

2017

Physician-Assisted Suicide: Removing Residency Requirements in the U.S. to Comport with an International Right to Health

Alexi Silverman

Follow this and additional works at: <http://digital.sandiego.edu/ilj>

 Part of the [International Law Commons](#)

Recommended Citation

Alexi Silverman, *Physician-Assisted Suicide: Removing Residency Requirements in the U.S. to Comport with an International Right to Health*, 19 San Diego Int'l L.J. 193 (2017)

Available at: <http://digital.sandiego.edu/ilj/vol19/iss1/8>

This Comment is brought to you for free and open access by the Law School Journals at Digital USD. It has been accepted for inclusion in *San Diego International Law Journal* by an authorized editor of Digital USD. For more information, please contact digital@sandiego.edu.

Physician-Assisted Suicide: Removing Residency Requirements in the U.S. to Comport with an International Right to Health

ALEXI SILVERMAN*

In 1948, the UN General Assembly passed a resolution, known as the International Bill of Human Rights. The Bill contains the Universal Declaration of Human Rights, articulating a human right to health. A subsequent treaty, the International Covenant on Civil and Political Rights states that “every human being has the inherent right to life.” Furthermore, the International Covenant on Economic, Social and Cultural Rights protects access to healthcare. However, these treaties do not explicitly recognize a “right to die,” leaving the decision of whether to allow euthanasia and physician-assisted suicide within the discretion of individual countries.

With this international background in mind, this Comment will explore terminally ill individuals’ access to physician-assisted suicide in the United States, arguing that states that legalize this end-of-life option should remove their residency requirements. Part I will introduce the concept of the human right to health and how the right is interpreted by two countries—the United States and the Netherlands. Part II will discuss the current legal status of PAS in the United States. In Part III, this Comment will argue that states should remove their residency requirements for constitutional reasons,

* © 2017 Alexi Silverman. J.D. 2018 Candidate, University of San Diego School of Law. The author would like to thank Professor Dov Fox for his guidance throughout the writing process. The author would also like to thank her family, friends, and the San Diego International Law Journal editorial board for feedback and support.

as such discrimination against non-residents is likely unconstitutional under Article IV’s Privileges and Immunities Clause. Further, even if states do not remove their residency requirements for constitutional reasons, they should do so for moral reasons. The current PAS situation will be analogized to another controversial medical service—abortion—during the pre-Roe era, in which one state, New York, defied the masses and removed its residency requirement. Finally, Part IV will argue that states should remove residency requirements for human rights reasons.

TABLE OF CONTENTS

I.	INTRODUCTION	194
II.	INTERNATIONAL HEALTHCARE BACKGROUND.....	197
	A. <i>International Right to Health</i>	198
	1. <i>Right to Health in the Netherlands</i>	200
	2. <i>Right to Health in the United States</i>	201
III.	THE CURRENT PHYSICIAN-ASSISTED SUICIDE LANDSCAPE IN THE U.S.	203
	A. <i>Decisions at the U.S. Federal Level</i>	203
	B. <i>Decisions at the U.S. State Level</i>	204
	1. <i>Oregon</i>	205
	2. <i>Montana</i>	205
IV.	WHY STATES SHOULD REMOVE THEIR RESIDENCY REQUIREMENTS	206
	A. <i>States Should Remove Their Residency Requirements</i> <i>for Constitutional Reasons</i>	207
	1. <i>Access to PAS as a Medical Service is a Fundamental</i> <i>Right</i>	208
	a. <i>Access to Healthcare is a Fundamental Value in the</i> <i>United States</i>	210
	2. <i>None of the States’ Interests are Both Substantial</i> <i>and Legitimate</i>	213
	3. <i>There is a Less Restrictive Means to Achieve the</i> <i>State’s Interests</i>	215
	B. <i>States Should Remove Their Residency Requirements for</i> <i>Moral Reasons</i>	216
	1. <i>Pre-Roe Abortion Residency Requirements</i>	217
	2. <i>PAS Residency Requirements</i>	219
	C. <i>States Should Remove Their Residency Requirements for</i> <i>Human Rights Reasons</i>	223
V.	CONCLUSION	223

I. INTRODUCTION

It is early afternoon on New Year’s Eve and you are eagerly waiting to ring in a new year of health, wealth, and happiness with your loved ones. This is the perfect occasion to take time off work and make a trip up to wine country in the Golden State—your native, beloved home of California.

Just as you carry the champagne to the refrigerator for the night's festivities, you feel that familiar twinge of pain in your head. It comes so sharply and unexpectedly that you lose your grip on the glass bottle and it shatters as it hits the floor. Your husband runs into the kitchen. "Just another migraine," you tell him. That is, after all, what the neurologist diagnosed you with last year. Your husband nevertheless insists on taking you to the emergency room. Numerous hours and many scans later, a physician has confirmed your worst fear: you are not just suffering from migraines. Your life is about to drastically change—if not end—just as a new year begins.

This was the story of Brittany Maynard, a twenty-nine-year-old woman who was diagnosed with a malignant brain tumor and boldly fought for her death rather than her life.¹ Brittany is not the typical picture one paints of an ill individual who wishes to die. She was young, newly married, and hoping to start a family.² Perhaps these unique details are why her story attracted so much interest, especially among young adults.³ Brittany did not want to spend the rest of her life suffering in pain, knowing her condition was rapidly deteriorating.⁴

At the time, California, Brittany's home state, did not legalize aid-in-dying.⁵ Working against the clock, Brittany arranged to travel to Oregon,

1. See Stacey Kennelly, *Death with Dignity: Brittany Maynard's husband carries on the right-to-die fight*, DIABLO MAG. (Oct. 5, 2015), <http://www.diablogmag.com/October-2015/Death-With-Dignity-Brittany-Maynards-husband-carries-on-the-right-to-die-fight/> [<https://perma.cc/64XK-QGHU>]. This hypothetical situation mirrors the hours that led up to Brittany's diagnosis, although details have been changed.

2. See Joe Harkins, *Assisted Suicide: Who Decides—When, Where and How?*, MED. TOURISM MAG. (Nov. 4, 2014), <http://www.medicaltourismmag.com/news/2014/11/assisted-suicide-decides/> [<https://perma.cc/EVS2-BVAJ>] (noting Brittany's youth and beauty in contrast to an elderly patient faced with illness).

3. See Andrew Dugan, *In U.S., Support Up for Doctor-Assisted Suicide*, GALLUP (May 27, 2015), <http://www.gallup.com/poll/183425/support-doctor-assisted-suicide.aspx> [<https://perma.cc/4HXJ-KTBF>] (noting Gallup's Value and Beliefs Survey conducted May 2014 that recognized a significant increase in adults ages 18-34 who support physician-assisted suicide, likely due to Brittany Maynard's journey).

4. Bill Briggs, *Why Newlywed Brittany Maynard is Ending Her Life in Three Weeks*, NBC NEWS (Oct. 9, 2014, 5:08 AM), <http://www.nbcnews.com/health/cancer/why-newlywed-brittany-maynard-ending-her-life-three-weeks-n221731> [<https://perma.cc/XC3D-LFJ8>].

5. California's End of Life Option Act took effect June 9, 2016. Claudia Buck, *A better way to die? California's end-of-life law launches June 9*, SACRAMENTO BEE (May 5, 2016, 5:32 PM), <http://www.sacbee.com/news/local/health-and-medicine/article75967042.html> [<https://perma.cc/M34J-PABF>]. The End of Life Option Act's passing in October 2015 is undoubtedly owed in part to Brittany's fight. See *id.* This comment uses the terms aid-in-dying, physician-assisted suicide, death with dignity, interchangeably.

one of the few U.S. states that legally offered physician-assisted suicide (“PAS”), to effectuate her goal of dying.⁶ However, she still faced a steep hurdle as Oregon’s Death with Dignity law required, among other qualifications, that terminally ill individuals establish residency in Oregon.⁷ Prior to Brittany’s case, there were few reports of patients moving to states that legalized PAS to take advantage of their laws.⁸ In an interview with CNN, Brittany noted that most families do not have the resources or time to make such extensive life changes, stating:

I met the criteria for death with dignity in Oregon, but establishing residence in the state to make use of the law required a monumental number of changes I had to find new physicians, establish residency in Portland, search for a new home, obtain a new driver’s license, change my voter registration, and enlist people to take care of our animals, and my husband, Dan, had to take a leave of absence from his job.⁹

Acting with Compassion and Choices, an organization advocating for end-of-life rights, Brittany called for legal reform in the United States.¹⁰ She lobbied for all Americans to gain access to what she viewed as a health care right.¹¹ The aftermath of her passing opened up a serious dialogue: should a state be allowed to restrict its aid-in-dying procedure to its own residents, leaving non-residents to fend for themselves? Further, her passing raised a far more expansive question: is the right to die an international human right?

This Comment will explore terminally ill individuals’ access to physician-assisted suicide in the United States, arguing that states that legalize this

6. Kennelly, *supra* note 1. The U.S. jurisdictions that legalized physician-assisted suicide at the time were: Oregon, Washington, Montana, Vermont, and New Mexico. See Kennelly, *supra* note 1. The New Mexico Supreme Court has since overruled the state district court’s January 2014 ruling that PAS is a right under the state constitution. New Mexico, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/states/new-mexico/> (last visited Nov. 17, 2017). [<https://perma.cc/2KWU-79KE>]. Oregon was the closest geographic option to Brittany as a California resident.

7. OR. REV. STAT. ANN. § 127.860 (West 2017).

8. Alexander R. Safyan, *A Call for International Regulation of the Thriving “Industry” of Death Tourism*, 33 LOY. L.A. INT’L & COMP. L. REV. 287, 304 (2011).

9. Brittany Maynard, *My right to death with dignity at 29*, CNN (Nov. 2, 2014, 10:44 PM), <http://www.cnn.com/2014/10/07/opinion/maynard-assisted-suicide-cancer-dignity/> [<https://perma.cc/ZNS8-PCKZ>]; see also David Bryant, *The Need for Legalization and Regulation of Aid-in-Dying and End-of-Life Procedures in the United States*, 18 QUINNIPIAC HEALTH L.J. 287, 324 (2015) (recognizing that less economically fortunate patients cannot afford to move to take advantage of other states’ laws).

