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Are states that legalized physician-assisted death also
more lenient towards abortion?

School of Criminal Justice

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Introduction

On May 28, 1928 in Pontiac, Michigan, a boy named Jack Kevorkian was born to a family of Armenian immigrants; later on, he would grow up to be known as “Dr. Death” and assist in some 130 suicides from 1990 to 1998 (Schneider, 2011). Kevorkian was a medical pathologist who believed in the right of the terminally ill to decide when and how they die. In 1998, he was convicted of second-degree murder after he broadcasted on a national TV show a videotape of himself administering a lethal injection and causing the death of the patient; he was released on good behavior in 2008 and promised to never perform another assisted death again (Chua-Eon, 2011). Kevorkian died of pulmonary thrombosis on June 3, 2011 (Schneider, 2011).

Although Kevorkian was unable to perform any assisted death after his release, his persistent support for assisted death informed the public of a new way to end a painful life in a more humane way. While most of the states in the country prohibit physician-assisted death, those that do allow it have borrowed the reasoning from the arguments made for abortion. The Fourteenth Amendment to the United States Constitution ensures that no State shall deprive any person of life, liberty, or property, without due process of law, nor shall it deny to any person the equal protection of laws. Although abortion is not explicitly mentioned, courts have recognized that a woman’s right to terminate her pregnancy is included in the “liberty” protected under the Constitution and hence is a fundamental right (*Roe v. Wade*, 1973). At the same time, many cases have also reaffirmed the State’s compelling interest in the health of the mother and the potentiality of life, allowing for regulation, or even proscription, of abortion as long as it does not pose a substantial obstacle (*Casey v. Planned Parenthood of Southeastern Pennsylvania*, 1994). Similar to abortion, physician-assisted death also concerns an individual’s right to his or her own body, balanced against a State’s interest in protecting the life of its citizens.

There has been some research that investigates both abortion and physician-assisted death. For instance, Ho et al. (1992) studied whether personality correlates for the decision to terminate life and found that the level of conservatism was the most consistent predictor of attitudes toward euthanasia and abortion. In terms of specific groups of people who may have more experience in the medical field than others, Musgrave et al. (2000) discovered that the nurse-midwives displayed a positive relationship between their attitude to abortion and active euthanasia. Moreover, Shepperdson (1983) found that 37 of the 77 parents interviewed who had children with Down's syndrome were prepared to accept the idea that not all handicapped children should be kept alive at all costs, and that about three-quarters of the 37 gave some degree of support to doctors who helped a severely handicapped child to have a peaceful death. However, there has been little research in examining the laws regarding both physician-assisted death and abortion in different states in the United States.

The purpose of my honors thesis will be to examine the ways different states in the country create laws regarding physician-assisted death and abortion. First, the history of the laws related to both procedures in the United States will be discussed. Then, the paper will specifically focus on Oregon, Washington and Vermont. After studying the way the three states came to legalize physician-assisted death, the laws regarding abortion will be discussed, along with the comparison between the three states and the rest of the country. The rest of the paper will be devoted to the religious and political aspects of these regions in hopes of explaining why those three states that have legalized physician-assisted death also have laws that support abortion more than others.

History of Physician-Assisted Death in the United States

First, the history of physician-assisted death will be reviewed to help us better understand the standards and laws in place today. In the past, assisted suicide was banned and accordingly punished. This tradition was reflected for over 700 years in the Anglo-American common-law, as well as colonial and early state legislatures and courts: if one counsels another to commit suicide, and the other does indeed kill himself, then the advisor is guilty of murder, despite the consent and desire of the suicide victim (*Washington v. Glucksberg*, 1997, p.713). These bans mainly reflected the State's commitment to protecting and preserving all human life; this particularly protected the vulnerable groups, such as the elderly or the socially marginalized, as they could be pressured or coerced to "choose" to die, and any abuse that may have taken place could easily be concealed.

The idea of assisted death first crystalized in the form of legislative bills in 1906, when Ohio and Iowa suggested that physicians be able to administer a lethal dose of chloroform (Lopes, 2015, p.19). While both bills met opposition and later failed, physician-assisted death emerged as a new possible solution to handle suffering and death in a humane way, so that the individual wishing to die may choose to do so while preserving his or her dignity. As World War II came, euthanasia was used to "improve" the human race and eliminating the "defective", such as "criminals, the poor, *morons*, epileptics, [and] *imbeciles*" (Lopes, 2015, p. 45-46). Later on, these "mercy killings" were now aimed for family members and patients instead, so that they may not suffer another painful day. While they were categorized the same as murder, juries in many cases have refused to convict the person responsible for the death (Lopes, 2015, p.55). As suicide was no longer seen as "grave public wrong" (Lopes, 2015, p.66) and technologies for medical treatment advanced, the line between death and life became blurred.

Passive euthanasia was discussed for the first time in the case of Karen Ann Quinlan in 1976. Regarding the 21-year-old who lapsed into a persistent vegetative state, the New Jersey Supreme Court ruled that the constitutional right to privacy recognized in *Griswold* and *Roe* was broad enough to include a person's right to refuse life-sustaining treatment (*Matter of Quinlan*, 1976, p.18). Thus, a proper surrogate could request that the treatment be discontinued if he or she believes that the patient would have wanted so, and if a responsible attending physician concludes to the best of his medical judgment that there is no possibility of the patient ever emerging from the comatose present to a "cognitive, sapient" state (*Matter of Quinlan*, 1976, p.25). At the same time, the U.S. Supreme Court reaffirmed the commitment to preservation of life in *Cruzan v. Director, Missouri Dept. of Health* by stating that there needs to be "clear and convincing evidence" of the patient's wishes to be removed the life support if the surrogate were to make the choice for the incompetent (1990, p.261). It is important to note that passive euthanasia is different from physician-assisted death. Passive euthanasia involves quickening the death of a person by removing or changing any form of life support so that death may occur naturally, albeit faster; on the other hand, physician-assisted death is a form of active euthanasia and directly causes the death of a person because it was requested.

While the court was now more open to the idea of the right to euthanasia, it was not always covered by the right to privacy guaranteed under the Due Process. In *Washington v. Glucksberg* (1997), the U.S. Supreme Court held that a ban on physician-assisted suicide in Washington's Natural Death Act of 1979 did not violate the Fourteenth Amendment since assisted suicide was not a fundamental liberty interest (p.703). The Court then proceeded to reaffirm six related state interests previously identified in *Compassion in Dying v. State of Washington* (1996): the state's interest in preserving life; in preventing suicide; in avoiding the

involvement of third parties or the use of arbitrary, unfair, or undue influence; in protecting family members and loved ones; in protecting the integrity of medical profession; and in avoiding adverse consequences that may ensue (p.816). Likewise, the Supreme Court held in *Vacco v. Quill* (1997) that New York's prohibition on assisting suicide did not violate the Equal Protection Clause of the Fourteenth Amendment as assisted suicide was not a fundamental right (p.799). These cases highlighted the difference between passive and active euthanasia: the former was allowed since the patient had a constitutionally protected right in refusing unwanted medical treatment, whereas the latter involved actively killing the patient.

