

# MOVING THE NEEDLE: A CALL TO CHANGE AGE RESTRICTIONS IN AMERICAN PHYSICIAN-ASSISTED SUICIDE LAWS

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## I. INTRODUCTION

Death is a topic that most avoid. However, the issue of how Americans die presents important legal challenges that should not to be brushed aside, as it has significant implications on the quality of life for many. For the terminally ill, one of these challenges is gaining the legal ability to die with dignity with the assistance of a physician. Four states—Oregon, Vermont, Washington, and most recently California—have passed legislation legalizing physician-assisted suicide.<sup>1</sup> One notable feature of all of these laws is the fact that assisted suicide is limited only to those who are over eighteen years of age, which brings about the question: what would happen if a terminally ill minor wanted to use a physician’s assistance to die with dignity?

In this paper, I will attempt to answer this question by examining the legal implications of extending physician-assisted suicide to minors. Further, I will advocate that barring minors from death with dignity laws is bad policy, and that the United States should stop excluding minors from these laws on the basis of age alone. Instead, we should implement a “totality of the circumstances” test based on individual case-by-case determinations of a given patient’s competence.

I will begin by examining the details of the existing physician-assisted suicide statutes in the United States and around the world. In Part II, I will examine relevant constitutional jurisprudence concerning assisted-suicide in America, and the potential hurdles that past precedent places in the way of allowing minors to be included in death with dignity statutes. I will also examine the constitutional tensions between the specific decision-making rights of children and the general rights of American citizens through the

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<sup>1</sup> Mollie Reilly, *Right to Die Becomes Law in California*, HUFFINGTON POST (Oct. 6, 2015), [http://www.huffingtonpost.com/entry/right-to-die-california\\_560c6037e4b076812700b6d8](http://www.huffingtonpost.com/entry/right-to-die-california_560c6037e4b076812700b6d8); *‘Death with Dignity’ Laws by State*, FINDLAW, <http://healthcare.findlaw.com/patient-rights/death-with-dignity-laws-by-state.html> (last visited Jan. 6, 2016) [hereinafter *Death with Dignity*]. Montana also has recognized physician-assisted suicide as legal through a Montana State Supreme Court ruling, but has not passed any additional legislation or regulations to guide implementation of this ruling. See *Baxter v. State*, 224 P.3d 1211 (2009).

lens of civil commitment of children to mental institutions, which is an example of a situation where courts have given minors autonomous rights and the ability to challenge the treatment decisions of their parents and the state. Finally, I will address the main counterargument to my thesis by analyzing the issue of competence and will argue that achieving the age of eighteen does not have to be a requirement to die with dignity.

## II. ASSISTED SUICIDE LEGAL PRIMER

### A. AMERICAN STATUTORY LAW

In 1994, Oregon voters passed the Death with Dignity Act (“DWDA”) and became the first state to allow doctors to prescribe a lethal dose of medicine to terminally ill patients who request it.<sup>2</sup> Under this law, those seeking assisted suicide from a physician must be “18 years of age or older.”<sup>3</sup> A patient seeking this assistance must be diagnosed with a terminal illness, which is a determination made by an attending physician and a consulting physician.<sup>4</sup> For the purposes of this act, a terminal illness is defined as “an incurable and irreversible disease that has been medically confirmed, and will, within reasonable medical judgment, produce death within six months.”<sup>5</sup> Furthermore, there is an intricate procedure that patients must follow in order to request a prescription.<sup>6</sup> First, the qualified patient must make both an oral and written request for the medication and reiterate this request to his or her attending physician no less than fifteen days after the initial oral request.<sup>7</sup> The patient must also fill out a request form, described in §127.897 of this act.<sup>8</sup> This form must be signed and dated by the patient and two witnesses, who both must attest that to “the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request.”<sup>9</sup> Lastly, patients also have the ability to rescind their request at anytime, regardless of their mental state at the time they choose to rescind.<sup>10</sup>

Patients in Oregon have utilized the DWDA to end their lives on their own terms.<sup>11</sup> Since Oregon’s DWDA was passed in 1997, 1,327 people have obtained prescriptions for end of life drugs, and 859 patients have

<sup>2</sup> OR. REV. STAT. §§ 127.800-995 (2016) (The law passed with fifty-one percent of the vote); *Death with Dignity*, *supra* note 1.

<sup>3</sup> OR. REV. STAT. § 127.800 (2016).

<sup>4</sup> *Id.*

<sup>5</sup> OR. REV. STAT. § 127.800(12) (2016).

<sup>6</sup> OR. REV. STAT. § 127.840 (2016).

<sup>7</sup> *See id.*

<sup>8</sup> OR. REV. STAT. § 127.897 (2016).

<sup>9</sup> OR. REV. STAT. § 127.810 (2016) (The law also requires that: (1) one of the two witnesses is neither a relative of the patient either through blood, marriage or adoption, (2) that the witness is not entitled to any portion of the patient’s estate, and (3) that the witness is not the owner or an employee of the hospital or facility where the patient is receiving medical treatment. Furthermore, the patient’s attending physician does not qualify as one of the two witnesses required under this section).

<sup>10</sup> OR. REV. STAT. § 127.845 (2016).

<sup>11</sup> OR. PUB. HEALTH DIV., OREGON’S DEATH WITH DIGNITY ACT ANNUAL REPORT—2014 2 (2015).

chosen to end their lives by taking the medication.<sup>12</sup> In 2014, the majority of DWDA patients suffered from cancer, and there has been an increase in the number of amyotrophic lateral sclerosis (“ALS”) patients utilizing the DWDA.<sup>13</sup> Moreover, the Oregon Public Health Division found that eighty-nine and a half percent of DWDA patients in Oregon died in their homes and that ninety-three percent of patients had been enrolled in hospice care when they had their DWDA prescriptions written.<sup>14</sup> This statistic indicates that the DWDA has allowed patients to end their lives at home with loved ones, instead of suffering in a hospital bed.<sup>15</sup>

States that have followed Oregon in legalizing physician-assisted suicide have modeled their laws after Oregon’s DWDA.<sup>16</sup> In 2008, Washington voters approved the Washington Death with Dignity Act (“WDWDA”), and in 2014, California lawmakers passed the End of Life Option Act.<sup>17</sup> Like Oregon’s DWDA, both of these laws require that the patient seeking treatment is eighteen years of age or older, that there are two doctor requests, and the patient is six months away from death.<sup>18</sup> None of these laws mention whether a juvenile has the ability to seek this kind of treatment or the competence to request it.<sup>19</sup> This raises the question: is there a demand amongst patients under the age of 18 to obtain death with dignity?

#### B. EUROPEAN LAW

The movement to secure minors’ right to die with dignity has gained momentum in Europe.<sup>20</sup> In 2014, a mother in the United Kingdom was granted the right to end her twelve-year-old daughter’s life by withdrawing a feeding and hydration tube that was keeping her alive.<sup>21</sup> The twelve-year-old was Nancy Fitzmaurice, who was born with meningitis, septicemia, and hydrocephalus.<sup>22</sup> Nancy was blind and unable to eat on her own; she was initially expected to live only four years.<sup>23</sup> In 2012, Nancy suffered a post-

<sup>12</sup> *Id.*

<sup>13</sup> *Id.* (In 2014, 68.6% of DWDA patients suffered from cancer, which was a decrease of 11.8% from the previous year. Meanwhile, ALS patients using the DWDA more than doubled in 2014 from 7.2% to 16.2%).

<sup>14</sup> *Id.*

<sup>15</sup> *See id.*

<sup>16</sup> *See Death with Dignity.*

<sup>17</sup> The Washington Death with Dignity Act, WASH. REV. CODE §§ 70.245.010–.904 (2016); End of Life Option Act, CAL. HEALTH & SAFETY CODE § 443 (West 2016).