10. See *About Compassion & Choices*, COMPASSION & CHOICES <https://www.compassionandchoices.org/who-we-are/> (last visited Nov. 17, 2017) [<https://perma.cc/4QFR-T69Q>].

11. Catherine E. Shoichet, *Brittany Maynard on decision to die: Now ‘Doesn’t Seem Like the Right Time’*, CNN (Nov. 3, 2014, 7:34 AM), <http://www.cnn.com/2014/10/29/health/oregon-brittany-maynard-video/> [<https://perma.cc/J2FR-XTDD>].

end-of-life option should remove their residency requirements. Part I will introduce the concept of the human right to health and how the right is interpreted by two countries—the United States and the Netherlands. Next, Part II will discuss the current legal status of PAS in the United States. Part III will then analyze whether states should remove their residency requirements, both for constitutional and moral reasons.

First, this Comment will argue that states should remove their residency requirements for constitutional reasons, as such discrimination against non-residents is likely unconstitutional under Article IV's Privileges and Immunities Clause. Second, even if states do not remove their residency requirements for constitutional reasons, they should do so for moral reasons. The current PAS situation will be analogized to another controversial medical service—abortion—during the pre-*Roe* era, in which one state defied the masses and removed its residency requirement. Finally, Part IV will argue that states should remove residency requirements for human rights reasons.

II. INTERNATIONAL HEALTHCARE BACKGROUND

End-of-life care is often analyzed with an eye towards medicine; however, it may also be viewed from a human rights perspective.¹² To understand if a right to die exists, it is imperative to examine how the United Nations views human rights.¹³

First, Section A will provide a background into whether there is an international right to health. One of the questions that this section seeks to answer is whether the United Nations (“UN”) treats health as a human right. If so, would physician-assisted suicide fall under the definition of health?

Next, Subsections 1 and 2 will explain the laws two countries adopted with regard to PAS and whether the end-of-life option fits within their country's definition of the right to health. Subsection 1 looks at the United States, a country that does not recognize PAS within its definition of health.

12. Marta Kikena de Matto, *Creating a Space for End of Life: A Leap-Frog Opportunity for Developing Countries from a Health and Human Rights Perspective*, 17 J. HEALTH CARE L. & POL'Y 187, 189–90 (2014).

13. *Overview*, UNITED NATIONS, <http://www.un.org/en/sections/about-un/overview/index.html> (last visited Nov. 17, 2017) [<https://perma.cc/688G-WFWM>]. The UN is a governing international organization containing 193 member states, which is almost every country in the world. *Id.*

Subsection 2 will look at the Netherlands, a country that has cut against the grain and enacted legislation cementing euthanasia as part of the right to health within its own borders.¹⁴

A. *International Right to Health*

The Charter of the United Nations was signed into law in June of 1945.¹⁵ Most countries in the world have since ratified it.¹⁶ In 1948, the UN General Assembly passed a resolution, known as the International Bill of Human Rights (“the Bill”).¹⁷ The Bill was created to promote universal recognition and respect for the rights and freedoms of people of all nations.¹⁸ The Bill contains the Universal Declaration of Human Rights (“UDHR”).¹⁹ Later, in 1966, the two separate treaties were passed: the International Covenant on Economic, Social and Cultural Rights (“ICESCR”),²⁰ the International Covenant on Civil and Political Rights (“ICCPR”),²¹ and two Optional Protocols.²² Each will be discussed in part.

The ICCPR states that “every human being has the inherent right to life.”²³ Although the UDHR does not explicitly define human rights, it articulates a human right to health: “Everyone has a right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services.”²⁴ The ICESCR goes further and promises that Member States

14. Euthanasia differs from PAS in that a physician (rather than the patient himself) administers fatal doses to the patient. Although this distinction poses separate and unique challenges, it will not be analyzed in depth in this comment.

15. See U.N. Charter, available at <http://www.un.org> [<https://perma.cc/JM3D-NJVQ>].

16. *Id.*

17. G.A. Res. 217 (III), International Bill of Human Rights (Dec. 10, 1948), available at [https://undocs.org/A/RES/217\(III\)](https://undocs.org/A/RES/217(III)).

18. U.N. Office of the High Comm’r for Human Rights, The International Bill of Human Rights: Fact Sheet No.2 (Rev. 1), (June 1996) <http://www.ohchr.org/Documents/Publications/FactSheet2Rev.1en.pdf> [<https://perma.cc/74L7-Q87W>]; see also *UN Member States on the Record*, UNITED NATIONS, <http://www.un.org/depts/dhl/unms/founders.shtml> (last visited Jan. 30, 2018) [<https://perma.cc/539P-X6DW>].

19. G.A. Res. 217 (III) A, Universal Declaration of Human Rights (Dec. 12, 1948).

20. International Covenant on Economic, Social, and Cultural Rights, *adopted and opened for signature* Dec. 16, 1966, 999 U.N.T.S. 171 (entered into force Mar. 23, 1976) [hereinafter “ICESCR”].

21. International Covenant on Civil and Political Rights, *adopted and opened for signature* Dec. 16, 1966, 999 U.N.T.S. 171 (entered into force Mar. 23, 1976) [hereinafter “ICCPR”].

22. One optional protocol is a part of the International Covenant on Economic, Social, and Cultural Rights, and the other optional protocol is a part of the International Covenant of Civil and Political Rights.

23. ICCPR, art. 6.

24. G.A. Res. 217 (III) A, *supra* note 19, art. 25 (Dec. 12, 1948).

to the treaty will “recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”²⁵ Scholars point to this provision as one that protects access to healthcare, even though parties may adopt whichever system they desire to fulfill such access.²⁶ In response, the UN Committee on International Economic, Social and Cultural Rights published General Comment 14 as a framework for countries that ratified the ICESCR.²⁷

In addition to the treaties and resolutions mentioned above, there are other legal documents that address access to health care. The Convention on the Elimination of All Forms of Discrimination Against Women, the Convention on the Rights of the Child, and the International Convention on the Elimination of All Forms of Racial Discrimination address socioeconomic concerns.²⁸ The Organization of American States and its Declaration of the Rights and Duties of Man address social concerns.²⁹ Article 11 provides that “every person has the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing and medical care, to the extent permitted by public and community resources.”³⁰

The UN also established the World Health Organization (“WHO”), an organization that promotes international health and acts as a legislative agency in regulating international health.³¹ The WHO defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”³² The organization also preserves a

25. ICESCR art. 12(1).

26. Martin Buijsen, *Autonomy, Human Dignity, and the Right to Healthcare: A Dutch Perspective*, 19 CAMBRIDGE Q. OF HEALTHCARE ETHICS 321, 327 (2010).

27. Eleanor D. Kinney, *The International Human Right to Health: What Does This Mean for Our Nation and Our World?* 34 IND. L. REV. 1457, 1467–68 (2001); see also U.N. Econ. & Soc. Council [ECOSOC], Comm. on Econ., Soc. and Cultural Rights [CESCR], Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights: General Comment No. 14, P 12(b), U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000), <http://www.refworld.org/pdfid/4538838d0.pdf> [<https://perma.cc/QG7M-5JFU>]

28. Eleanor D. Kinney, *Recognition of the International Human Right to Health and Health Care in the United States*, 60 RUTGERS L. REV. 335, 342–43 (2008).

29. Kinney, *supra* note 27, at 1461.

30. *Id.*

31. *Id.* at 1460.

32. Constitution of the World Health Organization, July 22, 1946, 62 Stat. 6279, 14 U.N.T.S. 185.

right to the “highest attainable standard of health.”³³ In the past, the WHO employed a strategy called “Health for All,” which advised Member States that providing equal access to healthcare is both a legal and moral obligation.³⁴

Despite the right to health set forth by the United Nation treaties and by the WHO, no explicit “right to die” has been internationally recognized. For example, in 2002, the European Court of Human Rights heard a case that involved a terminally ill English woman who wished for her husband’s assistance in her death.³⁵ The Court determined that the right to life could not be interpreted as also conferring the right to die.³⁶ For now, individual countries retain discretion to enforce euthanasia and physician-assisted suicide laws rather than complying with a uniform international standard.

1. Right to Health in the Netherlands

The Netherlands, a member of the U.N., ratified the ICESCR in 1978.³⁷ Unlike in the United States, international treaties reign supreme over the Dutch Constitution.³⁸ The Netherlands thus recognizes health care as a right for its citizens and provides coverage to all.³⁹ Even further, the Dutch Constitution provides in Article 22, in its “fundamental rights,” that “the authorities shall take steps to promote the health of the population.”⁴⁰ Notably, the Netherlands’ health system ranked fifth overall in a 2014 Commonwealth Fund survey, while the United States’ health system ranked last.⁴¹

Although the Netherlands has not codified an explicit “right” to die, in 2000, the Dutch parliament created an exemption under its Criminal Code.⁴² This exemption allows doctors to participate in both euthanasia

33. *Id.*

34. Jason B. Saunders, *International Health Care: Will the United States Ever Adopt Health Care for All?—A Comparison Between Proposed United States Approaches to Health Care and the Single-Source Financing Systems of Denmark and the Netherlands*, 18 SUFFOLK TRANSNAT’L L. REV. 711, 715–16 (1995).

35. *Pretty v. United Kingdom*, 35 Eur. Ct. H.R. 2, 2–3 (2002).

36. *Id.*

37. U.N. Office of the High Comm’r for Human Rights, Status of Ratification Interactive Dashboard, <http://indicators.ohchr.org> [<https://perma.cc/CVS3-V42F>].

38. ANTONIO CASSESE, INTERNATIONAL LAW 229 (2nd ed. 2005). *See infra* Part I.A.2.

39. Saunders, *supra* note 34, at 716.

40. Gw. [Constitution] art. 22, sub. 1, <https://www.government.nl/topics/human-rights/contents/human-rights-in-the-netherlands> [<http://perma.cc/5F5S-YZLE>].