On October 27, 1997, Oregon was the first state to legalize physician-assisted death through the Oregon Death with Dignity Act. It allowed terminally-ill patients to end their lives by voluntarily self-administering lethal medications (Oregon Health Authority, 2014). In 2001, Attorney General John Ashcroft declared an interpretive rule that physician-assisted death was not a legitimate medical practice and that using controlled substances for this purpose would violate the Controlled Substances Act (*Gonzales v. Oregon*, 2006, p.243). In response, in *Gonzales v. Oregon* (2006), the Supreme Court ruled that the attorney general did not have the authority to "make a rule declaring illegitimate a medical standard for patient care and treatment specifically authorized under state law" (p.245). Therefore, physician-assisted death was recognized as a legitimate medical procedure as authorized by the State.

While the country overall has become more accepting towards physician-assisted death, the assisted-death bans have been reaffirmed in almost all states. In order to protect independence and dignity at the end of life, many states are instead providing the opportunities for living wills, surrogate healthcare decision-making, and the withdrawal or refusal of life-sustaining medical treatment (*Washington v. Glucksberg*, 1997, p.716). There are currently only

four states that legalize the procedure via legislation: Oregon, Washington, Vermont, and California. Montana has only legalized assisted suicide by physician through court ruling (*Baxter v. Montana*, 2009). Because California's End of Life Act will go into effect on January 1, 2016 (S. 128, 2015), this paper will only focus on Oregon, Washington and Vermont.

History of Abortion in the United States

Next, we will discuss the history of abortion-related laws in the United States. In the 19th century, the common law allowed for abortion before "quickening", or the fetus's very first recognizable movement in the uterus, which could often be observed from the 16th to the 18th week of pregnancy (*Roe v. Wade*, 1973, p.133). Before quickening, the fetus was considered to be part of the mother, and therefore its destruction was the mother's choice to make. This "quickening" distinction was reflected in the English statutory law that came into effect in 1803: abortion of a quick fetus was a capital crime, but lesser penalties were imposed on abortions before quickening (*Roe v. Wade*, 1973, p.137). While the American law was similar to the English statutory law until mid-19th century, by the end of the 1950's, abortion at any point of pregnancy was banned in most jurisdictions in the United States, unless it was to save or preserve the life of the mother (*Roe v. Wade*, 1973, p.139). The prohibition of abortion in the past was explained by three reasons: to discourage illicit sexual conduct (*Roe v. Wade*, 1973, p.148), to restrain pregnant women from putting themselves in danger since abortion was not a safe medical procedure (*Roe v. Wade*, 1973, p.149), and to protect prenatal life (*Roe v. Wade*, 1973, p.150).

In 1973, a landmark decision of the United States Supreme Court, *Roe v. Wade*, established the basis for all abortion cases. In a related previous case *Griswold v. Connecticut*

(1965), the Supreme Court held that the Connecticut birth control law that prohibited anyone from using any form of birth control was unconstitutional because it intruded upon the right to marital privacy (p.483). Although it may not explicitly say so in the Bill of Rights, an individual has a right to personal marital, familial, and sexual privacy as it is protected by the “penumbras” of the Bill (*Griswold v. Connecticut*, 1965, p.483). Likewise, in *Roe v. Wade*, the Court used a similar reasoning to find that while the right to terminate a pregnancy is not explicitly stated in the U.S. Constitution, it is included in the personal “liberty” protected by the Due Process Clause of the Fifth and Fourteenth Amendments. Therefore, before the end of the first trimester, a pregnant woman should have a choice as to whether or not she wants an abortion. After the stage subsequent to viability, in which the fetus is “potentially able to live outside the mother’s womb, albeit with artificial aid”, the State may regulate the abortion procedure in ways that both protect the maternal health and the prenatal life (*Roe v. Wade*, 1973, p.160). As medical advancements made abortion a safer procedure, the State was focused on protecting prenatal life. However, now that the Court acknowledged that a woman has the right to choose to terminate her pregnancy, the laws had to find a balance between protecting the potentiality of the fetus’s life and the woman’s right to her own body.

Furthermore, in *Planned Parenthood of Southeastern Pennsylvania v. Casey* (1994), the essential holding of *Roe v. Wade* was reaffirmed. While the trimester framework previously established was rejected, the Court restated that a State can regulate abortions before viability and can prohibit abortions after viability. This was based on *stare decisis*: the Court’s power lies in its legitimacy and stability in the law, and thus the legal precedent should be respected (Paulsen, 2008, p.1168-1169). Moreover, the “undue burden” test was created, by which the State cannot put a “substantial obstacle in the path of a woman seeking an abortion before the

fetus attains viability” (*Casey v. Planned Parenthood of Southeastern Pennsylvania*, 1994, p.853). In this particular case, the Court recognized that it was not an undue burden to require a woman to obtain informed consent, wait twenty-four hours, obtain parental consent if minor, and let the clinic maintain medical records. However, the requirement to notify the spouse if married failed the “undue burden” test and consequently violated the woman’s right to “liberty” under the Fourteenth Amendment (*Casey v. Planned Parenthood of Southeastern Pennsylvania*, 1994, p.858-859). Many laws established after *Casey* have used these examples as a reference, and consequently such requirements as informed consent, waiting periods, or parental consent may be observed in many states.

The latest Supreme Court case about abortion was *Gonzales v. Carhart* (2007), that upheld the Partial-Birth Abortion Ban Act of 2003 prescribing the “intact dilation and extraction” (D & E) method. This intact D & E method required a doctor to pierce or crush the skull and extract the fetus largely intact (*Gonzales v. Carhart*, 2007, p.125). This was preceded by another Supreme Court case, *Stenberg v. Carhart* (2000), in which the Court struck down the Nebraska law which made partial-birth abortion illegal without a health exception for the mother. Even though the two cases both dealt with similar abortion procedures, the Partial-Birth Abortion Ban Act was upheld in *Gonzales* while it was not in *Stenberg*; the difference is that the former case dealt with only intact D & E method, while the latter dealt with the D & E method in general, which also includes a procedure in which the fetus is removed from the womb piece by piece. In *Gonzales*, the Court stated that “a moral, medical, and ethical consensus exists that the practice of performing a partial-birth abortion is a gruesome and inhumane procedure that is never medically necessary and should be prohibited” (*Gonzales v. Carhart*, 2007, p.125).

Subsequently, this case was seen by many as a restriction to abortion rights, as well as chilling of the medical profession.

The courts, as well as the public, have struggled to find a balance between the State's interests in protecting the rights of pregnant women and the lives of the fetuses. As can be seen in *Gonzales v. Carhart* (2007), there are restrictions to getting an abortion. However, the fundamental reasoning behind *Roe v. Wade* (1973) and *Planned Parenthood of Southeastern Pennsylvania v. Casey* (1994) is still used to decide just how much freedom or restriction a state can place on its citizens.

