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Aid-in-Dying Nonprofits

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Aid-in-Dying Nonprofits

TAIMIE BRYANT*

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I. INTRODUCTION

As a recently married young woman in love with the opportunities of life, Brittany Maynard had every reason to want to live and no reason at all to wish to die.¹ Then, in the wake of a diagnosis of aggressive, incurable brain cancer, everything changed.² Brittany came to understand that life would bring excruciating pain and seizures before death released her.³ She cared, also, about the toll those changes would take on her family.⁴ Because medical science offered little, Brittany chose to move from California to Oregon where she could lawfully receive a life-ending dose of medication from a licensed physician.⁵ At that time, Oregon was one of only five jurisdictions where physicians could write such a prescription without fear of prosecution for homicide or assisting a patient to commit suicide.⁶ Aid-in-dying⁷ nonprofits played active roles in advancing those

1. See 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/index.html> [<https://perma.cc/ZX2E-HRLR>]; see also Belinda Luscombe, *Why a Young Woman with Brain Cancer Moved to Oregon to Die*, TIME (Oct. 8, 2014), <https://time.com/3481599/brittany-maynard-death-with-dignity-oregon-right-to-die-law> [<https://perma.cc/2WPH-4LEY>].

2. Maynard, *supra* note 1.

3. *Id.*

4. *Id.*

5. *Id.*

6. *Id.*; see Oregon Death with Dignity Act, OR. REV. STAT. §§ 127.800–897 (2018). At that time, the other two jurisdictions besides Oregon with state statutory laws allowing physicians to prescribe lethal dose prescriptions to qualified individuals were Vermont and Washington. Patient Choice at End of Life Act, VT. STAT. ANN. tit. 18, §§ 5281–93 (2019); Washington Death with Dignity Act, WASH. REV. CODE §§ 70.245.010–.904 (2019). At that time, the option was also available in Montana and New Mexico by judicial decision, but the New Mexico Supreme Court subsequently decided in 2016 that patients do not have a constitutional right to receive physician assistance with dying. *Morris v. Brandenburg*, 376 P.3d 836, 857 (N.M. 2016). The Montana Supreme Court decided that there is no constitutional right to assistance but that patient consent to receive a lethal dose prescription would shield the physician from legal liability for knowingly providing a lethal dose prescription. *Baxter v. State*, 224 P.3d 1211, 1211–222 (Mont. 2009).

7. For purposes of this Article, “aid in dying” is a general term I define as assistance to enable one to avoid irremediable end-of-life suffering by ending one’s life. It does not include palliative care or patient-directed withholding of care or voluntary

legal opportunities for terminally ill individuals, and many, such as Death with Dignity National Center and Compassion & Choices, also provide direct client services.⁸

According to Brittany's mother, Brittany relied on Death with Dignity National Center for assistance using Oregon's law.⁹ Then, with the hope of making the same opportunity available for others in her home state, Brittany partnered with Compassion & Choices to speak often, passionately, and persuasively for enactment of a medical aid-in-dying law in California.¹⁰ She persevered with advocacy and fulfilling her "bucket list" until her quality of life deteriorated to the point that she chose to die.¹¹

After Brittany's death on November 1, 2014, her family, along with nonprofits Compassion & Choices and Death with Dignity National Center,

stopping of eating and drinking (VSED). This Article considers aid in dying in two contexts: physician-assisted aid in dying, in which a physician provides a lethal dose prescription to a qualified individual; and aid in dying provided by a nonprofit that supplies information and companionship, but no physical means of ending life, to qualified individuals. The former goes by various names, including aid in dying (AID), medical aid in dying (MAiD), physician-assisted death (PAD), and physician-assisted suicide (PAS). I use the term MAiD (medical aid in dying) to distinguish it from assistance that does not involve a physician's providing a lethal dose prescription. I use the term "assisted dying" when referring to the second type of assistance in which the nonprofit does not provide the means to cause death. I do not use the term "assisted suicide" because of the differing state statutory definitions of that term and because of sociocultural bias associated with the term. I use the term "aid in dying" as the general category including both MAiD and assisted dying.

8. *About Us*, COMPASSION & CHOICES, <http://Compassionandchoices.org/about-us> [<https://perma.cc/M497-ATLF>].

9. E-mail from Deborah Ziegler, to Taimie Bryant, Professor of Law, UCLA Sch. of Law (Nov. 9, 2019, 4:14 PM) (on file with author).

10. Dean Schabner, *Brittany Maynard, Advocate for Death with Dignity, Ends her Life*, ABC NEWS (Nov. 2, 2014, 9:50 PM), <https://abcnews.go.com/Health/brittany-maynard-advocate-death-dignity-ends-life/story?id=26644431> [<https://perma.cc/2M59-ES9G>].

11. *Id.*; see also Dan Hirschhorn, *Terminally Ill Woman Who Planned Assisted Suicide Dies*, TIME (Nov. 2, 2014, 9:28 PM), <https://time.com/3553770/brittany-maynard-dies/> [<https://perma.cc/S4BK-TCTE>].

continued Brittany's legacy of advocacy.¹² California's End of Life Option Act came into effect about one and a half years later on June 9, 2016.¹³

As compelling as Brittany's story was to the many who supported her decisions, there was no shortage of critics. Some opponents, such as the Catholic Church and the National Right to Life Committee, are legally organized as nonprofits and advocate to prevent the development of aid-in-dying opportunities. They question the beliefs that the life Brittany led was hers to end and that it was compassionate to help her avoid suffering through assistance to end her life.¹⁴ The National Right to Life Committee goes further in its position against aid in dying, arguing that a "right to die" could be understood as a "duty to die," when one seeks to avoid

12. Judy Lin, *Brittany Maynard Speaks from the Grave*, U.S. NEWS & WORLD REP. (Mar. 25, 2015, 11:56 AM), <https://www.usnews.com/news/politics/articles/2015/03/25/brittany-maynard-video-supports-california-aid-in-dying-bill> [<https://perma.cc/3SMX-ECT9>] (describing efforts of Debbie Ziegler, the mother of Brittany Maynard, and Dan Diaz, Maynard's husband, in support of legislation proposed in California to allow doctors to prescribe life-ending medication to terminally ill patients); see also "What Brittany Asked Us to Do": Deborah Ziegler's Advocacy for Death with Dignity Honors a Promise to Her Daughter, DEATH WITH DIGNITY (Oct. 20, 2017), <https://www.deathwithdignity.org/news/2017/10/brittany-asked-us-deborah-zieglers-advocacy-death-dignity> [<https://perma.cc/AE46-7Z4X>]; BRITTANY MAYNARD FUND, <http://thebrittanyfund.org/?nlb=1> [<https://perma.cc/N8XZ-AC36>].

13. California's End of Life Option Act, CAL. HEALTH & SAFETY CODE §§ 443–443.22 (Deering 2019); see Assemb. B. 15, 2015–2016 Leg., 2d Extraordinary Sess. (Cal. 2015) (providing that California's End of Life Option Act was approved by the Governor on October 5, 2015).

14. See, e.g., Kelly Stewart, *Arguments Against Brittany Maynard's Assisted Suicide Ignore Her Point of View on Suffering*, NAT'L CATH. REP. (Nov. 26, 2014), <https://www.ncronline.org/blogs/grace-margins/arguments-against-brittany-maynards-assisted-suicide-ignore-her-point-view> [<https://perma.cc/A9KY-MKZB>] (enumerating various Catholic perspectives such as "death with dignity" as promoting "false sense of compassion," "cheapening of human life," avoidance of personal responsibility to others, and a "slippery slope" into eugenics and euthanasia); see also Josephine McKenna, *Pope Warns Against the 'False Sense of Compassion' in Euthanasia*, RELIGION NEWS SERV. (Nov. 17, 2014), <https://religionnews.com/2014/11/17/pope-warns-false-sense-compassion-euthanasia> [<https://perma.cc/WHP5-4BJT>]; Jason Welle, *On Love and Dignity and Dying*, JESUIT POST (Oct. 16, 2014), <https://thejesuitpost.org/2014/10/on-love-and-dignity-and-dying> [<https://perma.cc/F4L6-HNNW>] (arguing that there is dignity in suffering at the end of life); Phyllis Zagano, *A Woman's Right to Choose?*, NAT'L CATH. REP. (Nov. 5, 2014), <https://www.ncronline.org/blogs/just-catholic/womans-right-choose? ga=2.102993152.1285436599.1562539575-1932076566.1562539575> [<https://perma.cc/U4HM-5NVF>] (focusing on Brittany Maynard as exemplifying a pernicious trend in giving people an immoral and unethical prerogative to end life). Shortly after Maynard's death, the National Right to Life Committee issued a statement saying, "These ["Death with Dignity"] laws do not offer a patient 'dignity' but only abandonment from health care workers and family who are supposed to care for patients and loved ones in these dire times." Jolie Lee, *More Attention to Right-to-Die Debate After Maynard's Death*, USA TODAY (Nov. 3, 2014, 7:22 PM), <https://www.usatoday.com/story/news/nation-now/2014/11/03/right-to-death-debate-brittany-maynard/18407657> [<https://perma.cc/RV4T-HHQS>].

burdening others.¹⁵ Many believe that sufficient palliative care options should have been available,¹⁶ and at least one terminally ill individual wrote to Brittany to implore her to reconsider.¹⁷

In fact, the idea of ending one's life for quality of life reasons draws considerable morally based opposition. For instance, a prominent disability rights nonprofit organization argues that the aid-in-dying movement implies that some lives, notably those lived with disabilities, are not worth living.¹⁸ There are also objections based on pragmatic concerns, such as

15. Burke J. Balch & Randall K. O'Bannon, *Why We Shouldn't Legalize Assisted Suicide: Part III: What About the Terminally Ill?*, NAT'L RIGHT TO LIFE (Jan. 1, 2013), <https://www.nrlc.org/medethics/asisuid3/> [<https://perma.cc/UKP8-GMRW>].

16. According to the Institute of Medicine, pain management care is underdeveloped in the United States. See generally INST. OF MED. OF THE NAT'L ACADS., *DYING IN AMERICA: IMPROVING QUALITY AND HONORING INDIVIDUAL PREFERENCES NEAR THE END OF LIFE* (2015); JESSICA NUTIK ZITTER, *EXTREME MEASURES: FINDING A BETTER PATH TO THE END OF LIFE* (2017) (providing palliative care physician Dr. Zitter's description of hurdles to provision of palliative care options when such options are seen as alternatives to aggressive treatment); Lachlan Forrow, *Brittany Maynard Highlights Our System's Tragic Failures*, BOSTON.COM (Nov. 3, 2014), <https://www.boston.com/culture/health/2014/11/03/brittany-maynard-highlights-our-health-care-systems-tragic-failures> [<https://perma.cc/F9N7-6FSM>] (arguing that, while he opposes medical assistance to hasten death, Brittany Maynard's choice is understandable because the "gold standard" of end-of-life palliative care has not been achieved). Some believe that Brittany Maynard's situation and advocacy for the right to request physician assistance in dying invigorated discussion and improvement in palliative care options. See Lisa Schencker, *Assisted-Suicide Debate Focuses Attention on Palliative, Hospice Care*, MOD. HEALTHCARE (May 16, 2015, 1:00 AM), <https://www.modernhealthcare.com/article/20150516/MAGAZINE/305169982/assisted-suicide-debate-focuses-attention-on-palliative-hospice-care> [<https://perma.cc/N9HV-N2RY>]. The National Hospice and Palliative Care Organization argues that some medical situations, such as that of Brittany Maynard, involve high risk of unmanageable pain. Samuel H. LiPuma & Joseph P. DeMarco, *Palliative Care and Patient Autonomy: Moving Beyond Prohibitions Against Hastening Death*, 9 HEALTH SERVICES INSIGHTS 37 (2016), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5147517> [<https://perma.cc/HSD9-8MBN>].

17. Daniel E. Slotnik, *Brittany Maynard, 'Death with Dignity' Ally, Dies at 29*, N.Y. TIMES (Nov. 3, 2014), <https://www.nytimes.com/2014/11/04/us/brittany-maynard-death-with-dignity-ally-dies-at-29.html> [<https://perma.cc/4ERT-GDKK>].

18. *Disability Perspective Aired in Brittany Maynard Media Coverage*, NOT DEAD YET (Nov. 4, 2014), <http://notdeadyet.org/2014/11/disability-perspective-aired-in-brittany-maynard-media-coverage.html> [<https://perma.cc/4WQY-NMEJ>]. Not Dead Yet, a disability rights group, opposed aid-in-dying laws for a few reasons, including devaluation of lives lived with disability and the inadequacy of aid-in-dying laws to protect vulnerable people. *Id.*; see Lee, *supra* note 14 (describing the position of disability rights group Not Dead Yet as generally opposing the aid-in-dying laws and specifically criticizing the laws as containing inadequate safeguards and other critics of the availability of medical aid-in-dying).

ready access to lethal dose prescriptions by those for whom the prescription is not intended, once the patient has filled the prescription.¹⁹

Perhaps the overarching fear Brittany's decision raises is that, for every story like Brittany's, there is another story that plays differently: What about the person who begged her physician for assistance to die but changed her mind before irreversibly ending her life, or the person who is grateful that her attempt to die was not successful? What about the person who, unlike Brittany's physician, "assists" another by urging them to complete an act they had long promised to commit but who would not, but for that urging, have completed the life-ending act? How can anyone be sure that "assistance" did not shade into "encouragement," and how can anyone know whether an assistant actually had self-interested motives for helping? And, what should we think of decisions borne of a fear that the individuals would become a burden to those caring for them or for the purpose of not depleting the family's finances with expensive medical treatments? Although the public seems now to generally support aid in dying,²⁰ the specifics of individual cases are troubling, and concerns about possible misuse of the legal option or people's choice of death to relieve others' burdens makes crafting the best possible law difficult. Termination of a life is not, after all, reversible.

Brittany's situation and the strong activism of nonprofits advancing and opposing aid in dying highlights both societal discomfort with the idea of choosing to end one's life and the fact that modern medical science has become good at prolonging life but not as good at ensuring quality of life

19. Other possibilities opponents raise include illegal administration of the drugs to a patient who had qualified but was not yet ready to ingest it and the possibility of insurance companies' encouraging and covering life-ending medications in order to save the costs of care. See Marina Villeneuve, *Maine Becomes 8th State to Legalize Assisted Suicide*, AP NEWS (June 12, 2019), <https://www.apnews.com/7f0fe9d789294a02852c1669c892f382> [<https://perma.cc/GA9Y-PCB7>].

20. Art Swift, *Brittany Maynard's Story and Americans' Views on Assisted Suicide*, GALLUP (Nov. 5, 2014), <https://news.gallup.com/opinion/queue/179159/brittany-maynard-story-americans-views-assisted-suicide.aspx> [<https://perma.cc/EH6B-YFVE>] (describing poll results as generally favoring assisted dying but the degree of support is dependent on how questions about "assisted suicide" are worded). Some polls reflect more of an equal division between those who support and those who do not. For instance, a 2013 poll by the Pew Research Center reflected 47% in favor and 49% opposed, but as discussed above it is difficult to know how people are thinking because the wording of polling questions can have a significant impact. PEW RESEARCH CTR., *VIEWS ON END-OF-LIFE MEDICAL TREATMENTS* 31 (2013), <https://www.pewresearch.org/wp-content/uploads/sites/7/2013/11/end-of-life-survey-report-full-pdf.pdf> [<https://perma.cc/U9N6-GFBE>]. Moreover, 65% of medical care professionals in Massachusetts polled shortly after Maynard's death opposed medical aid in dying. Deborah Kotz, *Mixed Medical Views on Brittany Maynard's Choice to Die: Advocacy By Cancer Patient May Shift Views*, BOS. GLOBE (Nov. 4, 2014, 12:00 AM), <https://www.bostonglobe.com/lifestyle/health-wellness/2014/11/04/mixed-medical-views-brittany-maynard-choice-die/n5KpjnxO2eMdG8xE7KHHSJ/story.html> [<https://perma.cc/33E2-644F>].

all the way to life's end.²¹ Palliative end-of-life care cannot relieve all types of terminal condition pain,²² and irremediable existential angst associated with loss of autonomy and dignity can be profoundly difficult to endure.²³ Prolonged suffering of various kinds at the end of life has become more common because medical science helps individuals live long enough to experience suffering for longer periods of time.²⁴ Better palliative care would seem to be the answer, but if loss of autonomy is a primary factor in the decision to die sooner than would occur naturally, better palliative care may not be sufficient for all seekers²⁵ of aid in dying.

Ending one's life can be a tragically rational response to prolonged end-of-life suffering from physical and existential causes, yet suicide is heavily

21. See generally ZITTER, *supra*, note 16.

22. Graham Winyard & Liza Macdonald, *The Limits of Palliative Care*, 349 BRIT. MED. J., at g.4285 (2014), <https://www.bmj.com/content/349/bmj.g4285.full> [<https://perma.cc/EE3N-LXCYY>]; see ZITTER, *supra*, note 16, at 61, 305–08; Eric Metcalf, *When Your Pain Medication Isn't Working*, WEB MD, <https://www.webmd.com/pain-management/features/when-pain-medications-not-working#1> [<https://perma.cc/RS6J-JWVFV>] (describing the insufficiency of pain medications and the need to find alternative means of reducing pain). Even if pain could be relieved, other types of suffering may not be. See, e.g., Lindsey Bever, *How Brittany Maynard May Change the Right-To-Die Debate*, WASH. POST (Nov. 3, 2014, 3:10 AM), https://www.washingtonpost.com/news/morning-mix/wp/2014/11/03/how-brittany-maynard-may-change-the-right-to-die-debate-after-death/?noredirect=on&utm_term=.6b13bdc9a168 [<https://perma.cc/WJM2-9GJ8>] (quoting Barbara Coombs Lee of Compassion & Choices: “[Palliative care is] not a miracle. And it cannot prevent the kind of relentless, dehumanizing, horrific decline that Brittany faces, where her disease will cause unending seizures and headaches and nausea and vomiting and pressure in her brain, and the loss of every bodily function, including thinking and moving.”).

23. Indeed, loss of autonomy and dignity rank higher for many patients than the experience of severe physical pain. For instance, Mark A. O'Rourke, M. Colleen O'Rourke, and Matthew F. Hudson cite to a report that participant request for medical assistance in dying at the Seattle Cancer Care Alliance were due to “loss of autonomy (97.2%), inability to engage in enjoyable activities (88.9%), and loss of dignity (75.0%)” as a reason to oppose provision of aid-in-dying, arguing that these factors can be addressed without acceding to patient requests to receive aid in dying. Mark A. O'Rourke, M. Colleen O'Rourke & Matthew F. Hudson, Editorial, *Reasons to Reject Physician Assisted Suicide/Physician Aid in Dying*, 13 J. ONCOLOGY PRAC. 683, 684 (2017) (citing Loggers ET et al., *Implementing a Death with Dignity Program at a Comprehensive Cancer Center*, 368 NEW ENG. J. MED 1417 (2013)).

24. See, e.g., ZITTER, *supra* note 16, at 303–04.

25. See Pam Oliver, “Another Week? Another Week! I Can't Take Another Week”: Addressing Barriers to Effective Access to Legal Assisted Dying Through Legislative, Regulatory and Other Means 65 (2016) (unpublished Ph.D. dissertation, University of Auckland), <http://hdl.handle.net/2292/29864> [<https://perma.cc/4ARE-FZ9Q>] (“To avoid repetition of phrases, people seeking AD [assisted dying] are called ‘seekers’, reflecting their quest for a hastened death, whether or not they ultimately choose or achieve an assisted death.”).

stigmatized and is difficult to do. Little assistance is available to those seeking to end their lives with dignity. Against a backdrop of sociocultural fears of dying, let alone by a socially stigmatized act of suicide, “rational suicide” can seem an oxymoron.²⁶ Against a backdrop of legal penalties for assisting another to commit suicide, helping a person to die—whether that death is rational or not, or understood as “hastening death” and not suicide—is a radical concept and a dangerous act. And yet, the mission of several American nonprofits is to move the idea of rational suicide from the margins of society to the mainstream, as an acceptable response to certain life conditions. Often they choose to do that with political rhetoric vehemently distinguishing use of medical aid in dying through self-administration of a life-ending dose of medication from suicide, despite the fact that suicide is often also accomplished through self-administration of a life-ending dose of medication. Unfortunately, that subjects such organizations to criticisms of incoherence and of increasing the stigma associated with suicide through claims that people who use medical aid in dying should not be “lumped” with suicidal individuals because doing so would “offend” and “derogate” people using medical aid in dying.²⁷

26. See SUSAN STEFAN, RATIONAL SUICIDE, IRRATIONAL LAWS: EXAMINING CURRENT APPROACHES TO SUICIDE IN POLICY AND LAW 323–30 (2016). Indeed, some aid-in-dying nonprofits reject the term “suicide” in the context of ending end-of-life suffering, preferring instead to call it “hastening death.” Compassion & Choices, End of Life Choices California, and End of Life Liberty Project use the term hastening death. E.g., Rebecca Thoman, *Compassion & Choices Praises American Academy of Neurology for Dropping Opposition to Medical Aid in Dying*, COMPASSION & CHOICES (Mar. 5, 2018), <https://compassionandchoices.org/news/compassion-choices-praises-american-academy-neurology-dropping-opposition-medical-aid-dying/> [<https://perma.cc/Q3MT-DSK7>]; *End of Life Liberty Project*, CASCADIANOW!, <https://www.cascadianow.org/end-of-life-liberty-project> [<https://perma.cc/J4GU-2MHH>]; *Natural Death*, END LIFE CHOICES CAL., <https://endoflifechoicesca.org/end-of-life-choices/natural-death> [<https://perma.cc/938E-JEHS>]. Other aid-in-dying nonprofits, such as Final Exit Network, use the term suicide either because it is a generally understood word for an individual’s autonomous act to end life or, like Dignitas – To live with dignity – To die with dignity, because the organization believes that the cultural content of the term suicide must be changed to reflect compassionate acceptance of suicide in the context of irremediable suffering. E.g., *Our Service*, DIGNITAS, http://www.dignitas.ch/index.php?option=com_content&view=article&id=6&Itemid=47&lang=en [<https://perma.cc/MC3V-7S4D>]; FINAL EXIT NETWORK, <http://www.finalexitnetwork.org> [<https://perma.cc/M4CC-V4YC>].

27. See generally Michael Cholbi, *Whatever Happened to the Right to Die?* (unpublished manuscript) (on file with the author). Cholbi carefully parses the alleged differences between those seeking suicide and those seeking medical aid in dying and finds that there is no meaningful difference between the two populations. See *id.* at 8. Both terminally ill and suicidal people are susceptible to depression and anxiety, value autonomy, seek to end life in *expectation of* poor quality of life as much as *existing* poor quality of life, and are willing to use death as a means to an end. See *id.* at 7–9. While acknowledging that the approach of aid-in-dying nonprofits has short-term political efficacy, he concludes that “assisted dying for the terminally ill is suicide *tout court*.” *Id.* at 12.

Nonprofits have been relatively good at promoting change in norms. In the introduction to their book, *The Nonprofit Organization: Essential Readings*, editors David L. Gies, J. Steven Ott, and Jay M. Shafritz note that:

Repeatedly through history, citizens have recognized a need and then built a nonprofit constituency dedicated to ameliorating or eliminating it, even though the issue or its targeted people often were socially undesirable (at the time). In instance after instance over the years, this voluntary process has led to eventual public policy changes and government support (or tolerance) for what was originally a politically unacceptable cause, case, or issue.²⁸

Among their other roles and functions,²⁹ nonprofits are the organizational structure through which people come together to promote recognition of and solutions for social problems. Gies, Ott, and Shafritz provide the example of activism beginning in the 1960s on behalf of people with developmental disabilities.³⁰ Feminism and civil rights are but two more examples of ideas that have shifted, with the significant help and vigilance of nonprofits, from the margins to the center of American values.³¹ However, normative transitions do not happen without considerable resistance, collective soul-searching, and incomplete realization for long periods of time. At any

28. David L. Gies, J. Steven Ott & Jay M. Shafritz, Introduction to *The Nonprofit Organization: Essential Readings*, at xxiv (David L. Gies, J. Steven Ott & Jay M. Shafritz eds., 1990).

29. Sociologist David Horton Smith discusses ten types of impact nonprofits have on society, resulting in a nonprofit sector through which social change can occur. See generally David Horton Smith, *The Impact of the Volunteer Sector on Society*, in *THE NONPROFIT ORGANIZATION: ESSENTIAL READINGS*, *supra* note 28, at 347.

30. Gies, Ott & Shafritz, *supra* note 28, at xxiv. Sociologist David Horton Smith identifies a “central impact” of nonprofits being the provision of:

[S]ociety with a large variety of partially tested social innovations [and] . . . the prototyping test bed of many, perhaps most, new social forms and modes of human relations. . . . Nearly every function currently performed by governments . . . was once a new social idea and the experiment of some voluntary group, formal or informal—this is true of education, welfare, care for the aged, building roads, even fighting wars (volunteer citizen militias).

Smith, *supra* note 29, at 348.

31. Peter Dobkin Hall, *Historical Perspectives on Nonprofit Organizations in the United States*, in *THE JOSSEY-BASS HANDBOOK OF NONPROFIT LEADERSHIP AND MANAGEMENT* 3, 21 (David O. Renz & Robert D. Herman eds., 4th ed. 2016); see also Cheryl A. Hyde, *The Hybrid Nonprofit: An Examination of Feminist Social Movement Organizations*, 8 J. COMMUNITY PRAC. 45, 63 (2000) (considering role and structure of influential feminist nonprofits). Hyde discusses how social movement organizations can change the nature of public charity activity, not just participate in substantive advancement of debate on social issues.

given point in the history of activism, it is difficult to tell if there is progress or regress.

This Article examines what that transitional process looks like now in the context of aid-in-dying nonprofits' attempts to make medical aid in dying an acceptable, available option for those suffering irremediably at the end of life. Although there are nonprofits arrayed on all sides of this sociocultural quandary about individual autonomy in ending one's life, this Article focuses on particular nonprofits advocating for the availability of options for ending one's life as a legitimate response to irremediable end-of-life suffering to illustrate the challenges of moving an idea into the mainstream. The content of opposition emerging from *anti*-aid-in-dying nonprofits, such as the Catholic Church, Americans United for Life, and Not Dead Yet, is important, but since oppositional organizations are part of retaining the status quo, they are not the focus of this Article about aid-in-dying nonprofits' activism and client service provision to change the status quo.

Part II of this Article describes the legal status quo within which aid-in-dying nonprofits seek change. Almost all states explicitly prohibit assisting another to commit suicide, without exceptions for special circumstances, such as a physician seeking to help a patient die sooner in the context of irremediable end-of-life suffering.³² The wording of those statutes is ambiguous,³³ making it difficult to predict whether in any particular case there would be criminal liability for homicide or for assisting suicide or civil liability for wrongful death. Nevertheless, it is clear that assisting another to commit suicide is against public policy and against the law in the overwhelming majority of American jurisdictions.

