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FROM RIGHTS TO DIGNITY:
DRAWING LESSONS FROM AID IN DYING AND REPRODUCTIVE
RIGHTS

Yvonne Lindgren*

Abstract

In Roe v. Wade the Supreme Court identified the abortion right as “inherently, and primarily, a medical decision” to be decided between doctors and their patients. Early abortion case law closely linked the right to the doctor-patient relationship and situated abortion within the context of healthcare. Over the last forty years, however, the abortion right has come to be viewed almost exclusively as a constitutional right of decision-making or “choice.” Under the Court’s current analysis, the abortion right is cabined exclusively as a constitutional right to decide to terminate a pregnancy and, as a result, the Court has upheld significant restrictions on access to abortion-related healthcare.

The aid in dying (AID) movement has experienced the opposite trajectory between framings of healthcare and a constitutional right of decision-making. Originally identified as a “right to die” by advocates such as Dr. Jack Kevorkian, the movement has since transitioned to a right framed as healthcare. Dr. Timothy Quill’s call for “death with dignity” helped to reframe the AID movement from a narrow focus on decision-making at death to transforming the process of dying more generally. The transition to death with dignity coincided with an expanded public discourse about how poverty, disability, social and family support, and healthcare access impact end-of-life decision-making. At the same time, the goals of the movement expanded from court-won rights to

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changing healthcare practices, and increasing healthcare access, legal rights and social support for people facing the end of life.

It is a critical time to study and draw lessons from these two movements as they accelerate in opposite directions: Last year, pro-AID legislation was pending in twenty-five states, passed in California, and cases were filed in California and New York. The Supreme Court heard oral arguments this term in a Texas case on regulatory restrictions of abortion clinics. Further, more state abortion restrictions were enacted between 2011 and 2013 than in the entire previous decade. While other scholarship has compared AID and the abortion right to consider their doctrinal, moral and ethical similarities, this Article is the first to identify that these two movements arc in opposite directions between framings of healthcare and rights, with vastly different efficacy for the rights holder. I draw upon this comparison to consider how the history and discursive development of these two movements offers the possibility of framing healthcare more broadly within the context of dignity to achieve social justice goals beyond narrow constitutional rights status.

The transformation of AID from a constitutional rights frame to a healthcare frame highlights the importance of developing a healthcare model related to dignity that is undergirded by social support, legal rights and healthcare access. However, the history of the abortion right cautions against narrowly identifying healthcare within the confines of the individual doctor-patient relationship because it risks subordinating the decisional autonomy of patients to the decision-making of their doctors. Taken together, these movements gesture toward situating rights within a healthcare framing that considers how social, political and economic systems and relationships come to bear upon decision-making. I conclude that while constitutional rights status is important for anchoring a minimum protection of the right of patient decisional autonomy, a healthcare-as-dignity frame brings with it the possibility of addressing underlying conditions that deprive individuals of meaningful choice in these contexts.

INTRODUCTION

The current “death with dignity” framing of aid in dying (AID)¹ belies its early “right to die” origins that were marked by heated public conflict over morality,

¹ The term “aid in dying” has recently replaced the commonly used term “assisted suicide” to refer to a terminally ill competent patient’s decision to seek a physician’s help in prescribing medication to hasten the dying process. See David Orentlicher et al., *The Changing Legal Climate for Physician Aid in Dying*, 311 J. AM. MED. ASS’N 1961, 1961–62 (2014); Kathryn L. Tucker, *In the Laboratory of the States: The Promise of Glucksberg’s Invitation to States to Address End-of-Life Choice*, 106 MICH. L. REV. 1593, 1594–95 (2008)

ethics, and “life” similar to those that are ongoing in the reproductive rights arena, and primarily the abortion right. The early movement for AID was personified by Dr. Jack Kevorkian, a pathologist who claimed to have assisted more than one hundred individuals to terminate their lives. Dr. Kevorkian did not have ongoing doctor-patient relationships with the people he helped to die; rather, he conceptualized his help as a service to strangers in their quest to end their lives.² Dr. Kevorkian’s work is illustrative of the early framing of AID as an individual’s right of decision-making that was uncoupled from the context of healthcare. In this same period, the AID movement sought court recognition of a constitutional right to choose to terminate one’s life with the help of a physician.

It was Dr. Timothy Quill who first called for “death with dignity” in his article by the same name,³ and in so doing began the process of reframing the right to die from a constitutional rights claim to an issue of healthcare.⁴ After the Supreme Court’s rejection of a right of AID in *Washington v. Glucksberg*,⁵ the AID movement evolved from a focus on constitutional rights claims into one that included broader healthcare goals that sought to enhance the legal rights and healthcare access of people at the end of life. Thus, what began as a focus on decision-making at death transitioned into a movement to transform the *process of dying* more generally by increasing the social support, healthcare access, and legal rights of people in the dying process.⁶

(noting the important evolution in terminology from “suicide” to describe the choice of a mentally competent, terminally ill person to choose death); Judith Gordon, *New WSPA Policy on Value-Neutral Language Regarding End-of-Life Choices*, (Jan. 8, 2007), http://www.wapsych.org/resource/resmgr/Docs/New_WSPA_Policy_on_Value-Ne.docx (2007) [<https://perma.cc/DU73-H7WT>]; *infra* notes 88–96 and accompanying text.

² HOWARD BALL, *AT LIBERTY TO DIE: THE BATTLE FOR DEATH WITH DIGNITY IN AMERICA* 68–69 (2012).

³ Timothy E. Quill, *Death and Dignity: A Case for Individualized Decision Making*, 324 *NEW ENG. J. MED.* 691, 691–94 (1991). Others have been equally instrumental in shifting the way dignity is understood in the dying process. For example, Elizabeth Kubler-Ross is considered to be the mother of the hospice movement in the United States and an influential thinker on the care for the dying.

