to Death Penalty Practices in the United States." *Human Rights Quarterly* 28, no. 3 (Summer 2001): 15. <http://www.jstor.org/stable/27880271>.

⁵⁷ *Ibid.*, 16.

allow physician-assisted suicide.”⁵⁸ The fact that politicians are even debating this issue is a step towards legalization and norm creation.



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Chart 4: Legalization of Physician-Assisted Suicide

⁵⁸ Huntoon, Lawrence R. "Physician-Assisted Suicide and Euthanasia: The Destruction of Morals, Ethics, and Medicine." *Journal of American Physicians and Surgeons* 21.4 (2016): 98. *Journal of American Physicians and Surgeons*. Journal of American Physicians and Surgeons, Winter 2016. Web. 28 Mar. 2017. Citing Anderson, Ryan T. "Always Care, Never Kill: How Physician-Assisted Suicide endangers the weak, Corrupts Medicine, Compromises the Family, and Violates Human Dignity and Equality." *Backgrounders*(2015): 1-22. *The Heritage Foundation*. The Heritage Foundation, 24 Mar. 2015. Web. 27 Mar. 2017.

⁵⁹ Data: "Euthanasia & Physician-Assisted Suicide (PAS) around the World." Should euthanasia or physician-assisted suicide be legal? Accessed March 16, 2017. <http://euthanasia.procon.org/view.resource.php?resourceID=000136>; Euthanasia Research and Guidance Organization. "Assisted Suicide Laws Around the World - Assisted Suicide." Assisted Suicide Laws Around the World - Assisted Suicide. Accessed January 31, 2017. http://www.assistedsuicide.org/suicide_laws.html; "State-by-State Guide to Physician-Assisted Suicide - Euthanasia - ProCon.org." Should euthanasia or physician-assisted suicide be legal? Accessed March 16, 2017. <http://euthanasia.procon.org/view.resource.php?resourceID=000132>.; Lewis, Penney. "Assisted dying: What does the law in different countries say?" BBC News. October 06, 2015. Accessed March 16, 2017. <http://www.bbc.com/news/world-34445715>. Graph: Schmitz, Lucy . *Legalization of Physician Assisted Suicide*. March 16, 2017. Graph.

There have not yet been widespread comments on physician-assisted suicide by international organizations, but there has been a trend toward legalization, which indicates that physician-assisted suicide is in the very early stages of becoming a norm, before widespread recognition by international organizations. This is in part because physician-assisted suicide is so newly introduced into the world of human rights, just as international organizations only began to comment explicitly on the death penalty.

Today, ambiguity exists about physician-assisted suicide in the limited public comments made on the matter by international organizations. Though states on the vanguard of human rights have approved physician-assisted suicide, international organizations, slow moving and complex as they are, have not yet caught up. As an indicator of the debate surrounding this issue in the international community, there have been divergent positions on the issue held by the United Nations and the European Court of Human Rights. A UN press release from 2001 announcing the Human Rights Committee's conclusions and remarks on Netherlands, Czech Republic, Monaco, Guatemala and Democratic People's Republic of Korea demonstrates tepid support for the principle of physician-assisted suicide. When offered the opportunity to condemn the legalization of euthanasia and physician-assisted suicide in Netherlands, the committee refused to do so. Rather, it lists a number of concerns about the implementation of physician-assisted suicide laws, not the law itself. The press release states:

““Among its principal concerns, the Committee said that the law on euthanasia and assisted suicide contained a number of conditions under which the physician was not punished when he or she terminated the life of a person, among other things, on the “voluntary and well-considered request” of the patient in a situation of “unbearable suffering” offering “no prospect of improvement and “no other reasonable solution”. It was concerned lest such a system might fail to detect and prevent situations where undue pressure could lead to those criteria being circumvented.”⁶⁰

⁶⁰ United Nations . Meetings Coverage and Press Releases. "Human Rights Committee Concludes Seventy-Second Session: Issues Final Conclusions and Recommendations on Reports of

The fact that the committee chose to express concerns about specific circumstances of implementation, rather than with the general principle of state-sanctioned physician-assisted suicide is a step towards recognition and norm creation. However, the European Court of Human Rights found against the right to physician-assisted suicide when it “on January 20, 2011 [it] ruled that while there is a ‘human right’ to suicide, the state has no obligation to provide citizens with the means to commit suicide.”⁶¹

Though the ruling of the European Court of Human Rights does not indicate a receptive environment, the example of the process of normalization and then codification indicates that this is not a prohibitive barrier to norm-creation at this early stage in the life of the emerging right to physician-assisted suicide. Part of what contributes to the recognition of rights by international organizations and norm creation and stabilization in general is consistency of practice, which has not had time to develop yet in the short history of legalization of physician-assisted suicide. The example of the abolition of the death penalty provides an historical blueprint for my projections of how physician-assisted suicide is becoming a norm. Though this right is in its nascent stages, I predict it will follow a similar path. Public opinion turns in favor of legalization, and increasing numbers of states will legalize it. When enough momentum builds, as states with legal physician-assisted suicide grow almost exponentially, more international organizations will begin to respect the right, and it will become a norm.

Netherlands, Czech Republic, Monaco, Guatemala, and Democratic People's Republic of Korea." News release, July 30, 2001. United Nations Meetings Coverage and Press Releases. Accessed March 17, 2017. <http://www.un.org/press/en/2001/hrct610.doc.htm>.

⁶¹ Saunders, Peter. "20 things you might not know about assisted suicide in Europe." National Right to Life News Today. July 05, 2013. Accessed March 30, 2017. <http://www.nationalrighttolifenews.org/news/2013/07/20-things-you-might-not-know-about-assisted-suicide-in-europe/#.WN1RuBTLSfQ>.

Arguments Against Physician-Assisted Suicide

Though I argue that physician-assisted suicide is an emerging norm because more and more states in Europe and the Americas are legalizing the practice, public acceptance of assisted suicide varies from state to state, and is different in different demographics. Age, location, religion, race, and socioeconomic class can all contribute to one's beliefs about the role of the doctor and end-of-life care options. In addition to the predisposition of individuals for or against legalization based on their existing beliefs and identities, advocacy for and against physician-assisted suicide by activists and scholars can contribute to the issue's place in public consciousness. Advocacy can be effective; the arguments made by individuals on each side of this issue contribute to public opinion around legalization, and stem from core beliefs founded in the public's religious convictions and core values.

In some states, advocacy for physician-assisted suicide has been effective. In the states where the process is legal, sincere advocates who were affected by severe illnesses and terminal disease pushed for legalization. Dying in excruciating pain, or watching their loved ones do the same, advocates in Canada, the United States, and the Netherlands worked tirelessly through the court system and legislative bodies to legalize the option. Some of their key arguments have been articulated in the sections "Comportment with Existing Law" and "What Makes Physician-Assisted Suicide an Emerging Norm?"

Opposition to physician-assisted suicide largely comes from right wing organizations and religious groups, including, notably, The Heritage Foundation, and the Association of American Physicians and Surgeons, a non-partisan group which is regarded as conservative, which opposes

government involvement in the healthcare system.⁶² Because of language barriers to access to advocacy materials and articles in other languages, most of the texts I used to understand opposition to physician-assisted suicide are in English, and written from an American or Canadian perspective. While supporters of legalization argue in terms of the Human Rights implications of allowing patients to “die with dignity” rather than suffering, opponents largely do not use the lexicon of Human Rights law or theory. This makes squaring the two positions against each other difficult, because they use different frameworks to explain their points of view.

In arguing against physician-assisted suicide, the conservative Heritage Foundation lays out four key reasons to oppose legalization. These arguments seem to be characteristic of other organizations’ opposition to legalization. The first argument against physician-assisted suicide is that legalization is a threat to vulnerable people. In his *Backgrounder* article for the Heritage Foundation, Ryan T. Anderson states a belief that physician-assisted suicide poses a risk to patients who could feel “cultural pressures and economic incentives” to end their lives and avoid being burdensome to their family and caregivers.⁶³ Ultimately, he argues, “People who deserve

⁶² Association of American Physicians and Surgeons. "About AAPS." Association of American Physicians and Surgeons. Accessed March 29, 2017. <http://aapsonline.org/about-aaps/>.