Before examining whether the three states that have legalized physician-assisted death are also more accepting towards abortion, we will first study in depth the history of how the laws regarding physician-assisted death came into place in each state.

Physician-Assisted Death Laws in Oregon, Vermont and Washington

Oregon

The Oregon Death with Dignity Act (DWDA) was passed by Oregon citizens with 51 percent in favor in November 1994. Fifteen days before the Act was supposed to take effect, the National Right to Life Committee filed a class action complaint, claiming that it violated the Equal Protection Clause of the Constitution; subsequently, the district court found that the Act did not have sufficient safeguards to “prevent against an incompetent (i.e. depressed) terminally-ill adults from committing suicide, thereby irrationally depriving terminally-ill adults of safeguards against suicide provided to adults who are not terminally ill” (*Lee v. Oregon*, 1997, p.1385). This injunction was lifted in 1997 when the Ninth Circuit Court of Appeals dismissed the lawsuit (Lopes, 2015, p.85). As well, in November 1997, Measure 51 lobbied by the

Oregonian Right to Life chapter and the Oregon's Catholic Conference was presented to repeal the DWDA; however, voters rejected this measure by 60 percent to 40 percent and reconfirmed their support. Consequently, Oregon became the first state to allow physician assisted death. However, the Act came into question again on November 6, 2001, when U.S. Attorney General John Ashcroft issued a new interpretation of the Controlled Substances Act, which prohibited physicians from administering federally controlled drugs for terminally ill patients. In 2006, the U.S. Supreme Court in *Gonzales v. Oregon* ruled that the Attorney General could not use the federal Controlled Substances Act to prohibit physicians from prescribing drugs under the DWDA (Oregon Health Authority: History, 2014). Against all the efforts to abolish physician-assisted death, it was well supported by the public.

Under the DWDA, Oregon residents who are adults (18 years of age or older), capable of making and communicating health care decisions, and diagnosed by at least two physicians with a terminal illness that will lead to death within six months, can acquire prescriptions and self-administer the lethal medications. There are several requirements that must be met before the patient can request a prescription: (1) two oral requests by the patient must be made to the physician, separated by at least fifteen days, (2) a written request signed in the presence of two witnesses must be provided to the physician, (3) the diagnosis and prognosis must be confirmed by the prescribing physician and a consulting physician, (4) the two physicians must determine whether the patient is capable, (5) a psychological examination may be needed if either physician questions the patient's judgment due to a psychiatric or psychological disorder, (6) the patient must be informed of feasible alternatives to DWDA, such as comfort care, hospice care, and pain control, and (7) the prescribing physician must request, but may not require, the patient to notify the next-of-kin of the prescription request. The requirements ensure that the individual

requesting for the assisted death be mentally sane and well aware of the decision he or she is about to make. Moreover, health care providers have the right to refuse to participate in this Act. All prescriptions for lethal medications must be reported to the Department of Human Services (DHS). Also, pharmacists must be informed of the prescribed medication's intended use (Oregon Health Authority: Requirements, 2014).

As of February 2, 2015, a total of 1,327 people received DWDA prescriptions, and 859 patients died from ingesting said medications since the law was passed in 1997. During 2014, 155 people received prescriptions for lethal medications under the provisions of the DWDA, with 94 (60.6 percent) people actually dying from ingesting said medications; the rest did not take the medications and died of other causes. Additional 11 people who requested for prescriptions in 2011 and 2012 died, which amounts to 31.0 DWDA deaths per 10,000 deaths in total for 2014. The number of prescription recipients and deaths seem to be steadily increasing from 1998, the first year such data were recorded. The median age at death was 72 years, and the patients were commonly white (95.2 percent), were well-educated (47.6 percent with a baccalaureate degree), and had cancer (68.6 percent). Finally, the three main concerns at the end of life were: loss of autonomy (91.4 percent), decreasing ability to participate in activities that made life enjoyable (86.7 percent), and loss of dignity (71.4 percent) (Oregon Public Health Division, 2015).

Washington

In Washington's Natural Death Act (1979), the legislature recognized the fundamental right of an adult person to make decisions regarding his or her own health care, including the decision to withhold or withdraw life-sustaining treatment in the event of a terminal condition or permanent unconscious condition; this choice could also be made by an authorized representative

if the patient is unable to represent him- or herself. In 1991, the Washington state chapter of the Hemlock Society suggested an amendment to this Natural Death Act, which was also known as Initiative 119. This would allow terminally ill patients to receive physician aid-in-dying. However, this initiative failed after receiving only 46 percent of the vote (Humphry, 2013). Likewise, in *Washington v. Glucksberg* (1997), the U.S. Supreme Court held that assisted suicide was not a fundamental liberty interest and was not protected under the 14th Amendment, since it was not “deeply rooted in this Nation’s history and tradition” (p.703), but rather the ban protected the state interests of preserving life and preventing suicide, protecting the integrity of the medical profession, protecting the weak, and preventing any future movement toward euthanasia and other abuses.

In November 4, 2008, the Washington Death with Dignity Act (Initiative 1000), was passed and went into effect on March 5, 2009 (Washington State Department of Health, 2014). The requirements are similar to the ones in Oregon: competent adults (18 or older) living in Washington, who are expected to die within six months by an incurable and irreversible disease that has been medically confirmed by at least two physicians can request for a lethal injection or dosage. The patient must make an oral request and a written request separated by at least fifteen days, during which time the physician must offer an opportunity to rescind the request. The written request must be signed by the physician in the presence of two witnesses, and there must be 48 hours between the signed written request and the prescription for the lethal medication.

As of March 16, 2015, a total of 723 people have received DWDA prescriptions, and 485 patients died from ingesting the lethal medication since 2009. During 2014, medication was dispensed to 176 individuals, with 126 (71.6 percent) people actually dying from ingesting it; 17 died without the medication, and the ingestion status is unknown for the rest. As was the case in

Oregon, the number of prescription recipients and deaths seem to be increasing from 2009, the first year such data were recorded. The age at death ranged from 21 to 101 years old, and the patients were commonly white (92 percent), had at least some college education (76 percent), and had cancer (73 percent). Ninety-five percent of the 170 participants lived west of the Cascades, the pattern that has been present since 2009. Finally, the three main end of life concerns of participants who have died were: decreasing ability to engage in activities that made life enjoyable (94 percent), losing autonomy (89 percent), and loss of dignity (79 percent) (Washington State Department of Health, 2015).