<sup>18</sup> WASH. REV. CODE § 70.245.010–.030; S.B. 128, 2015-2016 Reg. Sess., at 4–7 (Cal. 2015); *Death with Dignity.*

<sup>19</sup> *See Id.*

<sup>20</sup> *See* Elizabeth Picciuto, *U.K. Courts Grant Mother Right to End Her 12-Year-Old Disabled Daughter’s Life*, THE DAILY BEAST (Nov. 4, 2014), <http://www.thedailybeast.com/articles/2014/11/04/u-k-courts-grant-mother-right-to-end-her-12-year-old-disabled-daughter-s-life.html>; *Under 12s have right to die: Dutch paediatricians*, TIMES LIVE (June 19, 2015), <http://www.timeslive.co.za/world/2015/06/19/Under-12s-have-right-to-die-Dutch-paediatricians>; *Assisted Suicide: Not for Adults Only?*, PATIENTS RIGHTS COUNCIL, <http://www.patientsrightscouncil.org/site/not-for-adults-only/> (last visited Sept. 13, 2016).

<sup>21</sup> Picciuto, *supra* note 20.

<sup>22</sup> *Id.*

<sup>23</sup> *Id.*

surgical infection, which caused pain so excruciating that she could be heard “screaming and writhing in agony.”<sup>24</sup> Strong painkillers were no help.<sup>25</sup> After Nancy became ill with this infection, her mother, Charlotte Fitzmaurice, petitioned to end her daughter’s life in order to alleviate Nancy of her terrible pain—a petition supported by doctors at London’s Great Ormond Street Hospital.<sup>26</sup> In August 2014, U.K. High Court judge Eleanor King granted Charlotte’s petition to remove her daughter Nancy’s life sustaining hydration.<sup>27</sup> This example, while not a direct request from a minor to end his or her own life, suggests that there is a demand for the ability to use a physician’s assistance to alleviate a terminally ill minor’s pain by ending his or her life.<sup>28</sup>

Other European countries have taken the movement to secure a juvenile’s right to a death with dignity even further. The assisted suicide law in the Netherlands allows terminally ill patients as young as twelve to receive a physician’s assistance in ending their lives.<sup>29</sup> Children between the ages of twelve and sixteen may obtain euthanasia or physician-assisted suicide, but a parent or guardian must “agree with the termination of life or the assisted suicide.”<sup>30</sup> As juvenile patients get older, there are fewer restrictions on access to assisted suicide; patients who are sixteen to eighteen-years-old need to have their parents involved in the decision making process, but the parents need not approve or agree with the patient’s decision.<sup>31</sup> By comparison, the Dutch law is far more liberal in allowing terminally ill minors to die with dignity than the policy in the United Kingdom; however, it is not even the most liberal law on the European continent.

In 2014, Belgium became the first country to remove any age restrictions on physician- assisted suicide.<sup>32</sup> Under this law, terminally ill patients under the age of eighteen may request assistance in ending their lives “if they are near death, and suffering ‘constant and unbearable physical’ pain with no available treatment.”<sup>33</sup> Like the assisted suicide laws in Oregon, Washington, and California, the Belgian law has a multi-step

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24 *Id.*

25 *Id.*

26 *Id.*

27 *Id.*

28 *See id.*

29 *Holland’s Euthanasia Law*, PATIENTS RIGHTS COUNCIL, <http://www.patientsrightscouncil.org/site/hollands-euthanasia-law/> (last visited Sept. 6, 2016).

30 *Id.* (producing an English translation of Chapter II Article 2,3 of Holland’s Euthanasia law). Although the terms “euthanasia” and “physician-assisted suicide” are often used interchangeably, the two terms individually have distinctive meanings. Physician-assisted suicide refers to a situation where a doctor prescribes a patient with a lethal dose of drugs that the patient takes on his own; whereas, in cases of euthanasia, the doctor actually administers the lethal dose of medicine. *What is the Difference Between Assisted Dying and Euthanasia?*, THE WORLD FEDERATION OF RIGHT TO DIE SOCIETIES, <http://www.worldrtd.net/qanda/what-difference-between-assisted-dying-and-euthanasia> (last visited Sept. 14, 2016).

31 *Id.*

32 *Belgium’s Euthanasia Law Gives Terminally Ill Children the Right to Die*, PBS NEWSHOUR (Jan. 17, 2015, 11:32 AM), <http://www.pbs.org/newshour/bb/belgium-terminally-ill-children-right-die/>.

33 *Id.*

procedure that must be followed in order to obtain treatment.<sup>34</sup> For example, a patient must obtain consent not only from his parents but also from three separate doctors, which is one more than is required by the laws in Oregon, Washington, and California.<sup>35</sup> Instead of making a categorical prohibition on this treatment based on age alone, the Belgian law allows for patients, parents, and doctors to collaborate and determine what the best course of action is regarding a patient's well being and his or her dignified death.<sup>36</sup>

These examples show that European countries are willing to allow minors to participate in the assisted suicide conversation and process, which is not possible in America because of the statutory age requirements.<sup>37</sup> Given the laws in places around the world, it is important to ask: how would physician-assisted suicide for minors work in America, and furthermore, what legal and constitutional foundation do proponents have to have to stand on to advocate for change in this policy sphere? The first step in answering these questions is to examine how the United States Supreme Court has handled this issue.

### C. AMERICAN CONSTITUTIONAL JURISPRUDENCE

While the Supreme Court has not dealt with the issue of juvenile assisted suicide directly, there is a line of cases pertaining to end of life care, and whether or not there is a fundamental right to a death with dignity in America. *Cruzan v. Director, Missouri Department of Health* is a seminal case for this issue, because it required the Supreme Court to articulate what rights patients have when choosing how they want to end their lives.<sup>38</sup> The central issue in this case was whether or not Nancy Cruzan, a patient who was in a vegetative state after suffering severe injuries in an automobile accident, had the fundamental right to withdraw the artificial feeding and hydration systems that were keeping her alive.<sup>39</sup> Ms. Cruzan had previously "suggested" to a former housemate that if she were in a situation where she could not live "at least halfway normally . . . she would not wish to continue on with her nutrition and hydration."<sup>40</sup> Initially, the state trial court found that Ms. Cruzan had a fundamental right to refuse her life sustaining treatment; however, the Missouri Supreme Court reversed, citing a strong policy preference favoring life.<sup>41</sup> The Missouri Supreme Court doubted Ms. Cruzan's ability to give consent, explaining that Ms. Cruzan's statements to her housemate "were unreliable for the purpose of determining her intent."<sup>42</sup> Additionally, the court declined to interpret the

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34 *Id.*; *See Death with Dignity*.

35 *Id.*

36 *See Death with Dignity*.

37 *Id.*

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

39 *Id.* at 269.

40 *Id.* at 268.