⁶³ Anderson, Ryan T. "Always Care, Never Kill: How Physician-Assisted Suicide endangers the weak, Corrupts Medicine, Compromises the Family, and Violates Human Dignity and Equality." *Backgrounder*(2015): 1. *The Heritage Foundation*. The Heritage Foundation, 24 Mar. 2015. Web. 27 Mar. 2017. Citing Public opinion data from Fairfield, Kathleen M., K. M. Murray, H. R. Wierman, P. K. Han, S. Hallen, E. L. Trimble, J. L. Warren, and C. C. Earle. "Disparities in Hospice Care Among Older Women Dying with Ovarian Cancer." *Journal of Gynecologic Oncology*125, no. 1 (2012): 14-18.; Nayar, Preethy, F. Qiu, S. Watanabe-Galloway, E. Biolesen, H. Wang, L. Lander, and M. Islam. "Disparities in End of Life Care for Elderly Lung Cancer Patients." *Journal of Community Health*39, no. 5 (October 2014): 1012-019. doi:10.1007/s10900-014-9850-x.; Lopresti, Melissa ,

society's assistance are instead offered accelerated death."⁶⁴ This is core to the opposition to legalization - rather than viewing assisting in the suicide of a suffering person, like advocates do, opponents view accelerating death as a betrayal of the responsibility of one person to another, to help an individual live, and take care of them through medical and palliative care. Additionally, one key vulnerable group that Anderson argues is at risk if physician-assisted suicide is legalized is the mentally ill. He cites that "nearly 95 percent of those who kill themselves have been shown to have a diagnosable psychiatric illness in the months preceding suicide."⁶⁵ However, this is a weak argument, because this statistic takes into account all suicides, without specifically measuring instances of the mentally ill killing themselves with the help of a physician, in compliance with the requirements for legal physician-assisted suicide.

Citing Supreme Court Justice Gorsuch, then a federal judge, Anderson also argues that there is a slippery slope from legalizing physician-assisted suicide to euthanasia, which is

Fritz Dement, and Heather T. Gold. "End-of-Life Care for People with Cancer from Ethnic Minority Groups: A Systematic Review." *American Journal of Hospice and Palliative Care* 33, no. 3 (April 2016): 291-305. doi:10.1177/1049909114565658.

; Emanuel, Ezekiel, Diane L. Fairclough, and Linda Emanuel. "Attitudes and Desires Related to Euthanasia and Physician-Assisted Suicide Among Terminally Ill Patients and Their Caregivers." *Journal of the American Medical Association* 284, no. 19 (November 15, 2000): 2460-468. Accessed March 4, 2015. <http://jama.jamanetwork.com/article.aspx?articleid=193281>.; Lilian Liou Cohen, "Racial/Ethnic Disparities in Hospice Care: A Systematic Review," *Journal of Palliative Medicine*, Vol. 11, No. 5 (June 2008), pp. 763–768; and Amanda Connolly, Elizabeth Sampson, and Nitin Purandare, "End-of-Life Care for People with Dementia from Ethnic Minority Groups: A Systematic Review," *Journal of American Geriatric Society*, Vol. 60, No. 2 (February 2012), pp. 351–360, <http://www.ncbi.nlm.nih.gov/pubmed/22332675> (accessed February 23, 2015).

⁶⁴ Anderson, Ryan T. "Always Care, Never Kill: How Physician-Assisted Suicide endangers the weak, Corrupts Medicine, Compromises the Family, and Violates Human Dignity and Equality." *Backgrounders*(2015): 2. *The Heritage Foundation*. The Heritage Foundation, 24 Mar. 2015. Web. 27 Mar. 2017.

⁶⁵ *Ibid.*, 5. Citing Hendin, Herbert. *Seduced by Death: Doctors, Patients, and Assisted Suicide*. New York: W.W. Norton, 1998.

sometimes involuntary, and can be even more dangerous to vulnerable or mentally or physically compromised individuals. Some opponents to physician-assisted suicide, including Judge Gorsuch and Anderson, doubt the honesty of activists in favor of legalization. Anderson says “While most activists in the United States publicly call only for [physician-assisted suicide], they have historically advocated not only PAS, but also euthanasia...”⁶⁶

Furthermore, opponents argue that the legalization of physician-assisted suicide fundamentally undermines the doctor-patient relationship and the implicit promise of doctors to their patients not to harm them. Citing an older version of the Hippocratic oath, Anderson quotes ‘I will keep [the sick] from harm and injustice. I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect.’⁶⁷ Though Anderson contends that this promise excludes physician-assisted suicide from the purview of a doctor, other oaths are not as clear on the issue. For instance, the more modern version of the Hippocratic Oath, written in 1964 and used frequently today, declares that “I will apply, for the benefit of the sick, all measures which are required, avoiding those twin traps of overtreatment and therapeutic nihilism.”⁶⁸ This version of the text seems significantly less fundamentally opposed to physician-assisted suicide than the version cited by Anderson. By condemning the “twin traps of overtreatment and therapeutic nihilism,” this version of the text seems to acknowledge that more treatment is not always better, and recognizes that the doctor’s duty is sometimes to end

⁶⁶ Anderson, Ryan T. "Always Care, Never Kill: How Physician-Assisted Suicide endangers the weak, Corrupts Medicine, Compromises the Family, and Violates Human Dignity and Equality." *Backgrounders*(2015): 3. *The Heritage Foundation*. The Heritage Foundation, 24 Mar. 2015. Web. 27 Mar. 2017.

⁶⁷ Edelstein, Ludwig. *The Hippocratic Oath: Text, Translation, and Interpretation*. Translated by Ludwig Edelstein. Baltimore, MD: Johns Hopkins Press, 1943. December 14, 2016. Accessed March 29, 2017. <http://guides.library.jhu.edu/c.php?g=202502&p=1335752>.

⁶⁸ Lasagna, Louis. "Guides: Bioethics: Hippocratic Oath, Modern version." Hippocratic Oath, Modern version - Bioethics - Guides at Johns Hopkins University. December 14, 2016. Accessed March 29, 2017. <http://guides.library.jhu.edu/c.php?g=202502&p=1335759>.

treatment, if not life. The difference between the two texts can be explained by a shift in the medical establishment toward supporting physician-assisted suicide. Nonetheless, some oppose the practice because physician-assisted suicide “corrupts the profession of medicine by permitting the tools of healing to be used as techniques for killing.”⁶⁹

Anderson articulates one other argument that is commonly used across groups that oppose the legalization of physician-assisted suicide. He believes that having the option of terminating the life of an ill or dying person before nature takes its course undermines the commitment of younger generations to care for and support the elderly. Having access to physician-assisted suicide promotes the belief that the elderly are burdens who can be done away with, rather than integral parts of the family and community. “The temptation to view elderly or disabled family members as burdens will increase, as will the temptation for those family members to internalize this attitude and view *themselves* as burdens.”⁷⁰ Essentially, the cost of caring for an ill family member will be judged against the expediency of killing a patient and ending social, emotional, and financial responsibilities for them. “Physician-assisted suicide offers a cheap, quick fix in a world of increasingly scarce healthcare resources.”⁷¹ This argument, too, falls short of convincing. While there is certainly a risk of caregivers exerting pressure on vulnerable patients to undergo physician-assisted suicide, the legal requirements of repeated, voluntary, oral and written requests for prescriptions for suicide-inducing drugs, and the requirement of self-administration of the medication mitigate this risk. In fact, as of July

⁶⁹ Anderson, Ryan T. "Always Care, Never Kill: How Physician-Assisted Suicide endangers the weak, Corrupts Medicine, Compromises the Family, and Violates Human Dignity and Equality." *Backgrounders*(2015): 2. *The Heritage Foundation*. The Heritage Foundation, 24 Mar. 2015. Web. 27 Mar. 2017.

⁷⁰ *Ibid.*

⁷¹ *Ibid.* 7.

2016, “in no jurisdiction was there evidence that vulnerable patients have been receiving euthanasia or physician-assisted suicide at rates higher than those in the general population.”⁷²

Additionally, opponents to legalization tend to view palliative care as sufficient in ameliorating the suffering of dying patients. Palliative care includes the use of painkillers and other medication to reduce discomfort. In some cases, it can even involve terminal sedation of a patient in their final days or hours. While this is sufficient to end the suffering of many people, and allows death to come naturally, in some cases, palliative care is not enough. According to the opposition group, the Maine Right to Life Committee, the reasons people choose physician-assisted suicide can be broken down as follows:

Reason for Choosing Physician-Assisted Suicide	Percentage of Respondents
Loss of Autonomy	91.5%
Decreased Ability to Engage in Enjoyable Activities	88.7%
Loss of Dignity	79.3%
Loss of Control of Body	50%
Becoming a Burden on Others	40%
Physical Pain or Fear of Physical Pain	23%

⁷³

Chart 5: Reasons for Choosing Physician-Assisted Suicide

⁷² Emanuel, E. J., B. D. Onwuteaka-Philipsen, J. W. Urwin, and J. Cohen. "Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe." *Journal of the American Medical Association* 316, no. 1 (July 5, 2016): 79-90. Accessed March 30, 2017. doi:10.1001/jama.2016.8499.

⁷³ Data: Maine Right to Life Committee. "Physician Assisted Suicide." Maine Right to Life. Accessed March 29, 2017. <https://www.mainerighttolife.com/physician-assisted-suicide>. Chart: Schmitz, Lucy. "Reasons for Choosing Physician-Assisted Suicide." Digital image. Spring 2017. Chart.