Against that legal and sociocultural backdrop of disfavoring assisting another to end his or her life and punishing those who do, Part III of this Article examines three approaches aid-in-dying nonprofits use to advocate for and to actually assist individuals suffering irremediably at the end of life. Those approaches include (1) use of free speech protections to provide specific, detailed information to irremediably suffering individuals about how to end their lives both before and during those individuals' life-ending acts, (2) pursuit of laws that shield physicians and pharmacists from providing lethal dose prescriptions to qualified patients while also assisting patients to use those laws when permitted by a jurisdiction, and (3) litigation and advocacy in support of legal recognition of the idea that physicians' provision of lethal dose prescriptions falls within their discretion as physicians treating patients with unique circumstances. Part III reveals the radical nature of

32. See *infra* notes 43–47 and accompanying text.

33. See *infra* Section IV.B.

aid-in-dying advocacy and client service provision, hurdles aid-in-dying nonprofits confront, reasons for delays in societal acceptance of aid in dying, and the importance of all three approaches for dealing with different kinds of situations.

Nonprofit organizations need funds with which to operate, but the goal of changing ideas about aid in dying is not one most commercial financial lenders would support because of its lack of reliable return on investment. Instead, aid-in-dying nonprofits count on revenues they raise from donors through their tax-exempt status in order to advocate for change and provide client assistance. Part IV brings into focus the regulatory framework within which nonprofits seek a status that assists with their financial goals while also shaping how they can pursue those goals. There are different types of tax-exempt organizations that receive varying degrees of exemption from taxation.³⁴ Exemption from any type of tax can be understood as a subsidy provided by the government.³⁵ Thus, in this context, the public, through government-provided tax exemptions, can be understood as “subsidizing” aid-in-dying nonprofits’ attempts to change the status quo to provide opportunities for ending one’s life under certain circumstances.

This tax subsidy is greatest as to Internal Revenue Code § 501(c)(3) organizations because donations to those organizations are tax deductible as “charitable” gifts,³⁶ which may increase potential contributors’ willingness to donate. Yet to obtain and maintain that most preferred status, the missions of Internal Revenue Code § 501(c)(3) organizations must not violate public policy, they may not seek legal change as a primary focus, and they must not engage in “substantial” lobbying for legislative reform.³⁷ Part IV describes

34. Bruce R. Hopkins & Virginia C. Gross, *The Legal Framework of the Nonprofit Sector in the United States*, in THE JOSSEY-BASS HANDBOOK OF NONPROFIT LEADERSHIP AND MANAGEMENT, *supra* note 31, at 43, 46–49.

35. The theory of public subsidy of tax-exempt organizations because they produce public goods is prevalent but only one theory of tax-exempt organization status in the United States. Rob Atkinson states that traditional subsidy theory is “pretty much the foundation of present law,” but also provides an overview of other theoretical perspectives. Rob Atkinson, *Theories of the Federal Income Tax Exemption for Charities: Thesis, Antithesis, and Syntheses*, 27 STETSON L. REV. 395, 403–04 (1997); *see also* Henry Hansmann, *The Rationale for Exempting Nonprofit Organizations from Corporate Income Taxation*, 91 YALE L.J. 54, 66 (1981) (“A rather common view of the exemption is that it is a means of subsidizing particular services—such as health care, education, research, and aid to the poor—that nonprofit organizations often provide.”).

36. *See* I.R.C. § 170 (2012).

37. *Id.* § 501(c)(3) (“[N]o substantial part of the activities of [the organization] is . . . attempting to influence legislation . . .”).

those requirements and how aid-in-dying nonprofits comply with those requirements, despite the fact that assisting others to die is against the law or public policy in the vast majority of American jurisdictions. In fact, all of the representative organizations discussed in this Article are I.R.C. § 501(c)(3) “educational” organizations through which they can actually engage in considerable activism and also provide client services in line with their missions of providing services to qualified individuals. Part IV considers how client service provision informs advocacy, but also how it limits advocacy; caring about client assistance can result in compromises in the law that dull its efficacy.

While Part III provides contrasts between aid-in-dying nonprofits, Part V focuses on the shared characteristics of many aid-in-dying nonprofit organizations. For instance, American aid-in-dying nonprofits do not appear to directly address sociocultural norms pertaining to suicide per se, even as they attempt, in quite different ways, to make ending one’s life more accessible to specific individuals suffering at the end of life. Yet, as philosopher Michael Cholbi argues, such organizations’ vehemently distinguishing medical aid in dying from suicide can further stigmatize suicide and increase its prevalence.³⁸

Aid-in-dying nonprofits also share the challenge that it is difficult to know if in fact any of their approaches is succeeding in making aid in dying at the end of life more accessible. Nor is it possible, at this point in the history of aid-in-dying nonprofit advocacy and client service provision, to conclude that one approach is superior. Indeed, this Article illuminates a central problem in nonprofit law and policy: How does one measure the progress of a social justice movement while change is in process?

II. SOCIOCULTURAL AND LEGAL IMPEDIMENTS TO AID IN DYING

Although suicide is generally viewed through a negative lens,³⁹ it is not illegal in any state. However, aid-in-dying nonprofits must steer clear of directly assisting irremediably suffering individuals to die—no matter how compelling the reason—because assisting suicide is illegal under the great majority of state laws.⁴⁰ A California court captured commonly offered

38. Cholbi, *supra* note 27, at 13–14.

39. See STEFAN, *supra* note 26, at 323–30; see also Jesse Bering, *Sometimes, You Won’t Feel Better Tomorrow*, SLATE (Feb. 15, 2019, 5:50 AM), <https://slate.com/technology/2019/02/mental-illness-suicide-rational-thought-getting-help.html> [<https://perma.cc/SLA7-HAP6>] (suggesting a more nuanced appraisal of suicidal decision-making, noting, “[w]hen experts are given edited case histories of people who died by suicide without knowing they’ve taken their own lives, they are far less likely to see a mental illness”).

40. See *infra* note 43.

rationales for the coexistence of legal tolerance for suicide alongside criminal penalties for assisting suicide when it wrote:

Suicide or attempted suicide is not a crime under the criminal statutes of California or any state. The absence of a criminal penalty for these acts is explained by the prevailing thought . . . that suicide or attempted suicide is an expression of mental illness that punishment cannot remedy.

A majority of states, however, impose criminal penalties upon one who assists another to commit suicide. One reason for the existence of criminal sanctions for those who aid a suicide is to discourage those who might encourage a suicide to advance personal motives. Another reason is the belief that the sanctity of life is threatened by one who is willing to participate in taking the life of another, even at the victim's request. A third justification is that although the suicide victim may be mentally ill in wishing his demise, the aider is not necessarily mentally ill.

These reasons justify a criminal statute punishing the aiding and encouraging of suicide, although suicide itself is not illegal. The state's interest in such a situation involves more than just a general commitment to the preservation of human life. [It is important to guard against potential abuses, and] [t]hird parties, even family members, do not always act to protect the person whose life will end.⁴¹

That judicial opinion is now more than a quarter of a century old, yet it is still the “prevailing thought” that suicide is generally an “expression of mental illness,”⁴² and the laws prohibiting assisting another to commit suicide remain as strong as ever. Out of fifty states, forty-four states currently have laws that make “assisted suicide” illegal.⁴³ Of those forty-four, forty-

41. *Donaldson v. Lungren*, 4 Cal. Rptr. 2d 59, 64–65 (Cal. Ct. App. 1992) (citations omitted).

42. See STEFAN, *supra* note 26, at 323–30; Bering, *supra* note 39.

43. ALA. CODE § 22-8B-4 (2019) (effective Aug. 1, 2017) (ban includes physician-assisted suicide); ALASKA STAT. § 11.41.120 (2019) (effective June 3, 2006); ARIZ. REV. STAT. ANN. § 13-1103 (2019) (effective July 24, 2014); ARK. CODE ANN. §§ 5-10-104, -106 (2019) (effective July 31, 2007) (bans physician-assisted suicide); CAL. PENAL CODE § 401 (Deering 2019) (effective Jan. 1, 2019); COLO. REV. STAT. § 18-3-104 (2019) (effective Aug. 8, 2012); CONN. GEN. STAT. § 53a-56 (2019) (effective Oct. 1, 1971); DEL. CODE ANN. tit. 11, § 645 (2019) (effective July 10, 1995); FLA. STAT. § 782.08 (2019); GA. CODE ANN. § 16-5-5 (2019) (effective July 1, 2015); HAW. REV. STAT. § 707-702 (2019) (effective June 26, 2019); IDAHO CODE § 18-4017 (2019) (effective July 1, 2011); 720 ILL. COMP. STAT. § 5/12-34.5 (West 2019) (effective July 1, 2011); IND. CODE § 35-42-1-2 (2019) (effective July 1, 2014) (“causing” suicide); IND. CODE § 35-42-1-2.5 (2019) (effective July 1, 2014) (“assisting” suicide); IOWA CODE § 707A.2 (2019); KAN. STAT. ANN. § 21-5407 (2019) (effective July 1, 2011); KY. REV. STAT. ANN. § 216.302 (LexisNexis 2019) (effective July 15, 1994); LA. STAT. ANN. § 14:32.12 (2019) (effective June 16, 1995); ME. STAT. tit. 17-A, § 204 (2019) (effective Sept. 19, 2019); MD. CODE ANN. § 3-102 (LexisNexis 2019); MICH. COMP. LAWS § 750.329a (2019) (effective Sept.

two have criminal prohibitions against “assisting,” while Hawaii makes “intentionally caus[ing]” a suicide illegal,⁴⁴ and Virginia has civil penalties for “assisting” suicide.⁴⁵ A few criminal bans have been added recently: Alabama in 2017, Ohio in 2017, and Utah in 2018.⁴⁶ Seven jurisdictions—Massachusetts, Nevada, North Carolina, Vermont, West Virginia, Wyoming, and the District of Columbia—have no statutes specifically criminalizing the aiding or assisting in a suicide. However, many of these jurisdictions have policy statements against “mercy killing” or “assisted suicide.”⁴⁷

1, 1998) (common law assisted suicide); MICH. COMP. LAWS § 752.1027 (2019) (effective Feb. 25, 1993) (criminal assistance to suicide); MINN. STAT. § 609.215 (2019) (effective Aug. 1, 1999) (the words severed “advising or encouraging” suicide were held unconstitutional by *State v. Melchert-Dinkel*, 844 N.W.2d 13 (Minn. 2014)); MISS. CODE ANN. § 97-3-49 (2019); MO. REV. STAT. § 565.023 (2019) (effective Jan. 1, 2017); MONT. CODE ANN. § 45-5-105 (2019); NEB. REV. STAT. § 28-307 (2019); N.H. REV. STAT. ANN. § 630:4 (2018) (effective Nov. 1, 1973); N.J. STAT. ANN. § 2C:11-6 (West 2019) (effective Aug. 1, 2019); N.M. STAT. ANN. § 30-2-4 (LexisNexis 2019); N.Y. PENAL LAW § 120.30 (McKinney 2019) (effective Sept. 1, 1967) (promoting a suicide attempt); N.Y. PENAL LAW § 125.15 (McKinney 2019) (effective Sept. 1, 1967) (second-degree manslaughter); N.D. CENT. CODE § 12.1-16-04 (2019); OHIO REV. CODE ANN. § 3795.04 (LexisNexis 2019) (effective Mar. 21, 2017); OKLA. STAT. tit. 21, § 813 (2019) (aiding suicide); OKLA. STAT. tit. 21, § 814 (2019) (furnishing weapon or drug); OR. REV. STAT. § 163.125 (2019) (second degree manslaughter); OR. REV. STAT. § 163.193 (2019) (assisting suicide; exemptions); 18 PA. CONS. STAT. § 2505 (West 2019) (effective June 6, 1973); 11 R.I. GEN. LAWS § 11-60-3 (2019) (ban refers to “[a]n individual or licensed health care practitioner”); S.C. CODE ANN. § 16-3-1090 (2019); S.D. CODIFIED LAWS § 22-16-37 (2019); TENN. CODE ANN. § 39-13-216 (2019); TEX. PENAL CODE ANN. § 22.08 (West 2019) (effective Sept. 1, 1994); UTAH CODE ANN. § 76-5-205 (LexisNexis 2019) (effective May 5, 2018); VA. CODE ANN. § 8.01-622.1 (2019) (effective July 1, 2015); WASH. REV. CODE § 9A.36.060 (2019) (effective July 22, 2011); WIS. STAT. § 940.12 (2019). .

44. HAW. REV. STAT. § 707-702 (“Manslaughter[.] . . . A person commits the offense of manslaughter if . . . the person intentionally causes another person to commit suicide . . .”).

45. VA. CODE ANN. § 8.01-622.1 (“Injunction against assisted suicide; damages; professional sanctions.”).

46. ALA. CODE § 22-8B-4 (including part of the 2017 “Assisted Suicide Ban Act,” criminalizing both assistance by individuals and by physicians or health care providers; for physicians and health care providers, specifically bans “prescrib[ing] any drug compound, or substance to a patient deliberately to aid in dying or assist[ing] or perform[ing] any medical procedure deliberately to aid in dying”); OHIO REV. CODE ANN. § 3795.04 (providing that “assisting suicide” is a felony); UTAH CODE ANN. § 76-5-205 (detailing the manslaughter statute amended to criminalize assisted suicide).

47. MASS. GEN. LAWS ch. 201D, § 12 (2019) (“Suicide or mercy killing.” “Nothing in this chapter shall be construed to constitute, condone, authorize, or approve suicide or mercy killing, or to permit any affirmative or deliberate act to end one’s own life other than to permit the natural process of dying.”); NEV. REV. STAT. § 449A.475 (2019) (“NRS 449A.400 to 449A.481 [Withholding or Withdrawal of Life-Sustaining Treatment], inclusive, do not condone, authorize or approve mercy-killing, assisted suicide or euthanasia.”); W. VA. CODE § 16-30-15 (2019) (“Nothing in this article shall be construed to legalize, condone, authorize or approve mercy killing or assisted suicide.”); WYO. STAT. ANN. § 35-22-414(c) (2019) (“This act [Wyoming Health Care Decisions Act] does not authorize mercy killing, assisted suicide, euthanasia or the provision, withholding or withdrawal of health care . . .”).

Even without statutes, there can be common law prohibitions⁴⁸ or medical practice rules that prohibit physicians from providing assistance.⁴⁹ Moreover, a state without an explicit statute may consider assisted suicide a criminal act by deeming it within the scope of homicide.⁵⁰ Also, sometimes a “silent” state will have a statute distinguishing lawful passive withholding

48. *See, e.g., In re Joseph G.*, 667 P.2d 1176, 1179 (Cal. 1983) (“At common law, an aider and abettor [of the suicide of another] was guilty of murder by construction of law because he was a principal in the second degree to the self-murder of the other.” (citing GLANVILLE WILLIAMS, *THE SANCTITY OF LIFE AND THE CRIMINAL LAW* 296 (1957))); *People v. Kevorkian*, 527 N.W.2d 714, 716 (Mich. 1994) (“Where a defendant merely is involved in the events leading up to the death, such as providing the means, the proper charge is assisting in a suicide, which may be prosecuted as a common-law felony under the saving clause [of the Michigan statutes, incorporating the common law of crimes] in the absence of a statute that specifically prohibits assisting in a suicide.” (citation omitted) (citing MICH. COMP. LAWS § 750.505 (2019))).

49. *See, e.g., MINN. STAT. § 147.091(w)* (2019) (“The following conduct is prohibited and is grounds for disciplinary action: . . . (w) Aiding suicide or aiding attempted suicide in violation of section 609.215 . . .”). Section 609.215 is Minnesota’s statute criminalizing assisted suicide and is part of Minnesota’s criminal code; however, § 147.091 is part of the Minnesota Medical Practice Act, setting forth grounds for disciplinary action. In other states, the medical practice statute merely penalizes “unprofessional conduct,” and then the state’s ban on assisted suicide will classify physician-assisted suicide as unprofessional conduct, thereby opening up the doctor to discipline. *See, e.g., ALA. CODE § 34-24-360* (2019) (giving the Alabama Medical Licensure Commission “the power and duty to suspend, revoke, or restrict any license to practice medicine” for commission of various offenses, including “unprofessional conduct”); *ALA. CODE § 22-8B-5* (2019) (including part of Alabama’s “Assisted Suicide Ban Act,” stating that “[a]ny physician or other health care provider who deliberately aids in dying in violation of this chapter shall be considered to have engaged in unprofessional conduct for which his or her license to provide health care services in the state shall be suspended or revoked by the appropriate licensing board”). Other states, as part of their criminalization of assisted suicide statute, have provisions covering discipline for doctors. *See, e.g., GA. CODE ANN. § 16-5-5(d)* (2019) (“Within ten days of a conviction, a health care provider who is convicted of violating this Code section [criminalization of assisting suicide] shall notify in writing the applicable licensing board for his or her licensure . . . Upon being notified . . . the appropriate licensing board shall revoke the license . . . or other authorization to conduct such health care provider’s occupation.”). Virginia’s statute makes assisted suicide illegal, which provides not criminal but civil penalties. *VA. CODE ANN. § 8.01-622.1(D)* (2019) (“A licensed health provider who assists or attempts to assist a suicide shall be considered to have engaged in unprofessional conduct for which his certificate or license to provide health care services in the Commonwealth shall be suspended or revoked by the licensing authority.”).

50. *See, e.g., WYO. STAT. ANN. § 6-2-107* (2019) (“Criminally negligent homicide. (a) Except under circumstances constituting a violation of W.S. 6-2-106 [Homicide by vehicle], a person is guilty of criminally negligent homicide if he causes the death of another person by conduct amounting to criminal negligence.”).

of life support in a way that leaves open the possibility that actively assisting suicide will be determined unlawful.⁵¹

Much turns on what constitutes “assisting” another to commit suicide. When aid-in-dying nonprofits provide information to people seeking aid in dying, are they “assisting” that person to commit suicide? When a patient has a conversation with a physician about a strong desire to end her life, is the physician assisting her by having that conversation or by providing a prescription that the patient subsequently uses as part of a suicide plan?

Statutory clarity is possible in this area of law. For instance, Arizona’s statute provides that “[a] person commits manslaughter by . . . [i]ntentionally providing the physical means that another person uses to commit suicide, with the knowledge that the person intends to commit suicide.”⁵² There may be evidentiary problems, but Arizona’s law steers clear of imperiling those who provide nothing other than education about such things as methods and risks. An aid-in-dying nonprofit that provides only information will not be successfully prosecuted under that law, no matter how specific the information provided or how closely the actions subsequently taken by the recipients follow the information they received.

Arizona’s statutory clarity is not the norm, however. Among the forty-four states that explicitly prohibit “assisting” or “causing” “suicide,”⁵³ it is not easy to decide definitively whether the statute would be violated in a particular situation, due to the lack of definitions for terms used in the statutes. This ambiguity could lead physicians to hesitate even to provide adequate pain relief to a severely and irremediably suffering patient, particularly if the patient has asked repeatedly for a prescription with which the patient could end the patient’s own life. Seen from that perspective, ambiguous laws seem unkind and ripe for reform. However, seen from the perspective of those concerned about the risks of greater societal receptivity to individuals’ ending their lives and about vulnerable individuals making irreversible decisions, ambiguous laws seem appropriate to prevent such acts by making would-be assistants, including physicians and aid-in-dying nonprofits, hesitant to provide help.

Without clarity comparable to that of Arizona’s law, it would not be difficult for ambitious prosecutors or prosecutors in a jurisdiction hostile to suicide and assisted suicide to exploit statutory ambiguity to charge a physician who provided prescriptions to a patient who had mentioned a

51. See, e.g., W. VA. CODE § 16-30-15 (providing that withholding of life support under specified conditions is not assisted suicide or murder and that “[n]othing in this article shall be construed to legalize, condone, authorize or approve mercy killing or assisted suicide”).

52. ARIZ. REV. STAT. ANN. § 13-1103(A)(3) (2019).

53. See *supra* note 43.

desire to die and had, in fact, stockpiled medications with which to commit suicide. When would a “reasonable” physician have known a patient’s intent?

Statutory ambiguity could also result in charging those, including aid-in-dying nonprofits, who “participate[d]” in another’s suicide by encouragingly discussing possible methods.⁵⁴ For instance, South Carolina’s statute limits criminal culpability to providing the physical means for another to commit suicide, the use of force or duress to intentionally cause another to commit or attempt to commit suicide, or participation in a physical act by which another commits suicide, knowing that the other intends to commit suicide.⁵⁵ The statute seems straightforward and to avoid criminalizing the provision of mere information, stating as follows:

- (A) As used in [South Carolina Code Ann. § 16-3-1090] . . .
 - (2) “Suicide” means the act or instance of taking one’s life voluntarily and intentionally.
- (B) It is unlawful for a person to assist another person in committing suicide. A person assists another person in committing suicide if the person:
 - (1) by force or duress intentionally causes the other person to commit or attempt to commit suicide; or
 - (2) has knowledge that the other person intends to commit or attempt to commit suicide and intentionally:
 - (a) provides the physical means by which the other person commits or attempts to commit suicide; or
 - (b) participates in a physical act by which the other person commits or attempts to commit suicide.⁵⁶

However, like several other states,⁵⁷ this statute covers “force” and “duress,” which could also involve some speech acts. Massachusetts does

54. *See, e.g.*, S.C. CODE ANN. § 16-3-1090(B) (2019).

55. *See id.*

56. *Id.* § 16-3-1090(A)–(B). There are other state statutes that criminalize “participation” in physical acts. *See, e.g.*, IDAHO CODE § 18-4017 (2019); 720 ILL. COMP. STAT. § 5/12-34.5 (West 2019); IND. CODE § 35-42-1-2, -2.5 (2017) (“assisting” and “causing”); IOWA CODE § 707A.2 (2019); KAN. STAT. ANN. § 21-5407 (2018); KY. REV. STAT. ANN. § 216.302 (LexisNexis 2019); MD. CODE ANN., CRIM. LAW § 3-102 (LexisNexis 2019); OHIO REV. CODE ANN. § 3795.04 (LexisNexis 2019); OKLA. STAT. ANN. tit. 21, § 813 (2019); 11 R.I. GEN. LAWS § 11-60-3 (2019); TENN. CODE ANN. § 39-13-216 (2019).

57. Other states that include “force,” “coercion,” or “duress” as considerations in their assisting suicide prohibitions are Kansas, Maryland, and South Carolina. KAN. STAT. ANN. § 21-5407; MD. CODE ANN., CRIM. LAW § 3-102; S.C. CODE ANN. § 16-3-1090. Some other states distinguish between assisting a suicide and “causing a suicide” or homicide, depending on the presence of force, coercion, or duress, with different penalties associated with their different classification. *See, e.g.*, IND. CODE § 35-42-1-2 (“Causing Suicide”); IND. CODE § 35-42-1-2.5 (“Assisting Suicide”); KY. REV. STAT. ANN. § 216.302 (treating

not have a statute specifically prohibiting assisted suicide but provides a recent example of the sufficiency of speech acts to result in conviction for involuntary manslaughter in the context of suicide.⁵⁸ On February 6, 2019, a Massachusetts appellate court confirmed the conviction for involuntary manslaughter of Michelle Carter, who was accused of repeatedly urging her boyfriend to follow through on his stated intent to commit suicide.⁵⁹ According to Justice Kafker’s ruling, Carter and her boyfriend were communicating by phone as he sat in a truck filling with carbon monoxide gas.⁶⁰ When he exited the truck, Carter ordered him to get back into the truck to complete the suicide and then listened to the sounds of the motor producing the carbon monoxide gas and her boyfriend coughing and moaning until he fell silent.⁶¹ Although she was not near the truck and had not participated in any physical act, such as purchasing the motor that was producing the carbon monoxide gas, Carter was convicted of involuntary manslaughter because her “actions and her failure to act,” encouragement and not trying to prevent the suicide, was held to constitute “wanton and reckless conduct that caused the victim’s death.”⁶²

How does one draw the line between Michelle Carter’s alleged actions and those of a nonprofit organization that explains methods and attends the death of individuals who use that information? Final Exit Network’s (FEN) words are significantly different from those of Carter’s alleged texts; FEN does not encourage individuals to commit suicide.⁶³ Yet the

causing a suicide by force or duress treated as a Class C felony and treating assisting a suicide without force or duress as a Class D felony).

58. See *Commonwealth v. Carter*, 115 N.E.3d 559, 574 (Mass. 2019).

59. See *id.* at 571; see also Kayla Epstein, Lindsey Bever & Kristine Phillips, *Her Texts Urged a Boyfriend to Kill Himself. A Judge Just Upheld Her Conviction*, WASH. POST (Feb. 6, 2019, 1:54 PM), https://www.washingtonpost.com/crime-law/2019/02/06/her-texts-urged-boyfriend-kill-himself-judge-just-upheld-her-conviction/?noredirect=on&utm_term=.b31a96b84b37 [<https://perma.cc/DTY8-Y6HU>].

60. *Carter*, 115 N.E.3d at 565.

61. *Id.* at 565–66.

62. *Id.*; see also Lindsey Bever & Kristine Phillips, *Michelle Carter, Who Urged Her Boyfriend to Commit Suicide, Found Guilty in His Death*, WASH. POST (June 16, 2017, 1:37 PM), https://www.washingtonpost.com/news/true-crime/wp/2017/06/16/shes-accused-of-pushing-him-to-suicide-now-a-judge-has-decided-her-fate/?utm_term=.57a6dd900bad [<https://perma.cc/Y6KW-HENE>]. The U.S. Supreme Court declined to hear Carter’s appeal, which argued that convicting Carter on the basis of words alone was a violation of the First Amendment. Marc Fortier & Caroline Connolly, *US Supreme Court Denies Michelle Carter’s Appeal in Texting Suicide Case*, NBC BOS., <https://www.nbcboston.com/news/local/us-supreme-court-denies-michelle-carters-appeal-in-texting-suicide-case/2061253> [<https://perma.cc/8J5H-WPQD>] (last updated Jan. 14, 2020, 7:35 AM).

63. *Who Is the Final Exit Network (FEN)*, FINAL EXIT NETWORK <http://www.finalexitnetwork.org/Mission.html> [<https://perma.cc/2X79-7P6J>] (“We do not encourage anyone to end their life and are opposed to anyone encouraging anyone to end their life. We do not provide the means for self-deliverance and we do not assist in self-deliverance.”).

question remains—can words alone ever be enough to convict for “assisting suicide”; should they be enough?⁶⁴

Even without the statutory language of “coercion” and “duress,” the South Carolina statute would contain ambiguity because of the undefined term “participates” in the phrase “participates in a physical act.”⁶⁵ Could there be speech acts, such as taunting an individual to kill herself after she has expressed commitment to end her life, that constitute “participation?” Could an aid-in-dying nonprofit run afoul of the law by reassuring a person that the method it describes will work, if the person hesitates after starting to use the method? What level of proof would be necessary to find that the words had been spoken and properly belonged in the category of “participatory?”