41 *Id.*

42 *Id.*

Missouri Constitution in such a way that would grant an unlimited right to refuse treatment and was skeptical that even the United States Constitution embodied such a right.<sup>43</sup> Finally, the court rejected the argument that Ms. Cruzan's parents should be able to order the termination of her medical treatment because "no person can assume that the choice for an incompetent in the absence of the formalities required under Missouri's Living Will statutes or the clear and convincing, inherently reliable evidence [of the patient's wishes] absent here."<sup>44</sup>

The Supreme Court affirmed the ruling of the state courts.<sup>45</sup> Writing for the majority, Chief Justice Rehnquist acknowledged that patients generally have the right to refuse treatment—a right based on both religious notions grounded in the First Amendment and also common-law "rights of self determination."<sup>46</sup> Rehnquist cited *Schloendorff v. Society of N.Y. Hospital* for the proposition that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his body . . . ."<sup>47</sup> However, Rehnquist also asserted that states play a role in this decision making process: "[w]e do not think a State is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death."<sup>48</sup> Due to the importance of the issue at stake, Missouri was correct in applying a heightened burden to weigh Ms. Cruzan's ability to consent to the removal of death-prolonging treatment.<sup>49</sup> Rehnquist acknowledged that Ms. Cruzan's parents loved her very much and had her best interests in mind, but he declined to hold the parents' "substituted judgment" in the same regard Ms. Cruzan's own wishes, and that the Constitution does not require the states to honor the decisions of parents in cases like this.<sup>50</sup>

What is especially important about this case is that Rehnquist recognized that patients do have the ability to determine whether or not they want to remove life-sustaining treatment, and that Missouri's clear and convincing evidence standard was a constitutional mechanism to guide this process.<sup>51</sup> While Ms. Cruzan did not meet the applicable standard in this case because there was no clear and convincing evidence of her desire to remove life-sustaining treatment, other patients may be able to direct doctors to remove feeding tubes and other mechanisms of death-prolonging care if they meet their respective state's guidelines.<sup>52</sup>

Justice O'Connor wrote a separate concurrence in this case to clarify the scope of the ruling and also to articulate what rights patients have in

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*Id.*44 *Id.* at 269 (internal quotations omitted).45 *Id.* at 287.46 *Id.* at 270.47 *Id.* at 269 (citing *Schloendorff v. Soc. of N.Y. Hosp.*, 211 N.Y. 125, 129–130 (1914)).48 *Id.* at 280.49 *Id.* at 281.50 *Id.* at 285–86.51 *Id.* at 284.52 *See id.* at 284–87.

these situations.<sup>53</sup> O'Connor emphasized the liberty interest at stake for patients who want to refuse treatment and that unwanted "incursions into the body" are "protected by the Constitution's Due Process Clause."<sup>54</sup> Furthermore, O'Connor noted that unwanted artificial feeding "cannot be readily distinguished from other forms of medical treatment."<sup>55</sup> Moreover, Justice O'Connor articulated that "the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water."<sup>56</sup> O'Connor also explained that she wrote separately to emphasize that this ruling is not a death knell for family members making decisions for their loved ones, and that this decision "does not preclude a future determination that the Constitution requires States to implement the decisions of a patient's duly appointed surrogate."<sup>57</sup> She emphasizes that this ruling applies narrowly to uphold Missouri's standards, in this instance, as constitutional.<sup>58</sup>

*Cruzan* is an important case for an analysis of juveniles' right to die with dignity. While the opinion centers on adults and their decision-making processes, *Cruzan* emphasizes the liberty interests at stake in these types of decisions, and that when a person is of sound mind, he or she has the liberty to refuse unwanted treatment.<sup>59</sup> Furthermore, *Cruzan* does not prohibit the possibility that a parent or a loved one could make decisions regarding end-of-life care, which would allow for parents in America to choose a dignified death for their terminally ill children, similar to Charlotte and Nancy Fitzmaurice's case in the United Kingdom.<sup>60</sup>

While *Cruzan* centered on the right to refuse life-prolonging medical treatment, the Court did not address whether or not a terminally ill patient has a right to ask a doctor to assist in ending the patient's life.<sup>61</sup> Seven years after *Cruzan*, the Supreme Court addressed the issue of physician-assisted suicide in *Washington v. Glucksberg*.<sup>62</sup>

The central issue in *Washington* was whether or not the State of Washington's prohibition on physician-assisted suicide infringed on a fundamental right protected by the substantive component of the Fourteenth Amendment's Due Process Clause.<sup>63</sup> The Respondent-Plaintiffs were three terminally ill patients and four Washington doctors who treated terminally ill patients and would have provided them

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53 *Id.* at 287 (O'Connor, J., concurring).

54 *Id.*

55 *Id.* at 288.

56 *Id.* at 289.

57 *Id.* at 292.

58 *Id.*

59 *See Id.* at 284–87.

60 *Id.* at 292; PBS NEWSHOUR, *supra* note 32.

61 *See generally* *Cruzan v. Dir., Mo. Dep't of Health*, 479 U.S. 261 (1990).

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

63 *Id.* at 705-706 (At the time this case was argued, Washington had not yet passed the WDWA, which would come in 2008). The Fourteenth Amendment provides that no state shall "deprive any person of life, liberty, or property without due process of law. . . ." U.S. CONST. amend. XIV, § 1.

assistance in ending their lives if not for the state's ban.<sup>64</sup> The trial court found the ban to be unconstitutional because it placed "an undue burden" on a constitutionally protected interest.<sup>65</sup> The Ninth Circuit affirmed this ruling en banc.<sup>66</sup> The Supreme Court granted certiorari and held that Washington's ban did not infringe on a fundamental right in violation of the Fourteenth Amendment's Due Process Clause.<sup>67</sup>

In order to determine whether or not the assisted-suicide ban was a violation of a fundamental right, the Court first had to determine whether or not there was a fundamental right to assisted-suicide.<sup>68</sup> Chief Justice Rehnquist began the majority opinion by examining United States legal traditions surrounding the issue of assisted suicide, a step that the Court typically performs when analyzing a fundamental rights due process claim.<sup>69</sup> After describing at length the history of suicide bans dating back to Colonial America, Rehnquist concluded that state assisted-suicide bans are deeply rooted in American tradition.<sup>70</sup> However, Rehnquist also recognized that modern day Americans are "increasingly likely to die in institutions from chronic illnesses," and to accommodate this, more states are permitting living wills, surrogate health-care decision making, and the withdrawal or refusal of life-sustaining medical treatment.<sup>71</sup> Rehnquist further argued that despite the changing healthcare landscape, voters and legislatures have re-affirmed prohibitions on assisted-suicide.<sup>72</sup> He supported this argument by citing the history of the Washington statute at issue in this case, which was enacted in 1975 and then bolstered four years later by the Natural Death Act, which stated that "withholding or withdrawal of life-sustaining treatment. . . shall not for any purpose, constitute a suicide" and that "[n]othing in this chapter shall be construed to condone, authorize or approve mercy killing . . ." <sup>73</sup> He also cited the fact that Washington voters in 1991 failed to pass a ballot initiative permitting physician-assisted suicide, and furthermore, in 1992, Washington added a provision to the Natural Death Act that specifically excluded physician-assisted suicide.<sup>74</sup> Rehnquist noted that the DWDA had passed in Oregon, but claimed that Oregon seems to be an outlier when it comes to assessing the issue and that the prevailing policy preference favoring bans on assisted suicide still stands.<sup>75</sup> He argued that "[d]espite changes in medical technology and notwithstanding an increased emphasis

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64 *Washington*, 521 U.S. at 707.

65 *Id.* at 708.

66 *Id.* at 708–09.

67 *Id.* at 735.

68 *See Id.* at 727.

69 *See Id.* at 710.

70 *See Id.* at 710–16.

71 *Id.* at 716.

72 *Id.*

73 *Id.* at 717.

74 *Id.*

75 *Id.* at 718–19.



on the importance of end-of-life decisionmaking, we have not retreated from this prohibition.”<sup>76</sup>

After concluding that American tradition does not support the practice of assisted suicide, Rehnquist turned to determining whether assisted suicide is a liberty interest that falls under the protection of the Due Process Clause.<sup>77</sup> Rehnquist noted that the Due Process Clause protects rights that are so deeply rooted in American history and tradition that they rise to the level of being fundamental rights.<sup>78</sup> These are rights that are “implicit in the concept of ordered liberty.”<sup>79</sup> The petitioners in *Glucksberg* attempted to analogize their facts to the facts of *Cruzan* to show that there is an established right to refuse medical treatment, and that this right should extend to physician-assisted suicide.<sup>80</sup> However, Rehnquist distinguished *Cruzan* by pointing out that there is a long established common law history of preventing unwanted treatment through the tort of battery; whereas, the legal foundation permitting doctors to assist in suicides is not nearly as robust.<sup>81</sup> Rehnquist also failed to extend right of privacy relied on in abortion cases to this case because unlike marriage, procreation, and child rearing, physician-assisted suicide is not “deeply rooted in our history and traditions” and is not subject to the same standard of heightened scrutiny that those other fundamental rights warrant.<sup>82</sup>

Since Rehnquist did not consider the right to obtain physician-assisted suicide to be a fundamental right, which would warrant a heightened doctrinal scrutiny, he subjected it to a rational basis review in order to determine its constitutionality, which in this case meant that the Washington law must have been rationally related to a legitimate government interest.<sup>83</sup> Rehnquist argued “[t]his requirement is unquestionably met here” and cited a number of state interests including: (1) an “unqualified interest in the preservation of human life,” which he pointed out is reflected in criminal homicide laws; (2) suicide prevention as a public health policy; (3) protecting the ethics of the medical profession since allowing doctors to assist in suicide could jeopardize their role as healers; (4) protecting vulnerable groups such as the elderly and the poor from “abuse, neglect, and mistakes” that could stem from undue coercion in end of life situations, such as the possibility of family members killing

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76 *Id.*

77 *Id.* at 719.