According to the Maine Right to Life Committee, these are the issues doctors should be working to solve, rather than hastening death. While some supporters of legalization believe that death can be the only solution to these problems under certain circumstances, this organization and others reiterate the need for palliative care in place of assisted suicide. They argue “[if you or a loved one does not receive adequate pain management from your physician, find another doctor. Suicide should never be prescribed as a medical treatment.”⁷⁴ While it is undeniably important for physicians to work with their patients to meet their needs in a palliative context, I contend that this obligation does not conflict with providing the option of physician-assisted suicide when other avenues are exhausted.

The other core component of many arguments opposing physician-assisted suicide consists of religious arguments. According to Kevin Drum of Mother Jones Magazine, “*Evangelium Vitae*... popularized the epithet ‘culture of death,’ which has since been adopted by born-again Christians to condemn both abortion and assisted suicide.”⁷⁵ Quoting scripture is common in texts opposing physician-assisted suicide, which argue that God values all life, and humans should not make the decision to end their life, as it is God’s role to choose when one dies.⁷⁶ According to this argument “the world values human life not as a gift from the Creator but according to its utility to the living.”⁷⁷ Quoting a modern version of the Hippocratic Oath which incorporates God, Lawrence R. Huntoon, in the conservative *Journal of American*

⁷⁴ Maine Right to Life Committee. "Physician Assisted Suicide." Maine Right to Life. Accessed March 29, 2017. <https://www.mainerighttolife.com/physician-assisted-suicide>.

⁷⁵ Drum, Kevin. "My Right to Die: Assisted Suicide, My Family, and Me." *Mother Jones Magazine*, Jan. & Feb. 2016. January 11, 2016. Accessed March 28, 2017. <http://www.motherjones.com/politics/2016/01/assisted-suicide-legalization-california-kevin-drum>.

⁷⁶ Berger, Ben. "Life Worth Living." *Clearly Caring Mini Edition*, October 2015, 3-5. Accessed March 28, 2017. http://www.clearlycaring.com/uploads/3/5/4/3/3543641/clearly_caring_mini-oct15.pdf.

⁷⁷ Berger, Ben. "Life Worth Living." *Clearly Caring Mini Edition*, October 2015, 1. Accessed March 28, 2017. http://www.clearlycaring.com/uploads/3/5/4/3/3543641/clearly_caring_mini-oct15.pdf.

Physicians and Surgeons, points out the oath says “above all I must not play at God,”⁷⁸ but Lawrence argues that “A physician’s decision to take the life of another human being, however, is playing God.”⁷⁹ Though these may be compelling arguments for members of the public who are religious, most states, including the United States, have secular governments. Because these arguments are not made in political or human rights contexts, they are difficult to argue against with human rights rhetoric. However, equally, they should not be influential in secular legislatures. Nonetheless, religious arguments can be persuasive to members of the public who are religious; because, “In the eyes of biblical literalists, physician-assisted suicide and certain palliative care measures may be seen as being in direct contradiction with biblical scripture, namely, those passages that emphasize the sanctity of life such as "Thou shalt not kill" (Exodus 20:13) and "Do not slay the innocent and righteous" (Exodus 23:7).”⁸⁰

Finally, one argument that is critical of the recent snowballing of legalization after another is the elitism of advocacy for physician-assisted suicide. Though this is not exactly an argument that opposes legalization outright, it pins the trend towards legalization on elites, and implicitly condemns the right as new and anti-populist. In opposing legalization, Ben Berger, writing in *Clearly Caring*, a publication of Christian Life Resources, argues “Citizens and policymakers need to resist the push by pressure groups, academic elites, and the media to

⁷⁸ Huntoon, Lawrence R. "Physician-Assisted Suicide and Euthanasia: The Destruction of Morals, Ethics, and Medicine." *Journal of American Physicians and Surgeons* 21.4 (2016): 98-101. *Journal of American Physicians and Surgeons*. Journal of American Physicians and Surgeons, Winter 2016. Web. 28 Mar. 2017. Quoting Tyson P. The Hippocratic Oath today. PBS NOVA; Mar 27, 2001. Available at: <http://www.pbs.org/wgbh/nova/body/hippocratic-oath-today.html>. Accessed Nov 8, 2016.

⁷⁹ Huntoon, Lawrence R. "Physician-Assisted Suicide and Euthanasia: The Destruction of Morals, Ethics, and Medicine." *Journal of American Physicians and Surgeons* 21.4 (2016): 98. *Journal of American Physicians and Surgeons*. Journal of American Physicians and Surgeons, Winter 2016. Web. 28 Mar. 2017.

⁸⁰ Burdette, Amy M., Terrence D. Hill, and Benjamin E. Moulton. "Religion and Attitudes toward Physician-Assisted Suicide and Terminal Palliative Care." *Journal for the Scientific Study of Religion* 44, no. 1 (March 2005): 81. Accessed April 2, 2017. <http://www.jstor.org/stable/3590520>.

sanctions [physician-assisted suicide].”⁸¹ Statistically, it is true that physician-assisted suicide is an elite problem. Legalization has taken place largely in wealthy western European countries, and in wealthier, whiter American states.⁸² “The 2014 report from the Oregon Health Authority says that the median age of [the Death with Dignity Act] patients is 72 years old; 95 percent are white, and three-quarters have at least some college education.”⁸³ In places where physician-assisted suicide is legal, wealthier, more educated, white people are more likely to take advantage of the option than poorer people and members of minority groups.

“The assisted-suicide movement has long been dominated by well-off, educated whites. As early as 1993, Dick Lehr reported in a *Boston Globe* series titled ‘Death and the Doctor’s Hand’ that every doctor he talked to said that patients who asked about assistance in dying were typically middle to upper class and accustomed to being in charge. As one oncologist put it, ‘These are usually very intelligent people, in control of their life—white, executive, rich, always leaders of the pack, can’t be dependent on people a lot.’”⁸⁴

While it is true that physician-assisted suicide is largely an emerging right in well off, better educated, more secular, and whiter countries, that does not diminish its status as a norm. Just because the wealthier people have traditionally advocated for and claimed this right does not mean that it does not extend to other people with other life experiences. I conjecture that the right has been developed in wealthier societies because these communities have access to more and better healthcare. Therefore, richer people can have their lives extended almost indefinitely in many

⁸¹ Anderson, Ryan T. "Always Care, Never Kill: How Physician-Assisted Suicide Endangers the weak, Corrupts Medicine, Compromises the Family, and Violates Human Dignity and Equality." *Backgrounders*(2015): 2. *The Heritage Foundation*. The Heritage Foundation, 24 Mar. 2015. Web. 27 Mar. 2017.

⁸² Euthanasia Research and Guidance Organization. "Assisted Suicide Laws Around the World - Assisted Suicide." *Assisted Suicide Laws Around the World - Assisted Suicide*. Accessed January 31, 2017. http://www.assistedsuicide.org/suicide_laws.html.

⁸³ Drum, Kevin. "My Right to Die: Assisted Suicide, My Family, and Me." *Mother Jones Magazine*, Jan. & Feb. 2016. January 11, 2016. Accessed March 28, 2017. <http://www.motherjones.com/politics/2016/01/assisted-suicide-legalization-california-kevin-drum>.

⁸⁴ *Ibid.*

cases, and many have found that the suffering that can accompany prolonged life outweighs the benefit of another week, month, or year. Even though legalization has been faster in Western Europe than in poorer regions of the world, the right is international, and therefore applies equally to all people. While certainly religious and cultural opposition to this new right may prevent its recognition by some states, the fact that the trend began with wealthier people does not undermine its justness.

Political Context of Physician-Assisted Suicide

Advocacy both for and against physician-assisted suicide has permeated American and European communities to such an extent that public opinion has largely swayed in favor of legalization. This popular support is a contributing factor to the wave of legalization that has been seen in recent years across Europe and North America. In democracies, where legislators are representatives of the people, and are therefore sensitive to the ebb and flow of public opinion polls and fickle voters, the impact of advocates on either on public opinion is felt in resultant legislation.

In the United States, recent years have seen increasing public support for physician-assisted suicide. This trend has occurred across age groups, but has been especially prominent among 18-34 year olds.⁸⁵ Between 2014-2015, support among 18-34 year-olds jumped 19 points. Similarly, support among all measured groups climbed. In fact, as of 2015, “Nearly seven in 10 Americans (68%) say doctors should be legally allowed to assist terminally ill patients in committing suicide, up 10 percentage points from last year. More broadly, support for euthanasia has risen nearly 20 points in the last two years and stands at the highest level in more than a decade.”⁸⁶ Although this statistic incorporates support for both euthanasia and physician-assisted suicide, the wording of the statement “doctors should be legally allowed to assist terminally ill patients in committing suicide” indicates that this statistic is reflective of support for physician-assisted suicide. In May 2015, support for physician-assisted suicide reached a peak of 68%, the highest level of support seen since 2001.⁸⁷ Some statisticians and scholars

⁸⁵ Dugan, Andrew. "In U.S., Support Up for Doctor-Assisted Suicide." Gallup.com. May 27, 2015. Accessed March 29, 2017. <http://www.gallup.com/poll/183425/support-doctor-assisted-suicide.aspx>.