If assisting suicide means only *physical* acts, such as providing the means or helping the person utilize the means, there is sufficient legal protection for *speech* acts to provide information, support, and companionship to individuals making one of the most important decisions of their lives.⁶⁶

64. See Doha Madoni, *Michelle Carter, Who Encouraged Boyfriend's Suicide, Appeals to the Supreme Court*, NBC NEWS (July 8, 2019, 3:20 PM), <https://www.nbcnews.com/news/us-news/michelle-carter-who-encouraged-boyfriend-s-suicide-appeals-supreme-court-n1027601> [<https://perma.cc/7CCR-C37C>] (explaining that Carter contends in her filing that the court's decision violates her First Amendment rights); see also Jess Bidgood, *She's Accused of Texting Him to Suicide. Is that Enough to Convict?*, N.Y. TIMES (June 6, 2017), <https://www.nytimes.com/2017/06/06/us/suicide-texting-manslaughter-trial.html?action=click&module=RelatedCoverage&pgtype=Article®ion=Footer> [<https://perma.cc/GCK3-3SGL>]; Lindsey Bever & Kristine Phillips, *Texting Guide Sentencing Provides No Closure, but Victim's Mother Declares: 'We Want to Move On,'* WASH. POST (Aug. 4, 2017, 5:57 AM), <https://www.washingtonpost.com/news/true-crime/wp/2017/08/03/michelle-carter-whose-texts-pushed-her-boyfriend-to-suicide-to-be-sentenced-in-his-death> [<https://perma.cc/LZ52-467E>]; Kate Taylor, *What We Know About the Michelle Carter Suicide Texting Case*, N.Y. TIMES (July 9, 2019), <https://www.nytimes.com/2019/07/09/us/michelle-carter-i-love-you-now-die.html> [<https://perma.cc/L924-QZB2>].

65. S.C. CODE ANN. § 16-3-1090 (2019).

66. For Final Exit Network's arguments in the litigation in which it has been involved, see generally Appellants' Brief, *Final Exit Network, Inc. v. State*, 722 S.E.2d 722 (Ga. 2012) (No. S11A1960), 2011 WL 5289141; Appellants' Supplemental Brief, *Final Exit Network*, 722 S.E. 2d 722 (No. 211A1960), 2011 WL 5289143; Brief Amicus Curiae for Final Exit Network, Inc. & Jerry Dincin & Appendix, *Melchert-Dinkel v. State*, 844 N.W.2d 13 (Minn. 2011) (No. A11-0987), 2011 WL 11720916; Appellant's Brief, *Final Exit Network, Inc. v. State*, 889 N.W.2d 296 (Minn. 2016) (No. A15-1826), 2016 WL 8315459; Complaint for Declaratory and Injunctive Relief, *Final Exit Network, Inc. v. Ellison*, 370 F. Supp. 3d 995 (D. Minn. 2019) (No. 18-cv-01025), 2018 WL 1858565; see also Amended Complaint, *Final Exit Network*, 370 F. Supp. 3d 995 (No. 18-cv-01025); Second Amended Complaint, *Final Exit Network*, 370 F. Supp. 3d 995 (No. 18-cv-01025).

However, if the definition of “assistance” includes speech with the intent to assist someone the speaker knows is intending to commit suicide, there is less opportunity to assist lawfully because aid-in-dying nonprofit speakers usually provide specific information when individuals contemplating suicide ask them. As will be described below, that is the current situation under Minnesota law, with the result that no aid-in-dying nonprofit can provide specific information to anyone considering ending his or her life, regardless of circumstances.⁶⁷

A legislature cannot foresee all possible prosecutions under a particular law, and without prosecution it is difficult to know if the scope of a state’s criminal prohibition of assisted suicide is actually limited to physical acts. Nonprofits interested in protecting individual autonomy and access to aid in dying cannot know in advance if their provision of mere educational assistance would survive prosecution. For example, Delaware’s current law provides as follows: “A person is guilty of promoting suicide when the person intentionally causes or aids another person to attempt suicide, or when the person intentionally aids another person to commit suicide.”⁶⁸ Legislation introduced in 2017 would amend the law to define the crime of aiding suicide or committing homicide by causing suicide as follows: “A person commits an offense if the person knowingly aids another in committing suicide,” and “[a] person may be convicted of . . . causing another person to commit suicide only if the person causes the suicide by force, threat, or coercion.”⁶⁹ It is unclear what would constitute “knowing aid” or “force, threat, or coercion.” When would the outcome of a self-imposed death lead to a post hoc characterization of another’s involvement prior to that death as force, threat, coercion, or knowing aid? Surely, the risk is greater when suicide as a general matter is strongly stigmatized. Unfortunately, aid-in-dying nonprofits that argue that “lumping” seekers of medical aid in dying with seekers of suicide is offensive and hurtful to the former may actually increase stigma associated with suicide and actually harm the ultimate goal of making aid in dying more available.⁷⁰

A state statute that casts even more doubt on what it means to “assist” a suicide is that of Louisiana, which provides that:

67. See *State v. Final Exit Network, Inc.*, 889 N.W.2d 296, 302–03 (Minn. Ct. App. 2016), *cert denied*, 138 S. Ct. 145 (2017) (mem.); see also *State v. Melchert-Dinkel*, 844 N.W.2d 13, 24 (Minn. 2014).

68. DEL. CODE ANN. tit. 11, § 645 (2019).

69. S.B. 209, 149th Gen. Assemb., Reg. Sess. (Del. 2018). The bill died in committee. *Senate Bill 2019*, DEL. GEN. ASSEMBLY, <https://legis.delaware.gov/BillDetail/26675> [<https://perma.cc/6K5T-C8TE>].

70. See Cholbi, *supra* note 27, at 7.

Criminal assistance to suicide is: (1) The intentional advising *or* encouraging of another person to commit suicide *or* the providing of the physical means *or the knowledge of such means* to another person for the purpose of enabling the other person to commit or attempt to commit suicide. (2) The intentional advising, encouraging, *or* assisting of another person to commit suicide, *or* the participation in any physical act which causes, aids, abets, or assists another person in committing or attempting to commit suicide.⁷¹

There are multiple opportunities in such a statute for a prosecutor to promote definitions for statutory terms that include acts in which nonprofits might engage to assist a terminally and irremediably suffering individual to die. The inclusion of providing knowledge of methods by which an individual could end his or her life means that there could be circumstances under which an individual, such as a volunteer for an aid-in-dying organization, could be prosecuted for merely informatively describing and discussing such options. In fact, as will be described in more detail later, one aid-in-dying nonprofit in particular, Final Exit Network, has been prosecuted and threatened with prosecution for providing information to individuals with knowledge of those individuals' intent to die.⁷²

III. AID-IN-DYING NONPROFIT APPROACHES TO AID IN DYING

Aid-in-dying nonprofits, like many other public benefit nonprofits unwilling to raise funds by charging client service fees and unable to raise funds through commercial financial markets,⁷³ must rely heavily on donative support of various kinds.⁷⁴ Tax-exempt status provides tax relief of various kinds to the organization, and the most privileged tax-exempt status, I.R.C. § 501(c)(3), enables donors to receive tax deductions for their charitable contributions.⁷⁵ Since many donors prefer tax deductibility of their donations,⁷⁶

71. LA. STAT. ANN. § 14:32.12 (2019) (emphasis added).

72. See *Final Exit Network*, 889 N.W.2d at 301.

73. Hansmann, *supra* note 35, at 72 (“[T]he exemption [of nonprofits from taxation] serves to compensate for difficulties that nonprofits have in raising capital, and . . . such a capital subsidy can promote efficiency when employed in those industries in which nonprofit firms serve consumers better than their for profit counterparts.”).

74. See William Landes Foster, Peter Kim & Barbara Christiansen, *Ten Nonprofit Funding Models*, STAN. SOC. INNOVATION REV., Spring 2009, at 32, 32–39. Aid-in-dying nonprofits fall primarily into the “heartfelt connector” and “beneficiary builder” models.

75. I.R.C. § 170(a)(1) (2012).

76. Receiving a tax deduction for charitable gifts means that a donor can reduce the donor's tax burden and give more. For example, without considering limits on deductions, suppose a donor in the 22% tax bracket gives \$1000 to charity. The taxpayer would pay

I.R.C. § 501(c)(3) organizations have the best chance of attracting such funding. To attain and maintain that status, I.R.C. § 501(c)(3) organizations' activities must be performed for the benefit of the public⁷⁷ and, therefore, cannot violate public policy.⁷⁸ They cannot engage in illegal activities in furtherance of their missions,⁷⁹ and their missions cannot be primarily about changing the law.⁸⁰

Given these restrictions and the current status of the law described in Part II, how can aid-in-dying nonprofits exist as I.R.C. § 501(c)(3) organizations? All of the aid-in-dying organizations considered in this Article are I.R.C. § 501(c)(3) organizations that engage in significant amounts of activism to change the law or how the law is interpreted.⁸¹ Part III describes the approaches and activities of these nonprofits, while Part IV considers in more detail why these activities do not disqualify these organizations as I.R.C. § 501(c)(3) organizations.

I.R.C. § 501(c)(3) aid-in-dying organizations use three basic legal approaches, described in more detail in this Part. One approach is to argue that legal prohibitions on assisting suicide cannot be so expansive as to preclude exercise of free speech rights under state and federal constitutions to provide information to individuals seeking that information. A good example of this approach is Final Exit Network,⁸² which defends the right

less taxes because she will deduct the \$1000 she gave to charity from her adjusted gross income before paying the 22% tax on the remaining taxable income.

77. *Exemption Requirements—501(c)(3) Organizations*, IRS, <https://www.irs.gov/charities-non-profits/charitable-organizations/exemption-requirements-501c3-organizations> [perma.cc/3PYW-M88B]; see *Exempt Purposes*, IRS, <https://www.irs.gov/charities-non-profits/charitable-organizations/exempt-purposes-internal-revenue-code-section-501c3> [https://perma.cc/3KRE-B2Y9].

78. IRS, ACTIVITIES THAT ARE ILLEGAL OR CONTRARY TO PUBLIC POLICY (1985), <https://www.irs.gov/pub/irs-tege/eotopicj85.pdf> [https://perma.cc/JML5-43L6].

79. See *id.*

80. Pursuit of legal reform is a legitimate public benefit, but organizations whose primary purpose is legal reform would not qualify as I.R.C. § 501(c)(3) organizations. If they meet other requirements, they could receive I.R.C. § 501(c)(4) status, which would enable them to engage in substantial amounts of legislative lobbying that I.R.C. § 501(c)(3) organizations cannot undertake. However, donations to those organizations would not be tax deductible under I.R.C. § 170. See I.R.C. § 170(c) (2012).

81. This Article does not purport to identify or categorize every aid-in-dying nonprofit in the United States. Organizations were selected for inclusion based on their exemplifying the different approaches described in the Article.

82. *Who Is the Final Exit Network (FEN)*, *supra* note 63 (“Through our legal efforts to support people’s right to self-deliverance, we seek to clarify existing laws that are ambiguous as to self-deliverance and possibly extend them where appropriate. We retain legal counsel with special expertise in end-of-life and free speech issues.”); see also Michael Majchrowicz, *The Volunteers Who Help People End Their Own Lives*, ATLANTIC (July 6, 2016), <https://www.theatlantic.com/health/archive/2016/07/the-volunteers-who-help-people-end-their-own-lives/489602> [https://perma.cc/HW2S-AA6F].

to provide education to people who are suffering without possibility of recovery and who have determined rationally—and not as a manifestation of transient despair or simple tiredness of living—that, all things considered, it is best to end their suffering by ending their lives. Final Exit Network limits access to this education by requiring a medical evaluation of an individual’s claims of irremediable suffering due to a health condition unresponsive to medical intervention.⁸³ Final Exit Network does not provide the means to commit suicide or physically assist in the use of the method chosen by an individual to end his or her life; it provides only education and if the individual requests, companionship at the time of death.⁸⁴

Aid-in-dying nonprofits such as End of Life Washington,⁸⁵ Death with Dignity National Center,⁸⁶ and Compassion & Choices⁸⁷ use a second approach, although, of course, they also educate those who request information about aid in dying. These organizations advocate for and utilize state medical aid-in-dying (MAiD) statutes, laws that create a statutory exception to legal prohibitions on assisting suicide.⁸⁸ Under these laws, a licensed physician can lawfully prescribe, and a licensed pharmacist can lawfully fill, a lethal dose of medication for a legally and medically qualified patient.⁸⁹ These laws restrict access to only some patients suffering at the end of life, and they require physicians to follow multiple steps before and after writing a

83. *Exit Guide Information Request*, FINAL EXIT NETWORK, <http://www.finalexitnetwork.org/Exit-Guide-Services.html> [https://perma.cc/6K3K-TLCT] (“Our Medical Committee evaluates all requests for guide support. Senior Guides ensure that the applicants comply with our official criteria.”).

84. *Id.* (“Our guides travel to you and educate you on your personal choices. You must, however, be able to competently choose, as well as be able to effect your exit.”); see also *Who Is the Final Exit Network (FEN)*, *supra* note 63 (“We hold that a mentally competent person with intolerable suffering or pain has the right to end his or her life, choosing the timing and persons present, and should be free of any restrictions by the law, clergy, medical profession, friends or relatives.”).

85. *About*, END LIFE WASH., <https://endoflifewa.org/about-us> [https://perma.cc/7XJQ-UNMT].

86. *About Us*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/about> [https://perma.cc/4ADH-C4F5].

87. *About Us*, COMPASSION & CHOICES, <https://www.compassionandchoices.org/about-us> [https://perma.cc/G9PB-F663].

88. See, e.g., *About Us*, *supra* note 86.

89. See generally *How Death with Dignity Laws Work*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/learn/access> [https://perma.cc/LW2U-T8B2].

lethal dose prescription.⁹⁰ End of Life Washington assists qualified individuals to use the law by, among other things, finding physicians and pharmacists willing to consider their requests, providing templates for advance care directives, and attending deaths, if requested by the individuals electing to use Washington's Death with Dignity Act.⁹¹ End of Life Choices Oregon⁹² and End of Life Choices California⁹³ similarly provide assistance to clients seeking to use their state laws. Compassion & Choices emphasizes assistance to physicians by providing information about compliance with legally required steps and appropriate drug formulations.⁹⁴

In addition to advocating for MAiD laws and assisting physicians interested in complying with MAiD statutes, Compassion & Choices also uses a third approach. Compassion & Choices and End of Life Liberty Project argue that a physician's decision to prescribe a lethal dose of medication should be legally recognized as a part of standard medical practice, that it should be protected as a private matter between a physician and a patient, and that such a prescription should not be legally understood as "assisting suicide."⁹⁵ There have been multiple attempts to secure declaratory judgments,⁹⁶ but currently the only example of a state following this approach is Montana, where a judge decided that physicians could defend themselves from prosecution for homicide by showing patient consent to receipt of lethal dose prescriptions.⁹⁷

Each of these three approaches is distinct, yet all are quite limited from a patient access point of view and require continual advocacy to secure

90. For a compilation of requirements found in MAiD statutes, see *Frequently Asked Questions*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/faqs> [<https://perma.cc/FC5R-ZG45>].

91. *What We Do*, END LIFE WASH., <https://endoflifewa.org/about-us/what-we-do> [<https://perma.cc/7PJ3-M58S>].

92. *How We Help*, END LIFE CHOICES OR., <https://eolcoregon.org> [<https://perma.cc/C4QN-XUDW>].

93. *What We Do—Services*, END LIFE CHOICES CA., <https://endoflifechoicesca.org/what-we-do/services/> [<https://perma.cc/DLE5-VAJW>].

94. See *What is Doc2Doc?*, COMPASSION & CHOICES, <https://compassionandchoices.org/d2d> [<https://perma.cc/WM2V-HTUP>].

95. *End of Life Liberty Project*, *supra* note 26.

96. See, e.g., *Final Exit Network, Inc. v. Ellison*, 370 F. Supp. 3d 995, 1003 (D. Minn. 2019); *Donaldson v. Lungren*, 4 Cal. Rptr. 2d 59, 60–61 (Cal. Ct. App. 1992); *Myers v. Schneiderman*, 31 N.Y.S.3d 45, 47 (2016), *aff'd*, 85 N.E.3d 57 (2017); Second Amended Complaint for Declaratory and Injunctive Relief, *Brody v. Harris*, No. CGC-15-544806, 2016 WL 1045794 (Cal. Super. Ct. Feb. 16, 2016), 2015 WL 10520851; Complaint for Declaratory Judgment and Injunctive Relief at 2, *Kligler v. Healey*, No. SUCV201603 254F, 2017 WL 2803074 (Mass. Super. Ct. May 31, 2017) (Civ. Action No. 16-3254F); Wendy Osher, *Circuit Court Dismisses Medical Aid-in-Dying Case*, MAUI NOW (July 16, 2017, 7:47 AM), <http://mauinow.com/2017/07/16/circuit-court-dismisses-medical-aid-in-dying-case> [<https://perma.cc/B7LF-S7EF>].

97. See generally *Baxter v. State*, 224 P.3d 1211 (Mont. 2009).

and defend. Indeed, as the detailed description below suggests, it is difficult to decide whether there has been much actual improvement in Americans' access to aid in dying. This is troubling in light of the 2015 Dying in America Report,⁹⁸ which revealed that Americans do not have consistent access to palliative care or respect for patient autonomy at the end of life, despite significant public support for greater end-of-life choice.⁹⁹

A. Utilization of Federal and State Constitutional Free Speech Rights

To a greater or lesser extent, *all* aid-in-dying nonprofits utilize free speech protection in advocacy and direct client service provision, but nonprofits differ as to grounding their organizational activities *primarily* in this protection. Nonprofits working within the framework of a MAiD statute are protected not so much by state and federal constitutional free speech rights as by the particular MAiD statute in their jurisdiction, which allows a patient who qualifies to lawfully receive a lethal dose prescription from a physician willing to prescribe it. If those organizations chose to help a client who does not qualify under the statute, they would be wholly dependent on free speech protection to provide information sufficient to enable those individuals to end their own lives without assistance, as legally defined under state law. This is a realistic possibility, since MAiD statutes do not cover all individuals similarly situated with regard to suffering irremediably from a terminal medical condition.¹⁰⁰

Final Exit Network is the American nonprofit that most fully utilizes free speech protections to assist qualified individuals to end their lives when experiencing irremediable end-of-life suffering.¹⁰¹ FEN and its volunteers trained as "exit guides" provide information to qualified individuals about how to purchase and autonomously use equipment and supplies so that the individuals themselves can end their lives, without FEN's participation or assistance in their deaths.¹⁰² FEN makes a legally significant distinction:

98. See generally INST. OF MED. OF THE NAT'L ACADS., *supra* note 16.

99. See *id.* at 25.

100. See, e.g., *Frequently Asked Questions*, *supra* note 90.

101. See generally *Who Is the Final Exit Network (FEN)*, *supra* note 63.

102. Final Exit Network medical staff make the determination about whether an individual qualifies to receive information about suicide from an exit guide. See *Exit Guide Information Request*, *supra* note 83. Exit guides are trained not to encourage suicide or to provide any assistance with the physical acts associated with the suicide. See *Who Is the Final Exit Network (FEN)*, *supra* note 63.

exit guides provide information and may *attend* the death but do not *participate* in or physically assist the individual.¹⁰³

FEN and its exit guides base their actions on some of the most powerful laws in the United States: federal and state constitutional freedom of speech laws.¹⁰⁴ Yet, FEN has been accused of operating “outside the law.”¹⁰⁵ In states with medical aid-in-dying statutes, operating outside the law tends to mean outside of the MAiD statute.¹⁰⁶ Even in states without such laws, FEN has been accused of operating outside the law because assisting another to commit suicide is a common criminal prohibition.¹⁰⁷

Whether FEN is actually operating outside the law depends on relevant legal definitions, such as “suicide,” “assisting suicide,” “death/dying,” and “education.” For instance, some argue that the border between the right to provide information and assisting suicide could lie in the legal definition

103. *Exit Guide Information Request*, *supra* note 83 (“Our guides travel to you and educate you on your personal choices. You must, however, be able to competently choose, as well as be able to effect your exit.”).

104. *See* STEFAN, *supra* note 26, at 351–53 (“The prosecutions of FEN members have resulted in making First Amendment law, with defendants successfully challenging criminal prohibitions on ‘intentionally advising and encouraging’ suicide as violative of their free speech rights.”); Majchrowicz, *supra* note 82 (“Exit guides, who tend to travel in pairs, educate their clients about all aspects of their eventual suicides and sit with them as they die. . . . The actual legality of exit guides’ actions varies state to state. . . . Exit guides’ primary defense is their First Amendment right to free speech, said the network’s general counsel, Robert Rivas, because that’s all exit guides do when they sit with a person about to die: They talk.”).

105. *See* Sarah Childress, *The Suicide Plan: The Evolution of America’s Right-to-Die Movement*, PBS (Nov. 13, 2012), <https://www.pbs.org/wgbh/frontline/article/the-evolution-of-americas-right-to-die-movement> [<https://perma.cc/K68R-VTDM>] (providing a timeline and describing arrest and prosecution of FEN members in 2009, 2011, and 2012); Rachel Herzog, *Fran Schindler Volunteers to Sit by the Deathbed of Those Who Ask*, DAILY TAR HEEL (Nov. 30, 2015, 12:17 AM), <http://www.dailytarheel.com/article/2015/11/franschindler-brings-the-gift-of-deathbed-presence-to-those-who-ask> [<https://perma.cc/P7KF-S355>] (“The Final Exit Network’s work exists outside the law’s framework. Assisting a suicide is illegal in many states, but that’s not what the group does”); *Who Should Be Able to Seek Assisted Suicide?*, NPR (Mar. 9, 2009), <https://www.npr.org/templates/transcript/transcript.php?storyId=101622533> [<https://perma.cc/KU5L-QHNA>] (describing FEN’s activities as part of “these networks, obviously, outside the structure of the laws in those two states [Oregon and Washington] that are working to help people if they wish to go this way”). In their Article about VSED as a good option for ending irremediable suffering at the end of life, Thaddeus Pope and Lindsey Anderson did not even mention the FEN approach despite including illegal euthanasia in the list of options. Thaddeus Mason Pope & Lindsey E. Anderson, *Voluntarily Stopping Eating and Drinking: A Legal Treatment Option at the End of Life*, 17 WIDENER L. REV. 363, 375–83 (2011).

106. *See, e.g., Frequently Asked Questions*, *supra* note 90.

107. *See* Majchrowicz, *supra* note 82. Currently forty-four states have laws that make “assisted suicide” illegal; of those forty-four, forty-two have criminal prohibitions. For detailed statutory citations, see generally *supra* note 43.

of “suicide.”¹⁰⁸ The argument is that, if a disease is cutting short an individual’s life, an individual is only hastening a death that is approaching due to identified, specific medical or psychological conditions.¹⁰⁹ The contention is that, if “suicide” means being the causative agent ending the person’s life, the individual stricken with a terminal illness is arguably not the causative agent and is only hastening a death that is already clearly on the horizon.¹¹⁰ It would follow that, if a person is not committing suicide, an assisting person is not assisting suicide and is not, therefore, engaging in a legally prohibited act.

Some aid-in-dying nonprofit organizations vehemently distinguish “hastening death” from “suicide” and “aid in dying” from “assisting another to commit suicide” because it is politically expedient to avoid any importation of the stigma of suicide.¹¹¹ However, distinguishing suicide from hastening death is not persuasive to those who view as dispositive the action of self-administration of life-ending medication as causing the actual physical death. Moreover, the argument has not gained any apparent legal traction.¹¹² For instance, in the California case of *Donaldson v. Van de Kamp*, Mr. Donaldson suffered from an incurable brain tumor that was predicted to result in a persistent vegetative state and death within five years of diagnosis.¹¹³ Mr. Donaldson wished to have his body cryogenically preserved before death, with the expectation of being brought back to life when technology would be sufficient to restore his body and successfully address the brain tumor.¹¹⁴ Mr. Donaldson and his coplaintiff, Dr. Mondragon, sought a declaratory judgment that premortem freezing of Mr. Donaldson’s body would not constitute reason to criminally prosecute Mondragon for homicide

108. See Margaret Pabst Battin, *‘Death with Dignity’: Is It Suicide?*, OUPBLOG (Nov. 7, 2015), <https://blog.oup.com/2015/11/death-with-dignity-suicide> [<https://perma.cc/4AFY-7QQL>] (“[W]hat about the ALS or the cancer patient? . . . [N]either wanted to die—they had been making every effort to avoid dying as they went through the medical treatment available. But now, given that they [are] already dying anyway, what they chose was to avoid the more difficult ways of dying that were clearly in their futures.”); *Terminology of Assisted Dying*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/terminology> [<https://perma.cc/MRV4-TUSQ>] (“Those facing a terminal illness do not want to die but—by definition—are dying. They are facing an imminent death and want the option to avoid unbearable suffering.”).

109. See Battin, *supra* note 108.

110. *Id.*

111. See Cholbi, *supra* note 27, at 6–7.

112. See, e.g., Herzog, *supra* note 105.

113. 4 Cal. Rptr. 2d 59, 60–61 (Cal. Ct. App. 1992).

114. *Id.* at 61.

or assisted suicide.¹¹⁵ Indeed, the argument was that this would preserve life instead of allowing the brain tumor to end Mr. Donaldson's life.¹¹⁶ The Court rejected the plaintiffs' arguments to hold that freezing Mr. Donaldson's body prior to his death would result in death and therefore, that assisting Mr. Donaldson would amount to either homicide or illegal assistance of another to commit suicide.¹¹⁷ Similarly, in 2010 a Connecticut court dismissed a lawsuit in which petitioners sought a declaration that "Conn. Gen. Stat. § 53a-56 does not provide a valid statutory basis to prosecute any licensed physician for providing aid in dying because the choice of a mentally competent terminally ill individual for a peaceful death . . . does not constitute 'suicide' within the meaning of § 53a-56(a)(2)."¹¹⁸

FEN does not question that hastening death in the context of a life-ending illness is suicide. However, it does challenge the idea that providing information about suicide is "assisting" a suicide, even if the information is provided to a person FEN knows to be contemplating suicide or is in the act of committing suicide.¹¹⁹ As discussed in Part II, statutory ambiguity can result in legal challenges regarding the nature of assistance. If a state explicitly or potentially includes speech acts in its prohibition of assisted suicide, the tightrope an organization such as FEN must walk between constitutional free speech provisions and criminal law becomes quite taut. Indeed, the scope of Georgia's assisted suicide criminal provision lay at the heart of Georgia's prosecution of FEN, its medical director, and its exit guides in 2010.¹²⁰

At that time, Georgia's statute provided that any person "who publicly advertises, offers, or holds himself or herself out as offering that he or she will intentionally and actively assist another person in the commission of suicide and commits any overt act to further that purpose is guilty of a felony."¹²¹ The Georgia Supreme Court decided that the law violated constitutional protections of free speech because it "proscribes speech based on content" in the form of advertising or holding oneself out as providing a service and that the statute was not tailored narrowly enough to promote the state's "compelling interest in preventing suicide"¹²² because the statute

115. *Id.* at 60–61.