78 *Id.* at 720–21.

79 *Id.* at 721 (quoting *Palko v. Connecticut*, 320 U.S. 319, 325 (1937)).

80 *Id.* at 724–25.

81 *Id.* at 725–26.

82 *Id.* at 726–28.

83 *Id.* at 728. The Supreme Court has established three doctrinal tiers to assess claims of discrimination under the 14th Amendment. The highest level of scrutiny is called “strict scrutiny,” which is deployed in cases where there is alleged discrimination based on race or national origin or an impediment of a fundamental right, here the classification must be narrowly tailored to a compelling state interest. This bar is rarely met. Classifications based on gender are judged under an intermediate level of scrutiny, where the state must show that a law is substantially related to a sufficient government interest. Classifications that fall outside of these categories are typically subjected to a rational basis review, in which the government must merely show that a law is rationally related to a legitimate government interest. *City of Cleburne Tex. v. Cleburne Living Ctr.*, 473 U.S. 432, 437–43 (1985).

loved ones early in order to save on healthcare costs; and (5) protecting against the possible threat of legal voluntary and involuntary euthanasia, noting that America could be headed down a dangerous path where non-terminally ill people could ask to be killed.<sup>84</sup>

After listing these state interests as justifications for a ban on assisted suicide, Rehnquist ended his opinion by writing: “[t]hroughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society.”<sup>85</sup>

Like Rehnquist proscribed, the debate on this issue continues to this day.<sup>86</sup> Given that the Supreme Court has not deemed physician-assisted suicide a fundamental right for adults—let alone minors—the road might be tougher for proponents.<sup>87</sup> Yet, after analyzing the rights of American juveniles, their ability to make competent decisions, and the relevant policy implications, it is clear that progress can be made on this issue.

### III. MOVING THE NEEDLE

An important aspect to consider in the effort to progress assisted suicide laws for minors is understanding the right that juveniles have in making autonomous decisions regarding their own well-being. An example that articulates this capability is the set of rights that children possess, which allows them to object to civil commitment to mental health institutions. While civil commitment does not carry the same end-of-life gravitas that comes with physician-assisted suicide, it is a good lens for viewing the physician-assisted suicide issue because it involves minors making decisions regarding their future and livelihood. More importantly, courts have recognized that minors should have a voice in these issues, and that a child’s decision can trump the desires of his or her parents and the state. Further, the hearing process for objections to civil commitment could be a useful mechanism to guide a possible implementation of an assisted suicide policy regime that includes minors.

Throughout the twentieth century, different states have used varying procedures and policies to commit children to mental institutions.<sup>88</sup> Prior to the 1950s, the process for committing children was “similar if not identical” to the process for committing adults.<sup>89</sup> By the mid-1970s policies had changed, and children could be admitted to mental institutions at the discretion of their parents without the right to a hearing.<sup>90</sup> This was

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84 *Id.* at 728–34.

85 *Id.* at 735.

86 *See Death with Dignity.*

87 *See generally Washington*, 521 U.S. at 735–36.

88 Christopher Slobogin et al., *LAW AND THE MENTAL HEALTH SYSTEM CIVIL AND CRIMINAL ASPECTS* 1018 (6th ed. 2014).

89 *Id.*

90 *Id.*

vastly different than the rights afforded to adults.<sup>91</sup> At that time, the process of civil commitment for adults had been reformed to provide court, or another lower judiciary body, hearings for patients objecting to their commitment.<sup>92</sup> As the decade progressed, the needle had been moved on this issue to provide children more rights to object to their commitment.<sup>93</sup> Some states began to revise “their statutes to require adult-type hearings, at least when the child objected to commitment or requested release.”<sup>94</sup> As these reforms were being passed, the question of what rights are constitutionally due to a minor when he or she objects to commitment in a mental institution came before the Supreme Court in *Parham v. J.R.*<sup>95</sup>

In *Parham*, Appellee-Plaintiff J.R. was a child who was being treated in a Georgia state mental hospital.<sup>96</sup> J.R. had filed a class action lawsuit seeking a declaratory judgment that “Georgia’s voluntary commitment procedures for children under the age of 18, Ga.Code §§ 88–503.1, 88–503.2 (1975), violated the Due Process Clause of the Fourteenth Amendment.”<sup>97</sup> J.R. prevailed at the district court level, in which a three-judge panel held that Georgia’s statutory scheme governing this process was unconstitutional and failed to adequately protect his rights under the Due Process Clause, a holding that Appellants later challenged.<sup>98</sup>

In his opinion, Chief Justice Burger framed the issue at stake as: “[the] process...constitutionally due a minor whose parents or guardian seek state administered institutional mental health care for the child.”<sup>99</sup> The procedure under § 88-503.1 provided that for a voluntary admission, there must first be an application for hospitalization, which must be signed by the child’s parent or guardian.<sup>100</sup> Further, upon the application of each patient at each hospital, the respective superintendent had the “power to admit temporarily any child for ‘observation and diagnosis.’”<sup>101</sup> If after this observation the superintendent found “evidence of mental illness” and that the child “is suitable for treatment,” the child could be admitted.<sup>102</sup> However, at the request of a parent or guardian, a child could be discharged after five or more days and the superintendent further had a duty to release a child if he or she no longer required treatment.<sup>103</sup>

After noting the procedures that children were afforded by statute, Burger continued his analysis by weighing and examining the welfare and health of the children seeking release, the combination of both the parents’

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91 *Id.*  
92 *See id.*  
93 *See id.*  
94 *Id.*  
95 *Id.*; *Parham v. J.R.*, 442 U.S. 584 (1979).  
96 *Parham*, 442 U.S. at 587.  
97 *Id.*  
98 *Id.* at 588.  
99 *Id.* at 587.  
100 *Id.* at 590–91.  
101 *Id.* at 591.  
102 *Id.*  
103 *Id.*

and the children's concerns, and the state's interests in its procedures.<sup>104</sup> He began by recognizing that children have liberties that ensure them autonomy from the state,<sup>105</sup> writing, "it is not disputed that a child, in common with adults, has a substantial liberty interest in not being confined unnecessarily for medical treatment . . . . Thus, the Court recognized that when it comes to being confined for treatment, minors have a constitutionally protected liberty interest and sense of autonomy against the state."<sup>107</sup>

Burger also provided that children have the right to question the decision-making of their parents and the government.<sup>108</sup> He recognized the fact "[t]hat some parents 'may at times be acting against the interests of their children,'" which "creates a basis for caution."<sup>109</sup> Burger acknowledged that it is not always in the best interest of a child to have her parents be the only voice in a conversation concerning his or her well-being, noting that in *Planned Parenthood v. Danforth* the Supreme Court deemed a statute that granted parents an absolute veto over a child's choice to have an abortion to be unconstitutional.<sup>110</sup> Like the decision in *Planned Parenthood*, Burger argued that "parents cannot always have absolute and unreviewable discretion to decide whether to have a child institutionalized."<sup>111</sup> Ultimately, Burger distinguished the facts in this case from *Planned Parenthood* because the Georgia statute here did not have an absolute veto provision and there was a system for independent review.<sup>112</sup> Burger stressed the importance of having an individualized determination process and that "[w]hat is best for a child is an individual medical decision that must be left to the judgment of physicians in each case."<sup>113</sup> Ultimately, the Georgia statute was upheld as constitutional; however, Burger's positions on the rights of children are important when it comes to the analysis of terminally ill minors' rights to physician-assisted suicide.<sup>114</sup>

Civil commitment of children through the reasoning of *Parham* provides a strong comparison tool for analyzing a minor's right to physician-assisted suicide. It illustrates how the same constitutional processes available for children to challenge medical treatment, in the form of an undesired commitment to a mental institution, are not available to children who either seek to end unwanted life-sustaining treatment or who desire a physician's assistance in a death with dignity.<sup>115</sup>

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104 *Id.* at 599–600.