41. KAREN DAVIS ET AL., MIRROR, MIRROR ON THE WALL: HOW THE PERFORMANCE OF THE U.S. HEALTH CARE SYSTEM COMPARES INTERNATIONALLY 7 (2014), http://www.commonwealthfund.org/~media/files/publications/fund-report/2014/jun/1755_davis_mirror_mirror_2014.pdf [<https://perma.cc/4F9A-UWFK>].

42. Lara L. Manzione, *Is There a Right to Die?: A Comparative Study of Three Societies (Australia, Netherlands, United States)*, 30 GA. J. INT’L & COMP. L. 443, 454 (2002).

and PAS without facing criminal prosecution.⁴³ However, in order to qualify to provide such assistance, physicians must meet statutory due care and notify a regional euthanasia review committee of the patient's death.⁴⁴ The Dutch government believes that the country's practice of euthanasia is consistent with the ICESCR and is not in violation of the ICCPR or the European Convention on Human Rights.⁴⁵ Despite voicing concerns, the U.N. Human Rights Committee has yet to rebuke the Dutch euthanasia law.⁴⁶ However, the Council of Europe has held that the law violates the right to life contained in Article 2 of the European Convention on Human Rights.⁴⁷

2. Right to Health in the United States

The United States has signed the UDHR as a Member State of the UN.⁴⁸ It has not taken the additional step of ratifying the ICESCR treaty, which would recognize a human right to health.⁴⁹ This is surprising, considering the majority of UN Member States have ratified the ICESCR, implicitly recognizing the international right to health.⁵⁰

The U.S. claims that the ICESCR is inconsistent with its Constitution.⁵¹ Because the U.S. Constitution is the "supreme law of the land," any international treaty that the U.S. becomes party to will not supersede the U.S. Constitution, unlike in the Netherlands.⁵² In addition, the U.S.

43. *Id.*

44. NETHERLANDS MINISTRY OF FOREIGN AFFAIRS, *The Termination of Life on Request and Assisted Suicide (Review Procedures) Act in practice 2*, http://www.patientsrightscouncil.org/site/wp-content/uploads/2012/03/Netherlands_Ministry_of_Justice_FAQ_Euthanasia_2010.pdf [<https://perma.cc/L2JU-QFJZ>].

45. *Id.*

46. *UN concern at Dutch euthanasia law*, BBC EUROPE (July 28, 2001), <http://news.bbc.co.uk/2/hi/europe/1461226.stm> [<https://perma.cc/T72H-KQXU>].

47. Article 2 provides: "Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law." European Convention on Human Rights, Apr. 11, 1950, 213 U.N.T.S. 221, I, Art. 2, http://www.echr.coe.int/Documents/Convention_ENG.pdf [<https://perma.cc/WJK6-FTUR>].

48. Kinney, *supra* note 27 at 1463.

49. *Id.*

50. *Id.* at 1464. One such nation-state is the Netherlands. *See infra* Part II.A.1.

51. Carlo V. DiFlorio, *Assessing Universal Access to Health Care: An Analysis of Legal Principle and Economic Feasibility*, 11 DICK. J. INT'L L. 139, 145 (1992).

52. *Do Treaties Trump the Constitution?*, TENTH AMEND. CTR., <http://tenthamendmentcenter.com/2013/06/06/do-treaties-trump-the-constitution/> [<https://perma.cc/RJ6X-76W4>].

Constitution does not expressly articulate a right to health or medical care.⁵³ The U.S. Supreme Court has interpreted the Constitution narrowly, refusing to find any obligation on the federal government to provide health care to U.S. citizens.⁵⁴ It has, however, acknowledged the fundamental right to privacy, which some healthcare services are privy to.⁵⁵

With no mandatory obligations, the U.S. has still voluntarily created a legal infrastructure that provides healthcare to some.⁵⁶ Congress has enacted statutes, including Medicare, Medicaid, the Children’s Health Insurance Program (“CHIP”), and the Emergency Medical Treatment and Labor Act (“EMTALA”), which grant specific groups of individuals a right to health care.⁵⁷ These statutes afford health care to low-income individuals, those aged 65 and above, children, and those with emergency medical conditions.⁵⁸ In addition, Congress may regulate the health care industry under its power to regulate interstate commerce.⁵⁹

Notably, the U.S. spends more money on healthcare than any other country.⁶⁰ In 2013, 17 percent of the United States’ Gross Domestic Product (“GDP”) was spent on healthcare.⁶¹ Nonetheless, the Commonwealth Fund ranked the U.S. healthcare system last overall.⁶² Because the U.S. is so technologically advanced, some scholars believe the country should lead the path in recognizing an international human right to health.⁶³ To date, the U.S. has also not recognized a right to die.⁶⁴

53. Kathleen S. Swendiman, CONG. RESEARCH SERV., R40846, HEALTH CARE: CONSTITUTIONAL RIGHTS AND LEGISLATIVE POWERS (2012), <https://fas.org/sgp/crs/misc/R40846.pdf> [<https://perma.cc/8YDQ-R2DD>].

54. Saunders, *supra* note 34, at 721–22.

55. *Id.* The Supreme Court has found privacy liberty interests to include: abortion, procreation, use of contraception, and bodily integrity. *Id.*

56. Swendiman, *supra* note 53.

57. *Id.*

58. *Id.*

59. *Id.*

60. Chloe Anderson & David Squires, *U.S. Health Care from a Global Perspective*, THE COMMONWEALTH FUND (Oct. 8, 2015), <http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-from-a-global-perspective> [<https://perma.cc/8YHS-MZGW>].

61. *Id.*

62. DAVIS ET AL., *supra* note 41.

63. See Kinney, *supra* note 27, at 1467.

64. See *infra* Part III.A.

III. THE CURRENT PHYSICIAN-ASSISTED SUICIDE LANDSCAPE IN THE U.S.⁶⁵

Many are familiar with Dr. Jack Kevorkian, a U.S. physician who was sentenced to prison in 1997 not because he assisted his patients in committing suicide, but because he pressed the button that delivered his last patient fatal medication.⁶⁶ The Hippocratic Oath includes a vow that in assuming their ethical responsibilities, physicians will not suggest that patients take deadly drugs nor offer such drugs.⁶⁷ Although Dr. Kevorkian became an example for many physicians that feared criminal liability, his acts influenced other physicians to better care for patients at the end of life.⁶⁸ At the time of Dr. Kevorkian's arrest, PAS remained illegal in the U.S.⁶⁹ However, some physicians began to openly challenge the law, the medical field, and society at large for condemning the practice.

A. Decisions at the U.S. Federal Level

The U.S. Supreme Court unanimously declined to recognize that the Due Process Clause of the Fourteenth Amendment protects a right to die in *Washington v. Glucksberg*.⁷⁰ To determine whether PAS was a liberty interest, the Court employed a historical analysis, noting that fundamental rights under the Due Process Clause are those rights that are deeply rooted in legal tradition.⁷¹ Writing for the majority, Justice Rehnquist recognized that states have punished suicide for centuries and that recent efforts to legalize PAS have failed to gain traction.⁷² Thus, he reasoned, assisted

65. Physician-assisted suicide is the process by which a doctor prescribes a patient medication in fatal doses, but the patient ultimately self-administers the medication. Bryant, *supra* note 9, at 291. This is in contrast to euthanasia, which consists of the physician administering fatal doses of medication directly to the patient. *Id.*

66. See Stephen Hoffman, *Euthanasia and Physician-Assisted Suicide: A Comparison of E.U. and U.S. Law*, 63 SYRACUSE L. REV. 383, 396 (2013).

67. Peter Tyson, *The Hippocratic Oath: Today*, PBS: NOVA (Mar. 27, 2001), <http://www.pbs.org/wgbh/nova/body/hippocratic-oath-today.html> [<https://perma.cc/S983-RN9H>].

68. See Keith Schneider, *Dr. Jack Kevorkian Dies at 83; A Doctor Who Helped End Lives*, N.Y. TIMES, (June 3, 2011), <http://www.nytimes.com/2011/06/04/us/04kevorkian.html> [<https://perma.cc/5JFU-2PKM>].

69. See *id.*

70. *Washington v. Glucksberg*, 521 U.S. 702, 728 (1997); see also *Vacco v. Quill*, 521 U.S. 793, 808–09 (1997) (holding that New York's ban on PAS did not violate the Fourteenth Amendment's Equal Protection Clause).

71. *Glucksberg*, 521 U.S. at 720–21.

72. *Id.* at 728.

suicide is not “deeply rooted in this Nation’s history and tradition” and could not be considered a fundamental right.⁷³ The majority further reasoned that a state’s choice to ban PAS implicated compelling state interests.⁷⁴ These compelling interests included: (1) preserving the sanctity of human life; (2) upholding the medical profession and the doctor-patient relationship; (3) protecting the terminally ill and severely disabled from harm (including both harm of coercion and harm of societal devaluation); and (4) preventing a broader license for voluntary, and perhaps involuntary, euthanasia.⁷⁵

Justice Rehnquist’s majority opinion and Justice Souter’s concurrence both devoted ample space to the concept of the states as experimental laboratories.⁷⁶ Both made clear that although PAS was not federally legal, each state could choose whether to experiment with PAS within its borders.⁷⁷ At the time of the decision, Oregon was the only state experimenting with PAS.⁷⁸ The Court indicated that Americans should continue to debate about the morality and legality of PAS, leaving the decision-making to the states.⁷⁹

B. Decisions at the U.S. State Level

As of the time of publication of this Comment, there are six jurisdictions that have legalized PAS through legislative enactment: Oregon, Washington, Vermont, California, District of Columbia, and Colorado.⁸⁰ All of the states that enacted PAS legislation adopted a residency requirement.⁸¹ This section examines two pivotal states—Oregon, the first state to legislatively create a right to PAS, and Montana, the only state to judicially interpret a right to PAS.

73. *Id.* at 721 (quoting *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1980)); *Id.* at 728.

74. *Id.* at 728.

75. *Id.* at 728–35.

76. *See id.* at 719, 735; *see id.* at 788 (Souter, J., concurring).

77. *Id.*

78. Brian Bix, *Physician Assisted Suicide and Federalism*, 17 NOTRE DAME L.J. ETHICS & PUB. POL’Y 53, 55 (2003).

79. *Washington v. Glucksberg*, 521 U.S. at 735.