116. *See id.*

117. *Id.* at 60, 64–65.

118. *Blick v. Office of Div. of Criminal Justice*, No. CV095033392, 2010 WL 2817256, at *5, *15 (Conn. Super. Ct. June 2, 2010).

119. Appellants' Brief at 1, 8, *Final Exit Network, Inc. v. State*, 722 S.E.2d 722 (Ga. 2012) (No. S11A1960), 2011 WL 5289141, at * 8.

120. *Final Exit Network*, 722 S.E.2d at 723.

121. GA. CODE ANN. § 16-5-5(b) (1994) (amended 2012).

122. *Final Exit Network*, 722 S.E.2d at 723–24.

prohibited only those assisted suicides in which there was public speech. The Court stated:

Had the State [of Georgia] truly been interested in the preservation of human life . . . it could have imposed a ban on all assisted suicides with no restriction on protected speech whatsoever. Alternatively, the State could have sought to prohibit all offers to assist in suicide when accompanied by an overt act to accomplish that goal. The State here did neither.¹²³

In 2015, the Georgia Legislature amended Official Code of Georgia Annotated § 16-5-5 to define “assists” as “the act of physically helping or physically providing the means”¹²⁴ by which an individual commits suicide, which means “the intentional and willful termination of one’s own life.”¹²⁵ Due to FEN’s raising the defense of free speech, Georgia’s law now has a particularly clear definition of “assisting” suicide compared to other states. It serves as an example of an aid-in-dying nonprofit’s influence on developing laws that allow for individuals to assist some seekers of aid in dying.

FEN confronted the same type of challenge in 2015 when it was prosecuted by the state of Minnesota for violating the criminal prohibition on “assisting suicide.”¹²⁶ In the 2014 case of *State v. Melchert-Dinkel*,¹²⁷ in which a nurse allegedly urged individuals to commit suicide so that he could watch, Minnesota decided that the state can prohibit assisting suicide that includes providing specific information to specific individuals with knowledge that the receiver of that information intends to use it specifically to end his or her life.¹²⁸ In 2015, on the basis of the *Melchert-Dinkel* definition of assisting suicide included in the jury instructions, the state of Minnesota successfully prosecuted FEN for assisting in suicide when its exit guides

123. *Id.* at 724.

124. GA. CODE ANN. § 16-5-5(a)(1) (Supp. 2018).

125. *Id.* § 16-5-5(a)(3).

126. *State v. Final Exit Network, Inc.*, 889 N.W.2d 296, 302 (Minn. Ct. App. 2016), *cert denied*, 138 S. Ct. 145 (2017) (mem.).

127. *State v. Melchert-Dinkel*, 844 N.W.2d 13, 24 (Minn. 2014).

128. *Id.* at 16; *see* MINN. STAT. § 609.215, subdiv. 1 (2018). After rejecting the state’s arguments that its statute prohibiting speech to cause another to commit suicide falls into one or all of the three exceptions—integral to criminal conduct, inciting criminal conduct, and fraud—the Minnesota Supreme Court upheld Minnesota’s law under a strict scrutiny analysis. *Melchert-Dinkel*, 844 N.W.2d at 17–18. The Court found that the state has a compelling interest in preserving human life and that the statute is narrowly drawn to protect that interest. *Id.* at 22. The Court pointed to the statutory term “another” to conclude that the statute was narrowly written to include only situations in which speech is directed to a specific person for the specific purpose of encouraging suicide and therefore does not include speech reflecting a general viewpoint on committing suicide. *Id.* at 16, 18.

provided information, knowing that the information would be used by the listener to commit suicide.¹²⁹

The Minnesota Court of Appeals upheld the conviction, and both the Minnesota Supreme Court and the U.S. Supreme Court denied review.¹³⁰ In order to protect its ability to help people with documented, prolonged suffering who are cognitively and emotionally competent to make the decision to end their lives, on April 16, 2018, FEN filed suit against the Attorney General of Minnesota seeking declaratory and injunctive relief to prevent application of the *Melchert-Dinkel* definition of assisting suicide when enforcing the criminal prohibition on assisting suicide.¹³¹ On February 22, 2019, the Minnesota District Court granted the defendants' motion to dismiss,¹³² leaving in place the risk of prosecution if FEN provides information to people FEN knows to be contemplating ending their lives, regardless of reasons.

In the Georgia and Minnesota prosecutions, as well as the subsequent Minnesota litigation, FEN focused heavily on the definition of free speech, which includes educating individuals about their options *and* providing companionship at the time of death for qualified individuals seeking to end their lives as a response to irremediable end-of-life suffering.¹³³ FEN consistently denies that it engages in physical acts to further a suicide, and its exit guides are trained to avoid violations of physical act prohibitions while attending a death.¹³⁴ The role this organization plays is to secure legal clarity about what constitutes assistance, as it did in Georgia, so that individuals wanting to end their lives to end prolonged end-of-life suffering can receive information and, if desired, companionship at the time of death.¹³⁵ FEN might have a long litigation path ahead considering legal hostility to assisting

129. *Final Exit Network, Inc.*, 889 N.W.2d at 301–02.

130. *Final Exit Network, Inc. v. Minnesota*, 138 S. Ct. 145 (2017) (mem.); *Final Exit Network, Inc.*, 889 N.W.2d at 301–02 (“After deciding *Melchert-Dinkel*, the Minnesota Supreme Court denied further review of *State v. Final Exit Network, Inc.*”); *State v. Final Exit Network, Inc.*, No. A13-0563, 2013 WL 5418170 (Minn. Ct. App. Sept. 30, 2013), *appeal after remand*, 889 N.W.2d 296 (Minn. Ct. App. 2016), *cert. denied*, 138 S. Ct. 145 (2017).

131. Complaint for Declaratory & Injunctive Relief at 1–2, *Final Exit Network, Inc. v. Ellison*, 370 F. Supp. 3d 995 (D. Minn. 2019) (No. 18-CV-01025), 2018 WL 1858565; *see also* Second Amended Complaint at 1–2, *Final Exit Network*, 370 F. Supp. 3d 995 (No. 0:18-cv-01-25-JNE/SER), 2018 WL 7047316.

132. *Final Exit Network*, 370 F. Supp. 3d at 1020. The Minnesota district court granted the defendants' motion to dismiss, holding that FEN's facial challenge claims were barred by collateral estoppel. *Id.* at 1019–20.

133. *Id.* at 1007, 1010; *Final Exit Network, Inc. v. State*, 722 S.E.2d 722, 724 (Ga. 2012).

134. *Who Is the Final Exit Network (FEN)*, *supra* note 63 (“We do not provide the means for self-deliverance and we do not assist in self-deliverance.”).

135. *Id.* (containing language from FEN's website sections pertaining to mission and exit guide services).

another to die and the apparent room in many state statutes for interpretations that could include speech acts as prohibited assistance or participation.¹³⁶ If FEN did not attend deaths, it might be easier to persuade factfinders that there was clear separation between providing information and participation. However, companionship is a compassionate response to someone taking such a momentous step, and providing information at the time of death can be critical to a successful outcome for the seeker.

B. State Medical Aid-in-Dying Statutes

Several aid-in-dying organizations work for the passage of MAiD statutes. MAiD statutes carve out an exception to criminal and civil prohibitions against assisted suicide to enable physicians to lawfully prescribe lethal doses of medication and for pharmacists to lawfully fill those prescriptions, knowing that the patient is going to die if the dose is ingested.¹³⁷ It is difficult to overstate how radical this is under current medical practice and law. Medical practice is oriented toward saving lives,¹³⁸ and the law prohibits

136. For examples of the state statutes that lack clarity to varying degrees about whether speech acts alone could lead to prosecution, see ALA. CODE § 22-8B-4 (2019) (effective Aug. 1, 2017); ALASKA STAT. § 11.41.120 (2019) (effective June 3, 2006); ARK. CODE ANN. §§ 5-10-104, -106 (2019) (effective July 31, 2007); CAL. PENAL CODE § 401 (Deering 2019) (effective Jan. 1, 2019); CONN. GEN. STAT. § 53a-56 (2019) (effective Oct. 1, 1971); FLA. STAT. § 782.08 (2019); HAW. REV. STAT. § 707-702 (2019) (effective June 26, 2019); ME. STAT. tit. 17-A, § 204 (2019) (effective Sept. 19, 2019); MICH. COMP. LAWS § 750.329a (2019) (effective Sept. 1, 1998) (common law assisted suicide); MICH. COMP. LAWS § 752.1027 (effective Feb. 25, 1993) (criminal assistance to suicide); MINN. STAT. § 609.215 (1998) (effective Aug. 1, 1999) (the words severed “advising or encouraging” suicide were held unconstitutional by *State v. Melchert-Dinkel*, 844 N.W.2d 13 (Minn. 2014)); MISS. CODE ANN. § 97-3-49 (2019); MO. REV. STAT. § 565.023 (2019) (effective Jan. 1, 2017); MONT. CODE ANN. § 45-5-105 (2019); NEB. REV. STAT. § 28-307 (2019); N.H. REV. STAT. ANN. § 630:4 (2018) (effective Nov. 1, 1973); N.J. STAT. ANN. § 2C:11-6 (West 2019) (effective Aug. 1, 2019); N.M. STAT. ANN. § 30-2-4 (LexisNexis 2019); N.Y. PENAL LAW § 120.30 (McKinney 2019) (effective Sept. 1, 1967) (promoting a suicide attempt); N.Y. PENAL LAW § 125.15 (McKinney 2019) (effective Sept. 1, 1967) (second-degree manslaughter); N.D. CENT. CODE § 12.1-16-04 (2019); OR. REV. STAT. § 163.125 (2017) (second degree manslaughter); OR. REV. STAT. § 163.193 (2019) (assisting suicide and exemptions); 18 PA. CONS. STAT. § 2505 (West 2019) (effective June 6, 1973); S.D. CODIFIED LAWS § 22-16-37 (2019); TEX. PENAL CODE ANN. § 22.08 (West 2019) (effective Sept. 1, 1994); UTAH CODE ANN. § 76-5-205 (LexisNexis 2019) (effective May 5, 2018); VA. CODE ANN. § 8.01-622.1 (2019) (effective July 1, 2015); WASH. REV. CODE § 9A.36.060 (2019) (effective July 22, 2011); WIS. STAT. § 940.12 (2019).

137. See ZITTER, *supra* note 16, at 307.

138. *Id.* at 16.

assisting someone to commit suicide. Nonprofit organizations focused on legal passage of aid-in-dying statutes emphasize that self-administration of life-ending medication is not suicide if undertaken in compliance with the statute, by legal definition of the statute.¹³⁹

Advocacy for MAiD statutes at the state level began with the failure of three terminally ill patients and an aid-in-dying nonprofit, Compassion in Dying, to convince the U.S. Supreme Court that access to aid in dying should be protected as a liberty interest under the Due Process Clause of the Fourteenth Amendment to the U.S. Constitution.¹⁴⁰ In its 1997 *Washington v. Glucksberg* decision, the Supreme Court echoed some of the concerns of the California appellate court in its 1992 decision of *Donaldson v. Van de Kamp*: the state may be legitimately concerned about the potential for abuse of a vulnerable person for self-interest when one helps another to die, about “the sanctity of life [being] threatened by one who is willing to participate in taking the life of another, even at the victim’s request,” and about the unfairness of finding culpable a person whose suicide was a manifestation of psychiatric illness, while, on the other hand, finding it fair to deem a presumably mentally competent person culpable for assisting another to commit suicide.¹⁴¹ The Supreme Court included additional justifications for its decision, such as preventing a possibly negative impact on the integrity of the medical profession and a slippery slope toward active euthanasia.¹⁴²

The key to state level advocacy is that, while the Court found no federal constitutional right to medical aid-in-dying, it did not foreclose states from enacting MAiD statutes. The Court stated, “[t]hroughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society.”¹⁴³

That debate has indeed continued. The result is a tumultuous period of various states considering MAiD and anti-MAiD statutes. In the twenty years since MAiD advocacy began, only nine jurisdictions have adopted these statutes¹⁴⁴ because opposition is strong, also. The following states

139. See generally Cholbi, *supra* note 27.

140. *Washington v. Glucksberg*, 521 U.S. 702, 705–08 (1997).

141. *Donaldson v. Van de Kamp*, 4 Cal. Rptr. 2d 59, 65 (Cal. Ct. App. 1992); see also *Glucksberg*, 521 U.S. at 729–32.

142. *Glucksberg*, 521 U.S. at 703–04.

143. *Id.* at 735.

144. See Michael Ollove, *Aid-in-Dying Gains Momentum as Erstwhile Opponents Change Their Minds*, PEW TRUSTS (Mar. 9, 2018), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/03/09/aid-in-dying-gains-momentum-as-erstwhile-opponents-change-their-minds> [https://perma.cc/PN8B-Z95K] (“Support for aid-in-dying is increasing—a recent Gallup poll found two-thirds in favor, up from half four years earlier. Major medical groups have dropped or softened their opposition.”). The nine jurisdictions are California, Colorado, District of Columbia, Hawai’i, Maine, New Jersey, Oregon, Vermont,

considered but did not enact MAiD statutes: Alaska, Arizona, Connecticut, Delaware, Indiana, Iowa, Kansas, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, New Hampshire, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Utah, and Wisconsin.¹⁴⁵ Sometimes MAiD statutes are proposed repeatedly; California, New Jersey, and Maine are but three examples of states that previously considered and rejected MAiD statutes before eventually enacting them.¹⁴⁶

Opposition to MAiD laws has taken the form of explicit criminal bans on medical aid in dying.¹⁴⁷ This is striking because the law in the vast

and Washington, with the most recent being Maine, which signed into law June 12, 2019, and will take effect ninety days after adjournment of the legislature, and New Jersey, effective August 1, 2019. However, both the Maine and New Jersey laws are currently under attack. *See Maine*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/states/maine/> [<https://perma.cc/4LJT-2YWE>]; *New Jersey*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/states/new-jersey/> [<https://perma.cc/4TMX-JKUE>]. For the statutes in the nine jurisdictions, see End of Life Option Act, CAL. HEALTH & SAFETY CODE §§ 443–.22 (West 2019); End-of-Life Options Act, COLO. REV. STAT. §§ 25-48-101 to -123 (2018); Death with Dignity Act, D.C. CODE §§ 7-661.01 to -.16 (2017); Our Care, Our Choice Act, HAW. REV. STAT. §§ 327L-1 to -25 (LexisNexis 2019); Death with Dignity Act, ME. STAT. tit. 22, § 2140 (2019); Medical Aid in Dying for the Terminally Ill Act, N.J. STAT. ANN. §§ 26:16-1 to -20 (West 2019); Oregon Death with Dignity Act, OR. REV. STAT. §§ 127.800–.897 (2018); Patient Choice at End of Life, VT. STAT. ANN. tit. 18, §§ 5281–93 (2019); Washington Death with Dignity Act, WASH. REV. CODE §§ 70.245.010–.904 (2019).

145. KATE McEVOY, 20 CONNECTICUT PRACTICE SERIES: CONNECTICUT ELDER LAW § 3:25 (2018).

146. California considered passage of MAiD law by ballot proposition in 1992, but it failed. *Death with Dignity in California: A History*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/death-with-dignity-california-history> [<https://perma.cc/TB3P-W5ZQ>]. In 1997, a “death with dignity” bill made it out of California Assembly committees but was not brought for a vote by the full Assembly. *Id.* In 2005, another bill, the California Compassionate Choices Act, failed. *Id.* The California End of Life Options Act was passed by the California Legislature and signed into law by then-Governor Jerry Brown on October 5, 2015. *Id.* In New Jersey, MAiD bills were introduced to the New Jersey legislature in the 2012–2013, 2014–2015, and 2016–2017 sessions, but all failed. *New Jersey*, *supra* note 144. The Aid in Dying for the Terminally Ill Act was introduced on January 9, 2018, in the New Jersey Assembly, and its companion bill was introduced in the New Jersey Senate on January 22, 2018. *Id.* A consolidated form of the bills passed in both houses on March 25, 2019, and was signed into law on April 12, 2019, by Governor Phil Murphy. *Id.* In Maine, Death with Dignity National Center reports that in the 2019–2020 session, in which the law was enacted, was the third time the legislature had considered a MAiD law. *Maine Death with Dignity Act Goes Into Effect*, DEATH WITH DIGNITY (Sept. 19, 2019), <https://www.deathwithdignity.org/news/2019/09/maine-death-with-dignity-act-in-effect/> [<https://perma.cc/7WAJ-9238>].

147. *See, e.g.*, ALA. CODE § 22-8B-4 (2019) (part of the 2017 “Assisted Suicide Ban Act,” criminalizing both assistance by individuals and by physicians or health care providers;

majority of states already prohibits assisting another to commit suicide, which would seem to cover physicians assisting patients to end their lives. Nevertheless, five jurisdictions have strengthened their prohibitions on assisting suicide by enacting explicit anti-MAiD statutes; three of these jurisdictions have done so since 2017.¹⁴⁸ For instance, in 2018, Utah criminalized “intentionally, and with knowledge that another individual intends to commit suicide or attempt to commit suicide, aid[ing] the other individual to commit suicide”¹⁴⁹ and excludes “practitioners”—professional medical care providers—only if the practitioner “provides medication or a procedure to treat an individual’s illness or relieve an individual’s pain or discomfort . . . unless the practitioner intentionally and knowingly provides the medication or procedure to aid the individual to commit suicide or attempt to commit suicide.”¹⁵⁰

As in the case of MAiD statutes, states may consider anti-MAiD statutes repeatedly. For instance, Montana’s legislature considered a MAiD ban in 2011 and again in 2019.¹⁵¹ Accordingly, aid-in-dying nonprofits must be as actively engaged in defeating anti-MAiD proposals as in advocating for enacting MAiD statutes. Compassion & Choices strongly opposed Montana’s 2019 anti-MAiD proposal and continues to monitor the legal situation there.¹⁵²

Opposition to medical aid in dying is reflected not only in external threats, such as anti-MAiD proposals and federal and state proposals that weaken MAiD laws, it is reflected also in the MAiD statutes themselves. All MAiD statutes include multiple requirements that significantly limit patient utilization of the laws.¹⁵³ They all contain similar qualification and procedural requirements because the first such law, which was enacted in

for physicians and health care providers, specifically bans “prescrib[ing] any drug compound, or substance to a patient deliberately to aid in dying or assist[ing] or perform[ing] any medical procedure deliberately to aid in dying”); OHIO REV. CODE ANN. § 3795.04 (Westlaw 2019) (making “assisting suicide” a felony); UTAH CODE ANN. § 76-5-205 (LexisNexis 2019) (providing the manslaughter statute amended to criminalize assisted suicide).

148. See UTAH CODE ANN. § 76-5-205(2)(b).

149. *Id.*

150. *Id.* §76-5-205(5) (emphasis added).

151. H.B. 284, 66th Leg., Reg. Sess. (Mont. 2019); Jacob Fuhrer, *Bill Aims to Ban Physician-Assisted Suicide in Montana*, KPAX (Jan. 29, 2019, 3:18 PM), <https://kpax.com/news/montana-legislature/2019/01/29/bill-aims-to-ban-physician-assisted-suicide-in-montana> [<https://perma.cc/6ELP-XX4J>]. The proposed law provides that a patient’s consent to receive a lethal dose prescription does not protect a physician from liability for providing that prescription. Fuhrer, *supra*. An attempt to pass a physician-assisted suicide ban in 2017 failed. *Id.*

152. *Montana*, COMPASSION & CHOICES, <https://compassionandchoices.org/in-your-state/montana> [<https://perma.cc/TKQ2-BAAX>].

153. See *Death with Dignity Acts*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/learn/death-with-dignity-acts/> [<https://perma.cc/YUG6-99FG>].

Oregon in 1994, has served as the basis for subsequently enacted laws.¹⁵⁴ All require the following: the seeker must be within six months of death,¹⁵⁵ cognitively competent to understand the import of taking life-ending medication,¹⁵⁶ submit to additional medical examinations if a physician believes that transient emotional states might be driving the decision,¹⁵⁷

154. OR. REV. STAT. §§ 127.800–.897 (2018); STEFAN, *supra* note 26, at 130 (“Oregon’s law is the oldest in the country. It was passed in 1994 but was not implemented until 1997. Most state initiatives since then have been patterned on Oregon’s law as a model.”); Pamela S. Kaufmann, *Aid-in-Dying Laws Present New Challenges for Health Care Providers*, A.B.A HEALTH ESOURCE (Sept. 27, 2018), https://www.americanbar.org/groups/health_law/publications/aba_health_esource/2016-2017/august2017/aidinying [<https://perma.cc/YNT9-P2MC>] (“The state AID statutes are modeled after the Oregon statute, the first state AID law.”).

155. See Browne C. Lewis, *A Graceful Exit: Redefining Terminal to Expand the Availability of Physician-Facilitated Suicide*, 91 OR. L. REV. 457, 484 (2012) (“The current system in place fails to serve the needs of two categories of patients. Some patients . . . who suffer from diseases that destroy the physical body, are not considered terminal because their doctors predict that they will survive longer than six months. . . . Another group of patients . . . suffer from progressive, irreversible brain disorders that gradually destroy their memories and their abilities to learn, reason, and make decisions. Those patients can physically survive their conditions for an indeterminate period of time.”); see also Cyndi Bollman, *A Dignified Death? Don’t Forget About the Physically Disabled and Those Not Terminally Ill: An Analysis of Physician-Assisted Suicide Laws*, 34 S. ILL. U. L.J. 395, 396 (2010) (“The current physician-assisted suicide statutes in Oregon and Washington do not permit a physically disabled person to be assisted by her doctors in committing suicide because she is unable to ingest the medications on her own. Further, the laws are limited to only those patients who are terminally ill, despite the fact that many patients suffer from long-lasting painful diseases which progressively become more unbearable, disqualifying them from being permitted to die with the assistance of their physician.”).

156. *Frequently Asked Questions*, *supra* note 90.

157. E.g., CAL. HEALTH & SAFETY CODE § 443.5(a)(1)(A)(ii) (West 2019) (“If there are indications of a mental disorder, the physician shall refer the individual for a mental health specialist assessment”); COLO. REV. STAT. § 25-48-108 (2019) (requiring referral to a licensed mental health professional if the attending or consulting physician believes that the individual may not be “mentally capable and making an informed decision”); D.C. CODE § 7-661.04 (2019) (“If, in the opinion of the attending physician or the consulting physician, a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer patient to counseling.”); HAW. REV. STAT. § 327L-6 (2019) (“The attending provider shall refer the patient for counseling.”); OR. REV. STAT. ANN. § 127.825 (“If in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient for counseling.”); VT. STAT. ANN. tit. 18, § 5283(8) (2019) (physician provided with immunity as long as they document specific required actions, including: “The physician either verified that the patient did not have impaired judgment or referred the patient for an evaluation by a psychiatrist, psychologist, or clinical social worker . . . for confirmation that the patient was capable and

make repeated requests,¹⁵⁸ endure waiting periods between requests, and be able to self-administer the life-ending medication.¹⁵⁹

These requirements create true hardship and disparate treatment among patients with indistinguishable degrees and types of end-of-life suffering. For instance, unlike a seeker whose illness does not destroy the seeker's cognitive capacity prior to a prognosis of death within six months, some seekers have illnesses, such as Alzheimer's, that rob them of cognitive capacity prior to that prognosis.¹⁶⁰ Simply because they have a different underlying illness—not because their suffering is less, those seekers have less access to medical aid in dying. Aid-in-dying nonprofits know that this is unfair, and some imagine that a successful constitutional Equal Protection challenge could be brought.¹⁶¹ However, advocates may be loath to challenge it if the six-month prognosis is understood as protective of both seeker and physician and also as necessary for passage of the law. It ensures that seekers are truly dying before physicians assist them in ending their lives. It protects physicians in that such a prognosis qualifies a person for hospice,¹⁶² which becomes an independent measure of qualification, besides the seeker's physician's certification, that a patient is suffering irremediably from a terminal condition.

The requirement of ability to self-administer medication also creates disparities among seekers. Seekers diagnosed with Parkinson's or ALS might not be able to self-administer life-ending medication when they eventually enter the last six months of their lives due to decreasing ability to swallow or to bring food, water, or medications to their mouths unassisted

did not have impaired judgment.”); WASH. REV. CODE § 70.245.060 (2019) (language virtually identical to Oregon's statute).

158. CAL. HEALTH & SAFETY CODE § 443.3 (West 2019) (requiring two oral requests, at least fifteen days apart, plus a written request); COLO. REV. STAT. § 25-48-104 (2019) (same); D.C. CODE § 7-661.02 (2019) (requiring two oral requests, at least fifteen days apart, plus written request before second oral request, at least forty-eight hours before medication is prescribed or dispensed); HAW. REV. STAT. § 327L-9 (2019) (requiring two oral requests at least twenty days apart, plus a written request); OR. REV. STAT. § 127.840 (2018) (requiring two oral requests at least fifteen days apart, plus written request); VT. STAT. ANN. tit. 18, § 5283 (2019) (same); WASH. REV. CODE ANN. § 70.245.090 (2019) (same).

159. See Bollman, *supra* note 155, at 396.

160. Norman L. Cantor, *My Plan to Avoid the Ravages of Extreme Dementia*, BILL HEALTH (Apr. 16, 2015), <http://blog.petrieflom.law.harvard.edu/2015/04/16/my-plan-to-avoid-the-ravages-of-extreme-dementia> [<https://perma.cc/HTW7-V8V4>]; *Cognitive Function, Dementia, and Alzheimer's Disease*, U.S. DEP'T HEALTH & HUM. SERVICES (Feb. 12, 2019), <https://nccih.nih.gov/health/alzheimer> [<https://perma.cc/M9ZS-N2M9>].

161. Telephone Interview with Robb Miller, former Exec. Dir. & Bd. Member, End of Life Wash. (Jan. 25, 2019).

162. See, e.g., *Hospice Care*, U.S. CENTERS FOR MEDICARE & MEDICAID SERVICES, <https://www.medicare.gov/coverage/hospice-care> [<https://perma.cc/3J24-QZS8>] (requiring a terminally ill diagnosis with life expectancy less than six months and patient electing for palliative care).

by another.¹⁶³ Such individuals would not be able to use aid-in-dying statutory law no matter how cognitively competent they might be, unless they can self-administer the life-ending medication.¹⁶⁴ Aid-in-dying nonprofits conceded to this requirement because self-administration is key to separating the physician and other medical care providers from the patient's death, avoiding claims that a patient was assisted or that someone provided "euthanasia."¹⁶⁵ Those nonprofits know that an Americans with Disabilities Act challenge could be brought to require accommodation for those who cannot orally self-administer life-ending medication.¹⁶⁶ Yet, the belief is strong that this requirement enabled enactment of existing laws and facilitates passage of new laws.¹⁶⁷ The self-administration requirement enables healthcare providers, family members, and friends to avoid any direct involvement in an individual's death.