105 *Id.* at 600.

106 *Id.*

107 *See id.*

108 *See id.* at 603.

109 *Id.*

110 *Id.* (citing *Planned Parenthood of Mo. v. Danforth*, 428 U.S. 52, 96 (1976)).

111 *Id.* at 604.

112 *See id.*

113 *Id.* at 608.

114 *Id.* at 620–21.

115 *See generally id.* at 600–08.

Both children's civil commitment and physicians-assisted suicide implicate the decision-making processes of minors, which in many cases, can be in conflict with the desires of the child's parents or the state.<sup>116</sup> Both situations involve medical determinations that are made by medical professionals, whether it is a superintendent of a mental hospital in the case of civil commitment or the attending and consulting physicians in the case of end-of-life treatment determinations.<sup>117</sup> However, unlike the processes involved with challenging a wrongful civil commitment, where the committed child, the child's parents, and the hospital are all involved in the conversation through consultations or a hearing with a neutral fact-finder, the same cannot be said with physician-assisted suicide.<sup>118</sup>

In *Parham*, Chief Justice Burger warned against the unconstitutional nature of an absolute veto in cases of both civil commitment and abortion because it infringes on a child's "substantial liberty interest in not being confined unnecessarily for medical treatment."<sup>119</sup> However, in the assisted suicide realm, the law essentially creates an absolute veto because there is no mechanism for minors to enter the conversation at all.<sup>120</sup> Given that in all the states where physician assisted suicide is legal the required age to receive the treatment is eighteen, the state has effectively vetoed any chance that a minor has to receive this treatment before any doctors or parents are consulted.<sup>121</sup>

For civil commitment determinations, individualized assessments of children conducted by doctors are an incredibly important piece in determining whether a commitment of a child is wrongful.<sup>122</sup> These evaluations allow a doctor to assess the child and determine if his or her confinement in a mental institution is justified.<sup>123</sup> In the case of assisted suicide, removing the strict bar of eighteen years of age would take these decisions out of the hands of lawmakers and put them under the control of doctors and families, who are in a better position to make the best decisions regarding the administration of healthcare and the protection of the individual well-being of each child. This policy recommendation is in-line with Burger's philosophy on children and medical treatment—namely, that "[w]hat is best for a child[,] is an individual medical decision that must be left to the judgment of physicians in each case."<sup>124</sup>

Removing the strict age requirement from assisted suicide laws would unlikely create a major shift in the actual administration of the treatment. For example, out of the 105 people who died via the DWDA in Oregon, only one person was between the ages of 18–34, two people were between ages 35–44, and three people were between ages 45–54; however, to the

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116 See generally *id.* at 584.

117 *Id.* at 591; *Death with Dignity*.

118 *Death with Dignity*.

119 *Id.* at 600.

120 *Id.*

121 *Death with Dignity*.

122 See *Parham*, 442 U.S. at 591–93.

123 *Id.*

124 *Id.* at 608.

few patients or families that would be impacted by this change, it could make a world of difference. Like the case of Nancy Fitzmaurice, there are families in America who seek this treatment or weigh it as a possible option.<sup>126</sup> There are terminally ill children in America who, like adults, do not want to continue to suffer their last years in constant, miserable pain or endure a quality of life that is far below their healthier peers.<sup>127</sup>

A stark example of this is the story of Julianna Snow.<sup>128</sup> At the age of two, Julianna was diagnosed with Charcot-Marie-Tooth disease (“CMT”).<sup>129</sup> CMT is a neurodegenerative illness, which degenerates the nerves like “a wire frays if the insulation around it breaks down.”<sup>130</sup> People who suffer from CMT experience symptoms at varying degrees, but Julianna’s case was particularly severe.<sup>131</sup> By the age of four, the CMT had deteriorated Julianna’s nerves to the point where she could not even squeeze her own toy and required the use of a feeding tube because she could not chew or swallow; a common cold for Julianna could turn into a deadly case of pneumonia.<sup>132</sup> As a result of her illness, Julianna had to endure a great deal of intrusive and painful treatment.<sup>133</sup> Several times a day, Julianna would have to undergo naso-tracheal suctioning (“NT”); “a nurse would put a tube down her nose and throat, forcing it past her gag reflex and into her lungs to suck the mucus out of the tiny pockets in her airways.”<sup>134</sup> It was too dangerous to sedate her for the procedure, so Julianna had to feel everything.<sup>135</sup> Julianna’s nurse described this procedure as something that is “not for the faint of heart.”<sup>136</sup> If Julianna was having a good day she could go two hours between NT procedures; if not, they would need to happen more often.<sup>137</sup>

Although the treatments in the hospital moderately improved Julianna’s condition and kept her alive, she despised them, and her objection to the treatment resulted in the following conversation between Julianna and her mother, Michelle:

MICHELLE: Julianna, if you get sick again, do you want to go to the hospital again or stay home?

JULIANNA: Not the hospital.

MICHELLE: Even if that means that you will go to heaven if you stay home?

<sup>125</sup> OR. PUB. HEALTH DIV., *supra* note 11, at 4.

<sup>126</sup> Picciuto, *supra* note 20. See Elizabeth Cohen, *Heaven Over Hospital: Dying Girl, Age 5 Makes a Choice*, CNN (Oct. 27, 2015, 2:39 PM), <http://www.cnn.com/2015/10/27/health/girl-chooses-heaven-over-hospital-part-1/>.

<sup>127</sup> See Cohen, *supra* note 126; Picciuto, *supra* note 20.

<sup>128</sup> Cohen, *supra* note 126.

<sup>129</sup> *Id.*

<sup>130</sup> *Id.*

<sup>131</sup> *Id.*

<sup>132</sup> *Id.*

<sup>133</sup> *Id.*

<sup>134</sup> *Id.*

<sup>135</sup> *Id.*

<sup>136</sup> *Id.*

<sup>137</sup> *Id.*

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JULIANNA: Yes.

MICHELLE: And you know that mommy and daddy won't come with you right away? You'll go by yourself first.

JULIANNA: Don't worry. God will take care of me.

MICHELLE: And if you go to the hospital, it may help you get better and let you come home again and spend more time with us. I need to make sure that you understand that. Hospital may let you have more time with mommy and daddy.

JULIANNA: I understand.

MICHELLE: (crying) – I'm sorry, Julianna. I know you don't like it when I cry. It's just that I will miss you so much.