Vermont

In May 2013, the Patient Choice and Control at End of Life Act (PCEOL), also known as Act 39, was passed by the Vermont Legislature (Vermont Department of Health, 2015). It is said to be based on the Oregon DWDA and has many similarities. The patient must be suffering with a terminal condition, be capable, be making an informed decision, have made a voluntary request for medication to hasten his or her death, and be at least 18 years old and a Vermont state resident. The patient must be informed, both verbally and in writing, his or her medical diagnosis and prognosis; range of treatment options; all feasible end-of-life services including palliative care, comfort care, hospice care, and pain control; range of possible results; and the probable result of taking the prescribed medication. The prescribing physician must refer the patient to a second physician for medical confirmation (Vermont Department of Health: Physician Reporting Form, 2015). This consulting physician must confirm the patient's diagnosis and prognosis and that the patient is capable, is making an informed choice, and has made a voluntary request (Vermont Department of Health: Consulting Physician Reporting Form, 2015). Also, the primary physician must verify that the patient did not have impaired judgment. There has to be 48 hours

after the patient's written request is signed, his or her second oral request is made, and the physician offers the patient the opportunity to rescind the request until the medication is prescribed. The written request must be signed by two witnesses. Act 39 and the Patient's Bill of Rights require physicians to inform patients of all options for care and treatment in order to make a fully-informed choice, including the possibility of physician assisted death (Vermont Department of Health: Patient Request for Medication Form, 2015).

While both Oregon and Washington must make an annual statistical report on information as required by the Death with Dignity Acts, Vermont only requires that physicians provide a written report to the Health Department indicating that all the necessary steps have been taken (Vermont Department of Health, 2015).

Similarities and Differences between the Three States

In all three states, physician-assisted death is available only to those in the terminal phase of illness, with only six months to live or less; the diagnosis and prognosis are confirmed by two different physicians. The patients wishing to participate must be 18 years old or more and residents in respective states. They must also be capable and subsequently make a voluntary decision, witnessed by two others; both witnesses need to be disinterested in Vermont, while only one needs to be in Oregon and Washington. This decision must be informed, meaning that physicians are required to provide the patients with such information as the prognosis and diagnosis of the illness, alternatives to assisted death, and possible treatments and results. While there must exist a "treating" relationship between one of the physicians and the patient in Oregon and Washington, it is currently not required in Vermont. In other words, in the former states, the physician must have "primary responsibility for the care of the patient and treatment of the patient's terminal disease" (Tucker, 2014, p.692). In all three states, the two requests made by

the patient must be separated by at least fifteen days, and at least 48 hours between the last request and the prescription of the lethal medication by the physician. These waiting periods ensure that patients do not make a hasty or whimsical choice, but that they absolutely wish to hasten their death. Finally, in all three states, physicians who choose to participate in the respective Acts are protected from civil or criminal liability or professional disciplinary action as long as they follow the requirements.

Abortion Laws in Oregon, Vermont and Washington

Oregon

In 1969, even before *Roe v. Wade* (1973), Oregon became one of the first states to legalize abortion. Through SB 193, abortion was allowed during the first 150 days of pregnancy if the fetus had a physical or mental defect, if the fetus was the result of rape or incest, or if the mother's physical or mental health was at substantial risk because of the pregnancy (Oregon Right to Life, 2013). As well, all abortions were required to be performed by a physician and in a hospital setting, after two physicians justified in writing that the abortion was necessary given the woman's circumstances (Oregon Right to Life, 2013). After the bill was passed, an abortion counseling service was established by the Planned Parenthood Association in order to appoint appropriate physicians to women who wanted an abortion; however, it was not until the 1990's that the clinics actually performed the procedures (Adams, 2012, p.12).

After the Supreme Court recognized a woman's right to terminate her pregnancy to be guaranteed under the Fourteenth Amendment in *Roe v. Wade* (1973), the abortion laws in Oregon were nullified as they were more restrictive than the privacy defined by *Roe*; therefore, women could now get abortion in a safe manner during the first trimester of their pregnancy.

Furthermore, in *Planned Parenthood Association, Inc. v. Department of Human Resources of State of Oregon* in 1984, the Supreme Court of Oregon determined that the rule limiting state medical assistance for abortions was unconstitutional under privileges and immunities clause of State Constitution. In other words, the state was now required to fund “medically necessary” abortions – procedures that are required when the health of the mother is endangered due to medical problems caused or aggravated by the pregnancy (p.568). The Oregon Right to Life committee calculated that Oregon tax payers pay for one out of three abortions; in 2014, it totaled \$1,656,323.00 (Oregon Right to Life, 2015). This support for reproductive rights was further advanced through SB 397, which would protect abortion rights even if *Roe* were to be overturned (Oregon Right to Life, 2013). Thus, a woman’s right to choose to get an abortion became the choice of the state alone.

Currently, Oregon is known as the only state in the country with absolutely no abortion restrictions. So far, any attempts to restrict abortions have not been successful, such as restricting abortion funding (in 1978 and 1986), requiring parental notification (in 1990 and 2006), and making most abortions illegal (in 1990) (City of Portland, 2014). As well, Oregon does not require a licensed physician to perform abortions, nor does it have to be in a hospital (Guttmacher Institute, 2015). Physicians are not required to provide any information about the fetus or abortion, including its alternatives; consequently, there are no mandatory waiting periods between when the woman receives counseling and the procedure is performed (Guttmacher Institute, 2015). There are no gestational limits so that women can get an abortion at any point of the pregnancy, and partial-birth abortion is allowed (Guttmacher Institute, 2015). One hindrance to getting an abortion in Oregon is that physicians, medical staff members and hospitals are allowed to refuse to give any information about abortion or perform the procedure. Moreover,

individuals may refuse to provide family-planning services under personal or religious beliefs, and employers whose religion is against contraception may require health-insurance plans to exclude coverage for contraception (NARAL, 2015).

The Oregon Right to Life committee found in 2008 that abortion is the leading cause of death in the state with 29 fetuses getting aborted every day, compared to 1 person dying in a motor vehicle accident, 5 from cerebrovascular disease, 5 from respiratory disease, 18 from heart disease, and 21 from cancer (Oregon Right to Life, 2008). Most fetuses are said to be aborted around 8 weeks into development (Oregon Right to Life, 2014). The majority of women getting an abortion are 20-24 years of age (32.1 percent), closely followed by 25-29 (24.5 percent) (Centers for Disease Control and Prevention, 2011). Over time, rates seem to be consistently dropping, from 2006 with 12,246 abortions reported to around 12,000 in 2007 and 2008, around 10,000 from 2009 to 2012 to finally 8,283 in 2013 and 8,231 in 2014 (Johnston, 2015).

Washington

In 1970, the Washington Early-term Abortion Bill, also known as Referendum 20, was approved with 56.49 percent of Washington citizens' vote and consequently legalized abortion in the early months of pregnancy (Matern, 1996). Under the Bill, the termination of pregnancy was allowed (1) by and under the supervision of a licensed physician, (2) within four lunar months after conception when the fetus is not viable, (3) if the woman resided in Washington for at least ninety days, (4) with the woman's consent and that of a husband if she is residing with him, or with her consent and that of her legal guardian if she is not married and under eighteen years of age, and (5) if there is no objection from the hospital, physician or any other person participating in the abortion (Secretary of State). Many of these restrictions were lifted when *Roe v. Wade* affirmed a woman's right to her own body. For instance, abortion could now be performed

through the 24th week of pregnancy, and the woman did not have to be a Washington resident (Matern, 1996). Also, during the first trimester, a facility that had “such legal/medical controls as would be protective of her health” could perform abortion (Matern, 1996). As *Casey* further defined, or limited, the restrictions that could be placed on a woman seeking an abortion, the spousal and parental notifications were eliminated.