Aid-in-dying nonprofits participated in the development of MAiD statutes that include a number of other requirements designed ostensibly to ensure a seeker's autonomous, stable decision and to reduce the possibility of undue influence from others. Cast as protections for people who may be inadequately informed or who could be unduly influenced or coerced, requirements, such as waiting periods, repeated requests, and limitations on who can serve as a witness to such requests, create barriers to utilization of the law quickly enough to ease the suffering of seekers slow to realize that their suffering cannot be alleviated and will not end before death. Nevertheless, aid-in-dying nonprofits agreed to all of these requirements, believing them to be necessary for passage of the very first MAiD statute and all MAiD statutes thereafter.¹⁶⁸

Aid-in-dying nonprofits using a MAiD approach are surely also aware that laws they sponsor and defend exacerbate physician reluctance to

163. Lewis, *supra* note 155, at 485; *Symptoms and Diagnosis*, ALS ASS'N, <http://www.alsa.org/about-als/symptoms.html> [<https://perma.cc/J7PV-FHTJ>]; see also *Speech & Swallowing Problems*, PARKINSON'S FOUND., <https://www.parkinson.org/Understanding-Parkinsons/Symptoms/Non-Movement-Symptoms/Speech-and-Swallowing-Problems> [<https://perma.cc/LM9K-94BK>]; *Tremor*, PARKINSON'S FOUND., <https://www.parkinson.org/Understanding-Parkinsons/Symptoms/Movement-Symptoms/Tremor> [<https://perma.cc/WZ4M-FGL4>].

164. See Bollman, *supra* note 155, at 396; Lewis, *supra* note 155, at 485.

165. Amanda M. Thyden, *Death with Dignity and Assistance: A Critique of the Self-Administration Requirement in California's End of Life Option Act*, 20 CHAP. L. REV. 421, 422 (2017).

166. Telephone Interview with Robb Miller, *supra* note 161.

167. *Id.*

168. *Id.*; see also *Frequently Asked Questions*, *supra* note 90.

assist a seeker. There are extralegal factors, such as physicians' discomfort with helping patients to die, in apparent conflict with the requirement of helping patients to get better,¹⁶⁹ and legal factors, such as physicians' difficulties in gaining knowledge of the extensive rules these statutes contain, which can lead to liability exposure if not followed. Physicians have also expressed lack of confidence in their ability to adequately assess patient mental health in accordance with statutory requirements, uncertainty about the efficacy of medications they would prescribe, and impatience with extensive paperwork requirements.¹⁷⁰ MAiD statutes also have employer opt-out provisions, which enable an employer to prevent an otherwise willing physician from writing a lethal dose prescription.¹⁷¹

169. See STEFAN, *supra* note 26, at 222 (“Many doctors are uncomfortable with an official, state-sanctioned program that formally links doctors with providing the means of ending life to their patients, even while they concede that there may be a place for unofficial mercy.”); Linda Ganzini et al., *Oregon Physicians’ Attitudes About and Experiences with End-Of-Life Care Since Passage of the Oregon Death with Dignity Act*, 285 JAMA 2363, 2366 (2001) (“Thirty percent of all physician respondents agreed with a statement that writing a lethal prescription for a patient under the Death with Dignity Act was immoral and/or unethical, 59% disagreed, and 11% neither disagreed nor agreed.”); Lawrence O. Gostin & Anna E. Roberts, *Physician-Assisted Dying: A Turning Point?*, 315 JAMA 249, 249 (2016) (“Whether PAD [physician-assisted dying] is incompatible with the physician’s oath to ‘do no harm’ is hotly contested.”); JoNel Aleccia, *Legalizing Aid in Dying Doesn’t Mean Patients Have Access to It*, NPR (Jan. 25, 2017, 5:00 AM), <https://www.npr.org/sections/health-shots/2017/01/25/511456109/legalizing-aid-in-dying-doesnt-mean-patients-have-access-to-it> [<https://perma.cc/EH2C-PYWD>] (“Many doctors in California remain reluctant to participate because of misunderstandings about what the law requires, says Dr. Jay W. Lee, past president of the California Academy of Family Physicians. ‘I believe that there is still a strong taboo against talking about death openly in the medical community. It feels like a threat to what we are trained to do: preserve and extend life,’ Lee says . . .”). For statements by individual doctors, see, for example, ATUL GAWANDE, *BEING MORTAL: MEDICINE AND WHAT MATTERS IN THE END* 244–45 (2014) (“I fear what happens when we expand the terrain of medical practice to include actively assisting people with speeding their death. I am less worried about abuse of these powers than I am about dependence on them.”); Ira Byock, Opinion, *Think Twice About ‘Death with Dignity,’* L.A. TIMES, Feb. 1, 2015, at A19 (“I believe that deliberately ending the lives of ill people represents a socially erosive response to basic human needs.”).

170. See, e.g., Arthi Kumaravel, *Physician Aid-in-Dying: Practical Considerations*, 13 AM J. PSYCHIATRY, Aug. 2018, at 3, 4 (“As the practice of physician aid-in-dying is legalized further in the United States and gains momentum globally, multiple practical concerns arise, particularly regarding implementation among patients with impaired cognition or psychiatric disorders and clarification of the role of psychiatrists.”); David R. Grube, *Ten Facts About Medical Aid in Dying*, MD MAG. (Aug. 28, 2018), <https://www.mdmag.com/medical-news/ten-facts-about-medical-aid-in-dying> [<https://perma.cc/4P5X-3HER>] (“Many dying patients in Oregon are unable to utilize the Death with Dignity Act because they die before the entire process can be completed and doctors can be reluctant to practice because of the paperwork.”).

171. See, e.g., End of Life Option Act, CAL. HEALTH & SAFETY CODE § 443.15 (West 2019) (“[A] health care provider may prohibit its employees, independent contractors, or other persons or entities, including other health care providers, from participating in activities

Due to restrictions on patient access and hindrances to physician participation, aid-in-dying options have less utility and are, in fact, not used very often.¹⁷² Perhaps one could claim that existing MAiD laws are just starting points and that, once accepted, they will serve as the platform for more compassionate laws that cover more situations and people, with fewer impediments to physician participation. Yet, there is no evidence of that; so far, the laws are far from evolving to secure greater access to medical aid in dying.

under this part while on premises owned or under the management or direct control of that prohibiting health care provider or while acting within the course and scope of any employment by, or contract with, the prohibiting health care provider.”). For an example of how this plays out in practice, see, for example, Aleccia, *supra* note 169 (discussing situation of Annette Schiller, who was seeking assistance under California’s medical aid-in-dying law: “In California’s Coachella Valley, where Annette Schiller lived, the three largest hospitals . . . all opted out of the new state law. Affiliated doctors can’t use hospital premises, resources or systems in connection with aid in dying, hospital officials said. . . . In practice, however, that decision has had a chilling effect, says Dr. Howard Cohen, a Palm Springs hospice doctor whose firm also prohibits him from writing aid-in-dying prescriptions or serving as an attending physician.”); Lindsey Holden, *When SLO Woman Could No Longer Fight for Her Life, She Chose to Fight for Her Death*, TRIBUNE, <https://www.sanluisobispo.com/news/health-and-medicine/article218638260.html> [https://perma.cc/AD8N-DGFF] (last updated Oct. 5, 2018, 7:47 AM) (Part 1); Lindsey Holden, *Assisted Death Came Peacefully for SLO Woman. But She Faced a Painful Fight to Fulfill Her Wish*, TRIBUNE, <https://www.sanluisobispo.com/news/health-and-medicine/article218699615.html> [https://perma.cc/VH69-DUNM] (last updated Oct. 4, 2018, 1:33 PM) (Part 2, describing the story of San Luis Obispo, California, resident and terminal cancer patient Christine Whaley, who could not find a doctor in San Luis Obispo to prescribe end-of-life medication, and ended up seeking assistance from UCLA where she had been receiving some treatment.); Tara Law, *Colorado Doctor Fired After Suing to Provide Patient with Aid-in-Dying Medication*, TIME (Sept. 3, 2019), <https://time.com/5666225/colorado-doctor-fired-aid-in-dying-medication> [https://perma.cc/7VQ9-3MVV] (discussing the response of Centura Health, a Catholic and Adventist faith-based medical care network, to an employee physician’s suit to allow her to prescribe lethal dose prescriptions in accordance with Colorado’s Access to Medical Aid in Dying Law, despite the network’s using the “opt-out” provision in the law).

172. See Paula Span, *Physician Aid in Dying Gains Acceptance in the U.S.*, N.Y. TIMES (Jan. 16, 2017), <https://www.nytimes.com/2017/01/16/health/physician-aid-in-dying.html> [https://perma.cc/F7UL-FMPF] (“Aid in dying . . . may be a vehemently debated issue . . . but it ultimately has affected a tiny proportion of people. . . . [A]fter nearly 20 years in Oregon and eight in Washington, far fewer than 1 percent of annual deaths involve a lethal prescription.”); see also Fenit Nirappil, *A Year After D.C. Passed Its Controversial Assisted Suicide Law, Not a Single Patient Has Used It*, WASH. POST (Apr. 10, 2018), https://www.washingtonpost.com/local/dc-politics/a-year-after-dc-passed-its-assisted-suicide-law-only-two-doctors-have-signed-up/2018/04/10/823cf7e2-39ca-11e8-9c0a-85d477d9a226_story.html?utm_term=.e4ee9f3092dd [https://perma.cc/U6SW-4DDW].

In fact, as each new state considers adoption of a MAiD statute, more requirements are included than in previously enacted state laws. For instance, California’s law requires more certification of qualification and more paperwork than previously enacted statutes in other states.¹⁷³ Aid-in-dying advocates were not completely disappointed when Maryland’s 2019 proposed MAiD bill was not enacted because bill amendments “imposed so many roadblocks that few, if any, physicians or patients would likely opt to take advantage of the bill even if it became law.”¹⁷⁴ Indeed, this is one reason organizations such as Compassion & Choices and End of Life Liberty Project would develop the alternative approach of pursuing litigation, including declaratory judgments with the core claim that physicians providing lethal dose prescriptions are not assisting a suicide and are, instead, practicing medicine with appropriate and lawful regard for the needs and choices of their patients.

C. Judicial Opinions as a Basis for Protecting Patients’ Rights of Access to Aid in Dying

Compassion & Choices and End of Life Liberty Project support use of a third basic legal approach to aiding qualified people who choose to end their lives: judicial opinions that protect patients’ rights to aid in dying as a matter of patients’ reasonable expectations of medical treatment options provided by their physicians.¹⁷⁵ In 2014, it seemed that this approach could gain traction when a New Mexico district court judge held that New Mexico residents have a constitutional right to receive physician assistance

173. See End of Life Option Act, CAL. HEALTH & SAFETY CODE § 443 (West 2019); CAL. HEALTH & SAFETY CODE § 443.8 (West 2019) (providing the items to be in individual’s medical record, including all oral and written requests; attending and consulting physicians’ diagnoses, prognoses, and specific determinations; report of mental health specialist’s assessment, if performed; attending physician’s offer to withdraw or rescind request at time of second oral request; attending physician’s note documents fulfillment of extensive requirements under other sections, plus notation of the aid-in-dying drug prescribed); CAL. HEALTH & SAFETY CODE § 443.9 (West 2019) (requiring submission of qualifying patient’s document to State Department of Public Health and submission of multiple documents by the attending physician at specified times); CAL. HEALTH & SAFETY CODE § 443.22 (West 2019) (attending physician checklist and compliance form, consulting physician compliance form, and attending physician follow-up form; updating of forms, including sample form that may be updated by the Medical Board of California).

174. Ovetta Wiggins, *No Aid-in-Dying in Maryland this Year: Bill Fails With Tie Vote in Senate*, WASH. POST (Mar. 27, 2019), https://www.washingtonpost.com/local/md-politics/2019/03/27/2d128d82-4ffd-11e9-88a1-ed346f0ec94f_story.html?noredirect=on&utm_term=.b760528bca1e [<https://perma.cc/U5ZJ-GDX8>].

175. Kathryn L. Tucker, *Aid-in-Dying Is Health Care*, JURIST (June 10, 2018, 11:41 AM), <https://www.jurist.org/commentary/2018/06/kathryn-tucker-aid-dying> [<https://perma.cc/3XH2-6EW9>]; *Morris v. Bradenburg*, COMPASSION & CHOICES, <https://compassionandchoices.org/legal-advocacy/past-cases/morris-v-bradenburg> [<https://perma.cc/3MK4-Q3T5>].

in dying.¹⁷⁶ However, the New Mexico Supreme Court ultimately held in 2016 that there is no such constitutional right.¹⁷⁷

Justice Edward Chavez, writing the New Mexico Supreme Court's unanimous decision, acknowledged that "the State does not have a legitimate interest in preserving a painful and debilitating life that will imminently come to an end."¹⁷⁸ Nevertheless, Justice Chavez focused on the concern that "end-of-life decisions are inherently fraught with the potential for abuse" and that "[r]egulation in this area is essential, given that if a patient carries out his or her end-of-life decision it cannot be reversed, even if turns out that the patient did not make the decision of his or her own free will."¹⁷⁹

Concern about vulnerable individuals has been a focus in other judicial opinions, as well. Among its reasons for rejecting the argument that Washington state's ban on physician-assisted suicide violates patients' constitutionally protected liberty rights, the U.S. Supreme Court concluded in *Washington v. Glucksberg* that protecting vulnerable individuals and groups could legitimately lie at the heart of a state's rejection of physician-assisted suicide.¹⁸⁰ How can an individual's autonomy at end of life be protected while, at the same time, protecting individuals from undue influence from others or from making impulsive or poorly informed decisions? This question can be understood as an enormously challenging, legitimate question about the tension between vulnerability and autonomy. On the other hand, this question can be understood as a regressive tactic to preserve the status quo. How often is progress delayed because of arguments that the change would not be good for the intended beneficiary of change?¹⁸¹ At the very

176. *Morris v. Brandenburg*, No. D-202-CV-2012-02909, 2014 WL 10672977, at *1 (Dist. Ct. N.M. Jan. 31, 2014), *rev'd*, 356 P.3d (N.M. Ct. App. 2015), *aff'd*, 376 P.3d 836 (N.M. 2016).

177. *Morris v. Brandenburg*, 376 P.3d 836, 857 (N.M. 2016).

178. *Id.* at 838.

179. *Id.* at 849, 857.

180. 521 U.S. 702, 731, 735 (1997).

181. Regarding the historical argument that slavery is beneficial to enslaved people, see Clyde Wilson, *John C. Calhoun and Slavery as a "Positive Good": What He Said*, ABBEVILLE INST. (June 26, 2014), <https://www.abbevilleinstitute.org/clyde-wilson-library/john-c-calhoun-and-slavery-as-a-positive-good-what-he-said> [<https://perma.cc/YA42-7933>] ("Never before in history, he continued, has the black race 'attained a condition so civilised and so improved, not only physically but morally and intellectually in the course of a few generations it has grown up under the fostering care of our institutions, as reviled as they have been, to its present comparative civilised condition.' The rapid increase of numbers, nearly equal to the white population, Calhoun, said 'is conclusive proof' of the advancement and of the relative comfort of this class of Southern labourers."). Regarding the historical

least however, this area of law highlights how little we know about “vulnerability,” “autonomy,” and “autonomous” decisions.¹⁸²

Right now, only Montana has a common law decision that allows medical aid in dying,¹⁸³ which was established by its supreme court decision in *Baxter v. State*.¹⁸⁴ Plaintiffs included Robert Baxter, a terminally ill individual, physicians who would provide lethal dose prescriptions to such patients if legally permitted, and the nonprofit Compassion & Choices.¹⁸⁵ When the matter reached the Montana Supreme Court, it was narrowed to “whether the consent of the patient to his physician’s aid in dying could constitute a statutory defense to a homicide charge” brought against the physician who wrote the lethal dose prescription.¹⁸⁶ The defense of patient consent would not be upheld if it were “against public policy to permit the conduct or the resulting harm, even though consented to.”¹⁸⁷ The Montana Supreme Court decided that it was not against public policy to allow the physician to use the defense of patient consent in the event of prosecution for murder of the patient.¹⁸⁸ Grounding its decision in the Terminally Ill Act, the court concluded that patients are acting autonomously when they decide to self-administer drugs that cause their own deaths; the physician is not killing them.¹⁸⁹

As noted by a Montana Supreme Court judge who concurred in the decision, the majority’s decision “is not necessarily limited to physicians,” since patient consent could also cover possible prosecution of pharmacists who fill the prescription.¹⁹⁰ But what is a qualifying “terminal illness?” It was

argument that same-sex marriage would be harmful to gay identity, see Paula L. Ettelbrick, *Since When Is Marriage a Path to Liberation?*, OUT/LOOK NAT’L LESBIAN & GAY Q., Fall 1989, at 9, 14–17; see also THE MARRYING KIND?: DEBATING SAME-SEX MARRIAGE WITHIN THE LESBIAN AND GAY MOVEMENT (Mary Bernstein & Verta Taylor eds., 2013). For laws characterized as beneficial to women but arguably not, see, for example, Mark Joseph Stern, *Laws to Protect Women Often Do Just the Opposite*, SLATE (Feb. 9, 2016, 9:51 AM), <https://slate.com/human-interest/2016/02/laws-to-protect-women-often-do-just-the-opposite.html> [<https://perma.cc/GJ5Y-Y593>].

182. See generally Margaret P. Battin, *Physician-Assisted Dying and the Slippery Slope: The Challenge of Empirical Evidence*, 45 WILLAMETTE L. REV. 91, 127–28 (2008); Katie Franklin, *Physician Assisted Death, Dementia, and Euthanasia: Using an Advanced Directive to Facilitate the Desires of Those with Impending Memory Loss*, 51 IDAHO L. REV. 547, 567–68 (2015); Megan S. Wright, *End of Life and Autonomy: The Case for Relational Nudges in End-of-Life Decision-Making Law and Policy*, 77 MD. L. REV. 1062 (2018).

183. Alyssa Thurston, *Physician-Assisted Death: A Selected Annotated Bibliography*, 111 L. LIBR. J. 31, 39 (2019).

184. *Baxter v. State*, 224 P.3d 1211, 1222 (Mont. 2009).

185. *Id.* at 1211, 1214.

186. *Id.* at 1215.

187. MONT. CODE ANN. § 45-2-211(2)(d) (2019); see *Baxter*, 224 P.3d at 1215.

188. *Baxter*, 224 P.3d at 1215.

189. *Id.* at 1217–22.

190. See *id.* at 1223 (Warner, J., concurring).

clear in Robert Baxter’s case; he died the day the trial court issued its opinion.¹⁹¹ But what if a patient’s illness is still considered “treatable,” although not likely to be fully successful? What if the patient is suffering primarily from what some, but not all, physicians would consider a treatable psychiatric illness? Would the supreme court’s decision cover family or friends who attend the death? Would they be vulnerable to prosecution for assisting suicide? If so, under what circumstances?

The Montana Supreme Court’s decision in *Baxter* is not a MAiD statutory equivalent; there is no detailed “safe harbor” of rules a physician can follow to avoid prosecution and no statutory immunity for physicians and pharmacists who choose to assist a patient.¹⁹² A risk-averse physician could be concerned about the possibility that an after-the-fact assessment of what the physician actually did in a particular case involving a particular patient could result in a successful prosecution for homicide, if the prosecutor argues persuasively that the physician’s acts were not contemplated or covered by the court’s decision in *Baxter*.

There is limited evidence that physicians provide lethal dose prescriptions to patients in Montana,¹⁹³ but there is no evidence that the *Baxter* decision has served as a template for such judicial decisions elsewhere. Yet, in

191. Kirk Johnson, *Montana Court to Rule on Assisted Suicide Case*, N.Y. TIMES (Aug. 31, 2009), <https://www.nytimes.com/2009/09/01/us/01montana.html?mtrref=www.google.com&assetType=REGIWALL> [<https://perma.cc/R66R-ZZWD>].

192. *Baxter*, 224 P.3d at 1215.

[I]f the State prosecutes a physician for providing aid in dying to a mentally competent, terminally ill adult patient who consented to such aid, the physician may be shielded from liability pursuant to the consent statute. This consent defense, however, is only effective if none of the statutory exceptions to consent applies. *Id.* (emphasis added). The Montana Supreme Court then proceeded to analyze the four statutory exceptions: (1) incompetence; (2) youth, mental disease or defect, or intoxication; (3) force, duress, or deception; and (4) against public policy. *Id.* While the court found that consent to physician aid in dying was not against public policy, with respect to the first three exceptions, the court noted that “[t]he first three statutory circumstances rendering consent ineffective require case-by-case factual determinations.” *Id.*

193. See Jean T. Abbott, Jacqueline J. Glover & Matthew K. Wynia, *Accepting Professional Accountability: A Call for Uniform National Data Collection on Medical Aid-in-Dying*, HEALTH AFF. (Nov. 20, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20171109.33370/full> [<https://perma.cc/C6Y3-8QM8>]; JoNel Aleccia, *At Some Veterans Homes, Aid-in-Dying Is Not An Option*, KAISER HEALTH NEWS (Feb. 13, 2018), <https://khn.org/news/california-joins-states-that-would-evict-veterans-who-seek-aid-in-dying-option> [<https://perma.cc/2DDU-UQAY>] (“Dr. Eric Kress, a Missoula physician who prescribes the lethal medication, says he has transferred patients to hospice, to relatives’ homes, even to extended-stay hotels to avoid conflict [with Veterans Administration facilities].”).

comparison to the highly restrictive MAiD statutes, judicial recognition that a physician's medical practice can include helping a patient to die would seem an attractive avenue for advancing those interests.

In a recent Article specifically about North Carolina law, which does not have specific criminal or civil laws prohibiting assisting suicide, Kathryn Tucker, Executive Director of the nonprofit End of Life Liberty Project, argues that physician-assisted suicide is part of "health care" that physicians can provide lawfully within the existing standard of care; there is no need for a MAiD statute or judicial decision.¹⁹⁴ Indeed, Tucker argues that "[e]nacting statutes modeled after the Oregon Death with Dignity Act serves no necessary or useful purpose . . . and indeed stifles the evolution of the practice that would occur in a standard of care environment."¹⁹⁵ It is possible that some physicians take that view; there is only limited empirical data about physician assistance that occurs outside of MAiD statutory contexts.¹⁹⁶ Tucker writes that medical aid in dying "has been openly practiced in Montana since 2009,"¹⁹⁷ but she does not provide or cite to any empirical evidence to support that claim.¹⁹⁸ Even if such activity is occurring, there is no assurance that the physician, pharmacist, and other involved medical care provider would escape being a "test case" prosecution if a physician wrote a lethal dose prescription, a pharmacist filled it, and a patient then consumed it for the purpose of ending the patient's own life. Without a declaratory judgment or decision such as *Baxter*, there is risk. Even *with*

194. Kathryn L. Tucker, *Aid in Dying in North Carolina*, 97 N.C. L. REV. ADDENDUM 1, 2, 17 (2019).

195. *Id.* at 5 n.15 ("The time has come to abandon this way of thinking [enacting PAS statutes]—to put an end to end-of-life law." (citing Lois Shepherd, *The End of the End-of-Life Law*, 92 N.C. L. REV. 1693, 1696 (2014))).

196. *Id.* at 17; *see also* Pope & Anderson, *supra* note 105, at 381 n.129 ("[F]ourteen of the fifty-eight physicians who had been asked by patients to administer lethal injections complied with those requests." (citing Anthony J. Back et al., *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA 919, 921 (1996))).

197. Tucker, *supra* note 194, at 17–18.

198. Similarly, John Carbone, Aditi Sethi-Brown, Beth Rosenberg, and Haider Warraich report that there is no evidence of any prosecution of physicians for providing medical aid in dying. John Carbone et al., *Aid in Dying in North Carolina*, 80 N.C. Med J. 128, 128 (2019), <http://www.ncmedicaljournal.com/content/80/2/128.full> [<https://perma.cc/Y3GK-JX7D>]. *But see* Aleccia, *supra* note 193 (identifying a Missoula physician who does prescribe lethal dose medication). Ezekiel J. Emanuel, E.R. Daniels, D.L. Fairclough, and B.R. Clarridge reported in 1998 that 15.8% of fifty-six oncologists participating in "structured in-depth" telephone interviews said that they had provided euthanasia or physician assistance in dying. Ezekiel J. Emanuel et al., *The Practice of Euthanasia and Physician-Assisted Suicide in the United States: Adherence to Proposed Safeguards and Effects on Physicians*, 280 JAMA 507, 508 (1998). Thus, there could be some cases of euthanasia or medical aid in dying occurring in many states in the United States without direct relationship to the existence of MAiD statutes or, in the case of Montana, without direct relationship to *Baxter v. State*.

a *Baxter*-type decision, there is risk that the holding in *Baxter* would not cover a particular situation that could be distinguishable.

North Carolina law lacks any prohibition on assisting suicide, let alone an explicit prohibition on a physician's provision of aid in dying. An End of Life Option Act was proposed in the 2017–2018 session but did not advance in that session or the 2018–2019 session.¹⁹⁹ That proposed MAiD statute was not unusual in that it, like other MAiD statutes, contained extensive requirements that both patients and physicians would have to meet before a physician would be able to provide medical aid in dying.²⁰⁰ Until and unless such a law is enacted in North Carolina, however, a lack of explicit prohibition does not mean that physicians would necessarily be safe from prosecution under homicide or wrongful death statutes.²⁰¹ Cautious physicians concerned about retention of their medical practice licenses and exposure to civil litigation or criminal prosecution might do well to follow lawsuits underway in other jurisdictions.