⁴ Professor Robert Schwartz persuasively made this argument in a lecture entitled *How Physician Aid in Dying Became a Medical, Not a Legal, Issue* presented at the UCSF/UC Hastings Consortium on Law, Science and Health Policy on August 28, 2012.

⁵ 521 U.S. 702, 705–06 (1997).

⁶ At the same time, the movement continued to push for the legal rights to AID at the state level. In 2009, the Montana Supreme Court recognized the right of terminally ill competent patients to AID by drawing upon the “dignity” language in its state constitution. *See Baxter v. State*, 224 P.3d 1211, 1213 (Mont. 2009). In recent years, AID has experienced trending successes, with five states legalizing aid in dying: Oregon and Washington by public referendum, Vermont and California through legislation, and Montana through judicial decision. A case is currently pending in the New Mexico Supreme Court. *Morris v. Brandenburg*, No. D-202-CV 2012-02909 (N.M. Dist. Ct. Jan. 31, 2014), *rev’d*, 356 P.3d 564 (N.M. Ct. App. 2015), *cert. granted*, 369 P.3d 369 (N.M. Aug. 31, 2015) (No. 35,478).

By contrast, the abortion right has experienced the opposite trajectory between framings as a constitutional right of decision-making and a right of healthcare. The abortion right was originally identified by the *Roe v. Wade* Court as “inherently, and primarily, a medical decision” to be decided between doctors and their patients.⁷ Over the last forty years, however, the abortion right has come to be viewed almost exclusively as a constitutional right of decision-making or “choice.”⁸ Under the Supreme Court’s current analysis, the abortion right is cabined exclusively as a constitutional right to decide to terminate a pregnancy and the Court has upheld significant restrictions on access to abortion-related healthcare under the undue burden analysis developed in *Planned Parenthood of Southeastern Pennsylvania v. Casey*.⁹ In marked contrast with the AID movement, there has recently been a dramatic retraction in the social support, legal rights, and healthcare access of women seeking abortion-related healthcare. Courts, legislatures, and public discourse continue to narrowly identify reproductive rights almost exclusively as the right of abortion articulated as an individual’s right of choice.¹⁰

Putting these two movements in sharp relief, I argue that the current framing of abortion rights more closely resembles the AID rights-framing of Dr. Kevorkian than the contextualized healthcare framing of Dr. Quill. It is a critical time to study and understand these movements as each is gaining significant momentum—again, in opposite directions: In 2015, twenty-five states plus the District of Columbia considered death with dignity legislation,¹¹ and AID legislation was signed into law in California¹² with cases filed in California¹³ and New York.¹⁴ This term the Supreme Court heard oral arguments in *Whole Women’s Health v. Hellerstedt*,¹⁵ a Texas case on regulatory restrictions of abortion clinics.¹⁶ Further, more state

⁷ Yvonne Lindgren, *The Rhetoric of Choice: Restoring Healthcare to the Abortion Right*, 64 HASTINGS L.J. 385, 387 (2013) (citing *Roe v. Wade*, 410 U.S. 113, 166 (1973)).

⁸ *Id.* at 387–88.

⁹ 505 U.S. 833, 874 (1992).

¹⁰ *See id.* at 850–53.

¹¹ *Death with Dignity Around the US*, DEATH WITH DIGNITY (July 10, 2015), <http://www.deathwithdignity.org/advocates/national> [<https://perma.cc/FW2N-TASX>].

¹² Governor Jerry Brown signed the End of Life Options Act into law in October 2015. *See* CAL. HEALTH & SAFETY CODE §§ 443–444.12 (West, Westlaw through 2016 legislation).

¹³ Complaint, *Odonnell v. California*, No. 37-2015-00016404-CU-CR-CTL (Cal. Super. Ct. May 15, 2015) (seeking to allow doctors to prescribe lethal medications to certain patients who want to hasten death).

¹⁴ End of Life Choices New York filed a complaint in *Meyer v. Schneiderman*, Index No. 151162/2015 (N.Y. Sup. Ct. filed Feb. 4, 2015), to establish aid in dying in New York. *See also* Anemona Hartocollis, *Lawsuit Seeks to Legalize Doctor-Assisted Suicide for Terminally Ill Patients in New York*, N.Y. TIMES (Feb. 3, 2015), <http://www.nytimes.com/2015/02/04/nyregion/lawsuit-seeks-to-legalize-doctor-assisted-suicide-for-terminally-ill-patients-in-new-york.html> [<https://perma.cc/W4DV-23AK>].

¹⁵ 136 S. Ct. 2292 (2016).

¹⁶ *See id.* at 2300.

abortion restrictions were passed between 2011 and 2013 than in the entire previous decade.¹⁷

While previous scholarship has compared AID and the abortion right to consider their doctrinal, moral, and ethical similarities,¹⁸ this Article is the first to consider the extent to which these two movements trace opposing trajectories between healthcare and rights framings. Comparing these two movements offers a rich opportunity to draw upon their successes and failures to develop a new healthcare frame which will situate both of these closely aligned rights in order to achieve social justice goals beyond narrow constitutional rights status. Taken

¹⁷ *More State Abortion Restrictions Were Enacted in 2011–2013 than in the Entire Previous Decade*, GUTTMACHER INST. (Jan. 2, 2014), <https://www.guttmacher.org/article/2014/01/more-state-abortion-restrictions-were-enacted-2011-2013-entire-previous-decade> [<https://perma.cc/LVG2-9T9Y>]. See e.g., *Casey*, 505 U.S. at 833 (applying the “undue burden” standard, and thereby replacing the earlier strict scrutiny standard that had previously been applied in cases involving restrictions on abortion); MELISSA MURRAY & KRISTIN LUKER, *CASES ON REPRODUCTIVE RIGHTS AND JUSTICE* 775–76 (West 2015) (describing that the undue burden standard replaced the earlier strict scrutiny standard and was originally proposed by Justice O’Connor in her dissent in *Thornburgh v. American College of Obstetricians and Gynecologist*, 476 U.S. 747 (1986)). In the wake of *Casey*’s lowered standard of review, there was a rapid increase in state-level regulation of abortion. *Id.*