80. *See 20 Years of the Oregon Death with Dignity Act*, DEATH WITH DIGNITY (Sept. 7, 2017), <https://www.deathwithdignity.org/news/> [<https://perma.cc/XJ88-SQEJ>].

81. *Id.* *See also* OR. REV. STAT. ANN. § 127.800 (West 2017); WASH. REV. CODE ANN. § 70.245 (West 2017); VT. STAT. ANN. tit. 18, § 113 (2017); CAL. HEALTH & SAFETY CODE § 443 (Deering 2017); D.C. CODE § 7-661.01 (2017); COLO. REV. STAT. § 25-48-102 (2017).

1. Oregon

Much like the U.S. Constitution, the Oregon Constitution does not grant any right of health to its citizens.⁸² However, the Oregon legislature established the Death with Dignity Act in 1997, becoming the first state to legalize PAS within its borders.⁸³ Washington, Vermont, and California modeled their PAS statutes after Oregon's.⁸⁴

To obtain PAS under the Death with Dignity Act, a patient must be: “capable” to make an informed decision, at least eighteen years of age, possessing an incurable disease that will lead to death within six months, and an Oregon resident.⁸⁵ The state legislature provides a non-exhaustive list to demonstrate how a person may establish residency, including: (a) an Oregon driver's license, (b) an Oregon voter registration, (c) a recent tax return from the state of Oregon, or (d) a property lease or ownership document in the state.⁸⁶

In addition, the patient must make a voluntary written and oral request for the lethal medication. Oregon imposes a minimum fifteen-day waiting period between the initial oral request and the writing of a prescription, as well as a forty-eight hour waiting period between the date the patient signs a written request and the writing of a prescription.⁸⁷ This allows the patient an opportunity to rescind his or her request should the patient change his mind.⁸⁸

2. Montana

Montana is the most explicit of all PAS states in granting its citizens a right to health.⁸⁹ Montana's state constitution protects “inalienable rights” which includes seeking “safety, *health* and happiness in all lawful ways.”⁹⁰ Thus, a Montana citizen has an inalienable right to seek PAS if it is a decision that invokes health. In the 2009 case of *Baxter v. State*, the Montana Supreme

82. See generally OR. CONST.

83. See OR. REV. STAT. ANN. § 127.800 (2017); Bix, *supra* note 78, at 55.

84. See WASH. REV. CODE ANN. § 70.245 (West 2017); Vermont Patient Choice and Control at the End of Life Act No. 39, VT. GEN. ASSEMB. (Vt. 2014); End of Life, Assemb. Bill No. 15 (Cal. 2015).

85. OR. REV. STAT. ANN. § 127.800.

86. OR. REV. STAT. ANN. § 127.860.

87. OR. REV. STAT. ANN. § 127.850.

88. OR. REV. STAT. ANN. § 127.845.

89. Kinney, *supra* note 27, at 1466.

90. MONT. CONST. art. II, § 3 (emphasis added).

Court held that there was no law preventing a physician from administering PAS to a patient seeking the procedure.⁹¹ However, the Montana legislature refused to prescribe the right by statute.⁹² While individuals are able to undergo the procedure due to the judiciary's decision, the procedure is not affirmatively legal.⁹³ Thus individuals in Montana who choose to undergo PAS proceed without any safeguards, such as those prescribed by the Oregon statute.⁹⁴

IV. WHY STATES SHOULD REMOVE THEIR RESIDENCY REQUIREMENTS⁹⁵

States that have adopted PAS through legislative enactment have not provided explicit reasons for imposing residency requirements. However, the residency requirements likely serve one or more of three possible state interests: (1) imposing an additional safeguard to obtaining PAS; (2) preventing an overburdening of the health care system; and (3) respecting other states' policies.

This section weighs the merits of a residency requirement, concluding that states should eliminate the requirement from their PAS legislation. The first part of the section argues that states should remove their residency requirements for constitutional reasons, as such requirements may unconstitutionally restrict the right to access medical services in violation of Article IV's Privileges and Immunities Clause. The second part of the section contends that states should remove their residency requirements for moral reasons because such requirements impose moral harm by predicating access to PAS on socioeconomic status. Finally, the third part of the section argues that states should remove their residency requirements for human rights reasons.

91. *Baxter v. State*, 2009 MT 449, 224 P.3d 1211.

92. *State-by-State Guide to Physician Assisted Suicide* (last updated Feb. 21, 2017), <http://euthanasia.procon.org/view.resource.php?resourceID=000132> [<https://perma.cc/25WX-U8KD>].

93. *Id.*

94. *See supra* note 89, and accompanying text.

95. This Comment does not address the prospect of federally legalizing PAS through legislative means. It is unclear whether Congress, through its enumerated powers, "could intrude into the states' authority to determine public policy regarding the health of their citizens." Michael S. Elliott, *The Commerce of Physician-Assisted Suicide: Can Congress Regulate a "Legitimate Medical Purpose"?*, 43 WILLAMETTE L.R. 399, 400 (2007).

*A. States Should Remove Their Residency Requirements for
Constitutional Reasons*

The Privileges and Immunities Clause, found in Article IV, Section 2, Clause 1 of the U.S. Constitution, prevents a state from discriminating against another state's residents.⁹⁶ For example, the Supreme Court has ruled that a state violates Article IV's Privileges and Immunities Clause when it excludes out-of-state individuals from practicing a trade within the state or provides preferential treatment to in-state individuals for employment opportunities.⁹⁷ Thus, state residency requirements enacted into legislation can be challenged under the Privileges and Immunities Clause.

In determining whether a state's residency requirements unconstitutionally discriminate against non-residents, the Court employs a two-step inquiry.⁹⁸ First, the Court analyzes whether the underlying activity is fundamental under the Clause.⁹⁹ If the activity subject to residency requirements is not fundamental, then the analysis stops there—the residency requirement is valid.¹⁰⁰ However, if the Court deems the underlying activity to be fundamental, analysis moves to the next prong: whether the state has a substantial and legitimate interest in treating non-residents differently.¹⁰¹ This treatment must be the least restrictive means available for the state to achieve its interest.¹⁰²

Thus, if PAS or the broader access to medical treatment is a fundamental right, and the state does not meet its burden of evincing a substantial and

96. RONALD D. ROTUNDA & JOHN E. NOWAK, 2 TREATISE ON CONSTITUTIONAL LAW: SUBSTANCE & PROCEDURE § 12.7(d)(i) (3d ed. 1999 & Supp. 2006). This is not to be confused with the Privileges or Immunities Clause of the Fourteenth Amendment, which would prompt an analysis if a state discriminates between its own residents, such as implementing a law that treats new residents differently from long-term residents. ERWIN CHERMERINSKY, CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES § 5.5.1 (5th ed. 2015).

97. Supreme Court of N.H. v. Piper, 470 U.S. 274, 288 (1985); Hicklin v. Orbeck, 437 U.S. 518, 533–34 (1978).

98. This approach is the strict scrutiny standard of judicial review. There are two lesser standards of review, rational basis review and intermediate scrutiny. Brett Snider, *Challenging Laws: 3 Levels of Scrutiny Explained*, FindLaw (Jan. 27, 2014, 9:05 AM), http://blogs.findlaw.com/law_and_life/2014/01/challenging-laws-3-levels-of-scrutiny-explained.html [<https://perma.cc/PHS4-XMJU>].

99. ROTUNDA & NOWAK, *supra* note 96, § 12.7(d)(ii).

100. *Id.*

101. *Id.*

102. CHERMERINSKY, *supra* note 96, § 5.5.3.

legitimate interest in its residential discrimination by the least restrictive means possible, the residency requirement is unconstitutional.¹⁰³

I. Access to PAS as a Medical Service is a Fundamental Right

The Privileges and Immunities Clause protects only “those privileges and immunities which are, in their nature, fundamental; which belong, of right, to the citizens of all free government.”¹⁰⁴ The Court has a much broader interpretation of a fundamental right under the Privileges and Immunities Clause than its narrow interpretation of a fundamental right under the Due Process and Equal Protection Clauses.¹⁰⁵ The Court has construed a fundamental right under the Privileges and Immunities Clause as one that “bear[s] upon the vitality of the Nation” or promotes “interstate harmony,” but the Court continues to articulate different tests.¹⁰⁶ One case in particular, *Doe v. Bolton*, even adopts a test implying access to PAS is a fundamental right under the Privileges and Immunities Clause.¹⁰⁷ This implication is one of the bases of this Comment: PAS is a fundamental right under the Privilege and Immunities Clause and thus, the residency requirement does not pass muster under the Court’s two step inquiry.¹⁰⁸

Many U.S. citizens remember January 22, 1973, as the day that the Supreme Court declared abortion a constitutionally protected right.¹⁰⁹ However, on the same day that the Supreme Court decided *Roe v. Wade*, it decided the lesser-known case of *Doe v. Bolton*.¹¹⁰ In *Bolton*, the Court held a Georgia law limiting abortions to Georgia’s own residents as unconstitutional under the Privileges and Immunities Clause.¹¹¹ The Court broadly concluded that a state could not enact a residency requirement that limited access to medical services within its borders.¹¹² This holding was interpreted in a 2016 federal district court case as holding that “[a] state cannot discriminate against out-of-staters with regard to access to medical care even though there is no constitutional right to medical care.”¹¹³

103. See ROTUNDA & NOWAK, *supra* note 96, § 12.7(d)(ii).

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

105. ROTUNDA & NOWAK, *supra* note 96.

106. *Baldwin v. Fish & Game Comm’n*, 436 U.S. 371, 383 (1978); *United Bldg. & Constr. Trades Council v. Camden*, 465 U.S. 208, 218 (1984).

107. *Doe v. Bolton*, 410 U.S. 179 (1973).

108. See discussion *infra*.

109. *Roe v. Wade*, 410 U.S. 113 (1973).

110. *Id.*; *Doe v. Bolton*, 410 U.S. 179.

111. *Bolton*, 410 U.S. at 200.