In *Webster v. Reproductive Health Services* (1989), the Supreme Court upheld the Missouri state that regulated the performance of abortion by requiring physicians to perform a viability test on a woman who seemed twenty or more weeks pregnant, by prohibiting use of public employees and facilities to assist abortions not necessary to save the mother’s life, and by preventing use of public funds, employees or facilities to encourage or counsel a woman to have an abortion not necessary to save the mother’s life (p.490). Subsequently, decisions regarding abortion were now up to state legislatures, instead of the federal government. Fearing that *Roe v. Wade* could be overturned, pro-choice organizations in Washington created the Reproductive Privacy Act, also known as Initiative 120 in 1991. Under the Act, every individual “possesses a fundamental right of privacy with respect to personal reproductive decisions”, such as birth control and abortion; moreover, the state is prohibited from discriminating against the exercise of these rights in the regulation of benefits, facilities, services, or information (Wash. Rev. Code Ann. §9.02.100, 1991). Initiative 120 also solidified state funding: any state-funded program that provides maternity care benefits, services or information must also provide women with substantially equivalent benefits, services or information that would allow them to voluntarily terminate their pregnancies (Wash. Rev. Code Ann. §9.02.160, 1991).

Like Oregon, Washington does not have many restrictions in place. The state does not require abortions to be performed by a licensed physician, nor in a hospital; as there is no

mandated counseling, there is no waiting period; there is no parental notification for minors seeking an abortion (Guttmacher Institute, 2015). Also, Washington allows partial-birth abortions (Guttmacher Institute, 2015). Finally, the Freedom of Choice ensures that abortion-related laws are decided by the state alone and would not be affected even if *Roe v. Wade* were overturned (Americans United for Life, 2010).

However, Washington also has laws that place some obstacles to getting an abortion. First, private medical facilities can refuse to perform abortion (Wash. Rev. Code Ann. §9.02.150, 1992). Moreover, only licensed physicians can provide a surgical abortion (Wash. Rev. Code Ann. §9.02.110, 1991). Finally, while Oregon and Vermont did not have a restriction as to when the woman may choose to terminate her pregnancy, Washington has a post-viability restriction: after viability, abortion is prohibited unless it is necessary to protect the woman's life or health (Wash. Rev. Code Ann. §9.02.110, 1991).

Washington's abortion rates also seem to be dropping, from around 25,000 abortions in 2006 and 2007 to 17,552 in 2014 (Washington State Department of Health, 2014). The majority of women getting an abortion are 20-24 years of age (32.3 percent), closely followed by 25-29 (24.4 percent) (Centers for Disease Control and Prevention, 2011). Most of the abortions (67.2 percent in 2011) seem to be before or at eight weeks of pregnancy, similar to Oregon (Centers for Disease Control and Prevention).

Vermont

In 1972, Vermont became the second state to legalize abortion after New York. Before then, abortion was not prohibited. However, a physician who performed abortion when the life of the mother was not at risk was subject to three to ten years in prison, and five to twenty years if the pregnant woman died during the procedure (*Beecham v. Leehy*, 1972, p.167). In other words,

it allowed a woman to terminate her pregnancy if she chose to, but prevented physicians to help unless the woman's life was endangered (Chicago Tribune, 1972). Therefore, women who did not have enough funds to travel elsewhere were forced to self-induce or obtain illegal abortion through non-sterile conditions, which resulted in sepsis, hemorrhage and even deaths (Lilly, 2008).

In January 1972, one year before *Roe v. Wade*, "Jacqueline R." and her physician brought action for declaratory judgments as to invalidity of the abortion statute; they argued that while abortion was allowed in Vermont, "unless her life itself is at stake, the law leaves [the pregnant woman] only to the recourse of attempts at self-induced abortion, uncounseled and unassisted by a doctor" (*Beecham v. Leehy*, 1972, p.169). The Supreme Court of Vermont subsequently found the statute unconstitutional and removed the criminal prosecution for physicians performing abortions, allowing women to obtain safe abortions even when their lives were not endangered; however, this statute was not properly repealed until March 2014 (Wilson, 2014). Later, Sister Elizabeth Candon, then president of Burlington's Trinity College, helped institute policies that would enable women to get advice regarding birth control and family planning; in 1976, she became the secretary of the Agency of Human Services and made Medicaid funds available for abortions (Bittinger, 2014).

Like Oregon and Washington, Vermont does not have many restrictions to getting an abortion. The state does not require a physician to perform an abortion, nor does it have to be in a hospital (Guttmacher Institute, 2015). Abortions can be performed at any point of pregnancy, even after viability; there is no state-mandated counseling, waiting period, or parental notification for minors (Guttmacher Institute, 2015). Furthermore, while in Oregon and

Washington health care professionals and institutions may refuse to provide care related to abortion, Vermont does not have this restriction in place (Guttmacher Institute, 2015).

Vermont's abortion rate has also been steadily decreasing from 1734 abortions in 2004 to around 1600 from 2005 to 2007, 1494 in 2008, around 1300 from 2009 to 2011 (Johnston, 2015), and finally 1270 in 2012 and 1217 in 2013 (Vermont Department of Health, 2013).

Comparison between the Three States and Others

All three states seem to have very little restrictions when it comes to getting an abortion. They do not require the abortion to be performed by a licensed physician nor in a hospital, when in thirty-eight states in the country, a licensed physician must perform the abortion, and in nineteen, it must be in a hospital after a certain point in the pregnancy. While Oregon and Vermont do not have any gestational limits, Washington, along with forty-two other states, prohibit abortion after a specified point in the pregnancy, most often viability. Oregon, Vermont and Washington are three of the seventeen states in the country that provide public funding of medically necessary abortions, and do not limit private insurance in any way. Oregon and Vermont, along with forty-three other states, allow individual health care providers to refuse to perform abortion, while Vermont does not have such restrictions. Also, the three states do not require any parental involvement when a minor is seeking an abortion, compared to thirty-eight other states that do (Guttmacher Institute, 2015).

Moreover, none of the three states require women to receive counseling before obtaining an abortion, whereas seventeen states in the country do. In *Casey*, the Supreme Court claimed that it was not an "undue burden" to require physicians to provide information regarding the development of and consequences to the fetus, as well as assistance that is available if the woman decides to carry her pregnancy to full term. Although this information cannot be false,

misleading or irrelevant, the delivery of this information can be used to persuade the woman to choose childbirth over abortion and thereby promote the state's profound interest in potential life (*Planned Parenthood of Southeastern Pennsylvania v. Casey*, 1992). For instance, the risks of abortion may be discussed, such as its links to breast cancer or emotional and psychological consequences after the procedure, but not the risks of carrying the fetus to term. Thus, while women seeking an abortion in Oregon, Washington and Vermont may not get as much information as those in other states with mandated counseling, the lack thereof gives them less of a chance to doubt their decision to terminate their pregnancy. Since there is no counseling before the abortion, the three states do not have mandatory waiting periods. In the other twenty-eight states that do require this waiting period, it is usually twenty-four hours and enables the women to reflect upon their decision after considering the information that was given to them (Guttmacher Institute, 2015). Again, the women in Oregon, Washington and Vermont do not have this time to be able to change their decision, making it easier for them to obtain an abortion.