⁸⁶ Ibid.

⁸⁷ Ibid.

believe that support was tempered during Barack Obama’s first term, though still a majority of the American public supported this right. This has been ascribed to hysteria caused by rumors of “death panels” during and shortly after the passage of the Affordable Care Act.⁸⁸ Overall, though, as Chart 6 demonstrates, opinions of those across spectrums of age and political ideology have become significantly more supportive of physician-assisted suicide in recent years. This jump has been particularly prominent in the last year.

Support for Doctor-Assisted "Suicide," by Year

When a person has a disease that cannot be cured and is living in severe pain, do you think doctors should or should not be allowed by law to assist the patient to commit suicide if the patient requests it?

% Yes, should be allowed

	May 2014	May 2015	Change
	%	%	pct. pts.
18 to 34 years old	62	81	+19
35 to 54 years old	57	65	+8
55 and older	56	61	+5
Republicans	51	61	+10
Independents	64	80	+16
Democrats	59	72	+13

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Chart 6: Support for Doctor-Assisted Suicide by Year

The trend towards support of physician-assisted suicide in the American public can also be bolstered by the fact that as of 2015, 56% of Americans believe that physician-assisted suicide is “morally acceptable.” This represents a jump of 7 points since 2001, when support measured

⁸⁸ Ibid.

⁸⁹ Ibid.

at 59%.⁹⁰ However, belief that physician-assisted suicide is moral fell three points in 2016.⁹¹

This could be explained by political factors, including the growth of the right wing in American political debate. Nonetheless, the recognition of the morality of physician-assisted suicide not only by the state but also by the public contributes to norm formation, and stabilization of the right in a given community. Ever-growing belief in both the moral acceptability and legal right to physician-assisted suicide is mirrored by increased support for euthanasia, and other controversial issues. While the question of whether or not there is a right to euthanasia is not the focus of this work, the fact that the American people also support the legalization of euthanasia points to a broader support for the concept that there are ethical reasons for helping a suffering person in ending his or her life prematurely.

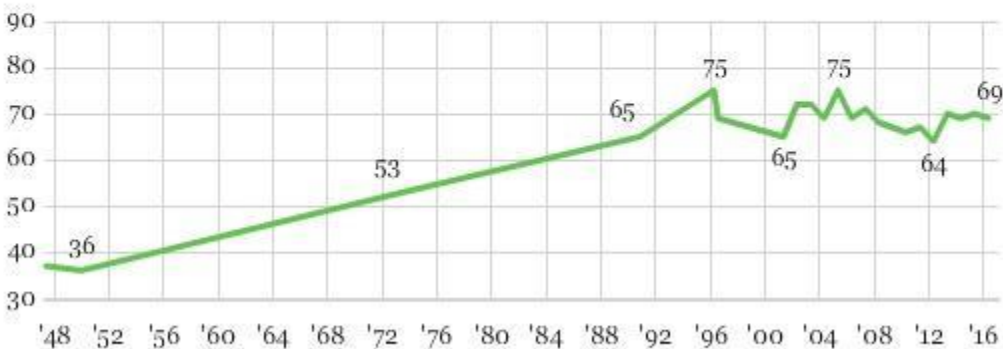
⁹⁰ Newport, Frank. "Americans Continue to Shift Left on Key Moral Issues." Gallup.com. May 26, 2015. Accessed March 31, 2017. [http://www.gallup.com/poll/183413/americans-continue-shift-left-key-moral-issues.aspx?utm_source=Social Issues&utm_medium=newsfeed&utm_campaign=tiles](http://www.gallup.com/poll/183413/americans-continue-shift-left-key-moral-issues.aspx?utm_source=Social+Issues&utm_medium=newsfeed&utm_campaign=tiles).

⁹¹ Dugan, Andrew. "In U.S., Support Up for Doctor-Assisted Suicide." Gallup.com. May 27, 2015. Accessed March 29, 2017. <http://www.gallup.com/poll/183425/support-doctor-assisted-suicide.aspx>; Swift, Art. "Euthanasia Still Acceptable to Solid Majority in U.S." Gallup.com. June 24, 2016. Accessed March 29, 2017. <http://www.gallup.com/poll/193082/euthanasia-acceptable-solid-majority.aspx>.

Support for Euthanasia

When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life by some painless means if the patient and his or her family request it?

■ % Yes



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Chart 7: Support for Euthanasia in the U.S.

Support for euthanasia in 2015 rose to 69%. Though the peak of American support for euthanasia has risen to as high as 75% since 1996, the fluctuation does not distract from a strong trend in support, which has risen since a low of 36% in 1950.⁹³ This trend of increased support among all sectors of American society for both the legal and moral right of physician-assisted suicide, and, more broadly, euthanasia, supports the idea that physician-assisted suicide is becoming a norm. As increasing numbers of people begin to support and accept this right, more states will act to legalize it. In a cycle, legalization leads to acceptance and expectation of the protection of this right, which in turn leads to support for physician-assisted suicide.

⁹² Swift, Art. "Euthanasia Still Acceptable to Solid Majority in U.S." Gallup.com. June 24, 2016. Accessed March 29, 2017. <http://www.gallup.com/poll/193082/euthanasia-acceptable-solid-majority.aspx>.

⁹³ Ross, Winston. "Dying Dutch: Euthanasia Spreads Across Europe." *Newsweek*, February 12, 2015. Accessed March 30, 2017.

Some of the key factors that contribute to public opinion include hearing and understanding the stories of sympathetic patients who desire to end their own lives with medical assistance. Take, for instance, the impact of Brittany Maynard. Following the publicity of the case of Brittany Maynard, a 29 year old woman with a fatal brain tumor, who decided to end her own life in November 2014, support for physician-assisted suicide rose in 2015.⁹⁴ Another indicator of opinion about physician-assisted suicide is political affiliation. Democrats and Independents are more likely to support physician-assisted suicide, which could be attributable to a number of factors, including the importance of Christian doctrines in right wing activism in this country, socioeconomic class, living conditions and location, and wealth.

One other central factor in predicting how an individual feels about physician-assisted suicide is the place and type of religion in one's life. In her article, "Religion and Attitudes Toward Physician-Assisted Suicide and Terminal Palliative Care," published in the *Journal for the Scientific Study of Religion* in 2005, Amy Burdette synthesizes data from several studies, including the 1998 General Social Survey, to analyze the impact of the strength and sect of religious belief on one's views about physician-assisted suicide.⁹⁵ Though public opinion about the issue has changed drastically since 2005, let alone 1998, the trend of opinion being largely influenced by these factors may be extrapolated to today.

Even older data demonstrates that "liberal Protestants, Jews, and those with no religious affiliation are generally supportive of physician-assisted suicide... while conservative Protestants

⁹⁴ Dugan, Andrew. "In U.S., Support Up for Doctor-Assisted Suicide." Gallup.com. May 27, 2015. Accessed March 29, 2017. <http://www.gallup.com/poll/183425/support-doctor-assisted-suicide.aspx>.

⁹⁵ Burdette, Amy M., Terrence D. Hill, and Benjamin E. Moulton. "Religion and Attitudes toward Physician-Assisted Suicide and Terminal Palliative Care." *Journal for the Scientific Study of Religion* 44, no. 1 (March 2005): 79. Accessed April 2, 2017. <http://www.jstor.org/stable/3590520>;

and Catholics tend to exhibit the greatest opposition...⁹⁶ Using data from the General Social Survey of 1998, Burdette and her colleagues determine that the important factors in determining the impact of faith on opinion about physician-assisted suicide and terminal palliative care are the strength of one's religious sect and frequency of attendance at religious services, because these factors are indicative of how much biblical scripture influences one's life more generally. Strength of affiliation and church attendance impact belief about physician-assisted suicide because "they often condition religious beliefs (e.g., biblical literalism, God images, and belief in an afterlife) that are perhaps more closely related to other attitudes."⁹⁷

Because beliefs about the afterlife and biblical literalism are related to the level of conservatism of one's Protestantism or Catholicism, mainline Protestants tend to support physician-assisted suicide more than more conservative Christians. Moderate Protestants believe God gives humans more autonomy than do those who are more conservative religiously. More conservative Protestants and Catholics tend to attend church more regularly, and support a literalist view of the bible, because they are more enmeshed in their religious communities on a daily basis. They tend to believe that God has absolute control of the transition from life to

⁹⁶ Burdette, Amy M., Terrence D. Hill, and Benjamin E. Moulton. "Religion and Attitudes toward Physician-Assisted Suicide and Terminal Palliative Care." *Journal for the Scientific Study of Religion* 44, no. 1 (March 2005): 79. Accessed April 2, 2017. <http://www.jstor.org/stable/3590520>. Citing Achille, M. A., and J. R. Ogloff. "When is a request for assisted suicide legitimate? Factors influencing public attitudes toward euthanasia." *Canadian Journal of Behavioral Science* 29, no. 1 (January 1997): 19-27; Ostheimer, J.M., and C.L. Moore, Jr. "The correlates of attitudes toward euthanasia." *Social Biology* 28, no. 1-2 (Spring 1981): 145-49; Ward, R. A. "Age and Acceptance of Euthanasia." *Journal of Gerontology* 35, no. 3 (1980): 421-31. doi:10.1093/geronj/35.3.421; Caddell, David P., and Rae R. Newton. "Euthanasia: American attitudes toward the physician's role." *Social Science & Medicine* 40, no. 12 (June 1995): 1671-681. doi:10.1016/0277-9536(94)00287-4; Hamil-Luker, Jenifer, and Christian Smith. "Religious Authority and Public Opinion on the Right to Die." *Sociology of Religion* 59, no. 4 (December 1, 1998): 373-85. doi:10.2307/3712123; Ostheimer, John M. "The Polls: Changing Attitudes Toward Euthanasia." *Public Opinion Quarterly* 44, no. 1 (Spring 1980): 123-28. doi:10.1086/268574.