112. *Id.*

113. *Austin v. Carwyle*, No. 3:15-CV-177-SA-SAA, 2016 U.S. Dist. LEXIS 52167, at *9 (N.D. Miss. Apr. 19, 2016).

Though access to medical care has not been ruled a fundamental right under the Due Process or Equal Protection Clause, it is a fundamental right under the Privileges and Immunities Clause as held in *Bolton*.¹¹⁴ This somewhat contradictory statement has been supported by longstanding judicial doctrine and is substantiated by scholars in other medical contexts.¹¹⁵ In the PAS context, one scholar states:

PAS, where legal, would seem to be a “medical service” that, under *Bolton*, cannot be restricted to state residents. Since Supreme Court jurisprudence has clearly established that the Privileges and Immunities Clause is not so narrow as to require non-discrimination only where constitutionally protected rights are at stake, the fact that *Bolton* dealt with the constitutionally-protected right to abortion whereas *Glucksberg* and *Quill* established that PAS is not constitutionally guaranteed is unlikely to save the legality of PAS residency requirements.¹¹⁶

Under this reasoning, it does not matter that *Glucksberg* failed to recognize PAS as a constitutional right under the Due Process Clause. As long as PAS is within the scope of the Court’s definition of “medical services,” then access to PAS would be considered a fundamental right for purposes of the Privileges and Immunities Clause.

Though *Bolton* is widely cited, no subsequent Supreme Court case has supported the notion that access to medical services is a fundamental right for all citizens under the Privileges and Immunities Clause.¹¹⁷ Stemming from this is the additional concern that if *Roe v. Wade* were overturned, *Doe v. Bolton* would hold no water since it is *Roe*’s companion case. However, this fear is misplaced.¹¹⁸ The Supreme Court has said on numerous occasions

114. See CHEMERINSKY, *supra* note 96 § 5.5.2.

115. One medical context in which *Bolton* might operate is medical marijuana. The Privileges and Immunities Clause might be implicated if a state restricts medical marijuana use to its own citizens. Though medical marijuana is currently a Schedule I drug—defined as having no medical use—reclassifying medical marijuana might open up litigation under the Privileges and Immunities Clause. Because “access of nonresidents to health care services” is a protected right under the Clause, residency requirements for medical marijuana might not be constitutional. Brannon P. Denning, *Marijuana, Federal Power, and the States: Vertical Federalism, Horizontal Federalism, and Legal Obstacles to State Marijuana Legalization Efforts*, 65 CASE W. RES. 567, 592 (2015).

116. Russell Korobkin, *Physician-Assisted Suicide Legislation: Issues and Preliminary Responses*, 12 NOTRE DAME J.L. ETHICS & PUB. POL’Y 449, 460–61 (1998).

117. See Jessie Hill, *What is the Meaning of Health? Constitutional Implications of Defining “Medical Necessity” and “Essential Health Benefits” Under the Affordable Care Act*, 38 AM. J.L. & MED. 445, 454 (2012).

118. See Seth F. Kreimer, *The Law of Choice and Choice of Law: Abortion, The Right to Travel, and Extraterritorial Regulation in American Federalism*, 67 N.Y.U. L. REV. 451, 498-99 (1992) (“[E]ven if *Roe* is overruled and abortion becomes merely another regulated

that recognition as a constitutionally protected right is not necessary for fundamental right status under the Privileges and Immunities Clause.¹¹⁹ Thus, even if *Roe* had not recognized abortion as a constitutionally protected right, *Bolton* could still recognize *access* to abortion as a fundamental right in those states that had legalized it.

Moreover, it begs the question whether PAS would fit into *Bolton*'s definition of "medical service."¹²⁰ Clearly, abortion fits within the definition of medical service. It is not a far stretch to consider PAS under this definition as well. Almost a third of all abortions in the U.S. are "medical abortions."¹²¹ This consists of a patient taking a pill at a clinic or physician's office, obtaining a prescription for additional medicine, and taking the medicine in the confines of the patient's own home.¹²² This mirrors the series of events for PAS. Further, as the following section discusses, medical services encompass services that promote a patient's well-being.¹²³ Access to services that promote well-being has evolved into an important human value that will endure regardless of its constitutional status as a fundamental right.

a. Access to Healthcare is a Fundamental Value in the United States

Some may argue that access to PAS is inconsistent with the notion of access to medical services.¹²⁴ Individuals seek the assistance of health care

medical procedure, *Doe v. Bolton*'s conclusion that the privileges and immunities clause prevents a state in which abortion services are available from denying access to non-residents seems well grounded. The opportunity to obtain an abortion is no less a 'privilege and immunity' than the opportunity to practice law or to fish for shrimp. Article IV's long-standing obligation to 'place the citizens of each State upon the same footing with citizens of other States' will constrain efforts to bar inhabitants of other states from the abortion opportunities permitted to locals.'").

119. See Lori Johnson, *Within her Sphere: Determining a Woman's Place in the Constitutional Order Under the Privileges and Immunities Clause*, 79 MISS. L.J. 731, 749–50 (2010). The Privilege and Immunities Clause confers "already existing" rights when they are denied. *Id.* at 750. Even without recognition in court cases, the fundamental rights are still there. *See id.*

120. *Bolton* did not specifically define "medical service." However, scholars interpret *Bolton* as addressing health as a holistic concept, comprising an individual's physical, mental, and social well-being. Hill, *supra* note 117, at 453, 456–57.

121. Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability in the United States, 2011*, 46 PERSP. ON SEXUAL & REPROD. HEALTH 3, 8 (Mar. 2014).

122. *The Abortion Pill*, PLANNED PARENTHOOD, <https://www.plannedparenthood.org/learn/abortion/the-abortion-pill> (last visited Nov. 14, 2017) [<https://perma.cc/2ADL-HMG9>].

123. *Affordable Care Act Expands Protection Coverage for Women's Health and Well-Being*, HEALTH RESOURCES & SERV. ADMIN., <https://www.hrsa.gov/womensguidelines/> (last visited Feb. 25, 2017) [<https://perma.cc/QT8U-HNFL>].

124. See Ryan T. Anderson, *Physician-Assisted Suicide Corrupts the Practice of Medicine*, HERITAGE FOUND. (Apr. 20, 2015), <http://www.heritage.org/research/reports/2015/04/physician-assisted-suicide-corrupts-the-practice-of-medicine> [<https://perma.cc/MY5F-KW62>].

professionals to cure various conditions affecting their physical anatomy and at the most extreme, conditions that put their lives in peril. To these opponents, how can a decision that takes an individual's life be consonant with the mission of medical care? PAS, these opponents argue, is a sharp departure from the normal practices of the medical profession.¹²⁵ Allowing doctors to assist patients through PAS distorts the practice of medicine.¹²⁶ It is not a medical decision; it is a moral choice. PAS opponents argue that an individual with a terminal illness can manage pain with palliative care throughout the remainder of her illness.¹²⁷ However, palliative care does little to improve a patient's overall well-being and still subjects the patient to emotional suffering.¹²⁸ Further, there is evidence that medical practitioners themselves are beginning to consider health as an intrinsic, moral good that encompasses well-being.¹²⁹

Several societal factors support the notion that PAS is a medical service. First, the medical profession encourages a doctor-patient relationship that focuses not just on physical care, but also on the patient's mental and emotional well-being.¹³⁰ Physicians take the Hippocratic Oath promising to assume ethical responsibilities in their practice of medicine, creating a uniform standard for the benefit of patients.¹³¹ Although the classical oath disallowed PAS by stating: "I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect," this promise

125. See F. Michael Gloth, III, M.D., *Physician Assisted Suicide: The Wrong Approach to End of Life Care*, UNITED STATES CONF. CATH. BISHOPS (2003), <http://www.usccb.org/about/pro-life-activities/respect-life-program/upload/Physician-Assisted-Suicide-Wrong-Approach-RLP-2003.pdf> (providing principles of medicine that do not support PAS) [<https://perma.cc/H2BF-THVT>].

126. See *id.*

127. See *id.* ("The more compelling arguments for physician-assisted suicide—about avoiding great pain and suffering—do not seem to be motivating requests[.]")

128. See Jennifer A. Woo et al., *Clinical Challenges to the Delivery of End-of-Life Care*, 8(6) PRIM. CARE COMPANION J. CLIN. PSYCHIATRY 367, 368 (2006) (noting that the loss of dignity and distress a terminally ill patient may suffer while undergoing palliative care lessens the patient's desire to live).

129. Upamaka S. Rao, *Relationship with doctor crucial to patient's health, well-being*, BLADE (Feb. 3, 2014, 7:03 AM), <http://www.toledoblade.com/Medical/2014/02/03/Relationship-with-doctor-crucial-to-patient-s-health-well-being.html> [<https://perma.cc/4E4J-395Y>].

130. See Paula Berg, *Toward a First Amendment Theory of Doctor-Patient Discourse and the Right to Receive Unbiased Medical Advice*, 74 B.U.L. REV. 201, 237 (1994).

131. See Tyson, *supra* note 67. The first recorded Hippocratic Oath was taken in 1508. *When Did Medical Students Begin Taking the Hippocratic Oath?*, HIST. NEWS NETWORK (May 21, 2004, 1:33 PM), <http://historynewsnetwork.org/blog/5278> [<https://perma.cc/GCA7-VH7L>].

has since disappeared from the oath.¹³² An increasing number of physicians recognize that the historical oath has become but a mere formality due to advancements and changes in value within the American scientific, political, and social arenas.¹³³ Further, the modern Hippocratic Oath promotes a focus on the patient’s well-being by stating that “there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh . . . the chemist’s drug.”¹³⁴

Second, the American Medical Association (“AMA”), which acts as a governing organization to the medical field, has addressed PAS within its Code of Ethics for decades.¹³⁵ The AMA’s involvement supports the notion that PAS implicates the service of practitioners in the medical field. The latest edition of the Code, adopted in June 2016, maintains the viewpoint that “[p]hysician-assisted suicide is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks.”¹³⁶ However, at the same time, the AMA quietly approved a study by its Council on Ethical and Judicial Affairs that will examine whether to change the long-standing PAS policy in favor of a more neutral approach.¹³⁷

Finally, state legislatures recognize PAS as a medical service. The states that have enacted PAS through legislation use medical terms and nestle PAS statutes between other medical statutes.¹³⁸ Where the practice is legal, an individual cannot obtain end-of-life medication without first obtaining a doctor’s prescription.¹³⁹ The fact that doctors are involved in the PAS process means their knowledge must be relied upon when providing a lethal medication.