Finally, all three states allow partial-birth abortion. To understand better, partial-birth abortion is another term for intact dilation and extraction (D & E), during which the living fetus in the womb is partially delivered until its head lodges in the cervix, at which point the fetal skull is crushed or pierced. In *Gonzales v. Carhart* (2007), the Supreme Court rejected the idea that the partial-birth abortion ban imposed a substantial obstacle to late-term, but previability, abortions, as the State is allowed to "use its voice and its regulatory authority to show its profound respect for the life within the woman" (p. 128). In the states that prohibit the intact D & E procedure, physicians would have to consider other alternatives for late-term abortions, such as the D & E procedure or a prior injection to kill the fetus before delivering it (p.129). Although this may not be a "substantial" obstacle, it still limits women's options of obtaining abortions.

Without the prohibition of partial-birth abortion as is the case in Oregon, Washington and Vermont, physicians are able to freely choose which procedure to abort the fetus without any restrictions.

As discussed above, the three states that legalized physician-assisted death also seem to have more lenient laws regarding abortion. Many, if not most, of restrictions that were found constitutional in *Casey* and are hence present in many states today cannot be found in Oregon, Washington and Vermont. Accordingly, the National Abortion and Reproductive Rights Action League (NARAL), an organization that seeks to expand abortion rights, gave Oregon a grade of A in terms of abortion rights in 2015, resulting in rank 6 in the country overall (NARAL, 2015, p.69); Washington a grade of A+, resulting in rank 2 (NARAL, 2015, p.79); and Vermont a grade of A, resulting in rank 7 (NARAL, 2015, p.77). The three states have laws that are more pro-choice than pro-life regarding both abortion and physician-assisted death. Then, what characteristics make these states more open to the idea of giving an individual a choice at the cost of potential life? Each state's religions and political affiliations are accordingly identified and discussed in the following sections.

Religion

An individual's religion influences the way he or she views such controversial topics as abortion and physician-assisted death. Before studying each of the three states and their religious make-ups, several prominent religions and their views on the two issues are summarized in Table 1 first to establish a general idea of the differing opinions for each belief system.

	Abortion (Pew Research Center, 2013)	Physician-Assisted Death (Dignity with Death National Center)
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American Baptist Church	Does not completely oppose abortion except as a “primary means of birth control”.	Prioritizes an individual’s dignity and strives to minimize the suffering, thereby respecting the choice for end of life care.
Buddhism	Does not have an official position, while many believe that life begins at conception and killing is morally wrong.	Only approves suicide for people who have achieved the enlightenment of selflessness and freedom from anger, hate or fear as a person’s state of mind at the time of death impacts the way the new life begins.
Catholicism	Opposes abortion in all situations.	Opposes any killing of a human being, even to eliminate suffering.
Episcopal Church	Only allows abortion in cases involving rape or incest, the mother’s physical or mental health at risk, or fetal abnormalities; still recognizes the woman’s right to terminate her pregnancy.	Believes in some cases that it is morally wrong to take a human’s life even to reduce suffering, while others approve of assisted dying in rare cases.
Evangelical Lutheran Church in America	Allows abortion before viability but opposes after viability except when the mother’s life is at risk or when fetal abnormalities pose a fatal threat to a newborn.	Supports physician-assisted death.
Hinduism	Condemns abortion (except when the mother’s health is at risk) as it is seen as violent.	Opposes physician-assisted dying, while some believe that it is a good deed, or even a moral obligation, to help end a painful life.
Islam	Allows abortion in cases of rape or in which a mother’s life is at risk before four months of pregnancy, the point at which a fetus is thought to become a “living soul” in Islam.	Forbids assisted dying according to the Qur’an.
Judaism	Thinks of abortion as a means of keeping safe the life and well-being of a mother in traditional teachings.	Restricts physician-assisted death.
Presbyterian Church in America	Perceives abortion as a personal decision while disapproving it as a means of birth control or as a method of convenience.	Has no official position on physician-assisted death.
Southern Baptist Convention	Opposes abortion except when the mother’s life is in danger	Believes it violates the sanctity of human life.
United Church of Christ	Believes in the right to a safe abortion, as well as reproductive rights.	Supports individual freedom and responsibility.

<p>United Methodist Church</p>	<p>Opposes abortion, but recognizes the importance of life and well-being of the mother; sanctions abortion under proper medical procedures.</p>	<p>Believes in individual freedom of conscience to choose when and how to die.</p>
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Table 1. Religious views on abortion and physician-assisted death

Each religion has such distinct views on abortion and physician-assisted death, depending on its own belief systems and long-standing traditional views that were written in the codified book it follows. Because there are many variances in Christianity, many studies have instead studied different levels of faith in Christianity and how it affects policies in general or an individual’s opinions. In terms of abortion, McIntosh and his colleagues (1979) found that individuals who rank high on church attendance tend to have anti-abortion positions despite the degree of liberal ideologies taught at certain church or denominational preferences. Hertel et al. (1974) also discovered that amongst liberal and conservative Christian nurses and social workers in Tennessee, members of liberal Christian denominations are more likely to approve of abortion than those of conservative denominations, but when considering both conservatives and liberals, frequent church attenders are less likely to approve abortion. As can be seen, although Christianity generally respects life and does not fully support abortion, individuals form their own thoughts based on their level of devoutness: the more religious a person is, the less accepting he or she is to abortion. Regarding physician-assisted death (PAD), similar results were found. Curlin et al. (2008) specifically studied physicians who object to PAD and found that high religious physicians are more likely to object to the procedure than those with low religiosity.