¹⁸ See, e.g., RONALD DWORKIN, *LIFE’S DOMINION: AN ARGUMENT ABOUT ABORTION, EUTHANASIA, AND INDIVIDUAL FREEDOM* 3 (1993) (discussing similarities between the abortion and euthanasia issues); George J. Annas, *The Promised End—Physician-Assisted Suicide and Abortion*, 35 DUQ. L. REV. 183, 183 (1996) (arguing that “the constitutional rights applicable to decision making about reproduction are not likely to be easily transposed to decisions individuals make at or near the end of their lives.”); Susan Frelich Appleton, *Assisted Suicide and Reproductive Freedom: Exploring Some Connections*, 76 WASH. U. L. Q. 15, 15–16 (1998) (analyzing how the substantive due process protection articulated in *Glucksberg* may be applied in future reproductive rights cases); Seth F. Kreimer, *Does Pro-Choice Mean Pro-Kevorkian? An Essay on Roe, Casey, and the Right to Die*, 44 AM. U. L. REV. 803, 813 (1995) (considering the ethical and moral rationales underlying the abortion and right to die cases such as the life at stake and the moral duty to preserve life); Sylvia A. Law, *Physician-Assisted Death: An Essay on Constitutional Rights and Remedies*, 55 MD. L. REV. 292, 297–98 (1996) (analyzing whether there is a liberty or privacy right to physician assisted suicide by comparing, *inter alia*, similar arguments made in context of the abortion right); Philip Prygoski, *Abortion and the Right to Die: Judicial Imposition of a Theory of Life*, 23 SETON HALL L. REV. 67, 68 (1992) (comparing how the judicial definition of “life” changes between the abortion cases and the right-to-die cases); Robert A. Sedler, *Abortion, Physician-Assisted Suicide and the Constitution: The View from Without and Within*, 12 NOTRE DAME J.L. ETHICS & PUB. POL’Y 529, 530 (1998) (comparing the legal, social and political contexts in which the abortion right and the right to die issues were litigated and their aftermath); Marc Spindelman, *Are the Similarities Between a Woman’s Right to Choose an Abortion and the Alleged Right to Assisted Suicide Really Compelling?*, 29 U. MICH. J.L. REFORM 775, 775 (1996) (discussing the legal and cultural distinctions between abortion and assisted suicide).

together, the discursive development of these movements gesture toward the potential gains of situating rights within a healthcare framing that considers how social, political, and economic systems and relationships come to bear upon decision-making. I conclude that while constitutional rights status is important for anchoring a minimum protection of the right of patient decisional autonomy, a healthcare-as-dignity frame brings with it the possibility of addressing underlying conditions that deprive individuals of meaningful choice in these contexts.

The AID movement has been successful in seeking to address how AID impacts those who are most vulnerable in society due to multiple forms of oppression such as race, poverty, disability, and lack of healthcare access.¹⁹ As the Supreme Court recognized in *Washington v. Glucksberg*,

The risk of harm is greatest for the many individuals in our society whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized social group . . . If physician-assisted suicide were permitted, many might resort to it to spare their families the substantial financial burden of end-of-life health-care costs.²⁰

The AID movement's legislative and healthcare agenda transformed, from an original focus on court-won rights, to a movement that addresses the challenges faced by the most vulnerable in society, by increasing healthcare access, legal rights, and social support for patients. For example, the AID movement has helped transform the way doctors are trained in end-of-life care and palliative care, ensured greater legal rights to patient control in end-of-life decision-making, and secured near-universal availability of hospice care along with state subsidies to fund hospice programs. By contrast, the abortion rights movement has been largely focused on asserting and defending constitutional claims in court and less successful than AID in addressing broader social justice goals such as the ways in which multiple forms of oppression—including race, poverty, immigration status, disability, age, and healthcare access—foreclose meaningful choice in the reproductive lives of women more broadly, not simply in the context of abortion.

I argue that the history of the death with dignity movement highlights the significant gains that can be achieved when constitutional rights of decision-making are reframed as rights related to healthcare. First, identifying the right as healthcare shifts the focus from decision-making to the conditions in which people make healthcare decisions more generally. As a result, the movement has the opportunity to garner support from opponents and to focus its energy on enhancing social support, legal rights, and healthcare access. The shift away from the constitutional right of decision-making offers the opportunity to consider how the social, legal, and

¹⁹ Those questions were put forth by opponents to AID as well as by Supreme Court amici and justices at oral argument. See discussion *infra* Section II.A.iv.

²⁰ *Washington v. Glucksberg*, 521 U.S. 702, 732 (1997) (citing New York Task Force 120).

healthcare contexts in which decisions are made profoundly affect an individual's decision-making. Second, the trending success of AID suggests that courts and legislatures are more willing to accept the claim of an individual's decisional autonomy within the context of healthcare than on ultimate questions of life and death. This conclusion seems to be borne out by recent court decisions in both Montana and New Mexico that upheld patients' right to AID based upon the right of patients to make healthcare decisions within the doctor-patient relationship rather than on constitutional rights questions.²¹

At the same time, the history of abortion rights caution that while deferring to decision-making within the context of a doctor-patient relationship may win legislative and court victories in the short term, it raises the potential of creating an incomplete right that is shared between doctors and patients.²² Narrowly identifying a constitutional right of healthcare that conceptualizes the right as a relationship of two—doctor and patient—runs the risk of subordinating the constitutional right of bodily autonomy to the decision-making of doctors. Rather, the history of the abortion right suggests that healthcare must be conceptualized as a broader framing that considers how decision-making in these contexts takes place within a multitude of relationships and social structures.