One such case is in Massachusetts, a state that does not have a prohibition on assisting suicide but that does have a statement against “suicide or mercy killing” or “any affirmative or deliberate act to end one’s own life.”²⁰² On October 24, 2016, Roger Kligler and his physician, Alan Steinbach, filed a complaint seeking a “declaration that Medical Aid in Dying is not a criminal offense under the laws of the Commonwealth of Massachusetts, or in the

199. H.B. 879, 2019 Gen. Assemb., Reg. Sess. (N.C. 2019). Whether the legislature will enact a MAiD statute at some point is not predictable. According to Nolo Press, North Carolina has previously considered and rejected such a law. *North Carolina’s End of Life Option Act*, NOLO, <https://www.nolo.com/legal-encyclopedia/north-carolinas-death-with-dignity-act.html> [<https://perma.cc/87BN-ZXJ8>]. “Spurred by Maynard’s decision and the resulting publicity, North Carolina legislators introduced a death with dignity bill for the first time in 2015. That bill and another introduced in 2017 failed to pass.” *Id.* House Bill 789 was still sitting in the Committee on Rules, Calendar and Operations at the close of the 2017–2018 legislative session, and the same has occurred with the most recent End of Life Option Act in the 2019–2020 legislative session. See *House Bill 879*, N.C. GEN. ASSEMBLY, <https://www.ncleg.gov/BillLookUp/2019/HB879> [<https://perma.cc/5Y3V-QD9W>]. It was referred to the House Committee on Rules, Calendar, and Operations on April 22, 2019, and nothing has happened to it since. *Id.*

200. N.C. H.R. 879.

201. A physician might also be exposed to medical licensing or medical malpractice insurance issues. For discussion of state medical licensing and disciplinary action risks for physician-assisted suicide, see generally *supra* note 49.

202. MASS. GEN. LAWS ANN. ch. 201D, § 12 (West 2019). For suicide or mercy killing, the statute provides: “Nothing in this chapter shall be construed to constitute, condone, authorize, or approve suicide or mercy killing, or to permit any affirmative or deliberate act to end one’s own life other than to permit the natural process of dying.” *Id.*

alternative, a declaration that prosecution of physicians who provide Medical Aid in Dying is unlawful and unconstitutional as applied [in the Medical Aid in Dying context].”²⁰³ The plaintiffs survived a motion to dismiss, but the court stated “[t]he complexity of establishing the parameters of a right to physician assisted suicide ultimately may militate against recognition of such a right.”²⁰⁴ The court denied plaintiffs’ summary judgement motion on January 14, 2020, except for holding that Massachusetts physicians can advise patients about medical aid-in-dying options that are lawfully available in other jurisdictions.²⁰⁵ Compassion & Choices filed a notice of appeal on February 26, 2020.²⁰⁶

A court in Hawaii, another jurisdiction without a criminal prohibition against medical aid in dying at the time of the lawsuit, also dismissed such a case stating, “the relief sought by the plaintiffs is political, not judicial, in nature and should be addressed by the political branches of government.”²⁰⁷ Hawaii subsequently did enact a MAiD statute, which is modeled on MAiD statutes previously enacted in other states.²⁰⁸ While Tucker persuasively advocates for legal recognition of a standard of care that includes medical aid in dying to avoid highly restrictive MAiD statutes, the track record in Hawaii and other states is not a basis for optimism. Indeed, such lawsuits could prompt legislative attempts to explicitly prohibit MAiD as easily as they could prompt legislative enactment of MAiD statutes.

There are similar lawsuits in New York²⁰⁹ and California.²¹⁰ The petitioners in these cases claim that physician assistance provided to a terminally ill, mentally competent individual seeking to end his or her life is not within

203. Complaint for Declaratory Judgment and Injunctive Relief at 2, *Kligler v. Healey*, No. SUCV201603254F, 2017 WL 2803074 (Mass. Super. Ct. May 31, 2017) (Civ. Action No. 16-3254F).

204. *Kligler*, 2017 WL 2803074, at *1, *3.

205. *Kligler v. Healey*, No. SUCV201603254F, 2020 WL 736968, at *12 (Mass. Sup. Ct. Jan. 14, 2020); *see also* Shira Schoenberg, Massachusetts Court Considers Whether to Legalize Physician-Assisted Suicide, MASSLIVE (Mar. 26, 2019), <https://www.masslive.com/news/2019/03/massachusetts-court-considers-whether-to-legalize-physician-assisted-suicide.html> [<https://perma.cc/N9BR-3QGQ>] (“Suffolk Superior Judge Mary Ames held a hearing Tuesday [March 26, 2019,] on motions to dismiss the case.”).

206. Notice of Appeal, *Kligler*, No. SUCV201603254F (Mass. Sup. Ct. Feb. 26, 2020).

207. *See Osher*, *supra* note 96.

208. H.B. 2739, 29th Leg., Reg. Sess. (Haw. 2018).

209. *See generally* *Myers v. Schneiderman*, 31 N.Y.S.3d 45 (App. Div. 2016), *aff’d*, 85 N.E.3d 57 (N.Y. 2017).

210. Second Amended Complaint for Declaratory and Injunctive Relief at 1, *Brody v. Harris*, (Cal. Super. Ct. May 8, 2015) (No. CGC-15-544806) (arguing that § 401 of the California Penal Code, or the “Assisted Suicide Statute,” provides that, “‘every person who deliberately aids, or advises, or encourages another to commit suicide, is guilty of a felony,’ does not encompass the conduct of a licensed physician providing aid in dying to a mentally competent, terminally ill patient who has requested such assistance” (quoting CAL. HEALTH & SAFETY CODE § 401 (West 2019) (amended 2018))).

the scope of those jurisdictions' prohibitions on assisting suicide. Courts in each of those jurisdictions rejected that argument,²¹¹ leaving in place risk of prosecution if a physician, pharmacist, or other health care provider assists an individual to die. The legal starting point for such a case is different in North Carolina and Massachusetts since those jurisdictions lack an explicit prohibition on medical aid in dying, but a cautious physician might want to bring a suit seeking a judicial declaration of the legality of one's provision of medical aid in dying.

Even if a court, like the Montana Supreme Court in *Baxter*, were to validate the lawfulness of physician assistance in a particular case of a specific patient before the court, such a decision could not provide as much clarity as a statute because it cannot anticipate all possible physician-patient scenarios. Risks associated with such ambiguity could result in a self-protective response among Montana physicians and pharmacists who might well want more certainty before assisting a terminally ill, suffering individual. This understandable caution would inevitably result in similarly situated individuals receiving different kinds of opportunities, depending on their own and their physicians' knowledge and courage. It turns out then, that this aid-in-dying nonprofit advocacy approach is no more likely to be successful than the MAiD approach. Perhaps it could be said that compassion gaps in this context are borne of *insufficient* specificity to be reassuring and helpful to physicians wanting to help patients, while compassion gaps in the aid-in-dying statutes arise from *excessive* specificity, which burdens both physicians and patients who seek to use the statutes.

IV. TAX-EXEMPT STATUS REQUIREMENTS OF AID-IN-DYING NONPROFITS

Part II of this Article reviewed the extent to which the laws in the vast majority of states prohibit assisting another to commit suicide. If, in order to receive the most financially beneficial tax-exempt I.R.C. § 501(c)(3) status, nonprofit organizations' missions and activities must not be illegal, violate public policy, or focus on legislative lobbying, how can aid-in-dying

211. In New York, the court held that this was a matter for the legislature. *Myers*, 31 N.Y.S.3d at 65. The New York legislature has considered a medical aid-in-dying statute three times without enacting one. James Gormly, *State's Highest Court Rules There Is No Constitutional Right to Assisted Suicide*, LEGIS. GAZETTE (Sept. 7, 2017), <http://legislativegazette.com/states-highest-court-rules-there-is-no-constitutional-right-to-assisted-suicide> [<https://perma.cc/V85L-B8UJ>].

nonprofits do all of the things described in Part III of this Article? Aid-in-dying nonprofits assist some individuals seeking aid in dying, encourage physicians to assist such individuals, and pursue statutory and common law advances to make aid in dying more accessible.²¹² Viewed from the perspective of compassion for those suffering irremediably at the end of life, these activities are not radical. However, viewed from the perspective of current law, which embodies stigma associated with suicide and physicians' training to avoid causing their patients to die, these activities are radical. If regulators grant these organizations preferred tax status, taxpayers will be supporting these activities in the amount of tax exemptions and deductions these organizations and their donors receive, respectively.²¹³ What then do regulators do, and what should they do about aid-in-dying nonprofits? The short answer to this question is that interpreters of the law must allow for reasonable interpretations of the requirements in this and other similar social movement contexts, *if* the goal of moving ideas from the margin to the mainstream of society is a recognized value of tax-exempt organizational contributions to society. Regulators do, in fact, allow for considerable activity, including through use of a relatively narrow definition of "legislative lobbying"—a mechanism through which social change can affect legal change through nonprofit activism.²¹⁴

A. Violation of Public Policy

That the purpose and activities of a nonprofit organization cannot violate public policy is both a state and federal law requirement.²¹⁵ The U.S. Supreme Court held in *Bob Jones University v. United States* that race-based classifications and rules violate the requirement that an organization seeking

212. *E.g.*, *About Us*, *supra* note 86 (exemplifying one aid-in-dying nonprofit's mission of helping individuals, physicians, and the passing of laws to help people hasten their own deaths).

213. This is the "subsidy theory." See Atkinson, *supra* note 35, at 404; see also Hansmann, *supra* note 35, at 66.

214. The prohibition of I.R.C. § 501(c)(3) from legislative lobbying may be more about preventing disproportionate voice of particularly wealthy donors who would receive a tax deduction for contributions to legislative objectives than limiting nonprofit participation. Such donors can participate substantially through I.R.C § 501(c)(4) organizations, which are also tax exempt but do not provide tax deductibility of donations. Indeed, the rule that I.R.C. § 501(c)(3) organizations can respond to legislators' requests for input, without imperiling their status under the I.R.C. § 501(h), suggests that limiting participation is not the primary objective of the limitation on legislative lobbying by nonprofits.

215. For federal requirements, see *Bob Jones Univ. v. United States*, 461 U.S. 574, 585–86 (1983); IRS, *supra* note 78 ("The Supreme Court stated [in *Bob Jones University*] that entitlement to tax exemption depends on meeting certain common law standards of charity—namely that an institution seeking tax exempt status must serve a public purpose and not be contrary to established public policy.").

tax-exempt status cannot violate public policy and must serve a charitable purpose, even if the race-based discrimination is grounded in religious beliefs.²¹⁶ However, the Internal Revenue Service has not used public policy justifications for denying or revoking an organization's tax-exempt status since the *Bob Jones University* decision.²¹⁷ In the case of aid in dying specifically, the U.S. Supreme Court in *Washington v. Glucksberg* explicitly allowed for aid-in-dying legal development at the state level.²¹⁸ While not an endorsement of any particular approach, the Court's opinion signals that the mere existence of state laws enabling aid in dying, and nonprofit organizations designed to work within those laws, would not violate federal public policy.²¹⁹

At the state level, organizations encounter the same type of requirement—that they not violate public policy—when they seek to incorporate under state law as a nonprofit organization.²²⁰ As a historical matter, some states refused nonprofit applications when a proposed nonprofit would replicate the work of other nonprofits in the area and cause “market saturation,” or when the proposed nonprofit's mission focused on changing the law or providing education that could lead to violating the law.²²¹ Now, however, state regulators accept incorporation applications for “any lawful purpose,” without much apparent scrutiny.²²² Even the Euthanasia Research and

216. *Bob Jones Univ.*, 461 U.S. at 604.

217. In 1984, the IRS stated that no other type of discrimination, such as “sex discrimination,” had been prohibited as clearly as race-based discrimination. IRS, UPDATE ON PRIVATE SCHOOLS AND IMPACT OF *BOB JONES UNIVERSITY V. U.S.* (1984), <https://www.irs.gov/pub/irs-tege/eotopicb84.pdf> [<https://perma.cc/TWJ4-AJP9>]. It compared the existence of civil rights legislation with the absence of an Equal Rights Amendment and stated that it would monitor the development of public policy as to other types of discrimination. *Id.*

218. 521 U.S. 702, 735 (1997).

219. *Id.* at 735 n.24.

220. States vary in their specific nonprofit incorporation requirements, but “public benefit” or “public charity” organizations seeking tax exemption must meet or exceed the “charitability” definitional requirements equivalent to I.R.C. § 501(c)(3) organizations and must seek incorporation with missions that provide public benefit. Differences emerge within and among states with regard to the definition of charitability for tax exemptions from property tax, income, and sales and use taxes. ELIZABETH SCHMIDT, *NONPROFIT LAW: THE LIFE CYCLE OF A NONPROFIT ORGANIZATION* 239–43 (2d ed. 2017).

221. *Id.* at 53.

222. *Id.* But see Michael Kimmelman, *What D'Ya Call a House of Sex? A Museum.* *Oh.*, N.Y. TIMES (Jan. 18, 2000), <https://www.nytimes.com/2000/01/18/arts/what-d-ya-call-a-house-of-sex-a-museum-oh.html> [<https://perma.cc/5MFX-YWMV>]. New York Board of Regents denied an application for a sex museum because it would “make a mockery of the institution of the museum.” *Id.* The museum was established as a for-profit organization

Guidance Organization, which is the primary financial sponsor of a group dedicated to finding effective and efficient means of ending one's life,²²³ is a registered nonprofit in Oregon and a recognized I.R.C. § 501(c)(3) organization.²²⁴

B. *Illegal Conduct*

If illegal activities are required to fulfill an organization's mission, it cannot qualify as a tax-exempt organization.²²⁵ Final Exit Network was successfully prosecuted for "assisting a suicide" in Minnesota because the Minnesota Supreme Court accepts the interpretation that speech about life-ending methods directed to someone the speaker knows is intending to commit suicide is unlawful as "assisting suicide."²²⁶ However, FEN did not lose its tax-exempt status.²²⁷ FEN did not intentionally violate any law, and having exhausted all legal avenues to contest that decision, FEN is no longer providing assistance to people living in Minnesota.²²⁸

MAiD statutes create the lawful conditions under which a physician can prescribe a lethal dose prescription, but if Congress decided to amend the Controlled Substances Act (CSA)²²⁹ to exclude the use of prescription medications for MAiD purposes, compliance with MAiD statutes and focusing nonprofit activity on MAiD statutes would be unlawful.

C. *Charitable Activity*

I.R.C. § 501(c)(3) requires an organization's mission and activities to be "charitable," and the statute itself provides for several categories

instead of a public benefit charitable organization. *Id.* The Museum of Sex in New York is now a registered private foundation, which is a type of nonprofit organization, and provides donation receipts acceptable for tax deduction purposes. *Support*, MUSEUM SEX, <https://www.museumofsex.com/museum/corporate/support/> [<https://perma.cc/S2M4-85RQ>].

223. *Help Ergo in Its Work To Achieve Choices in Dying*, FINAL EXIT, http://www.finalexit.org/ergo_membership.html [<https://perma.cc/KW2F-DJEK>].

224. *Euthanasia Research & Guidance Organization*, CHARITY NAVIGATOR, <https://www.charitynavigator.org/index.cfm?bay=search.profile&ein=931118314> [<https://perma.cc/5X9H-Y747>]; see *Charitable Activities Registered in Oregon*, OR. DEP'T JUST., <https://justice.oregon.gov/charities> [<https://perma.cc/3FXV-RH7U>] (search for "Euthanasia Research and Guidance Organization" under "Charitable Organizations Registered in Oregon," to show current registration number 20375 in the charitable organizations division of the Oregon Department of Justice).

225. See *Bob Jones Univ. v. United States*, 461 U.S. 574, 591 (1983).

226. See *supra* notes 118–22 and accompanying text.

227. See *Who Is the Final Exit Network (FEN)*, *supra* note 63.

228. See *History of Final Exit Network*, FINAL EXIT NETWORK, <http://www.finalexitnetwork.org/About-Us.html> [<https://perma.cc/7BHA-A3YG>].

229. See generally 21 U.S.C. §§ 801–971 (2012).

of charitable endeavors.²³⁰ As in the cases of public policy and illegal conduct, how the IRS interprets this requirement significantly influences the extent to which aid-in-dying nonprofits can move ideas into the mainstream of society.

Almost all aid-in-dying nonprofits are classified as “educational” organizations. This is partially due to the nature of I.R.C. §501(c)(3) categorical options²³¹ and a matter of historical development. One of the earliest, if not the earliest, aid-in-dying organizations was the Hemlock Society, which was founded by Derek Humphry in 1980 and existed until 2003.²³² In regard to the organization’s work:

“Hemlock had two strings to its bow,” Humphry says. “One, to help people who were suffering and wanted to die because of their terminal illness in whatever way we could without getting into trouble. . . . And two, change the law to permit physician-assisted suicide for the terminally ill—not for any old, depressed person.”²³³

From this starting point, other nonprofit organizations identified in this Article emerged with these same goals of lawful organizational conduct to assist those currently suffering irremediably at the end of life while carefully distinguishing between transient and persistent commitments to end life, and also to advocate for legal reform to encourage compassionate responses to such suffering in the future.

Derek Humphry has also served as an early and continuing advisor to Final Exit Network,²³⁴ whose mission statement reads as follows: “To serve those who are suffering intolerably from an incurable condition which has become more than they can bear and to increase the awareness of all Americans concerning their basic human right to a death with dignity.”²³⁵

230. I.R.C. § 501(c)(3) (2012) (covering “[c]orporations . . . organized and operated exclusively for religious, charitable, scientific, testing for public safety, literacy, or educational purposes, or to foster national or international amateur sports competition (but only if no part of its activities involve the provision of athletic facilities or equipment), or for the prevention of cruelty to children or animals”).

231. *Id.*

232. Luke Turf, *Exit This Way*, WESTWORD (June 8, 2006, 4:00 AM), <https://www.westword.com/news/exit-this-way-5089577> [<https://perma.cc/4XPP-VZ53>]; *History of Final Exit Network*, *supra* note 228.

233. Turf, *supra* note 232.

234. *History of Final Exit Network*, *supra* note 228.

235. FINAL EXIT NETWORK, INC., FORM 990: RETURN OF ORGANIZATION EXEMPT FROM INCOME TAX (2016), http://990s.foundationcenter.org/990_pdf_archive/800/800119137/800119137_201706_990.pdf [<https://perma.cc/K8BG-HDQU>].

Similarly, End of Life Washington’s mission states that it “[p]rovides advocacy, resources, and support to people facing terminal illness and their loved ones.”²³⁶ The mission statement for Compassion & Choices reads: “To educate, support, and advocate for patient rights at the end of life.”²³⁷ These read very similarly because of their classification as educational organizations. Although Final Exit Network looks very different from End of Life Washington when it comes to the specific services they provide seekers of aid in dying, they are all the same as to their relationship to the Internal Revenue Service: They are educational charitable organizations.²³⁸ IRS regulations of educational organizations begin with a definition of educational as pertaining to “(a) The instruction or training of the individual for the purpose of improving or developing his capabilities; or (b) The instruction of the public on subjects useful to the individual and beneficial to the community.”²³⁹ A potential hurdle for aid-in-dying organizations is Treasury Regulation § 1.501(c)(3)-1(d)(3), which states:

An organization may be educational even though it advocates a particular position or viewpoint so long as it presents a *sufficiently full and fair exposition of the pertinent facts* as to permit an individual or the public to form an independent opinion or conclusion. On the other hand, an organization is not educational if its principal function is the mere presentation of unsupported opinion.²⁴⁰

It would be quite burdensome to the organizations and those they serve if aid-in-dying organizations had to give a “full and fair exposition” of all end-of-life options including continued or new treatment options, palliative care, voluntary stopping of eating and drinking,²⁴¹ right to try options,²⁴²

236. END OF LIFE WASH., FORM 990: RETURN OF ORGANIZATION EXEMPT FROM INCOME TAX (2016), http://990s.foundationcenter.org/990_pdf_archive/911/911412987/911412987_201706_990.pdf [<https://perma.cc/AX6X-4682>].

237. COMPASSION & CHOICES, FORM 990: RETURN OF ORGANIZATION EXEMPT FROM INCOME TAX, (2015), http://990s.foundationcenter.org/990_pdf_archive/841/841328829/841328829_201606_990.pdf [<https://perma.cc/7TVA-HAT8>].

238. *See We Serve*, FINAL EXIT NETWORK, <http://www.finalexitnetwork.org/Home.html> [<https://perma.cc/3C3X-2A69>].

239. Treas. Reg. § 1.501(c)(3)-1(d)(3) (2012).

240. *Id.* (emphasis added).

241. A full description of VSED and its legality is provided by health law scholar and bioethicist Thaddeus Pope. *See* Thaddeus Mason Pope, *VSED—Voluntarily Stopping Eating & Drinking*, THADDEUS POPE, <http://thaddeuspope.com/vsed.html> [<https://perma.cc/8R9E-6TVX>]; *see also* Pope & Anderson, *supra* note 105.

242. “Right to try” is the right to try investigational drugs that have not yet been approved by the FDA, despite the patient’s not having been included in a clinical trial. *What Is Right to Try?*, RIGHT TO TRY, <http://righttostry.org/about-right-to-try> [<https://perma.cc/7VVZ-YK3Z>]. Many states have right to try laws, but federal law now also provides access to a patient if the patient has a life-threatening illness, has exhausted all available forms of treatment, inability to participate in a clinical trial, and provides informed consent. *Id.*

and terminal sedation²⁴³ in order to educate people about medical aid in dying. Indeed, opponents of MAiD statutes have sought inclusion of just such a requirement.²⁴⁴

Although the literal words of Treasury Regulation § 1.501(c)(3)-1(d)(3) would seem to require the provision of that information as “sufficiently full and fair exposition of the pertinent facts,” an appellate court decided in 1980 that the “full and fair exposition” requirement was unconstitutionally vague.²⁴⁵ Over the next few years, the IRS developed and legally tested a “methodology test” to clarify what is meant by “full and fair exposition.”²⁴⁶ This test does not require aid-in-dying organizations to provide information about continuing treatment, palliative care, or alternative means of ending one’s life, such as voluntary stopping of eating and drinking.

According to current guidelines, an educational organization or its materials *fail* the methodology test to determine whether there has been “sufficiently full and fair exposition of pertinent facts” if: (a) a significant portion of the presentation of the organization’s views in its educational materials is unsupported by facts; (b) facts purporting to support the organization’s views are distorted; (c) the organization’s educational materials make substantial use of inflammatory and disparaging terms, and the expression of views is based more on emotional than objective grounds; (d) the organization’s materials are not aimed at developing understanding on the part of the intended audience because the organization fails to take the listener’s or reader’s background and training into account.²⁴⁷

This methodology-focused test of full and fair exposition provides substantial room for aid-in-dying nonprofits to educate individuals and the community at large about a wide range of relevant topics without worry about legal challenge for failure to cover topics beyond those organizations’ chosen scope, as long as they do not distort the information they do provide. Indeed, it is the definitional breadth of education under IRS treasury regulations²⁴⁸ that grounds the opportunity for nonprofit educational

243. “Terminal sedation” involves deeply sedating a patient while not providing hydration and nutrition, with the expectation that the patient will die from dehydration during sedation. Johannes J.M. van Delden, Editorial, *Terminal Sedation: Source of a Restless Ethical Debate*, 33 J. MED. ETHICS 187, 187–88 (2007). The choice to use terminal sedation is fraught with ethical issues. *Id.*

244. See, e.g., *infra* note 247 and accompanying text.

245. *Big Mama Rag, Inc. v. United States*, 631 F.2d 1030, 1034–35 (D.C. Cir. 1980).

246. *Nat’l All. v. United States*, 710 F.2d 868, 871, 874 (D.C. Cir. 1983).

247. Rev. Proc. 86-43, 1986-2 C.B. 729, § 3.03.

248. See generally Treas. Reg. § 1.501(c)(3)-1(d)(3) (2019).

organizations to move ideas from the margins of society to the mainstream and then into law, with the benefit of taxpayer support. Due to this breadth, aid-in-dying organizations could play a powerful role in shifting attitudes about suicide as rational in some contexts and in enacting legal rules that allow those suffering irremediably at the end of life to end their lives peacefully. This breadth of permissible education also means that organizations can take very different approaches to the same challenge of securing greater autonomy in choice of end-of-life assistance and care.

By contrast, Minnesota’s current definition of education in the context of “assisted suicide” is quite narrow; one is unlawfully assisting suicide and not lawfully educating about suicide if one provides specific information about suicide methods to someone the speaker knows is intending to commit suicide.²⁴⁹ Minnesota courts rejected FEN’s position that it only educated people suffering irremediably from a terminal condition who approached them for information about how to die.²⁵⁰ In fact, this is the core of FEN’s aid-in-dying legal reform effort: distinguishing education about suicide from assisting suicide.²⁵¹ It is the means through which ideas about rational suicide, hastening death, and assisting another to die can change dynamically over time. While FEN’s situation illustrates this most dramatically, the same is true of the work of other aid-in-dying nonprofits that seek liberalization of laws and views about autonomy of patients to choose to end their lives as a rational approach to severe, unrelenting suffering at the end of life.

D. Pursuit of Legal Reform

If an organization is primarily devoted to legal reform, it does not qualify as an I.R.C. § 501(c)(3) organization, and its donors’ contributions are not tax deductible.²⁵² I.R.C. § 501(c)(3) states explicitly that no substantial

249. See *supra* text accompanying notes 129–32.

250. See *State v. Final Exit Network, Inc.*, 889 N.W.2d 296, 299–300 (Minn. Ct. App. 2016), *cert denied*, 138 S. Ct. 145 (2017) (mem.).

251. The constraining variable in the educational nonprofit context is not the definition of “education” as much as it is the money available to accomplish the organization’s mission. Financial support from the general public is important as a source of funds that are not available from the financial sector and, also, to maintain the most desired status as an Internal Revenue Code § 501(c)(3). Generally, at least one-third of an organization’s funds must come from the general public, or the organization loses that preferential status that enables donors to take charitable deductions and for organizations to enjoy such benefits as freedom from income tax, including investment income tax. One measure of the strength of a nonprofit organization is the number of volunteers willing to participate in and to support its activities. A high level of public support and participation indicate that the organization is truly working to benefit the public, as required of a public benefit organization. See I.R.C. § 509 (2012).

252. *Id.* § 501(c)(3) (stating explicitly that “no substantial part” of a I.R.C. § 501(c)(3) organization’s activities can consist of attempting “to influence legislation”).

part of an I.R.C. § 501(c)(3) organization’s activities can consist of “attempting, to influence legislation.” Such an organization could qualify as an I.R.C. § 501(c)(4), but it would be classified as a “social welfare” organization and, as such, would be unable to accept tax-deductible donations for its work.²⁵³ One simple way to address this is for an I.R.C. § 501(c)(3), which accepts tax-deductible donations, to establish an I.R.C. § 501(c)(4) to do legislative work and accept non-tax-deductible donations exclusively for that work. Aid-in-dying nonprofit, Death with Dignity National Center, has both types of organizations, but most other aid-in-dying nonprofits account for their legal advocacy and the volume of their other activities in ways that enable them to claim that it is not a substantial part of the organization’s activities.²⁵⁴ In this way, the organizations can attract tax-deductible contributions and legitimately hold themselves out as charitable educational organizations rather than social welfare organizations.