JULIANNA: That's OK. God will take care of me. He is in my heart.<sup>138</sup>

Julianna's parents honored her wishes and stopped bringing her to the hospital.<sup>139</sup> Initially, it was thought that Julianna's decision would certainly hasten her death; however, as of November 3, 2015, it had been a year since her last infection.<sup>140</sup>

Julianna's story is important because it raises the key issue in this debate: the competence of someone under the age of eighteen to make a decision regarding his or her death.<sup>141</sup> Specific to Julianna's case, there is a deep divide between those who think that she was competent to make this decision and those who do not. Diana Scolaro, the nurse that cared for Julianna in the intensive care unit, supported Julianna's parents' decision to honor her wishes.<sup>142</sup> She said, "[y]ou have to know what it's like to hold down a child and hear them scream so you can stick a tube down their nose. It's one thing to do that when you know you'll have a success at the end, but for Julianna, there is no success."<sup>143</sup> Scolaro commented further on how grave Julianna's situation in the hospital truly was:

We pulled her from death's door so many times last year . . . and I don't think we could pull her through another big crisis . . . I want her living and dying in her princess room, at home, surrounded by her family, not in the cold technology of a hospital . . . There is no cure for her. Every day is a blessing. Every day is a gift.<sup>144</sup>

The support that Julianna's parents have received from those who cared for Julianna is a sign that a meaningful conversation about end-of-life

<sup>138</sup> *Id.*

<sup>139</sup> Elizabeth Cohen, *Heaven Over Hospital: Parents Honor Dying Child's Request*, CNN (Nov. 3, 2015, 11:38 PM), <http://www.cnn.com/2015/10/27/health/girl-chooses-heaven-over-hospital-part-2/index.html> [hereinafter *Heaven Over Hospital*].

<sup>140</sup> *Id.*

<sup>141</sup> See *id.*

<sup>142</sup> *Id.*

<sup>143</sup> *Id.*

<sup>144</sup> *Id.*

treatment can occur between a doctor, a child, and a child's family.<sup>145</sup> In this case, the conversation concerned the removal of treatment, but in other situations this conversation could concern using a physician's assistance to end a child's misery.<sup>146</sup> All assisted suicide laws in the United States require approval from multiple physicians, and it seems—at least in Julianna's situation—that there was support for her decision to end treatment.<sup>147</sup> Although Julianna was not seeking a doctor's assistance in ending her life, it does not take a large inferential leap to see that if Julianna could get support from her doctors to make this decision, that there are other doctors in America who would support a terminally ill minor's decision to end his or her life with dignity.

Many doctors have weighed in on Julianna's case and, unsurprisingly, they have varying opinions.<sup>148</sup> Art Caplan, who is a bioethicist at New York University and a former consultant on end-of-life cases at Children's Hospital of Philadelphia, commented on Julianna's decision and her parents' choice to honor it, saying that Julianna had "zero chance" of being able to comprehend the concept of death as it related to her.<sup>149</sup> On the other hand, Dr. Chris Feudtner, who worked with Caplan at Children's Hospital of Philadelphia as a pediatrician and ethicist and is also the chairman of the American Academy of Pediatrics section on hospice and palliative medicine, disagrees and supports Julianna's choice.<sup>150</sup> He said, "[t]o say her experience is irrelevant doesn't make any sense . . . She knows more than anyone what it's like to be not a theoretical girl with a progressive neuromuscular disorder, but to be Julianna."<sup>151</sup> At his own hospital, there have been cases when Dr. Feudtner has asked dying children what they want to do regarding their end-of-life treatment and care.<sup>152</sup> He notes that he does this in cases where the right thing to do falls into a gray area, as opposed to a situation where a child refuses chemotherapy for non-religious reasons to combat a highly treatable case of leukemia, which objectively would be the wrong medical decision.<sup>153</sup>

Dr. Feudtner also commented on humans' ability or inability, regardless of age, to comprehend death and its surrounding unknown circumstances.<sup>154</sup> He said, "My 86-year-old father died in April, and I'm not sure he truly got it . . . He was bed-bound from cancer, and he said, 'If this is the best I get, get me a Smith & Wesson.' Did he mean that? I don't know."<sup>155</sup> Comments like this really illustrate how tough this issue is, and why lawmakers wanted to leave children out of this process all-together;

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145 *See id.*

146 *Id.*

147 *Id.*; *Death with Dignity.*

148 *Heaven Over Hospital.*

149 *Id.*

150 *Id.*

151 *Id.*

152 *Id.*

153 *Id.*

154 *Id.*

155 *Id.*



but in the end, Dr. Feudtner thought that Julianna's choice here was "reasonable" and that her parents were correct to listen to her and honor her decision.<sup>156</sup>

Given that the choice to request physician-assisted suicide is one of the most important decisions one can make, it is crucial that we are able to define who is and who is not competent to make such a choice. With age restrictions in place in all American physician-assisted suicide laws, it seems that the bar for competence laid out in the statute is the age of eighteen; however, one cannot convincingly argue that a tidal wave of competence flows into the mind of a person between 11:59 p.m. and midnight on his or her eighteenth birthday. Much work has been done in the mental health field to define competence for a number of applications, including accepting and refusing medical treatment.<sup>157</sup>

Among the experts who have attempted to define competence are Paul Appelbaum and Thomas Grisso.<sup>158</sup> Appelbaum and Grisso are the pioneers behind the MacArthur Treatment Competence Study, which defines competence using four categories rather than a single standard.<sup>159</sup> The first category, and the lowest requirement to meet out of the four, is "ability to communicate a choice," which simply requires that the patient or subject "make up his or her mind" and reach a decision.<sup>160</sup> The second category is the "ability to understand the relevant information" standard, which centers on the patient's "comprehension of information related to the particular decision at hand" and the patient's ability to "comprehend the concepts involved" in making such a decision.<sup>161</sup> The third category is the "ability to appreciate the nature of the situation and likely consequences," which requires that a patient "be able to apply information that is understood in a context-neutral sense to his or her own situation."<sup>162</sup> The final and most stringent category is the "ability to manipulate information rationally," which considers a patient's "reasoning capacity or ability to employ logical thought processes to compare the risks and benefits of treatment options."<sup>163</sup> Appelbaum and Grisso note that this standard does not concern the outcome of a decision but rather the underlying logic of the patient's decision-making process; therefore, "a patient who can understand, appreciate and communicate a decision may be impaired because she is unable to process information logically in accordance with her preferences."<sup>164</sup> Furthermore, the appreciation piece takes place when the subject can acknowledge the conditions of his or her illness and the value

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156 *Id.*

157 See generally Jessica Wilen Berg et al., *Constructing Competence: Formulating Standards of Legal*

*Competence to Make Medical Decisions*, 48 RUTGERS L. REV. 345 (1996).

158 *Id.* at 351.

159 *Id.* at 351 n.19.

160 *Id.* at 352.

161 *Id.* at 353–54.

162 *Id.* at 355.

163 *Id.* at 357.

164 *Id.*

of possible treatments.<sup>165</sup> This standard has been further defined to consider whether or not a patient is able to “knowingly and intelligently” evaluate the information at hand “and otherwise participate in the treatment decision by means of rational thought processes.”<sup>166</sup> Given that it is up to another human psychologist or physician to make this determination, this category is incredibly subjective and is “the hardest to operationalize,” which is why it is least often adopted for legal competence standards.<sup>167</sup> Moreover, when this category is adopted it is almost never alone and is usually a prong in a compound standard.<sup>168</sup> This issue of subjectivity would likely come into play in the assisted suicide context if this fourth category were adopted as the standard to judge the competency of minors, because it would be up to doctors to make judgment calls as to whether or not a minor actually can manipulate the crucial information involved.<sup>169</sup>

Elyn Saks, a professor at the University of Southern California Gould School of Law, has also written extensively on the issue of competence and the ability to refuse medical treatment.<sup>170</sup> Saks identifies three criteria that must be present in an adequate definition of competence.<sup>171</sup> First, the standard must satisfy the “abilities” criterion: it must faithfully identify those abilities that are necessary to making decisions that deserve deference.<sup>172</sup> She argues that the ability to understand what decision a person is making is “probably necessary for competently making any decision.”<sup>173</sup> Second, the competency test shall include “the ‘unconventionality’ criterion,” which serves to protect a person’s values and belief systems regardless of their unconventionality.<sup>174</sup> This allows patients to incorporate their own interests into the decision-making process.<sup>175</sup> Saks points out “we cannot require the patient to have even the beliefs (much less the desires) of the ideal decision-maker unless they are shown to be knowably correct.”<sup>176</sup> The “[f]reedom to decide, includes, within limits, freedom to decide what is true no less than what is good.”<sup>177</sup> Finally, a competency definition must include an “irrationality” criterion, which “requires that a competency standard designate a reasonably small class of individuals as incompetent in the face of the pervasive influence of the irrational and unconscious.”<sup>178</sup> This criterion accounts for the fact that if

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165 *See id.* at 366.