When seen together, these two movements offer the potential for broadening our thinking about what reproductive rights and AID rights can look like in the future. By moving beyond the narrow frame of individualized decision-making, parties may be able to consider how social structures and institutions affect meaningful choice in these contexts. Both movements have sought to move beyond constitutional questions of choice—in the AID context as “death with dignity” and in the reproductive rights arena in the reproductive justice framework. However, the successes and failures of these two movements can inform a renewed vision of these rights within the context of healthcare articulated as a right related to dignity that is animated by social justice goals that enhance social support, legal rights, and healthcare access. Just as the transition from Dr. Kevorkian to Dr. Quill represented a change in focus from death to the process of dying, the death with dignity movement offers the possibility of moving beyond a framing that centers abortion to a broader movement that supports the reproductive choices of women and girls more generally throughout the continuum of their reproductive lives.

This Article proceeds in three parts. Part I begins by examining the legal and political parallels between the two movements. Both evince a tension between conceptualizing patient decision-making as a constitutional right versus a moral, ethical, or healthcare decision. In addition, both have ignited fierce public debate

²¹ See *Baxter v. State*, 224 P.3d 1211, 1214 (Mont. 2009); *Morris v. Brandenburg*, No. D-202-CV 2012-2909 (N.M. Dist. 2014), appeal docketed, *sub nom.* *Morris v. King*, No. 33,360 (N.M. Ct. App. 2014); see *infra* notes 94–103 and accompanying text.

²² This is especially significant in the current healthcare landscape in which Catholic-owned hospitals are increasingly consolidating to become the only healthcare providers available in some communities. This raises the possibility that AID will be available only to those with the means to find willing providers. See *infra* notes 187–188 and accompanying text.

and protracted legal battles driven by the same primary opponents. Next, Part I considers how, despite these parallels, the two issues have been framed very differently, alternatively as healthcare and constitutional rights. The early “right to die” framing of Dr. Kevorkian identified AID as an individual’s constitutional right of decision-making uncoupled from the realm of the doctor-patient relationship. In contrast, this Article highlights how the Supreme Court in *Roe v. Wade* identified abortion as a right of decision-making that was shared between patients and their physicians.

Part II describes how these two movements have traded places between framings of rights and healthcare. On the one hand, the Supreme Court failed to recognize a constitutional right of AID in *Washington v. Glucksberg* at the same time that a legislative and healthcare reform movement was gaining traction in passing laws to enhance the social support, legal rights, and healthcare practices for the dying. Part II considers the ways in which the confluence of these two factors served to recast AID from the Kevorkian-style framing of individual rights, to a healthcare framing. It further examines how Dr. Quill’s call for “death with dignity” explicitly resituated AID within the context of the doctor-patient relationship and helped to provide the conceptual framework for AID’s transition to healthcare in a way that was deeply reminiscent of the early abortion cases. Next, Part II describes how abortion moved in the opposite direction. Specifically, in abortion cases, women seeking abortion were reconceptualized by the Court from healthcare consumers to rightsholders while at the same time their access to legal rights, healthcare access, and social support were sharply curtailed.

Part III draws upon the two movements to develop the notion of dignity-related healthcare. Part III begins with a discussion of the role of dignity as an animating principle in the law generally, and how dignity has been invoked in AID cases specifically. Next, this section explores how both dignity and healthcare are concepts that have been threaded through the jurisprudence of abortion. Part III argues that important lessons can be drawn from the AID movement’s legislative and healthcare reform efforts that were aimed at addressing the ways in which AID impacts those who are most vulnerable in society because of poverty, disability, and lack of healthcare access. The AID movement transformed the *process* of dying by seeking social justice goals rather than simply the constitutional right to make the AID decision. Part III concludes that the lesson to be drawn from the death with dignity movement is this: Healthcare must be reframed from an individual’s right to make the decision, to a fundamental shift in the way death is perceived, supported, and addressed in the healthcare system in response to patient vulnerability. Part III concludes that dignity-related healthcare should address how decision-making in these contexts—both AID and reproductive health—occurs within a systemic set of values, social, economic, and governmental structures. Part III argues that a similar shift is possible—and necessary, in the context of reproductive rights—from a focus

on abortion decision-making to a broader framing of reproductive healthcare, rights, and justice.²³

There is not a clear symmetry with respect to the ethical and legal tensions presented by these two issues. Indeed, much scholarship has compared their moral and ethical tensions—such as how to conceptualize the life at stake and the moral duty to preserve life,²⁴ and considering how the definition of “life” changes in these two contexts.²⁵ Further, much scholarship has compared the legal issues presented by abortion and AID—such as whether there is a fundamental “right to life” that animates both,²⁶ whether the constitutional rights applicable to decision-making about reproduction can be transposed to decisions individuals make at or near the end of their lives,²⁷ and comparing the liberty and privacy rights presented by these cases.²⁸ This Article looks instead at how these two issues have transitioned over

²³ Scholarship and advocacy in reproductive justice offer a potential framework for achieving these goals. Reproductive justice seeks to support the rights of all women and girls to have meaningful reproductive choice, including the right to have children, the right not to have children, and the right to parent children. Reproductive justice envisions reproductive access and healthcare beyond narrow framings of constitutional rights with that goal of enhancing

the social, financial, political, and legal conditions required to make genuine choices about reproduction—choices that must be respected, supported, and treated with dignity. We are particularly concerned about advancing the position of marginalized populations whose reproduction has been forced, denied, or exploited. The rights to have children, not to have children, and to parent children are of an intimate, fundamental nature and ought to be accessible to all.

See UC REGENTS, UC BERKLEY SCHOOL OF LAW, *Center on Reproductive Rights and Justice*, (2016), <http://www.law.berkeley.edu/14379.htm> [<https://perma.cc/YL6M-4LKC>]; see discussion *infra* Section III.D.

²⁴ Kreimer, *supra* note 18, at 813 (considering the ethical and moral rationales underlying the abortion and right to die cases such as the life at stake and the moral duty to preserve life).