In Oregon, Washington and Vermont however, all three states mainly do not identify themselves with a particular religion. In a Gallup poll in 2009, Oregon was listed as the least religious state in the country (25 percent of residents with no particular religious identity),

Vermont second (24 percent), and Washington third (20 percent) (Newport, 2009). In a different Gallup poll in 2015, all three states were ranked among the bottom ten for church attendance (Newport, 2015). Even among the affiliated, the biggest percentage of people in each state do not believe in God (41 percent in Oregon, 37 percent in Washington, and 52 percent in Vermont) and do not believe that religion is important at all in one's life (47 percent in Oregon, 43 percent in Washington, and 54 percent in Vermont) (Pew Research Center, 2014). This lack of religiosity in all three states may explain why they are accepting of such procedures as abortion and physician-assisted death. The same poll done amongst the unaffiliated in 2014 also studied abortion in particular. In Oregon, while 79 percent of the unaffiliated (31 percent of adults in Oregon) said abortion should be legal in all/most cases, only 47 percent of Evangelical Protestants, the religion that is the most prominent in the state (29 percent of adults in Oregon), stated that abortion should be legal. In Washington, 82 percent of the unaffiliated (32 percent of adults) said the procedure should be legal in all/most cases, while only 33 percent of Evangelical Protestants, the religion most prominent in the state (25 percent of adults) agreed with the affiliated. In Vermont, 89 percent of the unaffiliated (37 percent of adults) said abortion should be legal; unfortunately, there was no data available that compares the unaffiliated with the religious for this particular state. Accordingly, people who do not identify with any religion seem to have more accepting views towards abortion. Regarding physician-assisted death, Burdette et al. (2005) discovered in their study that conservative and moderate Protestants seem to be less accepting of assisted suicide and terminal palliative care than nonaffiliates. Moreover, after interviewing physicians, terminally-ill cancer patients and the public, Suarez-Almazor et al. (1997) found that highest support for euthanasia and physician-assisted death was found in individuals with no religion. Individuals who do not have a particular religion or are less religious tend to be more supportive

of both abortion and physician-assisted death. While the reason for such findings is unclear, it may still explain why three states that are known to be the least religious in the country have pro-choice policies in terms of terminating a pregnancy or ending one's life under certain circumstances.

When focusing on the religious portion of the population, all three states are mostly Christian (61 percent in Oregon and Washington, 54 percent in Vermont) (Pew Research Center). In Oregon and Washington, the majority of Christians seems to be Evangelical Protestant (29 percent in Oregon and 25 percent in Washington) (Pew Research Center). As could be seen in Table 1, the Evangelicals allow abortion before viability and restricts it, but does not oppose completely, afterwards, which is the guideline established in *Casey* (1983); also, they support physician-assisted death. Therefore, along with the unaffiliated who generally support both procedures, the largest percent of those who do have a religion also seem to be accepting towards them.

However, different results were found in Vermont. The majority of Christians in this state are Catholic (22 percent) (Pew Research Center); Catholics fully oppose abortion and physician-assisted death in all situations. While this seems to contradict the state's policies that are supportive of abortion and allow physician-assisted suicide, it is important to note that Vermont was also found as the state with the lowest level of church attendance in the country in a Gallup poll done in 2015 (Newport). The aforementioned studies found that while religion does play a role in deciding a person's views on the two procedures, the level of religiosity is also important: the less religious a person is, the more likely he or she is to be more lenient towards those two. Therefore, while the majority of religious people in Vermont may have a religion that fully opposes both abortion and physician-assisted death, they may not exactly follow the teachings of

Catholicism. Of course, church attendance is not the only indicator of one's commitment to his or her religion. Among Christians in Vermont, 34 percent claim they attend religious services at least once a week, 41 percent once or twice a month/a few times a year, and 24 percent seldom/never (Pew Research Center, 2014). As well, 48 percent say they pray at least daily, 18 percent weekly, 11 percent monthly, and 23 percent seldom/never (Pew Research Center, 2014). At the same time, 65 percent of Christians claim that they seldom or never attend scripture study or religious education groups; instead, it seems that common sense is the leading source of guidance (51 percent) that determines what is right and wrong among Christians in Vermont, compared to 28 percent who follow religion (Pew Research Center, 2014). As well, the majority of Christians (61 percent) believe that right or wrong depends on the situation, while only 33 percent believe that there exist clear standards for right and wrong (Pew Research Center, 2014). This reaffirms the possibility that even though an individual may be religious and participate in the services provided to practice his or her religion, there are other factors that determine the decisions on such debatable topics as abortion and physician-assisted death.

While the lack of religiosity in the three states may have restricted the citizens less and given them more freedom to consider the issues of physician-assisted death and abortion on their own, the Catholic Church, that is vehemently opposed to both issues, has been bankrupt due to sex scandals, specifically in Oregon and Washington, and hence did not have the money to argue against assisted death or abortion (Lopes, 2015, p.109). Oregon and Washington were two of the thirteen U.S. Catholic dioceses that have filed for bankruptcy protection during the ongoing sexual abuse crisis in the Catholic Church, mostly involving priests sexually abusing children (BishopAccountability.org, 2015). Archbishop John G. Vlazny, while filing for Chapter 11 reorganization in bankruptcy court in the behalf of the Archdiocese of Portland in Oregon,

admitted that the Church had to pay almost \$21 million in 2003 alone and settled 100 such claims, with 60 more pending (2004). As well, it was reported that sex-abuse claims against the Roman Catholic Diocese of Spokane almost reached \$75.7 million (Stucke, 2004). Thus, not only did the residents' confidence in the Catholic Church decrease, the funds needed were unavailable for any efforts against abortion or physician-assisted death, as the money had to be spent on settling with victims who were sexually abused by clergy. This especially affected Washington, as the DWDA was passed in 2008, and just a few years before, the media was dominated by news related to sex scandals; it was reported that most of the cash donation to the "Coalition against Assisted Suicide" originating from Catholic parishes came from out of state (Lopes, 2015, p.133). As two of the least religious states in the country, Oregon and Washington were perhaps also able to enforce such pro-choice laws as the Catholic Churches failed to influence the residents and convince them of the Catholic teachings, that are opposed to both physician-assisted death and abortion.

Politics

Each state's political party affiliation and political ideology influence how laws regarding abortion and physician-assisted death are determined. First, prominent political parties present in each state as well as its ideology (conservative, moderate or liberal) will be discussed.

Both Oregon's United States senators are from the Democratic Party, as well as four of the state's five representatives (Oregon Blue Book). Since 1998, voters in Oregon chose Democrats for U.S. Presidents, closely followed by Republicans (Oregon Blue Book, 2012). In 2014, 47 percent of 419 adults living in Oregon identified themselves as Democrats/lean Democrats, 32 percent as Republicans/lean Republicans, and 47 percent with no political

affiliation (Pew Research Center). In terms of political ideology, according to Gallup, 33.8 percent said they were conservative, 33.7 percent moderate, and 27.5 percent liberal (2014).

Finally, in Washington, both of the United States senators are also Democratic, as well as six of the ten U.S. representatives (GovTrack, 2015). Since 1988, Democrats have been the primary choice in presidential elections (270towin, 2015). In 2014, 44 percent of 714 adults said they were Democrats/lean Democrats, 33 percent as Republicans/lean Republicans, and 23 percent with no affiliation (Pew Research Center). Moreover, 32.1 percent of adults in Washington said they were conservative, 35.6 percent moderate, and 27.4 percent liberal (2014).

Finally, in Vermont, both of the United States senators are Democratic (United States Senate), as well as the U.S. representative (GovTrack, 2015). Since 1992, the state voted for Democrats in presidential elections (270towin, 2015). In 2014, 57 percent of 306 adults said they were Democrats/lean Democrats, 29 percent as Republicans/lean Republicans, and 14 percent with no affiliation (Pew Research Center). For political ideology, 26.6 percent of adults in Vermont said they were conservative, 38.8 percent moderate, and 29.8 percent liberal (Gallup, 2014).