It is generally the case that nonprofits must engage in some legislative and other legal reform activities if they are going to generate change in the law and society. Many I.R.C. § 501(c)(3) organization managers believe that they should avoid legislative lobbying and legal reform,²⁵⁵ yet IRS rules since 1976 allow for considerable lobbying and much legal reform does not even fall into the category of legislative lobbying.²⁵⁶ FEN’s litigation about common law definitions of assisting suicide could change the law jurisdiction by jurisdiction but would not count as legislative lobbying. Nor would the litigation and advocacy work of Compassion & Choices and End of Life Liberty Project in pursuit of legal validation that physicians can, as a matter of their license to practice medicine, prescribe a lethal dose of medication when requested and warranted by a patient’s circumstances.

253. Treas. Reg. § 1.501(c)(3)-1(c)(3)(v).

254. *About Us*, *supra* note 86.

255. Nayantara Mehta, *Nonprofits and Lobbying: Yes, They Can!*, 18 ABA BUS. L. SEC. (Mar./Apr. 2009), <https://apps.americanbar.org/buslaw/blt/2009-03-04/mehta.shtml> [<https://perma.cc/R2VP-TTMG>] (“There is a widespread perception that nonprofits cannot lobby, or if they do lobby, they are exploiting some kind of legal loophole.”).

256. Marcia A. Avner, *Advocacy, Lobbying, and Social Change*, in THE JOSSEY-BASS HANDBOOK OF NONPROFIT LEADERSHIP AND MANAGEMENT, *supra* note 31, at 396, 400.

In 1976 legislation was passed that clarified and vastly expanded the amount of lobbying nonprofits can conduct. Equally important, on August 31, 1990, the Internal Revenue Service promulgated regulations that support both the spirit and the intent of the 1976 law. Together the law and the regulations provide more lobbying leeway than 99 percent of all nonprofits will ever need or want.

Id. (quoting Bob Smucker, *Nonprofit Lobbying*, in THE JOSSEY-BASS HANDBOOK OF NONPROFIT LEADERSHIP AND MANAGEMENT 230, 231–32 (2d ed. 2005)).

Without running afoul of the IRS requirement that I.R.C. § 501(c)(3) organizations must not engage in substantial legislative lobbying, many aid-in-dying organizations lobby extensively for legislative change. Equally important is their vigorous opposition to attempts to weaken existing aid-in-dying laws. One early challenge concerned the federal Controlled Substances Act. After the federal Drug Enforcement Agency issued an opinion in 1997 that lethal dose prescriptions were not written for a “legitimate medical purpose,” Attorney General Janet Reno responded in 1998 with a contrary opinion, echoing the Supreme Court in *Washington v. Glucksberg*, that the CSA was not “intended to displace the states as the primary regulators of the medical profession, or to override a state’s determination as to what constitutes legitimate medical practice.”²⁵⁷ Then in 2001, Attorney General John Ashcroft took the position that aid in dying was not a “legitimate medical purpose” for prescribing lethal dose prescriptions, even if provided as allowed in states with MAiD statutes.²⁵⁸ In 2006, the Supreme Court decided in *Gonzales v. Oregon* that the CSA as enacted did not confer authority on the Attorney General to prohibit Oregon physicians from assisting patients as allowed by MAiD statutes.²⁵⁹ Since Congress could amend the CSA to prohibit using controlled substances for MAiD, aid-in-dying nonprofits must remain vigilant.

Another example of the need for constant vigilance and activism arose very soon after the District of Columbia passed its Death with Dignity Act, which went into effect February 18, 2017.²⁶⁰ In 2018, the House of Representatives passed a provision in the federal budget to defund the reporting requirements of D.C.’s Death with Dignity Act.²⁶¹ If that budget provision had passed the Senate, the defunding requirement would have nullified the Death with Dignity Act. Death with Dignity National Center

257. Statement of Attorney General Janet Reno on Oregon’s Death with Dignity Act, No. 259, (June 5, 1998), <http://www.usdoj.gov/opa/pr/1998/June/259ag.htm.html> [<https://perma.cc/TJH6-6XYW>].

258. Dispensing of Controlled Substances to Assist Suicide, 66 Fed. Reg. 56,607, 56,608 (Nov. 9, 2001) (codified as amended at 21 C.F.R. 1306 (2012)).

259. 546 U.S. 243, 247 (2006).

260. D.C. CODE §§ 7-661.01-7 to .16 (2019).

261. Melissa Bailey, *Right-To-Die Fight Hits National Stage*, KAISER HEALTH NEWS (Feb. 16, 2017), <https://khn.org/news/right-to-die-fight-hits-national-stage> [<https://perma.cc/BCQ7-WW3H>]; Mikaela Lefrak & Martin Austerhuhle, *Congress Moves to Overturn D.C. ‘Death with Dignity Law,’* NPR (Feb. 14, 2017, 4:15 PM), <https://www.npr.org/2017/02/14/515228620/congress-moves-to-overturn-d-c-death-with-dignity-law> [<https://perma.cc/Q9KL-QKC2>]; Mikaela Lefrak, *Trump Budget Aims To Block Funding for D.C. Death with Dignity Law*, WAMU (May 23, 2017), <https://wamu.org/story/17/05/23/trump-budget-aims-block-funding-d-c-death-dignity-law> [<https://perma.cc/28W2-RYEW>].

and other aid-in-dying organizations successfully lobbied to prevent passage in the Senate.²⁶²

Yet another federal rule that federal funds cannot be used to assist veterans seeking to use a MAiD statute²⁶³ has resulted in access difficulties for veterans in all MAiD states except for Washington.²⁶⁴ Each state's department of veterans affairs decides how to implement federal rules, but Kathryn Tucker, Executive Director of End of Life Liberty Project, contends that most are taking an overly expansive approach.²⁶⁵ Tucker persuasively argues that “[n]othing exists in the federal statute’s language that would prohibit a resident from receiving aid-in-dying services at state homes, so long as they are not provided using federal funds or employees.”²⁶⁶

Another recent example of federal level defensive advocacy is End of Life Washington’s successful work with the Washington State Attorney General to invalidate the Trump administration “conscience rule.”²⁶⁷ The

262. *District of Columbia*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/states/district-of-columbia> [<https://perma.cc/2J7Y-UNMV>] (describing its advocacy efforts); see also Kim Callinan, *End-of-Life Group Thanks Senate for Rejecting House Rider to Repeal D.C. Death with Dignity Act*, COMPASSION & CHOICES (Aug. 1, 2018), <https://compassionandchoices.org/news/end-life-group-thanks-senate-rejecting-house-rider-repeal-d-c-death-dignity-act> [<https://perma.cc/ZDD3-PL4S>].

263. The language of the federal rule is:

It is the purpose of this chapter to continue current Federal policy by providing explicitly that Federal funds may not be used to pay for items and services (including assistance) the purpose of which is to cause (or assist in causing) the suicide, euthanasia, or mercy killing of any individual.

42 U.S.C. § 14401(b) (2012).

264. JoNel Aleccia, *supra* note 193.

265. *Id.*

266. *Id.*

267. E-mail from Robb Miller, former Exec. Dir. & Bd. Member, End of Life Wash., to Taimie Bryant, Professor of Law, UCLA Sch. of Law (May 24, 2019) (on file with author). On November 21, 2019, the District Court for the Eastern District of Washington invalidated the rule in its entirety. *Washington v. Azar*, No. 2:19-cv-00183-SAB, 2019 WL 6219541, at *12–13 (E.D. Wash. Nov. 21, 2019) (agreeing with plaintiffs that “medical care will be negatively impacted by the Rule [and that] . . . the Rule is arbitrary and capricious because HHS disregarded the comments and evidence showing the Rule would severely and disproportionately harm certain vulnerable populations, including women; lesbian, gay bisexual, and transgender people (LGBT individuals); individuals with disabilities; and people living in rural areas” and finding, also, that the “Rule is arbitrary and capricious because HHS failed to conduct a reasoned analysis of the requirements of basic medical ethics in adopting the Rule”), *appeal filed*, No. 20-3544 (9th Cir. Jan. 21, 2020). Several states’ attorneys general were similarly successful in their suit seeking invalidation of the rule. The District Court for the Southern District of New York invalidated the rule in its entirety.

conscience rule would have allowed health care institutions and providers to refuse, on religious or moral grounds, to provide services with which the provider disagrees.²⁶⁸ All MAiD statutes have opt-out provisions, but this could have provided for federal-level enforcement, including definitions of what constitutes objection and opting out, as well as potentially causing disparity of patient access *within* institutions that have not opted out.²⁶⁹

Defensive aid-in-dying nonprofit advocacy is also regularly necessary at the state level. For instance, in the 2017 legislative session in Washington, proposed legislation would have added the requirement that physicians discuss with a patient “treatment for the purpose of cure, and treatment for the purpose of extending the patient’s life,” if a patient requests a lethal dose prescription as provided under Washington’s Death with Dignity Act.²⁷⁰ Adding requirements to an already requirement-laden law reduces the likelihood of utilization because physicians will be concerned about missing or under-fulfilling a requirement such that they lose protection from prosecution or civil litigation. There is also the burden of increased time expenditure. Because there is no obligation to provide the prescription if a patient qualifies, physicians need not add on the uncertainty or burdens of time and paperwork associated with the law.

Another example is a bill proposed in February 2018 in California, which would have negative effects on California’s already elaborate End of Life Options Act.²⁷¹ California Senate Bill 1336 would require the physician to request that an otherwise qualified individual inform the physician orally or in writing as to the motivating reason or reasons behind the individual’s decision to request the aid-in-dying drug.²⁷² The question used to gather this information would allow for the selection of multiple choices including, at a minimum, the following possible choices: “(A) Pain or the fear of pain. (B) Concern about being a burden to others. (C) Loss of autonomy. (D) Sense of hopelessness.”²⁷³ The proposal allows patients to decline to answer.²⁷⁴ However, depending on how the physician approaches the matter or treats

New York v. U.S. Dep’t Health & Human Servs., 414 F. Supp. 3d 475, 580 (S.D.N.Y. 2019), *appeal filed*, No. 20-41 (2d Cir. Jan. 3, 2020).

268. Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed. Reg. 23,170 (May 21, 2018) (to be codified at 45 C.F.R. pt. 88).

269. See Law, *supra* note 171.

270. S.B. 5433, 65th Leg., Reg. Sess. (Wash. 2017), <http://lawfilesexst.leg.wa.gov/biennium/2017-18/Pdf/Bills/Senate%20Bills/5433.pdf> [<https://perma.cc/B34Q-J6E4>]. The bill did not become law. *SB 5433—2017–18*, WASH. ST. LEGISLATURE, <https://app.leg.wa.gov/billsummary?BillNumber=5433&Year=2017> [<https://perma.cc/K86L-VECZ>].

271. S.B. 1336, 20017–2018 Leg., Reg. Sess. (Cal. 2018).

272. *Id.*

273. *Id.*

274. *Id.*

this information as important for deciding whether to grant or deny a patient's request, patients will perceive varying degrees of freedom to decline to answer.

A requirement such as this adds to an already long list of requirements physicians must follow or be at risk of prosecution and loss of licensure. Moreover, answers patients give could be used against physicians. For instance, if patients identify a sense of hopelessness, has the physician missed a sign of need for mental health assessment if the physician has not ordered one? Should the choice of "concern about being a burden to others" alert the physician that there may be impermissible family member coercion? If the patient chooses "pain or the fear of pain," has the physician failed to provide enough information about palliative care options?

It is difficult to overstate how important aid-in-dying nonprofit organizations' work is in countering proposals to weaken existing MAiD laws. Indeed, the Death with Dignity National Center maintains a website with current information on every state, including proposed laws and attempts to amend or repeal MAiD laws.²⁷⁵ Aid-in-dying nonprofits do not initiate these proposals, yet they must exercise vigilance about how much of such work they are doing because of IRS rules that limit legislative lobbying. Moreover, organizations cannot simply consider this work a form of "education." Education in the legislative context—lobbying—is more circumscribed than education in other contexts for fear that some wealthy donors, whose identities the nonprofit does not have to reveal to the public, will play a disproportionate and hidden role in shaping laws.²⁷⁶ And yet, despite the limitation of such activities to no substantial part²⁷⁷ of the organization's activities, the regulations and laws in this area allow quite a bit of legislative activity.

275. *Maine*, *supra* note 144.

276. That partisan donors can give large amounts of money anonymously to nonprofits, swaying the development of law and policy on the basis of their donations, has given rise to debate about limitations for tax deductibility of donations. See, e.g., David Callahan, *The Price of Privacy: Four Problems with Anonymous Giving—and a Case for Reform*, INSIDE PHILANTHROPY (Aug. 24, 2017), <https://www.insidephilanthropy.com/home/2016/11/17/the-price-of-privacy-four-problems-with-anonymous-giving-and-the-case-for-reform> [<https://perma.cc/WM38-5UVS>] ("[W]hen wealthy donors speak loudly in the public square, using nonprofit proxies, citizens deserve to know who they are, along with what motives they may have—and all the more so when donors are using tax-subsidized dollars."); Kristin A. Goss, *Policy Plutocrats: How America's Wealthy Seek to Influence Governance*, 49 AM. POL. SCI. ASS'N 442, 442–43 (2016).

277. I.R.C. § 501(c)(3) (2012).

The general rule presented in I.R.C. § 501(c)(3) is that “no substantial part of the activities [of the organization can be] carrying on propaganda or otherwise attempting, to influence legislation.”²⁷⁸ If an organization conducts lobbying, there is no way to know in advance the limit of the no substantial part test. The test considers both financial investments and volunteer lobbying, but there is no definition of lobbying and no specific rule regarding how much is too much.²⁷⁹ All aid-in-dying nonprofits provide a variety of time and labor-intensive client services such that legislative lobbying could easily appear insubstantial.²⁸⁰ However, even if the risk of violating the I.R.C. § 501(c)(3) no substantial part test is low, the consequences of violation are severe: revocation of the organization’s tax-exempt status.²⁸¹

By contrast, an organization can predict with certainty how the no substantial part test will play out if it makes the I.R.C. § 501(h) election. This test is accompanied by detailed regulations that define “influencing legislation” and “lobbying expenditures.”²⁸² The test is strictly financial, in accordance with a formula derived from the organization’s “exempt purpose expenditures” that year.²⁸³ Organizations that elect the I.R.C. § 501(h) test can involve unlimited numbers of volunteers in lobbying without any impact on their I.R.C. § 501(c)(3) status. Such volunteer activity is invisible in the context of a purely financial calculation. Also, there are numerous statutory exceptions, such as work in response to a legislator’s request for the organization’s input on proposed legislation, which would not count as legislative lobbying.²⁸⁴ Moreover, organizations would have to exceed allowed lobbying amounts by 150% for four years before running the risk of loss of tax-exempt status.²⁸⁵ There is an excise tax on excessive lobbying,

278. *Id.*

279. *See Measuring Lobbying: Substantial Part Test*, IRS (Dec. 13, 2018), <https://www.irs.gov/charities-non-profits/measuring-lobbying-substantial-part-test> [<https://perma.cc/27WD-VAXK>].

280. For instance, aid-in-dying nonprofits provide information about MAiD statutory requirements, find physicians willing to write lethal dose prescriptions for qualified patients, assist the patient and family members with the pragmatic aspects of using MAiD statutes, and provide information about advance health care planning and various types of palliative care options.

281. *See* I.R.C. § 503(a)(1) (2012).

282. *Id.* § 501(h)(2).

283. *Measuring Lobbying Activity: Expenditure Test*, IRS (Feb. 25, 2019), <https://www.irs.gov/charities-non-profits/measuring-lobbying-activity-expenditure-test> [<https://perma.cc/V29Q-AL4B>].

284. *See* I.R.C. § 4911(d)(2) (2012).

285. *See id.* § 501(h)(1)(B); *Measuring Lobbying Activity: Expenditure Test*, *supra* note 283.

but the calculation is generous to nonprofit organizations.²⁸⁶ The consequence of all of these rules is that an organization can attempt to influence legislation in numerous ways, without running afoul of the requirements of I.R.C. § 501(h) or endangering its I.R.C. § 501(c)(3) status.

Nonprofit organizations working on aid in dying have been adept at using all of these Internal Revenue Code and Treasury Regulation opportunities. Many different types of organizations are classified as educational organizations, educational materials and activities are broadly defined to include even some portions of fundraising materials, and rules about full and fair exposition²⁸⁷ are generous and easy to follow. Educational and social action nonprofits currently working in the field of aid in dying have accomplished a lot through persistence, charismatic attraction of volunteers and supporters, and intelligent communication with all participants in the process of moving things forward. Even as the substantive laws themselves are rife with what this Article has called compassion gaps, the legal capacity for nonprofits to change the law is considerable.

Aid-in-dying organizations seek to disrupt and replace ideas about end-of-life autonomy and options. Some may characterize them as disruptive *despite* being public benefit charities. However, the way the rules pertaining to nonprofits are interpreted suggests that they are public benefit charities *because* they are disruptive; disruption is a valued role for nonprofit organizations. The challenges aid-in-dying nonprofits face are not primarily grounded in the rules that allow them to attain and maintain their status as public benefit charities able to receive tax-deductible contributions to support their disruptive missions.

The challenges aid-in-dying nonprofits face are grounded primarily in the legal and social contexts in which they seek change. They are also grounded in the fact that aid-in-dying nonprofits provide client services that instill a sense of urgency to secure lawful access to medical aid in dying. Such urgency can lead to compromise legislation that is difficult subsequently to liberalize, thereby providing greater access to more individuals suffering at the end of life who would choose to die peacefully sooner than to die later after extended suffering.

286. See generally I.R.C. § 4911 (2012); *Measuring Lobbying Activity: Expenditure Test*, *supra* note 283.

287. See generally Treas. Reg. § 1.501(c)(3)-1 (2012).

V. CONCLUSION

In 2014, the nonprofit Institute of Medicine²⁸⁸ released a report titled, “Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life.”²⁸⁹ That report and another report released by the Institute of Medicine the following year suggested that American end-of-life care could be improved substantially and should reflect more opportunity for individual access to palliative and other supportive assistance at the end of life.²⁹⁰ Polls also reveal substantial public support for greater end-of-life autonomy in choosing to hasten death under some circumstances.²⁹¹

Since at least 1980, aid-in-dying nonprofits have been actively working on this issue in diverse and creative ways, supported by a tax status that enables them to receive tax-deductible donations.²⁹² Yet, despite considerable medical research and public support for choice to end one’s life under some circumstances, there are not many milestones of success. At this point, there are no states other than Montana with affirmative common law protections for physicians to provide aid in dying,²⁹³ and courts in some states have explicitly rejected the opportunity to provide them.²⁹⁴ There are a small number of MAiD statutes, which even aid-in-dying nonprofits consider inadequate, and most proposed MAiD statutes are not enacted when first considered.²⁹⁵ FEN’s approach is vulnerable to vague definitions as to what constitutes assisting suicide,²⁹⁶ and in 2015, FEN was successfully prosecuted for assisting suicide in Minnesota, despite having done nothing

288. The Institute of Medicine is a nonprofit organization focused on health care and affiliated with the National Academies of Science. *The Institute of Medicine*, INST. FOR HEALTHCARE IMPROVEMENT, <http://www.ihi.org/resources/Pages/OtherWebsites/TheInstituteofMedicine.aspx> [<https://perma.cc/U5P3-MV9Q>].

289. INST. OF MED. OF THE NAT’L ACADS., *supra* note 16.

290. *See id.* at 7, 45–116, 407–41 (emphasizing need for continued expansion of access to palliative care, support for family oriented caregiving, and respect for end-of-life care centered on patient decisions).

291. Span, *supra* note 172 (reporting that, since 2002, between 66%–69% of Americans have responded affirmatively when asked in annual surveys if aid in dying should be allowed under some circumstances).

292. *See History of the End-of-Life Choice Movement*, COMPASSION & CHOICES, <https://compassionandchoices.org/resource/history-end-life-choice-movement> [<https://perma.cc/A5YF-MD7Y>]; *History of Final Exit Network*, *supra* note 228.

293. *But see* notes 203–05 and accompanying text (discussing the case *Kligler v. Healey* pending in Massachusetts).

294. *See Morris v. Brandenburg*, 376 P.3d 836, 857 (N.M. 2016). For case law rejecting petitions for declaratory judgments that physician-provided aid in dying is legal, see also *supra* note 96.

295. *See MCEVOY*, *supra* note 145, § 3.25.

296. *See supra* Part II (discussing the problem of ambiguous statutory definitions for “assisting” suicide).

more than provide information to a specific person in a specific private context about how to die.²⁹⁷

A. *Aid-in-Dying Nonprofits and the Stigma of Suicide*

What accounts for the apparent gap between public support for end-of-life options and the actual extremely limited availability of the option to end one's life as a legitimate, supported response to irremediable end-of-life suffering? The answer to that question is not simply a matter of anti-aid-in-dying nonprofits' ability to effectively counter the advocacy of aid-in-dying nonprofits. Nor is it primarily about legislators being out of touch with changing social values. After all, the extent of change in public attitudes is not clear, especially as long as suicide is stigmatized.²⁹⁸ Public support drops if aid in dying is described in a way that invokes the idea of suicide.²⁹⁹ Accordingly, most aid-in-dying nonprofits in the United States vigorously deny that medical aid in dying is a subset of suicide—an acceptable type of suicide under the specific circumstances of irremediable end-of-

297. For a description of the prosecution and subsequent litigation, see *supra* notes 118–22 and accompanying text.

298. See STEFAN, *supra* note 26, at 323–30; see also Lisa Schenker, *Assisted-Suicide Focuses Attention on Palliative Care, Hospice Care*, MOD. HEALTHCARE (May 16, 2015, 1:00 AM), <https://www.modernhealthcare.com/article/20150516/MAGAZINE/305169982/assisted-suicide-debate-focuses-attention-on-palliative-hospice-care> [<https://perma.cc/3XRP-F72D>] (“A Gallup poll last year found that 69% of Americans favored allowing doctors to ‘end a patient’s life by some painless means,’ though that figure dropped to 58% when people were asked if they supported allowing doctors to help incurable patients ‘commit suicide.’”). Gallup reported that of survey respondents between May 1–12, 2019, 79% responded that suicide is “morally wrong.” *Moral Issues*, GALLUP, <https://news.gallup.com/poll/1681/moral-issues.aspx> [<https://perma.cc/5MEG-7WZP>]. However, context appears to matter. During the same time period, 44% of survey takers responded that “doctor-assisted suicide” is “morally wrong,” while 52% responded that it is “morally acceptable.” *Id.*

299. Megan Brenan, *Americans’ Strong Support for Euthanasia Persists*, Gallup (May 31, 2018), <https://news.gallup.com/poll/235145/americans-strong-support-euthanasia-persists.aspx> [<https://perma.cc/C9NU-QT5P>] (“72% say doctors should be able to help terminally ill patients die. Fewer, 65%, express support when the question includes ‘commit suicide.’”); Lydia Saad, *U.S. Support for Euthanasia Depends on How It’s Described*, Gallup (May 29, 2013), <https://news.gallup.com/poll/162815/support-euthanasia-hinges-described.aspx> [<https://perma.cc/6LKS-CXM6>] (“In the same month that Vermont became the fourth state to legalize physician-assisted suicide, a May 2–7 Gallup survey finds 70% of Americans in favor of allowing doctors to hasten a terminally ill patient’s death when the matter is described as allowing doctors to ‘end the patient’s life by some painless means.’ At the same time, far fewer—51%—support it when the process is described as doctors helping a patient ‘commit suicide.’”).

life suffering.³⁰⁰ They claim instead that medical aid in dying and suicide are opposites.³⁰¹ Their purposes may include political expediency in passing MAiD statutes and avoidance of the application of laws that prohibit assisting suicide.

Cholbi describes the emerging consensus among U.S. aid-in-dying nonprofits as “anti-suicide but pro-assisted dying.”³⁰² He argues that, while aid-in-dying nonprofits’ rhetorical strategy may be politically expedient in the short term, it ultimately harms development of a “right to die” and the right to make autonomous choices at the end of life for two linked reasons: (1) there is no defensible conceptual, actual, or moral distinction between seekers of suicide and seekers of assisted dying,³⁰³ and (2) rhetoric that it is insulting to seekers of medical aid in dying to group them with seekers of suicide increases stigma associated with suicide.³⁰⁴ Accordingly, current advocacy choices could increase the stigma of suicide and hinder development of laws that provide meaningful access to aid in dying.

This may partially explain the gap between apparent public receptivity to medical aid in dying and limited, burdensome legislative outcomes. The public may support the general concept of aid in dying, but legislators must craft the actual laws containing the level of specificity believed sufficient to guard against error and abuses. Legislators grappling with the details of particular MAiD statutory proposals cannot stay at the level of abstraction at which the public can be supportive of medical aid in dying by superficially distinguishing it from assisting suicide; the actual and moral similarities between assisting another to commit suicide and medical aid in dying are more difficult to deny. Legislators may be willing to pass some kind of legislation, but it will likely be limited in scope and laden with safeguards experienced as obstacles. Current MAiD statutes exemplify this outcome.

Cholbi’s perspective on nonprofits’ increasing the stigma associated with suicide is worth particular consideration because it suggests a path forward that comports with aid-in-dying nonprofits’ long-term goals. Cholbi believes that the emerging consensus of “anti-suicide but pro-assisted dying” inadvertently “stigmatizes suicide in its effort to de-stigmatize assisted dying.”³⁰⁵ He describes the rhetoric of aid-in-dying nonprofits as calling

300. See Cholbi, *supra* note 27, at 2.

301. *Id.* at 7.

302. *Id.* at 2. Yet, Cholbi contends, “There is . . . no significant disjunction between the cases of assisted dying that this emerging consensus accepts and the cases of ‘suicide’ that it rejects.” *Id.*

303. *Id.* at 5 (“Properly understood, suicide and the seeking out of assisted dying . . . stand on a moral par, such that considerations that favor access to the latter militate equally strongly in favor of access to the former.”).

304. *Id.*

305. *Id.* at 5, 14.

for avoidance of “lump[ing] those who seek out physician-assisted dying with the suicidal [because it] will offend, hurt, and derogate those who take advantage of ‘death with dignity’ laws and their families.”³⁰⁶ He contends that this approach increases the stigma of suicide and that stigmatizing suicide increases the prevalence of suicide:

[T]here is good reason to suppose that stigmatization of suicide contributes to its prevalence. If Thomas Joiner’s theory of suicidal psychology is correct . . . , then this should not be surprising. For on Joiner’s theory, two of the main contributors to suicidal thinking are a thwarted sense of belonging and a sense of being a burden to others. It is not difficult to imagine suicidal persons reading Death with Dignity’s [National Center] account of suicidal thinking and experiencing a sense of exclusion at learning that they, unlike their terminally ill brethren seeking out medically assisted dying, are “impulsive” or “desperate” in wanting to die.³⁰⁷

Increasing stigma associated with suicide hinders efforts to make medical aid in dying accessible because of obvious similarities between the thought processes and situations of those seeking medical aid in dying and those seeking suicide. Cholbi carefully parses the alleged differences between those two populations and finds no meaningful differences between them. Both terminally ill and suicidal people are susceptible to depression and anxiety, value autonomy, seek to end life in *expectation of* poor quality of life as much as *existing* poor quality of life, and are willing to use death as a means to an end even though they may not actively “desire” or “intend” to die. While acknowledging that the approach of aid-in-dying nonprofits has short-term political efficacy, he concludes nonetheless that “assisted dying for the terminally ill is suicide *tout court*” and that “[p]roperly understood, suicide and the seeking out of assisted dying . . . stand on a moral par, such that the considerations that favor access to the latter militate equally strongly in favor of access to the former.”³⁰⁸

Cholbi describes his own position as “anti-anti-suicide.”³⁰⁹ He contends that such a position is compatible with a society’s attempts to make aid in dying accessible—closing the gap between public support and legislative insufficiency—and to make suicide rare but safe and legal under some

306. *Id.* at 7.