132. Tyson, *supra* note 67.

133. *Id.* This is further supported by the fact that the classical oath also stated, “I will not give to a woman an abortive remedy.” *Id.*

134. *Id.*

135. See Richard E. Coleson, *The Glucksberg & Quill Amicus Curiae Briefs: Verbatim Arguments Opposing Assisted Suicide*, 13 ISSUES L. & MED. 3, 67 (1997).

136. *Code of Medical Ethics, Chapter 5: Opinions on Caring for Patients at the End of Life*, AM. MED. ASS’N (2016), <https://www.ama-assn.org/sites/default/files/media-browser/code-2016-ch5.pdf> [<https://perma.cc/HCS7-U8SM>].

137. Steven Ertelt, *American Medical Association May Drop Its Opposition to Assisted Suicide*, LIFENEWS.COM (June 14, 2016, 5:29 PM), <http://www.lifenews.com/2016/06/14/american-medical-association-may-drop-its-opposition-to-assisted-suicide/> [<https://perma.cc/T3UU-PFXW>].

138. See, e.g., OR. REV. STAT. ANN. §§ 127.505-127.660 (West 2017) (Advance Directives for Health Care); OR. REV. STAT. ANN. §§ 127.666-127.684 (West 2017) (Physician Orders for Life-Sustaining Treatment Registry); OR. REV. STAT. ANN. §§ 127.700-127.737 (West 2017) (Declarations for Mental Health Treatment); OR. REV. STAT. ANN. §§ 127.760 (West 2017) (Consent to Health Care Services by Person Appointed by Hospital).

139. See *FAQs*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/faqs/> (last visited Nov. 18, 2017) [<https://perma.cc/94NW-T32C>].

Further developments show that society values access to medical care that is purely non-physical in nature. The introduction of the Affordable Care Act (“ACA”) into American legislation on March 23, 2010, necessitated extreme reform in the American healthcare system.¹⁴⁰ The federal government and the public at large advocated for healthcare as a basic human right for all, not a privilege afforded to some.¹⁴¹ The ACA not only seeks to promote physical health, but also takes the position that well-being is a public good.¹⁴²

Accordingly, even though PAS is not a constitutional right under *Glucksberg*, it is the position of this Comment that access to the PAS procedure is a fundamental right under the Privileges and Immunities Clause and fits within an evolving acceptance of healthcare access for all Americans. Thus, the next question to consider is whether the regulating state has a substantial interest in restricting PAS to its own residents at the expense of non-residents.

2. *None of the States’ Interests are Both Substantial and Legitimate*

Under the second prong of the test, the Court looks to whether the state has a substantial and legitimate interest in treating non-residents differently.¹⁴³ This treatment must be the least restrictive means available for the state to achieve its interest.¹⁴⁴ The Supreme Court has yet to find any residency requirement that meets this burden.¹⁴⁵

As mentioned earlier, there are three plausible state interests that the residency requirement might serve: (1) imposing an additional safeguard to receiving PAS; (2) preventing an overburdening of the health care system;

140. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of the U.S. Code).

141. Barack Obama, *United States Health Care Reform Progress to Date and Next Steps*, 316 J. AM. MED. ASS’N 525, 526 (2016); Dennis Thompson, *Most Americans View Access to Health Care as a Moral Issue*. . . , The HARRIS POLL (Sept. 8, 2015, 8:00 AM), <http://www.theharrispoll.com/politics/Health-Care-Moral-Issue.html> (noting that despite division over the Affordable Care Act, an increasing number of Americans view universal access to healthcare under a moral lens) [<https://perma.cc/X8KG-X9LM>].

142. See 42 U.S.C. § 18001 et. seq. It is notable that the ACA does not mandate palliative care services, an option that many patients choose as an alternative to PAS. Diane E. Meier, *Increased Access to Palliative Care and Hospice Services: Opportunities to Improve Value in Health Care*, 8 MILIBANK QUARTERLY 3 (Sept. 2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3214714/#_sec13title.

143. ROTUNDA & NOWAK, *supra* note 96, § 12.7(d)(ii).

144. CHEMERINSKY, *supra* note 96, § 5.5.3.

145. *Id.*

and (3) respecting other state's policies. First, a PAS state might enact a residency requirement to serve as an additional safeguard before a patient undergoes PAS within its borders. However, other safeguards are in place to ensure that the patient is qualified for a procedure that carries such deep consequences. Most states require patients to be: (1) diagnosed with a terminal condition with a prognosis of six or fewer months to live; (2) at least eighteen years old; and (3) mentally competent.¹⁴⁶ The patients must also make both oral and written requests for medication, subject to respective waiting periods.¹⁴⁷ Further, this state interest also does not proffer a valid explanation as to why the state would discriminate against non-residents. If additional safeguards are important to the state, then those safeguards should apply to in-state residents as well. Upon examination, the state interest seems pretextual. Accordingly, though requiring additional safeguards may be a legitimate state interest due to the gravity of PAS, it is likely not substantial because of the plethora of other safeguards in place.

Second, a state might enact a PAS residency requirement to prevent an influx of out-of-state patients that will overburden its health care facilities. This interest does not stand. The terminally ill who take advantage of PAS make up only a small portion of the population.¹⁴⁸ Further, there is statistical support that a considerable number of individuals in this demographic legally obtain the medication to have an option and do not actually die by PAS.¹⁴⁹ It is thus unlikely that this small population will overburden a state's health care system.¹⁵⁰ In addition, obtaining PAS is not time-consuming.¹⁵¹ The process only entails short consultations with physicians and the writing of a prescription.¹⁵² It is difficult to see how the duration of time spent by terminally ill patients at medical facilities adversely impacts the health care system's otherwise functioning state. Thus, an interest in overburdening the health care system with patients is neither legitimate nor substantial.

Finally, a state might implement a PAS residency requirement to avoid circumventing other states' laws against PAS. However, the Supreme Court

146. OR. REV. STAT. ANN. § 127.800.

147. OR. REV. STAT. ANN. § 127.840.

148. NAT'L HOSPICE AND PALLIATIVE CARE ORG., NHPCO'S FACTS AND FIGURES: HOSPICE CARE IN AMERICA at 4 (2015) (stating that 1.6-1.7 million patients received hospice services in 2014 and approximately 1,200,000 deaths while under the care of hospice).

149. See OR. PUB. HEALTH DIV., OREGON DEATH WITH DIGNITY ACT: 2015 DATA SUMMARY, <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf> [<https://perma.cc/5M96-8DDL>]. "Mere access to such treatment provides a great sense of comfort and relief for people already suffering." Bryant, *supra* note 9, at 324.

150. However, some may argue that the mere obtaining of a PAS prescription is a contributing factor to the overburdening of the health care system.

151. See *FAQs*, *supra* note 139.

152. *Id.*

held that “the constitutionality of one State’s statutes affecting nonresidents [cannot] depend upon the present configuration of the statutes of another State,” implying that a state’s interest in respecting other states’ policies is an insufficient argument under the test’s second prong.¹⁵³

Nonetheless, though this federalist fueled state interest may be substantial and legitimate, it is hard to see how a residency requirement satisfies its goal. Establishing residency does nothing to respect another state’s policies if the residency classification can merely be met with money. Establishing an additional residency is a luxury only available to the wealthy.¹⁵⁴ If a classification of residency can be bought, does that really honor the home state’s policy? Further, as will be discussed, New York’s pre-*Roe* policies show that removing a state’s residency requirement to receive a medical service does not disrupt a diversity of state policies.¹⁵⁵ Even so, the Supreme Court has never decided a Privileges and Immunities case in which the underlying state law was illegal in other states. Thus, it is possible that the Court would consider this a legitimate state interest.

3. *There is a Less Restrictive Means to Achieve the State’s Interests*

Of the three plausible state interests, only one is likely to be both substantial and legitimate: respecting other states’ policies. However, a state can achieve this substantial and legitimate interest in restricting access to PAS as a medical service by using less restrictive means. Rather than achieve the interest through a residency requirement, the PAS state can obtain preliminary approval from the terminally ill patient’s home state before the patient travels. This preliminary approval would be conditioned on the patient’s satisfaction of the other safeguards in place under the PAS state’s end-of-life statute. This alternative requirement imposes an additional step in the PAS process that would be less burdensome on the patient and would satisfy the state’s substantial and legitimate interest served by a residency requirement.

Preliminary approval will ensure states are not intruding on other states’ ability to govern their own residents. For example, an Arizona resident can

153. *Austin v. New Hampshire*, 420 U.S. 656, 668 (1975).

154. See Erika Rawes, *7 Things the Middle Class Can’t Afford Anymore*, USA TODAY (Oct. 25, 2014, 8:00 AM) <http://www.usatoday.com/story/money/personalfinance/2014/10/25/cheat-sheet-middle-class-cant-afford/17730223/> [<https://perma.cc/GS8N-ZTV2>].

155. ROSEMARY NOSSIFF, *BEFORE ROE: ABORTION POLICY IN THE STATES* 2, 5, 13 (2001) (discussing different state policies on abortion in the years prior to *Roe v. Wade*). See *infra* Part III.B.1.

request that his home state—a state that does not allow PAS—grant him preliminary approval for PAS in the state of California—a state that does allow PAS. The Arizona physician cannot give preliminary approval unless the physician believes the patient is of sound mental capacity and suffering from an imminent, life-threatening condition. Once the patient receives preliminary approval, he can travel to the state of California and, assuming the patient meets all of California’s PAS requirements, be allowed PAS in the state. This would ensure that California is not complicit in violating a moral or legal code because it disavowed Arizona, a problem that would otherwise be prevalent if not for requiring a physician’s consent in the patient’s home state.