All three states seem to be dominated by two political parties: Democratic and Republican. What are the two parties' views on abortion and physician-assisted death? In the 2012 Democratic National Platform, the Democratic Party "strongly and unequivocally" supports *Roe v. Wade* and a woman's right to choose whether or not to get an abortion, regardless of her ability to pay, and "oppose[s] any and all efforts to weaken or undermine that right". On the other hand, the Republican Party recognizes that an unborn child has a fundamental individual right to life that cannot be infringed and thus opposes financial support or public funding to promote or perform abortion (Republican Platform, 2012, p.13). Regarding

physician-assisted death, the Democratic Platform has been silent on euthanasia and assisted suicide (Priests for Life, 2008), while the Republic oppose active and passive euthanasia and assisted suicide (Republican Platform, 2012, p.14). According to the online survey of 1001 American adults, Democrats and independents are more likely to support euthanasia and assisted suicide than Republicans (Angus Reid Public Opinion, 2010).

In terms of conservatives and liberals, the former group believes that human life begins at the moment of conception and opposes abortion and any public funding for abortion, while the latter believes in the woman's right to decide what happens to her own body and the government's role in supporting that decision financially (Gemma, 2014). Likewise, conservatives argue that physician-assisted death should be illegal as it could lead to such problems as doctor-assisted suicides of non-critical patients or medical treatments being withheld by insurance companies; however, liberals believe that legalizing physician-assisted death would honor a person's right to die with dignity, so that he or she may die without pain or suffering (Editors, 2010).

Considering the information given above regarding the states and their political affiliations, it is impossible to conclude whether a certain state is completely Democratic or Republican, or completely conservative or liberal; both sides are very much present in each state. Therefore, it is appropriate to instead compare the three states at issue to others in the country and determine their political affiliations in comparison to other areas. First, in terms of Democratic vs. Republican, Washington was found as the most democratic state in the country in 2014 after studying voting trends and history; Oregon was ranked third; and Vermont was ranked fifteenth; both Washington and Oregon voted for Democratic president in the last seven elections (Vermont six in the last seven elections), and all three states had a Democratic-controlled

legislature (The Hill). Similarly, after interviewing more than 177,000 U.S. adults in 2014 and asking whether they identify with the Democratic or Republican Party, Gallup found that Vermont, which had been listed in the top 10 most Democratic for the last seven years, was again the fifth Democratic state in the country; Washington and Oregon were found to be leaning Democratic (Jones, 2015). In terms of political ideology, Vermont (29.8 percent) was ranked second for top liberal states, Oregon (27.5 percent) fifth and Washington (27.4 percent) seventh after Gallup interviewed 177,304 adults (Newport, 2015). Moreover, the Hill identified Washington as the most liberal state in 2014, closely followed by Oregon as third (Sullivan).

Thus, as three states that are considerably more Democratic and liberal than others in the country, Oregon, Washington and Vermont would show more support for a woman's right to terminate her pregnancy, as well as government funding for abortion, than other states. As well, although the Democratic Party has been silent on the issue of physician-assisted death, it has been found that it is more supportive of such procedure than Republicans. Coupled with the liberal view of the government as well as the population, it may be easier to understand and acknowledge an individual's right to preserve dignity and die without pain or suffering.

Conclusion

As previously discussed, the three states that have legalized physician-assisted death – Oregon, Washington and Vermont – also seem to be more accepting towards abortion. In other words, the three states seem to have pro-choice laws that not only allow for women to terminate their pregnancies more easily, but also acknowledge a terminally ill individual's choice to end his or her life. They seem to share some religious and political similarities in that they are three of the least religious states in the country, and that they are both Democratic and liberal. To add

more to the religious aspect, even those who were Christian did not particularly follow the teachings that oppose physician-assisted death and abortion because they are not very religious to begin with, and the Catholic Church failed to convince the population as they were surrounded by sex scandals at that time.

One crucial factor that I wish I could have explored is culture. It is extremely difficult, if not impossible, to exactly identify what characteristics make up culture and hence set its boundaries. The Merriam-Webster dictionary defines culture as “the beliefs, customs, arts, etc., of a particular society, group, place or time”. It is not only abstract ideas alone, but those that change with time and place. Many factors combine to establish and nurture an individual’s culture. Thus, it is challenging to specify the characteristics of culture and define them so. For instance, it is widely known that Vermont, as the second smallest state in the country, follows its own value system regardless of what the rest of the country thinks. Similarly, Washington is the only American state that have legalized marijuana for recreational use, same-sex marriage, and assisted death (Lopes, 2015, p.133), setting the trend for a liberal state. However, how could this possibly be measured or described? The history tells us so, which I hope I have explored to the best of my abilities in the previous sections, at least regarding physician-assisted death and abortion.

There were also many factors that were left unexplained due to the simple reason that they did not seem to easily link both physician-assisted death and abortion. In regards to the former topic, Oregon and Washington, along with other states west of the Rocky Mountains, have suicide rates that are higher than average (Lopes, 2015, p.109). Particularly in Washington, 1 in 20 residents report having suicidal thoughts, resulting in the state having one of the highest rates of suicidal thoughts in the country (Ho, 2011). Lopes argues in her book *Dying with Dignity*

that “[t]he entrustment to physicians with the duty to carry out the killing themselves, instead of leaving it to the patient, was perhaps an attempt to bypass the likelihood of botched (and painful) suicides” (2015, p.34). Moreover, this heightened prevalence may have caused desensitization to death and thus assisted suicide, although she cautions the readers that suicide and physician-assisted death are different in their applications and thus should not be considered as the same (2015, p.133). Despite this, high suicide rates cannot explain why these states also have laws that are more accepting towards abortion. The desensitization of death as argued by Lopes may justify why extinguishing the potentiality of the fetus’s life seems more tolerable in some states than others, but there exist some states such as Alaska and Wyoming that have suicide rates that are higher than Washington’s, but prohibit physician assisted death and have abortion laws that are not as accepting.

The beauty of the law is that while the set rules seem rigid and unshakable, they also evolve as the society and its way of thinking change. Abortion, disgraced and subsequently prohibited in the past, is now accepted as one of the fundamental rights guaranteed under the United States Constitution; physician-assisted death is well on its way as well. Oregon, Washington, Vermont, and recently California, have set their precedents for respecting a person’s choice to decide his or her own life more than the State’s interest in protecting all life or the potentiality thereof. However, even where they are legalized, it cannot be a straightforward, easy choice. Despite the fact that these states place more value on the individual’s right to his or her own body, it often concerns other people, such as family members or friends, who will inevitably be affected by this choice as well. As the states adopt different sets of rules with time, it is imperative that they not lose sight of maintaining the proper balance between the rights of all individuals and the potentiality of life.

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