166 *Id.* at 358.

167 *Id.* at 357.

168 *Id.* at 357–58.

169 *See id.*

170 *See generally* Elyn Saks, *Competency to Refuse Treatment*, 69 N.C.L. REV. 945 (1991).

171 *Id.* at 949–50.

172 *Id.* at 949.

173 *Id.* at 949–50.

174 *Id.* at 950.

175 *Id.*

176 *Id.*

177 *Id.*

178 *Id.*

every person whose decision-making processes showed irrationality then “virtually *no* competent decision-makers could be found.”<sup>179</sup>

After considering a number of different possible tests and standards, Saks concludes that the “most satisfactory standard of competency” is the “sophisticated ‘understanding and belief’” view.<sup>180</sup> A basic “understanding and belief” analysis consists of determining whether “the decision-maker [has] the ability to assess all evidence relevant to her decision.”<sup>181</sup> Saks argues that the sophisticated version of an “understanding and belief” view is superior to a “naïve” understanding and belief view, which merely requires that a patient understand and believe the information regarding treatment.<sup>182</sup> The sophisticated standard incorporates those two prongs but also takes into account unconventionality in the decision-making processes by adding the requirement that the decision should not be made in the face of a delusion, which is defined as “a belief for which there is no evidence.”<sup>183</sup> Saks argues that when we are trying to determine which views are acceptable, we should not accept those that are based on a delusion.<sup>184</sup> She argues that delusions should be the “polestar of incompetence” because “[i]f the standard reliably singles out patent falsehoods, it is not finding incompetency on the basis of unusual ways of looking at the world—or, worse yet, prescribing beliefs that misconstrue reality.”<sup>185</sup> These definitions of competence can serve as useful tools to assess the ability of minors to make decisions concerning end-of-life treatment such as physician-assisted suicide.

One of the main counterarguments used to oppose altering physician-assisted suicide statutes to include minors is that juveniles are not competent to make such an important decision; however, when applying Appelbaum and Grisso’s MacArthur standards and also Saks’ “sophisticated understanding and belief” test it is evident that children can be competent enough to make such decisions.<sup>186</sup>

For the purposes of this analysis, consider Julianna’s case—although Julianna is not affirmatively asking to die, she essentially is making a choice to end her treatment where the inevitable result is her death.<sup>187</sup> While this choice is heartbreaking, the important question to consider is: did she make it competently? When assessing Julianna’s request under Appelbaum and Grisso’s MacArthur standards an argument can be made that this decision was made competently.

The lowest bar for competence is the “ability to communicate a choice.”<sup>188</sup> To meet this standard, Julianna would merely have to make up

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179 *Id.*

180 *Id.* at 962.

181 *Id.* at 955.

182 *Id.* at 955–56.

183 *Id.*

184 *Id.*

185 *Id.* at 962.

186 *See id.* at 955–62; Berg et al., *supra* note 158, at 351–62; *Heaven Over Hospital*.

187 *Heaven Over Hospital*.

188 Berg et al., *supra* note 158, at 352.

her mind one way or another.<sup>189</sup> Here, it is evident that she was able to do this as she manifested her consent and communicated her choice to her parents regarding ending her treatments in the hospital.<sup>190</sup> When she initially refused her treatment, Julianna's mother asked her "Julianna, if you get sick again, do you want to go to the hospital again or stay home?"<sup>191</sup> Julianna replied to her mother that she did not want to go to the hospital; she communicated a clear choice here to end her treatment.<sup>192</sup>

Although the simple ability to request assisted-suicide by communicating a choice is available to adults, it is unlikely that a future law would use such a low standard for those who are under eighteen. However, when even more stringent tests are applied it still can be argued that Julianna could meet these standards.<sup>193</sup>

The second MacArthur standard is the "ability to understand the relevant information," and it appears that Julianna can meet this standard as well.<sup>194</sup> The standard is whether the patient is able to comprehend the information and concepts involved in making a particular decision.<sup>195</sup> This issue is something that experts involved in the end-life-treatment field such as Caplan and Dr. Feudtner have been split on, but Dr. Feudtner's analysis of this standard supports the proposition that Julianna had the capacity to consider the relevant issues, noting "[t]o say her experience is irrelevant doesn't make any sense . . . She knows more than anyone what it's like to be not a theoretical girl with a progressive neuromuscular disorder, but to be Julianna."<sup>196</sup> Julianna's mother also explained that she believed that Julianna had an adequate knowledge of what death was:

She's scared of dying, but has, to me, demonstrated adequate knowledge of what death is. (Julianna): 'When you die, you don't do anything. You don't think') . . . She hasn't changed her mind about going back the hospital, and she knows that this means she'll go to heaven by herself. If she gets sick, we'll ask her again, and we'll honor her wishes.<sup>197</sup>

This statement by Julianna's mother suggests that Julianna had the capacity to understand her situation.<sup>198</sup>

The third MacArthur standard is a determination as to whether a patient has the "ability to appreciate the nature of the situation and likely consequences."<sup>199</sup> Appelbaum and Grisso explain that this goes a step beyond assessing a factual understanding—this standard requires that the patient can apply information in the abstract to the patient's current

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189 *Id.*

190 *See Heaven Over Hospital.*

191 *Id.*

192 Berg et al., *supra* note 158, at 352; Cohen, *supra* note 126.

193 *See* Berg et al., *supra* note 158, at 353-58.

194 Berg et al., *supra* note 158, at 353-54; Cohen, *supra* note 126.

195 Berg et al., *supra* note 158, at 353-54.

196 *Heaven over Hospital.*

197 *Id.*

198 *See id.*

199 Berg et al., *supra* note 158, at 351.

situation.<sup>200</sup> There is evidence that Julianna would meet this standard because her conversations with her mother indicate that she has applied the risks involved with ending the NT treatment to her specific situation:

MICHELLE: Julianna, if you get sick again, do you want to go to the hospital again or stay home?

JULIANNA: Not the hospital.

MICHELLE: Even if that means you will go to heaven if you stay home?

JULIANNA: Yes. . . I hate NT. I hate the hospital.<sup>201</sup>

Here, Julianna is acknowledges the risks and chooses to go to heaven over enduring the NT treatment in the hospital, and this statement suggests that, to Julianna, the benefits of being home outweigh the risks of dying and going to heaven.<sup>202</sup>

The final and most stringent category to consider is whether a patient has the “ability to manipulate information rationally,” which is regarded as the toughest competency standard to meet and considers a patient’s “reasoning capacity or ability to employ logical thought processes to compare the risks and benefits of treatment options.”<sup>203</sup> A patient “who can understand, appreciate and communicate a decision may still be impaired because she is unable to process information logically, in accordance with her preferences.”<sup>204</sup> The appreciation piece takes place when the subject can acknowledge the conditions of his or her illness and the value of possible treatments, which is similar to the requirements of the third MacArthur standard.<sup>205</sup> This standard has been further defined to consider whether or not a patient is able to “knowingly and intelligently” evaluate the information at hand “and otherwise participate in the treatment decision by means of rational thought processes.”<sup>206</sup>

Given the evidence we have concerning Julianna’s situation, it is likely she would be able to meet this standard. The statements from Julianna and her mother indicate that she had an adequate understanding of her situation and the possible treatment options, which included the NT.<sup>207</sup> Furthermore, these conversations illustrated that Julianna had learned and understood the concept of death, applied it to her situation, and proceeded to make the choice to end her treatment in the hospital.<sup>208</sup> Furthermore, this standard requires that a patient use rational thought processes.<sup>209</sup> In this case, Juliana reasoned that ending her treatment will result in her going to

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200 *Id.*

201 *Heaven Over Hospital.*

202 *See id.*

203 Berg et al., *supra* note 158, at 357.

204 *Id.*

205 *See id.* at 366.