²⁵ Prygoski, *supra* note 18, at 68 (discussing the judicial definition of “life” in abortion cases and right-to-die cases).

²⁶ See, e.g., DWORKIN, *supra* note 18, at 3–9 (exploring whether there is a fundamental “right to life” argument for both the abortion and euthanasia issues).

²⁷ Annas, *supra* note 18, at 183 (arguing that “the constitutional rights applicable to decision making about reproduction are not likely to be easily transposed to decisions individuals make at or near the end of their lives.”).

²⁸ See, e.g., Appleton, *supra* note 18, at 15–16 (providing that substantive due process protection articulated in *Glucksberg* may be applied in future reproductive rights cases); Law, *supra* note 18, at 297 (analyzing whether there is a liberty or privacy right to physician assisted suicide by looking at similar arguments made in context of the abortion right); Sedler, *supra* note 18, at 530 (comparing the legal, social and political contexts in which the abortion right and the right to die issues were litigated and their aftermath); Spindelman,

time in opposite directions between framings of healthcare and constitutional rights. This Article uses this comparison to draw conclusions about how we should think about healthcare more broadly with respect to patient dignity and social support, legal rights, and healthcare access. My purpose is not to argue the similarity of the issues themselves, but rather to examine the ways in which their similarities offer important lessons to be applied both in the context of reproductive rights and healthcare and to future development of death with dignity.²⁹

I. THE EARLY FRAMING OF THE TWO MOVEMENTS

The Terri Schiavo case, which saw intense and divisive judicial and political battles, exemplifies the many legal and political parallels between the death with dignity and reproductive rights movements. Between 1998, when Michael Schiavo first petitioned the court to withdraw his wife's hydration and feeding tubes, and 2005 when his request was granted, the circuit court judge issued almost thirty separate rulings.³⁰ And more than thirty judges at the county, district, state, and federal judicial levels heard appeals of the case. Conservative organizations including Randall Terry's Operation Rescue, Roman Catholic bishops and cardinals in the United States, and even Pope John Paul II weighed in on the controversy.³¹ Conservative and religious organizations sought to closely align the Schiavo case and the right-to-die issue with the ideological agenda of the right-to-life movement.³² U.S. Senator Orrin Hatch, a Republican from Utah, stated that "[t]he torrent of accusations reflects the bitterness over the life-and-death issues in the Schiavo case . . . [these accusations] were a proxy on both sides for what provokes every ugly political conversation—that's abortion."³³ The Schiavo case still holds

supra note 18, at 775 (examining the legal and cultural distinctions between abortion and assisted suicide).

²⁹ While this Article seeks to identify lessons that can be drawn from the AID movement's success by drawing parallels to the many ways in which the two movements are similar, it must be acknowledged that despite their many similarities there are some significant differences between the abortion right and AID. First, the arguments for life in the abortion context relate to the fetus rather than to the pregnant woman herself, as is the case in AID. Further, only female-sexed persons have the potential to undergo the abortion procedure whereas all people, regardless of sex, face the potential of a degrading and painful end of life.

³⁰ *See, e.g.*, BALL, *supra* note 2, at 54 (noting that the judge on the case "would issue almost thirty separate rulings and orders in the case" over the course of five years).

³¹ *Id.*

³² *Id.* at 52–53. A member of U.S. Senator Mel Martinez's legal counsel stated in a memo to his boss in 2005, "This [the Schiavo case] is an important moral issue and the pro-life base will be excited that the Senate is debating this important issue." Mike Allen, *Counsel to GOP Senator Wrote Memo on Schiavo*, WASH. POST (April 7, 2005) <http://www.washingtonpost.com/wp-dyn/content/article/2005/04/06/AR2005040602042.html> [<https://perma.cc/95T8-M686>].

³³ Allen, *supra* note 32.

symbolic power: Republican presidential candidate Jeb Bush ran a recent campaign ad featuring a voice-over that he “fought time and again for the right to life,” over an image of Schiavo in her hospital bed.³⁴

There is significant overlap in the issues, controversy and conflict raised by the AID and reproductive rights movements. First, they share a common legal heritage—the legal foundation of AID cases explicitly rely upon *Roe v. Wade*³⁵ and its progeny when considering whether an individual has a right to make the decision to terminate her or his life.³⁶ Further, both evince a tension between conceptualizing patient decision-making as a constitutional right versus a moral, ethical, and healthcare decision. Finally, both have ignited fierce public debate and have experienced protracted legal and political battles driven by the same primary opponents. The Catholic Church and other pro-life groups see the ethical issues presented by AID as deeply aligned with those of abortion.³⁷ Those on the opposite side of the issue concur. For example, the National Women’s Law Center drew an explicit connection between these two movements in their support of California’s aid-in-dying law stating that there is “tremendous opposition to certain care at the end of life from the same forces that oppose women’s right to reproductive health care. Because these two issues implicate similar interests of privacy, autonomy, bodily integrity, and respect for the patient’s conscience and beliefs, we feel compelled to support [the bill].”³⁸

Despite their similarities, the two issues have experienced opposing legal trajectories and currently have significantly different framing both in their treatment in the law and in public perception. This Article argues that the dignity and healthcare framing of the AID movement has been more successful in achieving legislative, public policy, and court-won victories.

³⁴ Adam Howard, *Terri Schiavo’s Husband Calls Jeb Bush Ad ‘Disgusting,’* MSNBC (January 27, 2016), http://www.msnbc.com/msnbc/terri-schiavos-husband-calls-jeb-bush-ad-disgusting?cid=sm_fb_msnbc [<https://perma.cc/NBT3-LGHW>]. Then-Governor Jeb Bush has invoked Schiavo on the campaign trail, for example, telling attendees at the conservative Faith and Freedom conference last June, “I stood on the side of Terri Schiavo.” *Id.*

³⁵ 410 U.S. 113 (1973).