⁹⁷ Burdette, Amy M., Terrence D. Hill, and Benjamin E. Moulton. "Religion and Attitudes toward Physician-Assisted Suicide and Terminal Palliative Care." *Journal for the Scientific Study of Religion* 44, no. 1 (March 2005): 80. Accessed April 2, 2017. <http://www.jstor.org/stable/3590520>.

death.⁹⁸ Like conservative Protestants, Catholic doctrine tends to interpret the bible more literally, and consider that it is God's role to determine matters of life and death; however, like Protestants, the views of Catholics individually are also determined by the strength of their religious affiliation and their frequency of church attendance.⁹⁹ For those with strong religious affiliations "the legitimacy of a literalist view of the Bible is reinforced through close-knit ties with other religious affiliates... For conservative Protestants in particular, literalist beliefs are created and solidified through interpretative communities or networks of theologians, pastors, and lay people who share fundamental assumptions about biblical texts..."¹⁰⁰

At least as of 2005, unlike among conservative Protestants, moderate Protestant leaders held mixed opinions on physician-assisted suicide, because both congregants and clergy faced a debate over defining the limits of human freedom and God's power; however, there was more support for legalization among moderate Protestants, because they were less likely to take the Bible's word literally than were their conservative counterparts.¹⁰¹ Liberal Protestants tend to be

⁹⁸ Ibid., 81-83.

⁹⁹ Ibid., 83.

¹⁰⁰ Burdette, Amy M., Terrence D. Hill, and Benjamin E. Moulton. "Religion and Attitudes toward Physician-Assisted Suicide and Terminal Palliative Care." *Journal for the Scientific Study of Religion* 44, no. 1 (March 2005): 81. Accessed April 2, 2017. <http://www.jstor.org/stable/3590520>. Citing Boone, Kathleen C. *The Bible Tells Them So: The Discourse of Protestant Fundamentalism*. Albany, NY: State University of New York, 1988; Fish, Stanley. *Is There A Text in this Class?: The Authority of Interpretive Communities*. Cambridge, MA: Harvard University Press, 2003; Sherkat, Darren E., and Christopher G. Ellison. "The Cognitive Structure of a Moral Crusade: Conservative Protestantism and Opposition to Pornography." *Social Forces* 75, no. 3 (1997): 957-80. doi:10.2307/2580526.

¹⁰¹ Burdette, Amy M., Terrence D. Hill, and Benjamin E. Moulton. "Religion and Attitudes toward Physician-Assisted Suicide and Terminal Palliative Care." *Journal for the Scientific Study of Religion* 44, no. 1 (March 2005): 82. Accessed April 2, 2017. <http://www.jstor.org/stable/3590520>. Citing Roof, Wade Clark, and William MacKinney. *American Mainline Religion: Its Changing Shape and Future*. New Brunswick. Rutgers University Press, 1987; Wuthnow, Robert. *The Restructuring of American Religion: Society and Faith since World War II*. Princeton, NJ: Princeton University Press, 1988.

more politically liberal as well, supporting social issues that moderate and conservative Protestants oppose, such as same-sex marriage and physician-assisted suicide.¹⁰²

Considering the impact of religion on public opinion about physician-assisted suicide, the fact that the United States and other western countries have become less religious over the past few decades may be one reason why support for and legalization of physician-assisted suicide has taken hold. More Americans identify as “unaffiliated” than ever before, and the percentage of people identifying with Christian sects has declined significantly over the last decade.¹⁰³ As of 2016, only 53% of Americans responded to a Gallup survey by saying that religion is “very important” in their lives. This represents the lowest percent of Americans to whom religion is very important since this measure of religiosity began to be recorded, in 1992.¹⁰⁴ A shift towards less religious affiliation in this country supports increased acceptance of legalization of physician-assisted suicide; as fewer people take biblical language literally, fewer will be persuaded to oppose physician-assisted suicide using the religious arguments that are common among activists against legalization.

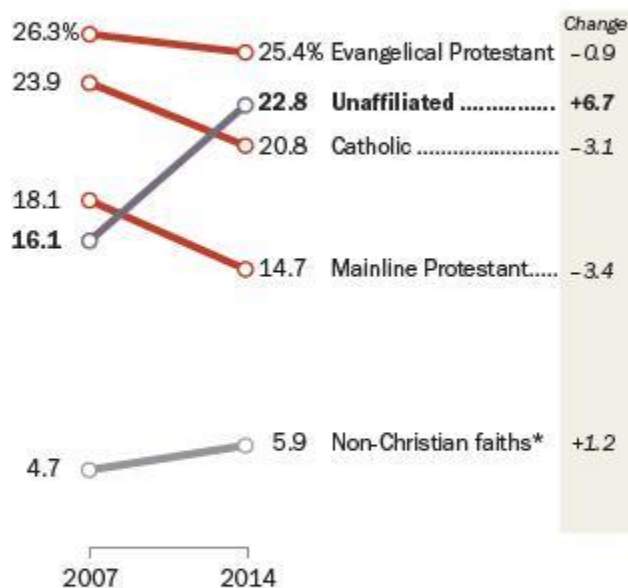
¹⁰² Burdette, Amy M., Terrence D. Hill, and Benjamin E. Moulton. "Religion and Attitudes toward Physician-Assisted Suicide and Terminal Palliative Care." *Journal for the Scientific Study of Religion* 44, no. 1 (March 2005): 82. Accessed April 2, 2017. <http://www.jstor.org/stable/3590520>.

¹⁰³ Pew Research Center. "America's Changing Religious Landscape." Pew Research Center's Religion & Public Life Project. April 30, 2015. Accessed April 02, 2017. http://www.pewforum.org/2015/05/12/americas-changing-religious-landscape/pf_15-05-05_rls2_1_310px/.

¹⁰⁴ Gallup, Inc. *How important would you say religion is in your own life -- very important, fairly important, or not very important?* 2017. Graph. <http://www.gallup.com/poll/1690/religion.aspx>

Changing U.S. Religious Landscape

Between 2007 and 2014, the Christian share of the population fell from 78.4% to 70.6%, driven mainly by declines among mainline Protestants and Catholics. The unaffiliated experienced the most growth, and the share of Americans who belong to non-Christian faiths also increased.



* Includes Jews, Muslims, Buddhists, Hindus, other world religions and other faiths. Those who did not answer the religious identity question, as well as groups whose share of the population did not change significantly, including the historically black Protestant tradition, Mormons and others, are not shown.

Source: 2014 Religious Landscape Study, conducted June 4-Sept. 30, 2014

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Chart 8: Changing U.S. Religious Landscape

¹⁰⁵ Pew Research Center. *Changing U.S. Religious Landscape*. 2014. Graph.

Religion's influence is dwindling not only in the United States, but also in other parts of the world. If religiosity is measured by self-reported service attendance, Europe has been relatively irreligious for more than a decade. While more recent information is difficult to access, data from the Standard Eurobarometer and the European Social Survey from 2004 show that Western Europe especially has been relatively irreligious for more than a decade. At that time, there were relatively low levels of trust for religious institutions in many European nations, and even lower levels of regular church attendance.

The only member state of the European Union in which more than half of the population attended weekly services was Ireland, with 54% attending. In other member-states a much smaller percent of the population attended church regularly. For instance, Sweden, Denmark, and Finland saw 5% or less of the population attending church weekly, and the number attending church in France, Germany, Luxembourg, Belgium, the Netherlands, and the United Kingdom fall below 15%.¹⁰⁶ Though service attendance is more common in central and Eastern Europe than further west, as of 2004, only 9 of the 25 member-states of the European Union saw at least 20% of their population attend religious services regularly.¹⁰⁷ This lack of trust in European institutions, and lack of strong religious affiliation over the past thirteen years explains relatively low opposition to physician-assisted suicide, and the success of legalization efforts in many western European countries. With China and Japan boasting the largest percentage of adults

¹⁰⁶ Manchin, Robert. "Religion in Europe: Trust Not Filling the Pews." *Gallup.com*. Gallup, Inc. , 21 Sept. 2004. Web. 02 Apr. 2017.