206 *Id.* at 358 (internal quotations omitted).

207 *Heaven Over Hospital.*

208 *See id.*

209 Berg et al., *supra* note 158, at 357.

heaven.<sup>210</sup> Given that it is not an uncommon belief that humans go to heaven when they die, coupled with the fact that no one truly knows what happens when we pass away, Julianna knowingly and intelligently evaluated her situation and used logical thought processes to decide to end her treatment.<sup>211</sup> The above analysis shows that it is possible to argue that Julianna was competent to make this decision under the standards laid out by the MacArthur Treatment Competence Study.

Moreover, Julianna could be deemed competent under Saks' "sophisticated understanding and belief test."<sup>212</sup> This test evaluates whether or not "the decisionmaker [has] the ability to assess all evidence relevant to her decision."<sup>213</sup> The sophisticated element of this test concerns whether the decisionmaker is making a choice based upon a delusion or a patent falsehood.<sup>214</sup> As evidenced by the statements above, Julianna likely meets this standard.<sup>215</sup> She was presented with the fact that if she refuses the treatment she will likely die, and she was told the grave consequences her decision and still refused the treatment.<sup>216</sup> Additionally, there is no evidence that she based her decision on any delusion, and this notion is evidenced by Dr. Feudtner's support of Julianna and her parents' decision.<sup>217</sup> It may be argued that Julianna's sense of heaven is delusional; however, if we accept that proposition, then most people who believe in heaven are delusional. It would then follow that many decisions regarding end-of-life treatment would be delusional, regardless of age, because the concept of heaven and the afterlife is present in many modern-day religions, which many people use as guidance when it comes to life and death situations.<sup>218</sup> Dr. Feudtner even expressed his doubts that his elderly father fully comprehended what would happen to him once he died, saying: "My 86-year-old father died in April, and I'm not sure he truly got it[.]"<sup>219</sup>

The vast unknown that surrounds death is not necessarily something that becomes clearer with age, and herein lies the crux of this paper.<sup>220</sup> There will never be a day where a person will wake up and suddenly understand all of the world's phenomena.<sup>221</sup> Furthermore, Saks' test for competence acknowledges and accounts for the fact that people use both conventional and unconventional methods of reasoning, but that does not necessarily mean that these people are incompetent.<sup>222</sup> Julianna's case is

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210 *Heaven Over Hospital*.

211 *Id.*; Berg et al., *supra* note 158, at 357–58.

212 Saks, *supra* note 171, at 962.

213 *Id.* at 955.

214 *Id.* at 962.

215 *Id.*; see *Heaven Over Hospital*.

216 *Heaven Over Hospital*.

217 *Id.*

218 *Id.*; *The Big Religion Chart: Comparison Chart*, RELIGIONFACTS (Mar. 17, 2004), <http://www.religionfacts.com/big-religion-chart> (indicating that major world religions such as Christianity and Islam believe in some form of heaven or paradise after death).

219 *Heaven Over Hospital*.

220 *See id.*

221 *See id.*

222 Saks, *supra* note 171, at 950.

particularly sensitive given her young age, and even despite her age, some of those who cared for her and analyzed her situation, supported her decision.<sup>223</sup>

The counterargument regarding age and competence is important but it is one that is not incredibly robust. Americans put a great deal of responsibility on people under the age of eighteen.<sup>224</sup> We allow children as young as fifteen drive, making split second decisions regarding not only their safety but also the safety of the people around them;<sup>225</sup> We allow minors to be charged and punished like adults for committing crimes under certain circumstances; and we also allow minors to consent to the abortion of a fetus without a parental veto.<sup>226</sup> Arguing that people cannot make competent decisions simply because they have not been alive for eighteen years is a lazy precaution that could have major effects on the well-being of terminally ill patients.<sup>227</sup>

#### IV. CONCLUSION

When it comes to assisted suicide for minors, doctors and mental health professionals are unable to allow minors to seek a death with dignity because of state statutory age limits.<sup>228</sup> A competency analysis performed by a physician or professional is preferable to the current system, which is why a “totality of the circumstances approach” for administering assisted suicide for people under the age of eighteen should be implemented. If doctors could deem Julianna’s decision a competent one, it follows that a terminally ill sixteen year-old with a terminal illness could also make a competent decision under either the MacArthur categories or the Saks “sophisticated understanding and belief” test.<sup>229</sup>

Like the laws in Belgium and the Netherlands, a future American law allowing assisted suicide for people under the age of eighteen would include an analysis by a physician, who could weigh the competency of the patient on a case-by-case basis, like the procedure used for civil commitment of children to mental health institutions.<sup>230</sup> There’s an old adage that “age is just a number;” however, American laws regarding assisted suicide take this “number” and use it to categorically exclude people, who may benefit from this procedure, without an individualized

<sup>223</sup> *Heaven Over Hospital*.

<sup>224</sup> See Kimberly Leonard, *Case Sparks Debate About Teen Decision Making in Health*, U.S. NEWS (Jan. 22, 2015), <http://www.usnews.com/news/articles/2015/01/22/case-sparks-debate-about-teen-decision-making-in-health>.

<sup>225</sup> Denise Witmer, *Driving Age by State*, VERY WELL (June 1, 2016), <https://www.verywell.com/driving-age-by-state-2611172>.

<sup>226</sup> *Planned Parenthood v. Danforth*, 428 U.S. 52, 74 (1976); *Juvenile Justice: State Laws*, PBS FRONTLINE, <http://www.pbs.org/wgbh/pages/frontline/shows/juvenile/stats/states.html> (last visited Sept. 4, 2016).

<sup>227</sup> See Leonard, *supra* note 225.

<sup>228</sup> *Death with Dignity*.

<sup>229</sup> Berg et al., *supra* note 158, at 351–62. See Saks, *supra* note 171, at 962.

<sup>230</sup> See Slobogin et al., *supra* note 88, at 1018; *Death with Dignity* (outlining the Belgian and Dutch laws).

determination regarding their condition, out of the fear that they are not competent to make such a decision because of their age.<sup>231</sup>

This is a controversial topic. Many questions remain as some still challenge the constitutionality and legality of the practice of assisted suicide for adults, while others have posed the question of whether depression is a justifiable condition to allow someone have a physician-assisted death.<sup>232</sup> Many of these questions remain unsolved because more work needs to be done in this area, but, for the reasons discussed in this paper, allowing minors to at least consider utilizing this treatment would be a policy shift in the right direction.<sup>233</sup> Removing the categorical age requirement from physician-assisted suicide laws would serve to provide terminally ill Americans not only the ability to end their excruciating pain and suffering, but would also allow them to end their lives on their own terms—a death with dignity.

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231 *See Death with Dignity.*

232 *Should People With Mental Health Disorders Have Access to Physician-Assisted Death?*, HEALTHYDEBATE (Jan. 21, 2016), <http://healthydebate.ca/2016/01/topic/should-people-with-mental-health-disorders-access-assisted-death>.

233 Sharon Kirkey, *Possibility That Incurable Depression Meets Criteria for Doctor-Assisted Suicide Raises Ethical Concerns*, NATIONAL POST (Feb. 13, 2015, 8:38 PM), <http://news.nationalpost.com/news/canada/possibility-that-incurable-depression-meets-criteria-for-doctor-assisted-suicide-raises-ethical-concerns>.