Preliminary approval would also incidentally serve the legitimate but less substantial interest of imposing an additional safeguard. The alternative requirement would better ensure prior to travel that a patient has a diagnosis of terminal illness, is of sound mind, and has the volition to end his or her life. It would ensure that two physicians believe that the patient is in the rare situation that would warrant the option of PAS if it were available. Additionally, it would decrease the risk of a citizen not meeting the requirements under the statute after expending time and money to travel.

Preliminary approval would be less burdensome and less financially restrictive on a non-resident patient than establishing residency in a new state. It would shift some of the burden of traveling to receive a medical service onto the government, and it would allow non-residents to access medical services under *Bolton*. Further, it would not impose any liability on a physician in a home state who is legally unable to aid a citizen in dying.

This solution is not without drawbacks. Some home state physicians may still resist granting approval for their citizens regardless of where the procedure is taking place, as they do not hold the moral value of PAS. Physicians are also not state actors, so the preliminary approval requirement would need to be codified just as the residency requirement is. Nonetheless, preliminary approval is a less restrictive means to serve the substantial and legitimate federalist interest of states not undermining other states’ laws for their residents.

B. States Should Remove Their Residency Requirements for Moral Reasons

Setting aside constitutional reasons, the moral reasons in favor of removing PAS residency requirements substantially outweigh any moral justifications for keeping the requirements. This is exemplified by looking to an earlier instance in which a lone state removed its residency requirement for a controversial medical procedure in defiance of the masses.

1. Pre-Roe Abortion Residency Requirements

Prior to *Roe v. Wade*, the overwhelming majority of states that legalized abortions limited the procedure to their own residents.¹⁵⁶ However, three states—Alaska, Hawaii, and Washington—permitted women to travel into their borders to receive “abortions on demand.”¹⁵⁷ Contrary to their name, these abortions were anything but on demand, as legislation still required women to become residents of the state for at least thirty days before receiving the procedure.¹⁵⁸ In 1970, however, New York enacted the most liberal law in the country, which allowed women to travel into its borders to receive abortions for any reason during the first twenty-four weeks of pregnancy without satisfying any residency requirement.¹⁵⁹ The only requirement in place was that a licensed physician perform the procedure.¹⁶⁰ Within the first two years of its implementation, sixty percent of the women taking advantage of the law were non-residents of New York.¹⁶¹

New York’s law likely chose not to discriminate between residents and non-residents because it viewed abortion as a moral good—a good so important that it transcended state lines. Although the state’s liberal policy invoked concerns for states that did not allow their citizens to receive abortions at the time, abortion was on its way to being viewed as a right with positive results that outweighed these concerns.¹⁶² For many New Yorkers, recognizing abortion as a fundamental right within their state meant that *all* people

156. See generally *Roe v. Wade*, 410 U.S. 113 (1973) (holding abortion is a constitutionally protected right).

157. Rachel Benson Gold, *Lessons from Before Roe: Will Past be Prologue?*, GUTTMACHER POL’Y REV. (Mar. 1, 2003), <https://www.guttmacher.org/about/gpr/2003/03/lessons-roe-will-past-be-prologue> [https://perma.cc/Q3K9-WS8A].

158. *Id.*

159. Brian Young, *Life Before Roe: A Brief Survey of US Abortion Law Before the 1973 Decision*, EWTN GLOBAL CATH. NETWORK (1995), <https://www.ewtn.com/library/PROLIFE/LIFBFROE.TXT> [https://perma.cc/RS3H-Z2XS].

160. James Arthur Knecht, *A Survey of the Present Statutory and Case Law on Abortion: The Contradictions and the Problems*, U. ILL. L.F. 177, 181 (1972).

161. Richard Perez-Pena, *‘70 Abortion Law: New York Said Yes, Stunning the Nation*, N.Y. TIMES (Apr. 9, 2000), <http://www.nytimes.com/2000/04/09/nyregion/70-abortion-law-new-york-said-yes-stunning-the-nation.html> [https://perma.cc/W5L9-FMVN]; David Harris et al., *Legal Abortion 1970-1971—The New York Experience*, AM. J. PUB. HEALTH 409, 410 (1973).

162. Rhonda Copelon & Sylvia A. Law, “Nearly Allied to Her Right to Be”—*Medicaid Funding for Abortion: The Story of Harris v. McRae*, WOMEN & L. STORIES 207, 208–10 (2011).

should have access to it, not just New York residents.¹⁶³ As more and more states agreed to view abortion through a moral lens, they began to acquiesce in its practice for all women. This practice may have convinced the Supreme Court to recognize abortion as a constitutional right only three years after New York's policy went into effect.

In theory, New York became a safe haven for women of all states. Nonetheless, some women in lower economic classes did not have the means to take advantage of New York's permissive policy.¹⁶⁴ Socioeconomic status was still the deciding factor between whether a woman would have access to a safe abortion in a hospital, or whether she would be forced to resort to obtaining the procedure in a back alley.¹⁶⁵ Even without the requirement that women lease or own property in New York or establish residency through other showings, many non-residents seeking an abortion could not afford to travel to New York.¹⁶⁶ Interstate travel was considered luxurious during the 1970s.¹⁶⁷ Therefore, it is likely that the great number of non-residents who received abortions in New York at this time were affluent.¹⁶⁸ Accessing New York's liberal law might also have hinged on a woman's geographic location to New York.¹⁶⁹ A New Jersey resident seeking an abortion would have had easier, cheaper access to the state of New York, for example, than a Nevada resident. Thus, the sixty percent of non-residents utilizing New York's procedure likely consisted of wealthy women and women who were residents of neighbor states.

Still, women who could not access abortions due to their socioeconomic status were willing to go to any length to terminate an unwanted pregnancy.¹⁷⁰ This included obtaining an abortion through illegal and commonly unsafe procedures.¹⁷¹ Some women were even faced with the dreadful decision to put their own life in danger rather than carry their unwanted fetus to

163. See Ryan Lizza, *The Abortion Capital of America*, N.Y. MAG., <http://nymag.com/nymetro/news/features/15248/> (last visited Feb. 25, 2015) [https://perma.cc/XUD3-EGDZ].

164. Gold, *supra* note 157.

165. David A. Grimes, *The Bad Old Days: Abortion in America Before Roe v. Wade*, HUFFINGTON POST (Jan. 15, 2015, 12:27 PM), http://www.huffingtonpost.com/david-a-grimes/the-bad-old-days-abortion_b_6324610.html [https://perma.cc/6RA6-YJGR].

166. Cynthia Gorney, *After Abortion Became Legal*, WASH. POST (Apr. 27, 1989), https://www.washingtonpost.com/archive/lifestyle/1989/04/27/after-abortion-became-legal/fe71eb63-d547-47ed-9b35-1def815c7841/?utm_term=.da1bc5278a66 [https://perma.cc/54KW-LB2V].

167. Suzy Strutner, *This is What Your Flight Used to Look Like (and It's Actually Crazy)*, HUFFINGTON POST (June 15, 2014, 8:00 AM), http://www.huffingtonpost.com/2014/06/15/air-travel-1950s_n_5461411.html [https://perma.cc/3AFB-CPD5].

168. Gold, *supra* note 157.

169. See *id.* (noting that 50,000 women traveled 500 miles to get to New York, but only 250 women traveled from 2,000+ miles).

170. Grimes, *supra* note 165.

171. *Id.*

term.¹⁷² The fact that abortions were made illegal in a woman's home state did not prevent abortions from happening; it just prevented safe abortions from happening. History proved that women who could not afford to move would simply resort to unsafe means to terminate their pregnancies.

New York's pre-*Roe* decision to remove residency requirements failed to provide the means for all women to receive a desired medical service in a legal and safe fashion. However, New York sent a message to the rest of the nation. It was the trailblazer that opened other legislative decision-makers' minds to allowing unrestricted access to abortion, so that women of all socioeconomic statuses could eventually undergo a legal and safe procedure. New York placed the moral value of protecting a woman's health above its concern of violating a neighbor state's ability to police its own citizens. And three years later, the nation collectively placed the moral value of protecting a woman's health and allowing her to act as her own decision-maker above its moral values against the procedure of abortion.¹⁷³

2. *PAS Residency Requirements*

Currently, six jurisdictions allow PAS through legislative means.¹⁷⁴ However, all six of those jurisdictions make receiving the service contingent on being a resident.¹⁷⁵ Though state legislators that ban PAS believe that they are preventing people from ending their lives, comparing the situation to pre-*Roe* abortion shows that banning the controversial medical service does not prevent people from receiving PAS; it merely eliminates safe and affordable means for receiving PAS. Individuals seeking PAS, like the women who sought abortions pre-*Roe*, are willing to go to any length to prematurely terminate their lives.

Residents of states that ban PAS currently have three options for ending their lives. They can: (1) establish residency in a state that legalizes PAS; (2) travel abroad and obtain PAS in a country that legalizes the procedure,

172. *Id.*

173. *See Roe v. Wade*, 410 U.S. 113 (1973).

174. *See supra* Part II.B.

175. *See supra* Part II.B. Montana is the lone state without a residency requirement. Though Montana's Supreme Court ruled that a physician could not be prosecuted for assisting in a patient's suicide, the legislature has failed to enact any safeguards for PAS. *See Baxter v. State*, 354 Mont. 234 (2009).

subject to the country's own requirements; or (3) pursue illegal and undignified means in their home state. All three options share certain characteristics: they are all expensive, time consuming, and demeaning.

First, like Brittany Maynard, U.S. citizens may choose to move and establish residency in a state that legalizes PAS.¹⁷⁶ Traveling domestically is less expensive than it was during the 1970s.¹⁷⁷ Unlike the pre-*Roe* era in which a woman's socioeconomic status impacted her ability to travel and receive a legal abortion, traveling interstate to receive medical services in modern times is more common and more financially accessible for middle-class and lower-class citizens.¹⁷⁸ However, establishing residency in another state is an act that typically involves buying or renting an apartment in a state, filing income taxes in the state, obtaining a state-issued driver's license, and/or obtaining voter registration.¹⁷⁹ This involves a great deal of money and time—two resources that are often unavailable to those most in need of the service. Though the advent of the Internet may make locating and purchasing property more available to the middle class, establishing the additional residence needed to obtain PAS is still a luxury unavailable to most people.¹⁸⁰

Terminally ill patients also incur costs from consulting with numerous physicians and from obtaining the medication used in PAS itself. Because the medication is banned from federal funding, patients are forced to pay out-of-pocket for these lethal doses.¹⁸¹ On average, this can cost patients between \$400 to \$600.¹⁸² Moreover, because choosing to go through with PAS is a serious and irrevocable decision, patients often choose to travel with their family and loved ones.¹⁸³ This can add thousands of dollars in additional airfare and hotel expenses. Thus, establishing residency in a state that legalizes PAS is out of reach for most Americans.