¹⁰⁷ Manchin, Robert. "Religion in Europe: Trust Not Filling the Pews." *Gallup.com*. Gallup, Inc. , 21 Sept. 2004. Web. 02 Apr. 2017.

who self-identify as atheists, perhaps recognition of the right to physician-assisted suicide could find fertile ground in Asia next.¹⁰⁸

While increased secularism in mostly-Christian, mostly-white Europe has led to legalization of physician-assisted suicide in thirteen states and jurisdictions, in other parts of the world which are more religiously observant, or where people hold more orthodox views on end-of-life care, legislators may be more less likely to oppose this emerging right. For instance, in the United States, legislation is largely crafted with the will of the white majority in mind, but Burdette found that African Americans are more likely to oppose physician-assisted suicide than are white Americans.¹⁰⁹ Though this discrepancy in support must be fully explained and addressed, the fact that this right first gained support among the white and less religious does not diminish its status as an emerging right.

Beyond the religious, one other category of people who are embroiled in a contentious debate over the role of physicians in aiding their patients in dying is medical professionals themselves. As of 2010, 45% of American physicians supported legalization of physician-assisted, while only 40% opposed. Until 2015, the American Medical Association and other reputable medical professional association opposed legalization.¹¹⁰ Since then, support has grown, and the American Medical Association and other groups have switched positions.

¹⁰⁸ Staufenberg, Jess. "The six countries in the world with the most 'convinced atheists'" *The Independent*. Independent Digital News and Media, 23 Mar. 2016. Web. 02 Apr. 2017.

¹⁰⁹ Burdette, Amy M., Terrence D. Hill, and Benjamin E. Moulton. "Religion and Attitudes toward Physician-Assisted Suicide and Terminal Palliative Care." *Journal for the Scientific Study of Religion* 44, no. 1 (March 2005): 86. Accessed April 2, 2017. <http://www.jstor.org/stable/3590520>. Citing Table 1.

¹¹⁰ Drum, Kevin. "My Right to Die: Assisted Suicide, My Family, and Me." *Mother Jones Magazine* Jan. & Feb. 2016: n. pag. *Mother Jones Magazine*. Mother Jones Magazine, 11 Jan. 2016. Web. 28 Mar. 2017; California Medical Association. "California Medical Association removes opposition to physician aid in dying bill." News release, May 20, 2015. California Medical Association. Accessed April 14, 2017. <http://www.cmanet.org/news/press-detail/?article=california-medical-association-removes>.

These official stances are in line with increased support for the right among physicians. In 2014, for the first time, a majority - 54% - of American physicians supported physician-assisted suicide.¹¹¹ This professional support for legalization demonstrates a wave that is quickly spreading across the United States and other parts of the world. When this report was released in 2014, Arthur Caplan, the founding head of the bioethics division of New York University's Langone Medical Center, found that this support "represents a remarkable shift," and predicted that "If physician opposition continues to weaken, it is likely that despite fierce resistance from some religious groups and some in the disability community, more states will... legalize."¹¹² So far, this has proven prescient, and, as more and more physicians are likely to follow the trend of the American public in general and increasingly support this right, it is likely that support from the medical community will contribute to legalization in other American states. Considering that support is even more widespread among doctors from other countries, legalization is likely to continue to spread internationally as well. Because public support in general and the support of medical professionalism for physician-assisted suicide is growing, while religiosity falls, the cascade stage of norm creation is likely to take hold soon, as more states continue to legalize this option.

¹¹¹ Kane, Leslie. "Medscape Ethics Report 2014, Part 1: Life, Death, and Pain." *Medscape Ethics Report 2014, Part 1: Life, Death, and Pain*. Medscape, 16 Dec. 2014. Web. 02 Apr. 2017. <<http://www.medscape.com/features/slideshow/public/ethics2014-part1#2>>.

¹¹² NBC News. "Most U.S. Doctors Now Support Aid in Dying: Survey." NBCNews.com. December 16, 2014. Accessed April 02, 2017. <http://www.nbcnews.com/health/health-news/most-u-s-doctors-now-support-aid-dying-survey-n269691>.

Problems of Implementation

Though physician-assisted suicide is an emerging norm, and trends in legalization and public and professional opinion around the issue, the practicalities of implementing laws which support the right to physician-assisted suicide can be difficult to address. Physician-assisted suicide affects vulnerable populations that are at risk for abuse and pressure to end their own lives. Furthermore, legalizing this process brings up a number of additional questions, which must be answered in the text of physician-assisted suicide laws. Who can access physician-assisted suicide? Under what circumstances? Can children undertake physician-assisted suicide with the consent of parents? Should people who have non-terminal illnesses be able to access this aid? What about those with permanent disabilities? What about the depressed or those with other mental illnesses?

In general, one of the core problems of implementation is the need to specify who can access physician-assisted suicide. Opponents to physician-assisted suicide fear that with the legalization of physician-assisted suicide comes an unavoidable trend. According to Lawrence Huntoon, "...if experience in other countries with physician-assisted suicide and euthanasia is any indication, those eligible for death-by-physician will expand to include the healthy and the very young as well."¹¹³ Though this argument goes particularly to the question of who is eligible for physician-assisted suicide, it encapsulates the core of political and human rights-based arguments against legalization. Essentially, the fear is that opening the door to this new right might lead to an over-broadening of this right, making people vulnerable to having this decision

¹¹³ Huntoon, Lawrence R. "Physician-Assisted Suicide and Euthanasia: The Destruction of Morals, Ethics, and Medicine." *Journal of American Physicians and Surgeons* 21.4 (2016): 98-101. *Journal of American Physicians and Surgeons*. Journal of American Physicians and Surgeons, Winter 2016. Web. 28 Mar. 2017.

made for them, rather than making an autonomous choice to use this process to end their life. Without proper regulation, and specific provision to prevent misuse, laws decriminalizing or legalizing physician-assisted suicide may be interpreted over time to encourage or even pressure patients into selecting physician-assisted suicide. Writing laws with protections for vulnerable groups is vital, even if that means excluding certain groups from the practice if there is no way to guarantee the voluntary nature of this decision by certain individuals. However, rather than uniformly excluding the ill, dying, or any other group from accessing this right, it is possible to craft legislation which ensures a fair process by which individuals can make this decision and maintain their autonomy while being protected from abuse or external pressure.

From jurisdiction to jurisdiction rules change about who can access physician-assisted suicide. For instance, in Washington, “only a qualified patient may make a written request for medication that they will self-administer to end their life. A qualified patient means a competent adult who is a Washington resident suffering from a terminal illness that will lead to death within six months.”¹¹⁴ However, in other American states and other countries, requirements of residency, terminal illness, age, and competency may vary. While some jurisdictions may maintain similar requirements, others, such as the Netherlands, have less stringent requirements. For example, in Holland, twelve-year-olds may be eligible for physician-assisted suicide with parental consent, and at age sixteen without.¹¹⁵ Furthermore, according to the laws of some

¹¹⁴ Washington State Department of Health. "Frequently Asked Questions." Washington State Department of Health. Accessed April 04, 2017. <http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/FrequentlyAskedQuestions>.

¹¹⁵ Minister of Justice, Minister of Health, Welfare and Sports, and Upper House, Parliamentary Year 2000-2001, 26 691, No 137. *Termination of Life on Request and Assisted Suicide (Review Procedures) Act*. Translated by Dutch Department of Justice. November 28, 2000. Amended Legislative Proposal, The Netherlands. Art. 2.2-2.4.; Huntoon, Lawrence R. "Physician-Assisted Suicide and Euthanasia: The Destruction of Morals, Ethics, and Medicine." *Journal of American Physicians and Surgeons* 21.4 (2016): 98-101. *Journal of American Physicians and Surgeons*.

jurisdictions, one must be a resident of the locale to be eligible for physician-assisted suicide, while in other locations, like Switzerland, this is not the case. In Switzerland, assisting in suicide is much less strictly regulated than in other countries. In fact, the nod to tacit acceptance of physician-assisted suicide in the Swiss Criminal Code states that “[any person who for commendable motives, and in particular out of compassion for the victim, causes the death of a person at that person’s own genuine and insistent request is liable to a custodial sentence not exceeding three years or to a monetary penalty.”¹¹⁶ This provision does not specify the age, consenting capacity, or illness of a person eligible for this treatment, nor does it specify that aid in dying must be from a physician. The only guidance for physicians as to who qualifies for this treatment in Switzerland comes from a non-binding recommendation of the Swiss Academy of Medical Sciences, which stresses that the doctor’s role is not to kill, but believes that

“While a doctor’s primary role is to alleviate symptoms and support the patient, there may be situations in which the patient asks for help in committing suicide and persists with this wish. In this dilemma... the doctor may either refuse to comply with patient’s request or accede to the request provided that he is satisfied that three conditions have been met - that the patient’s state of health makes it clear that he or she is nearing the end of life; that alternative possibilities have been discussed and, if desired by the patient, implemented; and that the patient who requests help to end his or her life is capable, free from external pressure and has thought through his or her decision. The Academy recommends also that, in such situations, a third person should verify that the third condition has been met.”¹¹⁷

Journal of American Physicians and Surgeons, Winter 2016. Web. 28 Mar. 2017. Citing Anderson, Ryan T. "Always Care, Never Kill: How Physician-Assisted Suicide Endangers the weak, Corrupts Medicine, Compromises the Family, and Violates Human Dignity and Equality." *Backgrounders*(2015): 1-22. *The Heritage Foundation*. The Heritage Foundation, 24 Mar. 2015. Web. 27 Mar. 2017.