³⁶ *Washington v. Glucksberg*, 521 U.S. 702, 778–79 (1997) (“The analogies between the abortion cases and this one are several. . . . There is, finally, one more reason for claiming that a physician’s assistance here would fall within the accepted tradition of medical care in our society, and the abortion cases are only the most obvious illustration of the further point.”).

³⁷ See BALL, *supra* note 2, at 52–53.

³⁸ Memorandum from Judy Waxman, Vice President of Health, Nat’l Women’s Law Ctr. to Members of the Cal. State Assembly (May 15, 2007). See Brief for the National Women’s Health Network and Northwest Women’s Law Center as Amici Curiae in Support of Respondents, *Vacco v. Quill*, 521 U.S. 793 (1997) (No. 95-1858); Leslie Bender, *A Feminist Analysis of Physician-Assisted Dying and Voluntary Active Euthanasia*, 59 TENN. L. REV. 519, 533 (1992).

A. *The Constitutional Framing of the “Right to Die”*

In the early movement for AID, the most vocal and recognizable champion of the right to die was Dr. Kevorkian, a retired pathologist who publicly claimed to have assisted in the deaths of more than one hundred individuals.³⁹ He did not have ongoing doctor-patient relationships with the people he helped to die; rather, Dr. Kevorkian helped strangers in their quest to end their lives without any clinical examination or discussion of treatment options.⁴⁰ He advertised his services in newspapers offering a dignified death to those who wished to end their lives.⁴¹ Rather than counseling patients, he offered an end to life at the request of the patient and understood his role as offering a service to clients.⁴² Thus, unlike the abortion right that was framed by the Court and by physicians as a right integrally related to the doctor-patient relationship, the early right to die framing of Dr. Kevorkian was articulated exclusively as a right of decision-making unrelated to the doctor-patient relationship.

The early AID movement sought to establish a right to die through the courts as a constitutionally protected choice based upon the liberty interest of the Due Process Clause of the Fifth and Fourteenth Amendments. These early cases, beginning in the 1970s, involved patients who lacked capacity to make the decision to be removed from life support because they were in a permanent vegetative state (PVS) or coma.⁴³ In 1976, the New Jersey Supreme Court in *In Re Quinlan*,⁴⁴ concluded that the life of a PVS patient could be ended by withdrawing life support and based its holding on early privacy cases, especially *Roe v. Wade*.⁴⁵ Echoing the *Roe* decision, the court stated that “[p]resumably this [personal privacy] right is broad enough to encompass a patient’s decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a

³⁹ BARRY ROSENFELD, ASSISTED SUICIDE AND THE RIGHT TO DIE: THE INTERFACE OF SOCIAL SCIENCE, PUBLIC POLICY, AND MEDICAL ETHICS 28 (2004); see BALL, *supra* note 2, at 68.

⁴⁰ BALL, *supra* note 2, at 68.

⁴¹ Howard Ball describes one such ad that ran in the *Detroit Free Press* that read, “Death Counseling / is someone in your family terminally ill? / Does he or she wish to die—and with dignity? / call physician consultant / ([Telephone Number]),” BALL, *supra* note 2, at 71 (citations and quotations omitted).

⁴² After several unsuccessful attempts to prosecute Dr. Kevorkian in the mid-1990s, he was convicted of second-degree murder in 1998 for an act of euthanasia that was taped and televised. The euthanasia was televised on CBS’s *60 Minutes* and involved administration of a lethal injection to a 52-year old man suffering from ALS, also known as Lou Gehrig’s Disease. BALL, *supra* note 2, at 72; ROSENFELD, *supra* note 39, at 28–29.

⁴³ See, e.g., *In Re Quinlan*, 355 A.2d 647, 662 (N.J. 1976) (discussing the vegetative condition of Karen Quinlan); *Cruzan v. Director, Missouri Dep’t of Health*, 497 U.S. 261, 266 (1990) (detailing Nancy Cruzan’s PVS).

⁴⁴ 355 A.2d 647 (N.J. 1976).

⁴⁵ *Id.* at 663 (referring to *Roe v. Wade*, 410 U.S. 113 (1973)).

woman's decision to terminate pregnancy under certain conditions."⁴⁶ By 1990, the Supreme Court in *Cruzan v. Director, Missouri Dep't of Health*⁴⁷ held that life support can be withdrawn from an incompetent patient when there has been shown by clear and convincing evidence that the PVS patient, when competent, indicated verbally or by an advance directive, that he or she did not want to be kept alive by machines in cases where there was no quality of life possible.⁴⁸

In 1997, the Supreme Court in *Washington v. Glucksberg*⁴⁹ and its companion case *Vacco v. Quill*,⁵⁰ held that the statutes in New York and Washington that prohibited assisting in a suicide did not violate the Fourteenth Amendment's Due Process Clause or the Equal Protection Clause.⁵¹ The Court drew an explicit connection with the abortion cases with respect to the role of the physician in the exercise of the right as well as the need to examine the issue within the nation's history and values.⁵² Citing the seven-hundred-year history of legal precedents supporting the prohibition of assisted suicide, the Court held that physician-assisted suicide was not a fundamental right and was not deeply rooted in the nation's history and tradition.⁵³ Further, the Court affirmed that the state had a legitimate interest in the preservation of human life.⁵⁴

The push to achieve court recognition of a constitutional right to AID took place in the context of a larger social movement led by lawyers, physicians, ethicists, and religious leaders. Physician organizations pressed for changes in the law around advanced healthcare directives and living wills, and physician groups

⁴⁶ Echoing a similar rationale as found in *Roe v. Wade*, the Court balanced the state's interest "in the preservation and sanctity of human life" with the individual's personal privacy interest to terminate life support. The Court held that the "State's interest [] weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the State interest." *Id.* at 663–65.

⁴⁷ 497 U.S. 261 (1990).