307. *Id.* at 13–14 (footnote omitted) (citing Bernardo Carpiello & Federica Pinna, *The Reciprocal Relationship Between Suicidality and Stigma*, 8 FRONTIERS PSYCHIATRY 35 (2017)).

308. *Id.* at 5, 12.

309. *Id.* at 14.

circumstances.³¹⁰ The pathway to that goal includes reducing the stigma associated with suicide, not fueling it.

This approach of attempting to reduce stigma associated with suicide has not been adopted by any American aid-in-dying nonprofit, but it may hold more promise for the aid-in-dying movement than is currently appreciated. What if destigmatizing suicide could lead to a more rational and compassionate approach to each individual whose circumstances—*whatever they are*—has led that person to consider a life-ending act? Imagine an individual who approaches an aid-in-dying nonprofit for assistance with dying for reasons that could be addressable with appropriate guidance and support such that the person could lead a fulfilling life. The individual feels comfortable talking about his or her reasons for wanting to die and expects to be heard respectfully because, after all, it is an aid-in-dying organization. If, having listened carefully to such an individual and with respect for the person's autonomy, an aid-in-dying organization offers individualized information and assistance with realistic, viable alternatives to such a life-ending act, the person may be more inclined to listen to the suggestions *because* the organization has the lawful ability to offer them expert and professional assistance to end his or her life if warranted.

Such aid-in-dying organizations may well be more successful in preventing suicide attempts than “anti-suicide” organizations. Such organizations may also build greater societal respect for individual autonomy at the end of life through destigmatizing suicide, even though not all suicides would be supported. Greater respect for autonomy could be expected to result in greater societal acceptance for medical aid in dying and increased legal access for those suffering at the end of life.

This is not just an imaginary scenario; this orientation to treating suicide attempt prevention seriously and individuals' wish to die respectfully are guiding ideas of Dignitas – To live with dignity – To die with dignity. Dignitas is a Swiss nonprofit membership association known internationally for helping irremediably suffering individuals to end their lives by self-administration of physician-prescribed medication.³¹¹ In fact however, Dignitas does comprehensive advisory work with an aim to *prevent* suicide attempts,

310. *Id.*

311. *FAQ*, DIGNITAS, http://www.dignitas.ch/index.php?option=com_content&view=article&id=69&Itemid=136&lang=en [<https://perma.cc/M2SQ-SP5Q>]. The correct name of this organization is as stated: Dignitas – To live with dignity – To die with dignity, which reflects the mission of the organization to help people to live with dignity if possible and, if not possible, to assist them lawfully to die, if the individual chooses. *Id.* The organization uses “Dignitas” as the short form of its name. *Id.* For more information about its focus on suicide attempt prevention, see *Suicide-Prevention and Suicide-Attempt-Prevention*, DIGNITAS, http://www.dignitas.ch/index.php?option=com_content&view=article&id=18&Itemid=58&lang=en [<https://perma.cc/8R2H-V3GK>].

including providing expert advice about palliative care and advance health care planning. Dignitas is not primarily focused on providing “accompanied suicide.”³¹²

Like Dignitas, many American aid-in-dying nonprofits also provide assistance with advance health care planning and information about palliative care options.³¹³ The difference lies in such organizations’ strenuous political rhetoric characterizing use of medical aid in dying as the polar opposite of suicide and not as a subset of suicide. If Cholbi is correct, this will ultimately backfire because of inherent contradictions, such as respecting some individuals’ autonomy but not that of others similarly situated with respect to suffering and by increasing the stigma of suicide. Increasing the stigma of suicide could result in increased willingness to prosecute in ambiguous cases of physician assistance, increased burdening of MAiD statutes with more requirements for both patients and physicians, increased enactment of anti-MAiD laws, and increasing suicide rates.

*B. Aid-in-Dying Nonprofits and the Challenge of Respecting the
Autonomy of Individuals Embedded in Social Networks*

Aid-in-dying nonprofits have agreed since the introduction of the first MAiD statutes that medical aid in dying should be available only to “qualified” patients. The list of qualifications is, in fact, quite long and accounts for much of the statutory detail in MAiD laws.³¹⁴ These qualifications embody the conceptual boundary between suicide and hastening a death that has already arrived on the near horizon. They include a prognosis of death within six months and the absence of decision-hindering conditions, such as depression and cognitive deficiency. They require verification of such

312. *FAQ*, *supra* note 311. Dignitas uses “accompanied suicide” as the term for providing medical aid in dying, which includes attending the death. *Id.*

313. *See, e.g., Advance Care Planning*, END LIFE CHOICES CAL., <https://endoflifechoicesca.org/advance-care-planning> [<https://perma.cc/R4LR-5MJ6>]; *Advance Directives*, COMPASSION & CHOICES, <https://compassionandchoices.org/end-of-life-planning/plan/advance-directives/> [<https://perma.cc/D36G-G368>]; *Advance Directive*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/advance-directive/> [<https://perma.cc/SGD9-4HB3>]; *Advance Directives*, END LIFE WASH., <https://endoflifewa.org/choices-and-planning/advance-directives> [<https://perma.cc/F2AB-EX89>]; *Benefits of Membership in Final Exit Network*, FINAL EXIT NETWORK, <http://www.finalexitnetwork.org/Benefits-of-Membership.html> [<https://perma.cc/E5N9-C54A>]; *End of Life Liberty Project*, *supra* note 26; *End-of-Life Choices*, END LIFE WASH., <https://endoflifewa.org/end-life-choices> [<https://perma.cc/G9RT-KY68>].

314. *See, e.g., CAL. HEALTH & SAFETY CODE* §§ 443.1–.22 (West 2019).

qualifications, and failure to do so can result in loss of legal protection from legal liability for homicide or for assisting another to commit suicide.

Aid-in-dying nonprofits' activism may be driven by political expediency, avoidance of the legal problems of assisting suicide, and provision of direct client services. The desire to address severe, irremediable end-of-life suffering may heighten willingness to compromise in order to get something—anything remotely reasonable—passed. Moreover, aid-in-dying nonprofits must be concerned with the fact that patients are embedded in social networks. Consider that, if individual patient qualification were the only issue, one might as well argue that gun dealers should be able to sell guns to individuals they know to be interested in ending their lives, if those individuals are qualified to do so. As a method of ending life, guns are highly effective³¹⁵ and less subject to the vagaries of individual physiology in response to lethal doses of medication, particularly now that the gold standard for lethal prescription medications is difficult to obtain.³¹⁶

No existing aid-in-dying nonprofit would pursue liberalizing accessibility to guns as a rational and efficient means of assisting individuals suffering at the end of life, even if it is, in some respects, no less radical than liberalizing access to lethal doses of medication. One highly significant reason for that is recognition that death is both individual and communal; how people die matters not only to the person who is dying but also to the people who love that person. Dying after peacefully falling asleep—whether naturally or induced by an overdose of sedatives—seems ideal from the perspectives of many dying people and, *also*, the people who gather to offer support and to express their love. In fact, Americans are increasingly turning away from isolated medicalized deaths and toward deaths coached by “death doulas,” whose assistance respects that an individual’s death is important to a dying individual’s social network.³¹⁷

315. See Madeline Drexler, *Guns and Suicide: The Hidden Toll*, HARV. PUB. HEALTH, https://www.hsph.harvard.edu/magazine/magazine_article/guns-suicide [<https://perma.cc/M7KN-EEJW>] (“[M]ore people in [the United States] kill themselves with guns than with all other intentional means combined, including hanging, poisoning or overdose, jumping, or cutting. Though guns are not the most common method by which people attempt suicide, they are the most lethal. About 85 percent of suicide attempts with a firearm end in death. (Drug overdose, the most widely used method in suicide attempts, is fatal in less than 3 percent of cases.)”).

316. See Taimie Bryant, *Aid in Dying: The Availability of Ideal Medications for Use in “Right to Die” Jurisdictions in the United States*, 34 QUINNIPIAC L. REV. 705, 707, 711 (2016) (discussing the legal problems associated with access to ideal barbiturates for aid in dying and possible solutions).

317. Hermione Elliott, Opinion, *Death Doulas Complement Nursing Care at the End of Life*, NURSING TIMES (Aug. 20, 2014), <https://www.nursingtimes.net/hermione-elliott-death-doulas-complement-nursing-care-at-the-end-of-life/5073875.article> [<https://perma.cc/MP23-F7R2>]; Deb Rawlings et al., *What Role Do Death Doulas Play in End-of-Life Care? A Systematic Review*, 27 HEALTH & SOC. CARE COMMUNITY, Aug. 2018, at e87, e90; see

Client service provision by aid-in-dying nonprofits includes attention to the medical details of dying and also, to the details of family and friends' opportunity to be present during the dying process, if so desired.³¹⁸ More than death doulas, such organizations assist individuals in finding their way through regulatory requirements, locating a willing physician and pharmacist, and safely self-administering the life-ending dose of medication.³¹⁹ Along the way, aid-in-dying nonprofits and patients come up against the reality that provision of a lethal dose of prescription medicines requires a physician knowingly to provide a lethal dose prescription and a pharmacist knowingly to fill it. The autonomy of the physician and of the pharmacist come into play at that point, resulting in laws that are properly characterized as "physician protection (from prosecution)" laws or as patient "right to ask (for assistance)" laws rather than "right to die" laws.

That people are embedded in social contexts is, perhaps, the greatest gift to a dying person and also the greatest impediment to a straightforward legal realization of individual autonomy at the end of life.³²⁰ In addition to those who support a dying individual's choice to stop living for reasons centered on that person's wellbeing and autonomy, individuals significant to the dying person may suggest for misguided or self-interested reasons that death is a good option.³²¹ The U.S. Supreme Court in *Washington v.*

also Antonia Blumberg, *A Growing Movement of 'Death Doulas' Is Rethinking How We Die: For End-of-Life Doulas, Accompanying the Dying Is Anything but Morbid*, HUFFINGTON POST (June 5, 2017, 8:44 AM), https://www.huffpost.com/entry/end-of-life-doulas_n_591cbce2e4b03b485cae51c2 [<https://perma.cc/8VJF-NLAZ>]; Ellen McCarthy, *Dying Is Hard. Death Doulas Want To Help Make It Easier*, WASH. POST (July 22, 2016), https://www.washingtonpost.com/lifestyle/style/dying-is-hard-death-doulas-want-to-help-make-it-easier/2016/07/22/53d80f5c-24f7-11e6-8690-f14ca9de2972_story.html?noredirect=on&utm_term=.c033123be031 [<https://perma.cc/5BE4-RX7W>]; Alina Tugend, *Doulas, Who Usher in New Life, Find Mission in Support for the Dying*, N.Y. TIMES (Jan. 23, 2015), <https://www.nytimes.com/2015/01/24/your-money/death-doulas-help-the-terminally-ill-and-their-families-cope.html> [<https://perma.cc/XM9N-J54P>]. Nonprofit organizations also operate in this area. See *About*, INELDA, <https://www.inelda.org/about> [<https://perma.cc/3H9P-QHQ4>] ("The International End of Life Doula Association (INELDA) is a nonprofit organization dedicated to bringing deeper meaning and greater comfort to dying people and loved ones in the last days of life.").

318. E.g., *Client Services*, END LIFE CHOICES OR., <https://eolcoregon.org/help-end-life-choices-oregon/client-services> [<https://perma.cc/JC55-SG3U>].

319. E.g., *id.*; *About Us*, *supra* note 86.

320. For a diagrammatic representation of the many social contexts and influences in which seekers make decisions, see Oliver, *supra* note 25, at 47 fig.1.

321. Self-interest on the part of the one who "suggests" hastening death can take the form of desire for financial gain, as for example when an heir apparent is expecting an inheritance

Glucksberg identified states' interest in protecting vulnerable individuals as a legitimate reason for limiting access to physician aid in dying,³²² and states have in fact focused on vulnerability to others' influence as a serious concern.³²³

Is it possible to determine with sufficient certainty that the choice to end life was, in fact, an individual's own decision? Sometimes it does not take another's explicit suggestion that death is a good choice; a person might adopt the perspective on one's own that others would be "better off" if one died sooner rather than later. Surely, there can be financial, emotional, and physical challenges associated with caring for one who is approaching the end of life. And surely, one suffering at the end of life can be aware and concerned about the extent of burden on loved ones. Is this a type of vulnerability against which the law should or could act? What about vulnerability borne of a transient, addressable despair?

MAiD statutes are crafted to reduce the possibility that a patient has been unduly influenced by someone else or that the patient does not understand the consequence of a decision to consume a lethal dose of medication. Some require physicians to assess explicitly an individual's reasons for using the aid-in-dying option and whether the decision was improperly influenced by other people.³²⁴ MAiD statutes' inclusion of required waiting

that would be diminished by further medical care expenditures for the individual contemplating use of aid in dying. Or, a self-interested person who supports another's decision to hasten death might want relief from financial expenditures on behalf of the dying individual. There can also be other, nonfinancial, reasons. For instance, in the case of *State v. Melchert-Dinkel*, the Minnesota Court considered particularly troubling facts:

Posing as a depressed and suicidal young female nurse, Melchert-Dinkel responded to posts on suicide websites by Mark Drybrough of Coventry, England, and Nadia Kajouji of Ottawa, Canada. In each case, he feigned caring and understanding to win the trust of the victims while encouraging each to hang themselves, falsely claiming that he would also commit suicide, and attempting to persuade them to let him watch the hangings via webcam.

844 N.W.2d 13, 16 (Minn. 2014).

322. 521 U.S. 702, 732 (1997).

323. *Melchert-Dinkel*, 844 N.W.2d at 18, 22; see also *Morris v. Brandenburg*, 376 P.3d 836 (N.M. 2016) (providing Justice Chavez's opinion, writing for the New Mexico Supreme Court, emphasizing that patient vulnerability to undue influence from others was an important reason for rejecting the idea that physician aid in dying falls within an individual's constitutionally protected right of privacy). *Morris*, 376 P.3d at 857 (concluding that one of the legal rationales behind the prohibition on assisting suicide was "the interest in protecting vulnerable groups—including the poor, the elderly, and disabled persons—from abuse, neglect, and mistakes due to the real risk of subtle coercion and undue influence in end-of-life situations or the desire of some to resort to physician aid in dying to spare their families the substantial financial burden of end-of-life health care costs").

324. See, e.g., Oregon Death with Dignity Act, OR. REV. STAT. § 127.815 (2018) (attending physician responsibilities); OR. REV. STAT. § 127.820 (2018) (consulting physician confirmation); OR. REV. STAT. § 127.825 (2018) (counseling referral); OR. REV. STAT. § 127.830 (2018)

periods, multiple requests, and assessments of emotional and cognitive status are also included for this purpose. Moreover, such requirements are replicated in all new MAiD proposals, despite the fact no evidence of abuse of vulnerable people has occurred in states with MAiD statutes.³²⁵ The concern remains great, and a lack of evidence does not mean that abuse is not occurring.

Aid-in-dying nonprofits, whose mission is to secure access to aid in dying, have participated in crafting these requirements, although, objectively viewed, such requirements limit patient autonomy to those who qualify under restrictive rules. Whether to seek passage of laws or in recognition of patient and physician circumstances, aid-in-dying advocates do not deny involvement in the creation of access limitations in MAiD, and some advocates say that the access burdens now associated with MAiD statutes have gone too far.³²⁶ Numerous requirements burden patients, and fear of making a mistake can plague physicians. Indeed, the requirements are now so numerous that physicians may well hesitate to help a patient for fear of legal exposure resulting from failure to follow every requirement exactly. In a legal environment still hostile to the ideas of suicide and physician assistance, small errors might not be overlooked. Aid-in-dying nonprofits' agreement that the Oregon statute should be used as a model in other jurisdictions has saddled progress in enacting medical aid-in-dying statutes with the weight of an increasing number of unwieldy rules.

The fact is that no aid-in-dying law, including a “physician’s best practices” model of access to physician assistance³²⁷—the Montana example—can eliminate all doubt about individual cases. Even with multiple statutory requirements, MAiD statutes cannot fully address concerns about patient decision-making and other aspects of assisting a patient to die, even if the circumstances of patient suffering seem compelling. Accordingly, a qualified

(informed decision); *see also* CAL. HEALTH & SAFETY CODE § 443.5 (West 2019) (determinations required prior to prescription of aid-in-dying drug).

325. Grube, *supra* note 170.

326. *E.g.*, Tucker, *supra* note 194, at 6; *see also* Sierra Hägg, *Obstacles Surface Due to Hawai'i's Aid-in-Dying 'Safeguards,'* BIG ISLAND NOW (Apr. 11, 2019, 1:50 PM), <http://bigislandnow.com/2019/04/07/obstacles-surface-due-to-hawaiiis-aid-in-dying-safeguards> [<https://perma.cc/Z935-NNR4>]; Span, *supra* note 172 (“Many force the dying to navigate an overly complicated process of requests and waiting periods, critics say.”); Wiggins, *supra* note 174 (“Advocates said the changes imposed so many roadblocks that few, if any, doctors or patients would likely opt to take advantage of the bill even if it became law.”).

327. *See generally* Kathryn L. Tucker, *Aid in Dying: An End of Life-Option Governed by Best Practices*, 8 J. HEALTH & BIOMEDICAL L. 9 (2012).

patient may ask a physician for a lethal dose prescription, but a physician may refuse without giving any reason. A physician may wonder about the difficulty of assessing whether the patient's request reflects a transient frame of mind, if the patient has been influenced by a self-interested person, such as an heir apparent, to choose death, if the patient will regret the choice when it is too late, if there would be inadvertent harm done to the patient's immortal soul, or if the medication will be ingested as directed or work as expected. Some physicians might resist the idea that a physician's role includes helping a patient to die or worry about their own immortal soul should they provide the means for a patient to end his or her life.³²⁸ Ultimately, each patient, each physician, and each pharmacist must navigate individual autonomy in relationship to each other.

Concern that a physician could be found legally culpable in a particular situation is a problem for physicians and patient access not only with regard to MAiD statutes. It is also a challenge for FEN because its medical personnel evaluate whether a particular person qualifies for assistance, and it is also a challenge for physicians and patients if a jurisdiction follows the example of Montana or allows physicians to prescribe lethal dose prescriptions as part of the "best practices" standard applied to physicians. How does a physician know whether a *particular* patient's situation would be adjudged inappropriate for aid-in-dying? In such a case, the physician could be prosecuted for homicide and sued civilly for wrongful death.³²⁹ The physician could also lose the license to practice medicine.³³⁰ The risk of these consequences could be very low in the case of an individual dying patient whose family fully supports the physician's decision to assist the patient by providing a lethal dose prescription, but if realized, the consequences would be extremely costly to the physician. Given the consequences of making an incorrect judgment, it is no wonder that a physician would be particularly reluctant to provide such a prescription without a longstanding relationship with the patient and evidence of the family's supportive perspective.³³¹ In an age of managed care in which longstanding patients and physician relationships are increasingly rare,³³² lethal dose prescriptions may be difficult to obtain.

328. See generally ZITTER, *supra* note 16.

329. Tucker, *supra* note 194, at 12–13, 18.

330. Alan Blinder, *Doctor Loses License over Assisted Suicide*, N.Y. TIMES (Dec. 30, 2014), <https://www.nytimes.com/2014/12/31/us/doctor-loses-license-over-assisted-suicides.html> [<https://perma.cc/6UQL-DEQ6>].

331. It is a patient's family members who would be most likely to file a civil wrongful death lawsuit, and so cautious physicians would be careful to keep records that document compliance with statutory requirements and would be interested in knowing whether family members are supportive of the patient's decision to hasten death.

332. See John La Puma, *Does the Doctor-Patient Relationship Mean More to Doctors than Patients?*, MANAGED CARE MAG. (Jan. 1, 1996), <https://www.managedcaremag.com/>

C. Aid-in-Dying Nonprofits' Role in the Context of Self-Administration of Life-Ending Medications

Even if a physician concludes that an individual's decision is autonomous, the physician can offer no more than a "do-it-yourself" approach to ending life. Indeed, all American aid-in-dying nonprofits' approaches share this characteristic of advocating for only a do-it-yourself means of ending one's life.³³³ The only significant difference between FEN's approach of counseling individuals, on the one hand, and, on the other, the MAiD approach and the approach of including within a physicians' best practices the option to provide lethal dose prescriptions is that the FEN approach does not necessarily include lethal doses of medication prescribed specifically for the purpose of ending one's life.

All do-it-yourself methods carry some degree of risk of failure because they require individuals inexperienced at ending their lives to follow instructions at a time they are the most impacted by illness and the circumstances leading to their desire to die sooner rather than "letting nature take its course." In this context of do-it-yourself ending of one's life, an important role that aid-in-dying nonprofits can play is providing knowledge important to the individual's ease and success. For instance, to succeed in ending life, the prescribed lethal dose of medicine must be entirely ingested quickly;³³⁴ sitting for ingestion is also thought to help avoid regurgitation, and certain other positions after the risk of regurgitation abates may help the medicine be more quickly effective.³³⁵ Experienced aid-in-dying nonprofit volunteers attending a death can be watchful about such things, allowing family members to trust in the greater knowledge of the volunteers and to focus on their loved one's transition.

At the same time, attending a death and providing assistance may, in a hostile sociocultural and legal environment, expose nonprofits to some risk

archives/1996/1/does-doctor-patient-relationship-mean-more-doctors-patients [https://perma.cc/GLK8-9DFH].

333. Aleccia, *supra* note 169; Majchrowicz, *supra* note 82.

334. According to Dr. Robert Wood of End of Life Washington Seattle, the lethal dose of medication must be consumed within three to four minutes, before the person falls asleep and cannot finish the dose. Interview with Robert W. Wood, Volunteer Med. Advisor, End of Life Wash., in Seattle, Wash. (May 29, 2015). According to Dr. Judy Neall Epstein of End of Life Choices California, the advisable consumption period is 90–120 seconds, with the result that the individual falls asleep very quickly. Interview with Judy Neall Epstein, President, End of Life Choices Cal. (Sept. 5, 2019).

335. Interview with Robert W. Wood, *supra* note 334.

of impermissibly assisting suicide. In this regard, aid-in-dying nonprofits operating in states with MAiD statutes have the advantage that some instances of medical aid in dying are legally approved, which could mean less scrutiny of every detail of nonprofit assistance as the individual is dying. FEN does not have that advantage because it is assisting people in jurisdictions without MAiD or in MAiD jurisdictions that do not cover the specifics of the individual it is assisting. There are no data about physicians prescribing lethal dose prescriptions in Montana, which is the only jurisdiction explicitly allowing such prescriptions. Accordingly, there are no data about aid-in-dying nonprofits assisting patients who have received a lethal dose prescription from such a physician under a “best practices” model.

D. Aid-in-Dying Nonprofits and the Future of Medical Aid in Dying

The role of aid-in-dying nonprofits is easy to state in relation to their mission statements: development of legal options for individuals irremediably suffering at the end of life and education of those individuals and society through client services, various programs, and legal advocacy.³³⁶ However, they are actually playing quite broad roles in sociocultural ideas about suicide, relational autonomy of patients and physicians, the interplay of autonomy and vulnerability, and legal definitions of assisting suicide.

Given the complexity of these ideas individually and their interrelationship, it is difficult to predict how aid in dying will evolve in the United States. Will the gap close between public support for access to aid in dying and actual access? If so, what direction will the United States take? Will the United States eventually develop laws such as those in Canada and the Netherlands, which allow physicians to provide euthanasia and self-administered lethal doses of medication?³³⁷ If so, under what types of restrictions, such as exclusion of minors suffering irremediably at the end of life?³³⁸ Will current MAiD statutes increase in number and utility over time? Or, will actual access to aid in dying be limited to white, educated

336. E.g., *About Us*, *supra* note 86; *Who Is the Final Exit Network (FEN)*, *supra* note 63.

337. Ezekiel J. Emanuel et. al., *Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe*, 316 JAMA 79 (2016), <https://jamanetwork.com/journals/jama/article-abstract/2532018> [<https://perma.cc/MG69-JNHB>] (surveying the legal status and data regarding practices and attitudes about euthanasia and assisted suicide in the United States, Canada, and Europe).

338. See Scottie Andrew, *Where Is Euthanasia Legal? Three Terminally Ill Minors Chose To Die in Belgium, New Report Finds*, NEWSWEEK (Aug. 7, 2018, 4:26 PM), <https://www.newsweek.com/child-euthanasia-legal-belgium-three-minors-died-1061587> [<https://perma.cc/9UQ9-WQZR>]; Marije Brouwer et al., *Should Pediatric Euthanasia Be Legalized?*, 2018 J. AM. ACAD. PEDIATRICS 141, 141, <https://pediatrics.aappublications.org/content/141/2/e20171343> [<https://perma.cc/5BAU-2BE8>].

individuals³³⁹ or shrink under the weight of numerous requirements for access and provision of aid in dying?³⁴⁰ Given the complexity of the laws and social issues, such as the heavy stigma associated with suicide, Americans will continue to struggle with access to aid in dying for some time. As long as that is true and as long as aid in dying takes the form of providing only do-it-yourself methods, aid-in-dying nonprofit organizations will continue to play important roles in shaping social and legal discourse about life, suicide, vulnerability, autonomy, and assistance to those suffering at the end of life.

339. According to the most recent report in 2017 of the Washington State Department of Health, 94% of those who died from ingestion of a lethal dose prescription issued in compliance with Washington's MAiD law were white, and 75% had a minimum of some college education. WASH. STATE DEP'T OF HEALTH, WASHINGTON STATE: DEATH WITH DIGNITY ACT REPORT 1 (2018), <https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2017.pdf> [<https://perma.cc/J44Z-XF3L>]. Similarly, Oregon reported that 94.4% of those who used Oregon's MAiD law were white and 69.5% had at least some college education. OR. HEALTH AUTH. PUB. HEALTH DIV., OREGON DEATH WITH DIGNITY ACT: 2017 DATA SUMMARY (2018), https://www.oregon.gov/oha/PH/PROVIDERPARTNER_RESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year20.pdf [<https://perma.cc/Y7DA-T9LR>].

340. See Span, *supra* note 172.