¹¹⁶ Federal Assembly of the Swiss Confederation. *Swiss Criminal Code*. December 21, 1937. Status as of January 1, 2017. Art. 114.

¹¹⁷ Select Committee on Assisted Dying for the Terminally Ill Bill. *Select Committee on Assisted Dying for the Terminally Ill Bill First Report*. 2005. House of Lords, London. Chapter 5: Overseas Experience; Point 197

These differences in scope of physician-assisted suicide laws around the world have to do with a variety of factors, including cultural differences having to do with mentality about health care, religion, maturity and human development, and competency. These differences in values and beliefs about life, death, and the medical profession can vary both between international states and within single jurisdictions. So, the, who ultimately decides which groups are eligible for physician-assisted suicide? Depending on who makes that call, the implementation of physician-assisted suicide legislation may vary drastically from state to state, even if each technically recognize the right.

One controversial group which some states include among those eligible for physician-assisted suicide, but some exclude, are the disabled. Oregon, like most jurisdictions, prohibits the non-terminally ill from undertaking physician-assisted suicide, but the Netherlands has no such restriction. “a terminal diagnosis is not required by the Dutch guidelines, and a person who faces unbearable suffering, in his or her own view, and who has been offered all forms of treatment but has no hope of improvement may request assistance in dying.”¹¹⁸ This is a major difference, which radically alters the scope and role of legalization of physician-assisted suicide in any given state. Many states require patients to have an illness which has been diagnosed as terminal, with six months or less to live, in order to access physician-assisted suicide. However, this is not universal, and predictions of life expectancy made by physicians can be wrong. Ultimately, some opponents feel that allowing anyone to obtain physician-assisted suicide gives too much power to the doctor. For example, Supreme Court Justice Neil Gorsuch “notes that for

¹¹⁸ Battin, Margaret P., Agnes Van Der Heide, Linda Ganzini, Gerrit Van Der Wal, and Bregje D. Onwteaka-Philipsen. "Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in “vulnerable” groups." *Journal of Medical Ethics* 33 (2007): 594. Accessed April 5, 2017. doi:10.1136/jme.2007.022335.

the Dutch notes that for the Dutch [who have relatively relaxed physician-assisted suicide laws], ‘it is the *physician’s* assessment of the patient’s *quality of life* as ‘degrading’ or ‘deteriorating’ or ‘hopeless’ that stands as the ultimate justification for killing.’”¹¹⁹

The discrepancy in legalization for this group between jurisdictions makes physician-assisted suicide for those with disabilities is especially controversial. Advocates, including Derek Humphry, founder of the defunct Hemlock Society, argue that some competent people with disabilities, who feel that their quality of life is so impinged by their disability that they do not wish to live any longer should be able to access medical aid in dying. This is especially important, say advocates, because people with some physical disabilities may not be able to commit suicide on their own, should they want to exercise this option.

Some of the groups that most fiercely oppose legalization are disability rights groups, who fear that legalization may lead to an environment where people with disabilities may be forced or encouraged to take this option. A leading organization of people with disabilities opposing physician-assisted suicide, Not Dead Yet, which argues that legalization provides a cheap cure to the problem of suffering, and therefore, people with lifelong disabilities will be encouraged or even forced to take this option. Furthermore, people with disabilities may choose physician-assisted suicide because they fear being a burden. To support this point, Not Dead Yet points out that Death with Dignity found that

“although intractable pain has been emphasized as the primary reason for enacting assisted suicide laws, the top five reasons Oregon doctors actually report for issuing lethal prescriptions are the “loss of autonomy” (92%), “less able to engage in activities”

¹¹⁹ Anderson, Ryan T. "Always Care, Never Kill: How Physician-Assisted Suicide Endangers the weak, Corrupts Medicine, Compromises the Family, and Violates Human Dignity and Equality." *Backgrounders*(2015): 3. *The Heritage Foundation*. The Heritage Foundation, 24 Mar. 2015. Web. 27 Mar. 2017. Citing Gorsuch, *The Future of Assisted Suicide and Euthanasia*, p. 111 (emphasis in original).

(90%), “loss of dignity” (79%), “loss of control of bodily functions” (48%) and “feelings of being a burden” (41%).”¹²⁰

Opponents also object to the idea that death can be the solution some choose to maintain their dignity. Not Dead Yet accuses advocates for including people with non-terminal disabilities of viewing those with disabilities as automatically lacking dignity. According to the organization, “In a society that prizes physical ability and stigmatizes impairments, it’s no surprise that previously able-bodied people may tend to equate disability with loss of dignity. This reflects the prevalent but insulting societal judgment that people who deal with incontinence and other losses in bodily function are lacking dignity.”¹²¹

However, advocates are not interested in making the choice to die *for* someone with a disability, rather, the individual may make his own decision. This right to decide preserves the dignity of the person with a disability whether or not they choose to end their life.¹²² Although some with disabilities oppose legalization, many disability rights groups support physician-assisted suicide, and view the inclusion of people with disabilities among those eligible for the treatment to be an affirmation of the autonomy of the individual, regardless of disability. According to Paul Spiers, president of Autonomy Now “a vocal few do not speak for a majority of the disability community.”¹²³

¹²⁰ Not Dead yet. "Not Dead Yet Disability Activists Oppose Assisted Suicide As A Deadly Form of Discrimination." Not Dead Yet. July 05, 2016. Accessed April 06, 2017.

<http://notdeadyet.org/assisted-suicide-talking-points>. Citing Oregon Health Authority. *Death with Dignity Annual Report, 2016*. February 21, 2017. Salem, Oregon.

¹²¹ Not Dead yet. "Not Dead Yet Disability Activists Oppose Assisted Suicide As A Deadly Form of Discrimination." Not Dead Yet. July 05, 2016. Accessed April 06, 2017.

<http://notdeadyet.org/assisted-suicide-talking-points>.

¹²² Humphry, Derek. *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying*. Eugene, OR: Hemlock Society, 1991.

¹²³ Death with Dignity. "Death with Dignity and People with Disabilities." Death With Dignity. Accessed April 05, 2017. <https://www.deathwithdignity.org/death-dignity-people-disabilities/>.

Though issues surrounding competence, the capacity to consent, and the physical ability to self-administer drugs may be especially thorny around people with disabilities, there is no evidence that people with disabilities are at any heightened risk of using physician-assisted suicide than is any other group.¹²⁴ The fears of some disability rights groups opposed to physician-assisted suicide are significant, and must be addressed and guarded against with careful legislation, however, to this point, the core of their fear is unfounded.

One of the other core difficulties when legislators attempt to define who can access physician-assisted suicide is competency. Activists and lawmakers generally want to prevent the abuse of vulnerable populations, so the competence of the individual choosing to die must be defined and evaluated. Though some laws do not explicitly state that the patient must be competent to make medical decisions, many jurisdictions insist that the individual must be competent. However, the factors that constitute legal competency are often vaguely defined, and the requirements for being considered competent differ internationally from state to state. The Oregon Death with Dignity Act represents one view of competency.

““Competent” 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 an informed decision to healthcare providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.”¹²⁵

Switzerland has a slightly different, where, unlike in Oregon, capacity to consent is assumed unless there is a diagnosis that precludes the ability to make this type of decision.

¹²⁴ Battin, Margaret P., Agnes Van Der Heide, Linda Ganzini, Gerrit Van Der Wal, and Bregje D. Onwteaka-Philipsen. "Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in "vulnerable" groups." *Journal of Medical Ethics* 33 (2007): 594. Accessed April 5, 2017. doi:10.1136/jme.2007.022335.

¹²⁵ Washington State Legislature, Senate, "The Washington Death with Dignity Act, 105th Cong., 1st sess., 1997, 202-205.

Article 16 of the Swiss Legal Code specifies that “A person is presumed to have capacity to act reasonably, unless he or she is deemed not to have such capacity because he or she is a child, suffers from a mental illness, mental infirmity, drunkenness or a similar condition.”¹²⁶ So, the distinction between the methods of determining competency in Switzerland and in Oregon, and other parts of the United States, is that in Oregon one has to be found to be competent before being allowed to undertake physician-assisted suicide, while in Switzerland, the assumption of competency stands, unless it is found to be compromised.