⁴⁸ Nancy Cruzan entered a PVS after a car accident. She remained in this state for four-and-a-half years when her parents requested she be removed from feeding and hydration tubes. The Court stated that both common law and the U.S. Constitution allow a competent patient to instruct medical professionals to remove life support systems so that the patient could die but that such a right was not a fundamental right and must be balanced against competing state interests. *See id.* at 265, 282–83. The Michigan Supreme Court in 1990 noted that a knowledgeable patient "may refuse life-sustaining medical treatment because the treatment itself is a violation of bodily integrity." *People v. Kevorkian*, 527 N.W.2d 714, 732 n.59 (Mich. 1994).

⁴⁹ 521 U.S. 702 (1997).

⁵⁰ 521 U.S. 793 (1997).

⁵¹ *Glucksberg*, 521 U.S. at 735; *Vacco*, 521 U.S. at 797.

⁵² *Glucksberg*, 521 U.S. at 711, 725.

⁵³ *Id.* at 711, 735.

⁵⁴ *Id.* at 728.

campaigned in favor of ballot measures for physician-assisted suicide.⁵⁵ At the same time, grassroots organizations such as the Hemlock Society, actively engaged in political mobilization and called for litigation to advance the cause of physician-assisted death. Many groups, including doctor organizations, lawyers, ethicists, laypersons, and religious leaders engaged in the political process to reform medical practices and to draft and sponsor AID legislation. As one scholar noted, the AID movement transformed what had been exclusively a private issue of death into a political movement in which “communication and negotiation occurred in public forums between institutions, organizations, and professional movements rather than in the seclusion of hospitals and courtrooms.”⁵⁶

B. *The Healthcare Framing of the Early Abortion Right*

In 1973, the Supreme Court in *Roe v. Wade*⁵⁷ identified a constitutional right of abortion and asserted that “the abortion decision in all its aspects is inherently, and primarily, a medical decision”⁵⁸ to be made in consultation with a “responsible physician.”⁵⁹ The *Roe* decision framed the healthcare interests present in the right of abortion as encompassing the right of doctors to practice medicine according to their professional judgment rather than recognizing abortion as a right of women’s health that necessarily included access to abortion services.⁶⁰ In describing the healthcare interest of the abortion right, the *Roe* Court stated:

⁵⁵ See DANIEL HILLYARD & JOHN DOMBRINK, *DYING RIGHT: THE DEATH WITH DIGNITY MOVEMENT* 18–19 (2001).

⁵⁶ *Id.* at 241.

⁵⁷ 410 U.S. 113 (1973). The Court held that a Texas criminal abortion statute violated women’s right of privacy encompassed by the Fourteenth Amendment’s concept of personal liberty. *Id.* at 154.

⁵⁸ *Id.* at 166.

⁵⁹ *Id.* at 153.

⁶⁰ As will be discussed in Section II.C. *infra*, this framing was widely criticized by feminists who argued that the Court’s opinion that emphasized the rights of physicians, necessarily compromised the full recognition of women’s constitutional right to abortion. See also Elizabeth Reilly, “*The Jurisprudence of Doubt*”: *How the Premises of the Supreme Court’s Abortion Jurisprudence Undermine Procreative Liberty*, 14 J. L. & POL. 757, 774–77 (1998). A Supreme Court clerk to Justice Lewis Powell, Junior, wrote a notation on an early draft of the *Roe* opinion that read, “The abortion decision inherently is a medical one, and the responsibility for that decision must rest with the physician.” Doesn’t it seem that this language overstates the doctor’s role and undercuts the woman’s personal interest in the decision? All medical decisions are the product of an agreement between patient and doctor. I see no reason, therefore, not to add a clause to this sentence indicating that the abortion decision must rest “with the physician *and his patient*.” Linda Greenhouse, *How the Supreme Court Talks About Abortion: The Implications of a Shifting Discourse*, 42 SUFFOLK U. L. REV. 41, 41 (2008) (citing Memorandum from Larry A. Hammond of Justice Lewis F. Powell, Jr., Supreme Court of the U.S. (Nov. 27, 1972) (on file with Lewis F. Powell, Jr., Collection, Box 5, Washington & Lee University Law School Library)).

The decision vindicates the right of the physician to administer medical treatment according to his professional judgment up to the points where important state interests provide compelling justifications for intervention. Up to those points, the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician.⁶¹

In considering the state's interest in protecting health and maternal life, the *Roe* Court asserted that "neither interest justified broad limitations on the reasons for which a physician and his pregnant patient might decide that she should have an abortion in the early stages of pregnancy."⁶² And again, "prior to this 'compelling' point, the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient's pregnancy should be terminated."⁶³ Thus, healthcare as it related to the abortion right was narrowly identified by the Court as relating to the decision-making between doctors and their patients. As discussed below, the *Roe* Court's framing of the abortion right as a decision shared between doctors and their pregnant patients was widely criticized for subordinating women's constitutional rights to the judgment of their healthcare providers.⁶⁴

Like the AID movement, the movement for reproductive rights sought court recognition of a constitutional right against a backdrop of a grassroots movement that articulated a broader vision of the interests involved. During the 1960s, the arguments for abortion rights were framed from many different concerns, including

⁶¹ *Roe v. Wade*, 410 U.S. 113, 165–66 (1973).

⁶² *Id.* at 156 (emphasis added).

⁶³ *Id.* at 163 (emphasis added).