176. See *supra* Introduction.

177. Derek Thompson, *How Airline Ticket Prices Fell 50% in 30 Years (and Why Nobody Noticed)*, ATLANTIC (Feb. 28, 2013), <https://www.theatlantic.com/business/archive/2013/02/how-airline-ticket-prices-fell-50-in-30-years-and-why-nobody-noticed/273506/> [<https://perma.cc/36MC-R7DN>].

178. Libby Zay, *Air Travel is Actually Really Cheap Now, Compared to the 1950s*, GADLING (July 30, 2013), <http://gadling.com/2013/07/30/air-travel-relatively-cheap/> [<https://perma.cc/LVM4-NX6Q>].

179. OR. REV. STAT. ANN. § 127.860.

180. See Rawes, *supra* note 154 (recognizing that the middle class cannot afford vacations, new vehicles, and necessities like medical care).

181. 42 U.S.C.S. § 14401. The Assisted Suicide Funding Restriction Act was introduced in 1997 and provides that federal funding may not be used for the illegal activities of assisted suicide, euthanasia, and mercy killing. *Id.*

182. *FAQs*, *supra* note 139.

183. See *Personal Stories*, DIGNITY IN DYING, <https://www.dignityindying.org.uk/why-we-need-change/personal-stories/> (recognizing terminally ill individuals who traveled with family and/or friends to end their lives by PAS) [<https://perma.cc/QH63-AN59>].

Second, Americans that are not residents of a state that legalizes PAS might seek to obtain the service by “going to Switzerland.”¹⁸⁴ Traveling abroad to obtain PAS is also an expensive and time-consuming ordeal. The best-case scenario for most is that they will obtain PAS abroad and spend their final days on earth in an unknown setting, possibly alone. The worst-case scenario—a scenario faced by many Americans—is that they spend their life savings to obtain PAS abroad, only to get turned away. Non-residents that do not correctly follow a country’s application procedures for PAS abroad—either due to a lack of information, money, or time—are often turned away from clinics and forced to fend for themselves.¹⁸⁵ Unfortunately, a possible outcome is that these individuals, in their fragile and deteriorating state, do not make it back to the U.S. They would be forced to find alternate illegal and dangerous means to die, and potentially die before obtaining these alternatives—a death that is all but “with dignity.”

Third and final, Americans can pursue illegal or undignified means in their home state. States that do not legalize PAS provide palliative care as an end-of-life option.¹⁸⁶ This care can be accessed in health facilities, such as hospitals and hospices.¹⁸⁷ Patients can choose to voluntarily stop eating and drinking or, if permitted in cases of extreme pain, receive terminal sedation.¹⁸⁸ For the patients that are able-bodied, however, there is the risk that they will seek to commit suicide by other means in their home state.¹⁸⁹

Just as women unable to access legal abortions were forced to pursue illegal and unsafe means to achieve their goal, patients unable to access

184. Julie Beck, ‘Going to Switzerland’ is a Euphemism for Assisted Suicide, ATLANTIC (Aug. 27, 2014), <http://www.theatlantic.com/health/archive/2014/08/going-to-switzerland-is-a-euphemism-for-assisted-suicide/379182/> [https://perma.cc/X6YC-Q9C8]. “Going to Switzerland” has become a recognized phrase for non-residents traveling to receive aid-in-dying in the country. *Id.*

185. The Dignitas clinic in Switzerland has turned away individuals that have shown up after traveling from another country without a prior appointment. Amelia Gentleman, *Inside the Dignitas House*, GUARDIAN (Nov. 19, 2009), <https://www.theguardian.com/society/2009/nov/18/assisted-suicide-dignitas-house> [https://perma.cc/36MC-R7DN].

186. See *FAQs*, *supra* note 139.

187. See *Caring Info*, NAT’L HOSPICE AND PALLIATIVE CARE ORG., <http://www.caringinfo.org/i4a/pages/index.cfm?pageid=1> [https://perma.cc/7K9R-DEUV].

188. *FAQs*, *supra* note 139.

189. See Sandra M. Alters, *Suicide, Euthanasia, and Physician-Assisted Suicide*, GALE (2010), <http://ic.galegroup.com/ic/ovic/ReferenceDetailsPage/ReferenceDetailsWindow?displayGroupName=Reference&zid=5cb440ad9a2dda9f9aa1249c9a51e15a&action=2&catId=&documentId=GALE%7CEJ1771600106&userGroupName=gotitans&jsid=e520b8d3f3fa2f6268ad5a92e9d1f165> [https://perma.cc/66P4-W2B4].

legal PAS are forced to pursue illegal and dangerous end-of-life measures that make dying with *dignity* impossible. This could include committing suicide through traditional means or, if a patient is too weak to commit suicide themselves, asking a family member to consummate the death.

None of the three alternatives to obtaining PAS are feasible or ideal, leaving the terminally ill who reside within a non-PAS state with no means to “die with dignity.” It is for this reason that states that acknowledge PAS as a fundamental right should do so for all Americans regardless of their residency. As New York observed long ago, it is illogical for a state to recognize an important right for its own residents, but not for non-residents.

The current PAS landscape is closely analogous to the pre-*Roe* environment. PAS is at the threshold of being viewed as a moral good on par with abortion.¹⁹⁰ As more states adopt legislation, it reflects changing moral views on behalf of state legislators and their citizen base, which notably includes physicians. It is time for a state to follow in New York’s footsteps and lead the moral debate towards a federally recognized right to PAS. The first step toward achieving this goal would be for a state to eliminate its residency requirement.

If one state were to remove its statutory residency requirement and allow physician-assisted suicide for all terminally ill individuals regardless of residency, it would substantially reduce the time, cost, and effort that patients currently undertake to circumvent the laws or illegally end their lives. It would also allow all U.S. citizens to “die with dignity.” If a state acknowledges that death with dignity is an important and fundamental right for its own residents, then it should morally acknowledge the right for non-residents as well. Further, it would send a message to the rest of the nation and world that the moral value in respecting a terminally ill individual’s health is more important than violating a neighbor state’s ability to police its own citizens.

Just as the Supreme Court federally recognized abortion just three years after New York’s liberal legislation went into effect, the Supreme Court might see the removal of a PAS residency requirement as an important stepping stone to the nation’s collective placement of the moral value of allowing individuals to end their pain and suffering above its moral value against the PAS procedure. This could, in turn, lead to the eventual

190. See *Death with Dignity Around the U.S.*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/take-action/> (recognizing that twenty-four states are considering death with dignity this year) [<https://perma.cc/LE5U-RJB3>]; see also Yvonne Lindgren, *From Rights to Dignity: Drawing Lessons from Aid in Dying and Reproductive Rights*, 16 UTAH L. REV. 779, 785 (2016) (explaining that social justice goals within healthcare are the driving force behind the death with dignity movement, just as a social movement supporting women was the driving force behind the abortion transformation).

overturning of *Glucksberg*.¹⁹¹ In the meantime, even though PAS has not been ruled a constitutional right, states should remove their residency requirements for moral reasons and allow all people to receive PAS within their borders.

C. States Should Remove Their Residency Requirements for Human Rights Reasons

As previously discussed, although the U.S. Constitution does not guarantee a right to health, international treaties that the U.S. has signed recognize such a right.¹⁹² The U.S. should recognize the international human right to health by ratifying the International Covenant on Economic, Social and Cultural Rights, as the Netherlands and other countries have done.¹⁹³ This would reflect the value that the U.S. holds in “the enjoyment of the highest attainable standard of physical and mental health” for all.¹⁹⁴

Additionally, the United States should better align its healthcare system to match the WHO’s definition of health. Because PAS is a service that promotes a terminally ill individual’s well-being, it likely falls under the standard of health provided in the international treaty.¹⁹⁵ Thus, PAS is an international human right that all individuals should be able to exercise in the U.S. regardless of residency, granted they meet the other legislative safeguards that are already in place.

V. CONCLUSION

States should remove their residency requirements for both constitutional and moral reasons. Constitutionally, access to PAS as a medical service is likely a fundamental right under the Privileges and Immunities Clause. Because none of the states’ interests are both legitimate and substantial, the residency requirements hold no constitutional muster. Further, there

191. See HOWARD BALL, *AT LIBERTY TO DIE: THE BATTLE FOR DEATH WITH DIGNITY IN AMERICA* 164 (2013) (recognizing that *Glucksberg* may not be overturned until the transition of a different court majority occurs).

192. See Part I. Although being a signatory does not mandate compliance, it does require the essence of the treaty be met. *The difference between signing and ratifying*, GOVERNMENT OF NETHERLANDS, <https://www.government.nl/topics/treaties/the-difference-between-signing-and-ratification> (last visited Jan. 30, 2018) [<https://perma.cc/T2ZZ-BX3M>].

193. See *supra* Part I.A.1.

194. International Covenant on Economic, Social and Cultural Rights art. 12(1), Dec. 16, 1966, 993 U.N.T.S. 3.

195. See *supra* Part I.A.

is a less restrictive means to achieve the state's most plausible interest— preliminary approval by a home state physician. Morally, if a state recognizes PAS as a fundamental right, it should do so for all U.S. citizens. Terminally ill citizens who cannot otherwise access PAS will be forced to end their lives by illegal, costly, and undignified means. A state that values “death with dignity” should not morally allow this to happen. Ultimately, a state's removal of its residency requirement could act as a stepping-stone to federal legalization and the U.S.'s recognition of an international right to health through ratification of the International Covenant on Economic, Social and Cultural Rights.