When competency is inconsistently defined, this presents a problem for physician-assisted suicide on an international level. In a globalizing world, where many people have access to information about policies in other countries via the Internet, and have physical access to these policies via flight and rail, individuals who want to exercise this right may travel to end their lives. Because competency is measured more stringently in some locations than in others, the restrictions that are placed on individuals based on this barometer are difficult to enforce. This is not to say that there should not be restrictions to protect individuals who cannot make this kind of decision from being pressured or coerced into suicide, but carefully employed language and phrasing must be used so as not to infringe on the rights of those who are capable of making this decision. Furthermore, standardization of a benchmark for which characteristics qualify someone as having the capacity to consent will make the legalization of this right more clear and universal.

¹²⁶ Schwarzenegger, Christian, and Sarah J. Summers. *Criminal Law and Assisted Suicide in Switzerland: Hearing with the Select Committee on the Assisted Dying for the Terminally Ill Bill, House of Lords*. Publication. Faculty of Law, University of Zurich. Zurich: University of Zurich, 2005. 2-6. Accessed April 4, 2017. <https://www.rwi.uzh.ch/dam/jcr:00000000-5624-ccd2-ffff-ffffa664e063/assisted-suicide-Switzerland.pdf>.

Similarly, standardizing other categories of exemption and inclusion, including standards of age, illness, and procedures for obtaining medications would make this right easier to implement in individual states and globally. As with the implementation of other rights, cultural factors, including religion, political opinion, class, and other identities may impact how the populace of a jurisdiction chooses to implement physician-assisted suicide; however, if there were greater standardization in the law across states patients would be more likely to know their rights, and the road to solidification of this emerging norm would be smoother.

Some opponents to physician-assisted suicide argue that the protections put in place to prevent risk of abuse for people in vulnerable populations are not sufficient, and may never be sufficient. Anderson of the Heritage Foundation warns that “[w]here [physician-assisted suicide] has been allowed, safeguards purporting to minimize this risk have proved to be inadequate and have often been watered down or eliminated over time.”¹²⁷ To support this claim, people often point to the Netherlands, where access to physician-assisted suicide has expanded to younger people and those suffering psychologically as well as physically since its initial legalization, largely due to court rulings in favor of expansions.¹²⁸ According to one 2017 study reporting on the use of physician-assisted suicide in Oregon, “[a]bout 3 percent of patients used the law because the cost of chemotherapy was too high, the study found.”¹²⁹ This reflects some use of physician-assisted suicide for harmful or exploitative reasons. However, data shows that there is

¹²⁷ Anderson, Ryan T. "Always Care, Never Kill: How Physician-Assisted Suicide Endangers the weak, Corrupts Medicine, Compromises the Family, and Violates Human Dignity and Equality." *Backgrounder*(2015): 2. *The Heritage Foundation*. The Heritage Foundation, 24 Mar. 2015. Web. 27 Mar. 2017.

¹²⁸ Patients Rights Council. "Background about Euthanasia in The Netherlands." Patients Rights Council. Accessed February 11, 2017. <http://www.patientsrightscouncil.org/site/holland-background/>.

¹²⁹ Terry, Lynne. "Study: Oregon patients using physician-assisted suicide steadily increase." OregonLive.com. April 06, 2017. Accessed April 08, 2017. http://www.oregonlive.com/health/index.ssf/2017/04/study_oregon_patients_using_ph.html.

no increased risk of suicide for people in any of the groups that are commonly thought of as vulnerable to pressure to exercise this right. According to "Legal physician-assisted dying in Oregon and the Netherlands: Evidence Concerning the Impact on Patients in "Vulnerable" Groups," an article by Margaret P. Battin in the *Journal of Medical Ethics*, vulnerable groups are no more likely to use physician-assisted suicide than are other people.

"Rates of assisted dying in Oregon and in the Netherlands showed no evidence of heightened risk for the elderly, women, the uninsured... people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses including depression, or racial or ethnic minorities, compared with background populations. The only group with a heightened risk was people with AIDS."¹³⁰

With clearer definitions of competency, and more universality in that can access medical aid in dying, legalization across an ever-expanding number of states internationally will be more likely. While advocates and detractors alike agree that vulnerable populations should be protected from abuse and exploitation, they see different ways to provide that safety net. Though opponents feel that there is no way to protect these populations while allowing physician-assisted suicide under some circumstances, the data does not bear this out. This heartening finding, that very few people feel pressured to undertake this option due to factors other than their own will.

¹³⁰ Battin, Margaret P., Agnes Van Der Heide, Linda Ganzini, Gerrit Van Der Wal, and Bregje D. Onwteaka-Philipsen. "Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in "vulnerable" groups." *Journal of Medical Ethics* 33 (2007): 591. Accessed April 5, 2017. doi:10.1136/jme.2007.022335.

Conclusions

Since 1940, thirteen states and jurisdictions have legalized physician-assisted suicide, and all of these localities except Switzerland have done so since 1994.¹³¹ In some nations with federal governments, like the United States, Canada, and Australia, some provinces or states have legalized physician-assisted suicide before or without support from the national government. The spread of legal physician-assisted suicide across countries and across the world is growing, and the number of states that legalize the option each year is generally increasing, as illustrated by Chart 4. Considering the existing trend towards legalization of physician-assisted suicide, indicators of public opinion on the issue, decreased international public commitment to religious institutions, the use of human rights-based rhetoric in advocacy and legalization, the historical example of norm creation in the case of the abolition of the death penalty, I contend that physician-assisted suicide is in the early stages of norm development, predict that this process of increased recognition will continue in the future. Through the norm-creating process, I predict that physician-assisted suicide will be widely considered a human rights norm.

As is the case with any right, though, that physician-assisted suicide is an emerging human rights norm does not mean that it will be universally respected. Legalization has gained traction largely in majority-white, wealthier, and more secular communities in Europe and the Americas, for a number of reasons explored in this paper. However, this does not mean that

¹³¹ "Euthanasia & Physician-Assisted Suicide (PAS) around the World." Should euthanasia or physician-assisted suicide be legal? Accessed March 16, 2017. <http://euthanasia.procon.org/view.resource.php?resourceID=000136>; Euthanasia Research and Guidance Organization. "Assisted Suicide Laws Around the World - Assisted Suicide." Assisted Suicide Laws Around the World - Assisted Suicide. Accessed January 31, 2017. http://www.assistedsuicide.org/suicide_laws.html; "State-by-State Guide to Physician-Assisted Suicide - Euthanasia - ProCon.org." Should euthanasia or physician-assisted suicide be legal? Accessed March 16, 2017. <http://euthanasia.procon.org/view.resource.php?resourceID=000132>; Lewis, Penney. "Assisted dying: What does the law in different countries say?" BBC News. October 06, 2015. Accessed March 16, 2017. <http://www.bbc.com/news/world-34445715>.

physician-assisted suicide is only needed by people in these states. Though public opinion data on this issue is not as available on this issue from non-European and American states, it is likely that places with more conservative religious observation are less likely to support this right. Nonetheless, once more states have legalized the option, other states may begin to follow the pattern, and a cascade will form.

Even with increased legalization of physician-assisted suicide around the world, implementation and solidification of this new right requires consistency of practice, both in terms of time and scale. That is to say, the establishment of universal understandings of who qualifies for access to physician-assisted will help with the process of norm creation, because respecting the right will become more defined. Furthermore, time itself will contribute to norm-creation. Legalization of physician-assisted suicide began in earnest in 1994, and 23 years is not enough time to firmly establish a pattern of state behavior that is indicative of a binding norm. Based on existing trends and indications of future behavior, there is every reason to believe this norm will be enhanced by continued practice over time.

It is culturally important that access to physician-assisted suicide is an emerging human rights norm, because it fundamentally expands the rights that protect all people from life into death. Other rights, such as the prohibition on the death penalty, the prohibition on genocide, and the right to life protect people from arbitrary killing by their state, but this is the first right that establishes a state obligation to allow for aid in dying.¹³² It is vital that this right is

¹³² General Assembly of the United Nations. *Second Optional Protocol to the International Covenant on Civil and Political Rights, aiming at the abolition of the death penalty*. December 15, 1989. United Nations, New York; General Assembly of the United Nations. *Convention on the Prevention and Punishment of the Crime of Genocide*. December 9, 1948. Paris. General Assembly of the United Nations. *Universal Declaration of Human Rights*. December 10, 1948. United Nations, New York. Art. 3.

recognized, because knowing it exists provides comfort for the ill and dying in places where physician-assisted suicide is legal. Even for people who do not end up using physician-assisted suicide, the ability to end life when suffering becomes overwhelming, on one's own terms, provides a sense of solace, and can make one's last days meaningful, rather than filled with fear. Like the provision of other human rights, legalization of physician-assisted suicide greatly increases the quality of life of people in a vulnerable situation. On ethical, legal, and theoretical grounds, physician-assisted suicide is a human right, and it is beginning to be recognized as such.

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