⁶⁴ See discussion *infra* Section II.C. See, e.g., Reva B. Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 273–79 (1992) (discussing regulation of abortion in the *Roe* era); Susan Frelich Appleton, *Doctors, Patients and the Constitution: A Theoretical Analysis of the Physician's Role in "Private" Reproductive Decisions*, 63 WASH. U. L.Q. 183, 197–201 (1985) (describing the past role of the physician as the decision maker); Ruth Bader Ginsburg, *Speaking in a Judicial Voice*, 67 N.Y.U. L. REV. 1185, 1199–200 (1992) ("The idea of the woman in control of her destiny and her place in society was less prominent in the *Roe* decision itself, which coupled with the rights of the pregnant woman the free exercise of her physician's medical judgment. The *Roe* decision might have been less of a storm center had it honed in more precisely on the women's equality dimension of the issue." (citations omitted)); Greenhouse, *supra* note 60, at 42 (providing a quote as an example of how Supreme Court justices discussed abortion in their opinions); LAURENCE H. TRIBE, *ABORTION: THE CLASH OF ABSOLUTES* 45 (1990) (arguing that the medical model, which emphasized the role of doctors in the abortion decision, reinforced the traditional role of women as dependent and not in control of their destiny). *But see* Sylvia Law, *Abortion Compromise—Inevitable and Impossible*, 1992 U. ILL. L. REV. 921, 932–33 (1992) (offering a critique of Tribe's *THE CLASH OF ABSOLUTES*).

public health, environmental and population concerns, sexual liberation, and feminist calls for repeal of laws criminalizing abortion as critical to women's equality.⁶⁵ A growing number of organizations supported the abortion right to give the poor access to a procedure that had been long available to women with means.⁶⁶ Physician organizations sought clearer guidelines to protect physicians against criminal liability, and feminists called for an outright repeal of laws criminalizing abortion as a means of achieving women's equality.⁶⁷ Feminists called for repeal of abortion laws and argued that the abortion decision should rest solely with the woman.⁶⁸ The demand for access to abortion was part of a larger conception of women's equality that included childcare, protections against rape, domestic violence, equal employment, equal pay, and equal opportunity in the public sphere of politics.⁶⁹

Despite the many legal and political parallels between these two movements, they differ in important ways. The early framing of AID was cast exclusively as the constitutional right of individuals to make the decision to end their lives. As personified by Dr. Kevorkian, AID was articulated as a constitutional claim entirely outside of the clinical context. By contrast, abortion was identified by the Court⁷⁰ as a constitutional right that was inextricably related to the doctor-patient relationship: “[the *Roe*] decision vindicates the right of the physician to administer medical treatment according to his professional judgment.”⁷¹ The next section describes how, as each developed over time, the two movements traded places with respect to healthcare versus rights framing.

⁶⁵ Linda Greenhouse & Reva B. Siegel, *Before (and After) Roe v. Wade: New Questions About Backlash*, 120 YALE L. J. 2028, 2034 (2011).

⁶⁶ See David J. Garrow, *Abortion Before and After Roe v. Wade: An Historical Perspective*, 62 ALB. L. REV. 833, 834 (1999).

⁶⁷ See Greenhouse & Siegel, *supra* note 65, at 2034.

⁶⁸ LINDA GREENHOUSE & REVA B. SIEGEL, *BEFORE ROE V. WADE: VOICES THAT SHAPED THE ABORTION DEBATE BEFORE THE SUPREME COURT'S RULING* 35 (2010); KRISTIN LUKER, *ABORTION & THE POLITICS OF MOTHERHOOD* 92, 95 (1984); Reva B. Siegel, *Roe's Roots: The Women's Rights Claims that Engendered Roe*, 90 B.U. L. REV. 1875, 1880–86 (2010).

⁶⁹ Reva B. Siegel, *Constitutional Culture, Social Movement Conflict and Constitutional Change: The Case of the De Facto ERA*, 94 CAL. L. REV. 1323, 1395–97 (2006).

⁷⁰ It is important to note that this framing was set forth by the Supreme Court in *Roe* and did not reflect the arguments being advanced by feminists in the women's rights movement. In contrast to the Supreme Court's framing, activists argued that the abortion decision should rest solely with the woman and was a constitutional right essential to “full human dignity and personhood of women.” Siegel, *supra* note 68, at 1881. Rather, the *Roe* Court's opinion straddled the framing of the doctor-led abortion reform movement that sought to clarify the rights of doctors to perform abortions and the women's rights movements call to establish the constitutional right of women to bodily autonomy. *Id.* at 1879–80.

⁷¹ *Roe v. Wade*, 410 U.S. 113, 165 (1973).

II. RIGHTS VS. HEALTHCARE: TRANSITIONS

A. From the “Right to Die” to “Death with Dignity”

The two movements transitioned over time to ultimately trade places with respect to how each was framed as a right related to healthcare and a right related to decision-making. In the case of AID, this came largely in response to the loss of constitutional rights recognition in *Washington v. Glucksberg*, and in the abortion context, the “choice” framing was in response to strong opposition from the antichoice movement. The result is that in its present framing, abortion is cabined exclusively as a constitutional right of decision-making that is uncoupled from the healthcare context, and AID has been identified as a right of healthcare decision-making within the doctor-patient relationship.

1. Reframing Aid in Dying as Healthcare

In the mid-1990s, the right to die movement began a transition to a new vision articulated as “death with dignity.”⁷² Dr. Quill became the leading figure in this shift from Dr. Kevorkian’s physician-assisted suicide to a healthcare framing of death with dignity.⁷³ In his article “Death and Dignity,” Dr. Quill described assisting his patient “Diane” to end her life after a long battle with acute leukemia.⁷⁴ His article stressed the central role of their relationship, the many discussions they had about her treatment options over the course of their eight-year relationship, his assessment that she was competent, not clinically depressed, and was fully informed about her

⁷² HILLYARD & DOMBRINK, *supra* note 55, at 3–4 (dividing the history of efforts to legalize euthanasia in three phases: the voluntary euthanasia movement, the right to die movement, and the death with dignity movement).

⁷³ For a discussion of the history of changing terminology in the AID movement, see David J. Garrow, *The Right to Die: Death with Dignity in America*, 68 MISS. L.J. 407, 407 (1998). In public opinion polling, public support for AID is much stronger when terms like “dignity” and “compassion in dying” are employed as opposed to “mercy killing” and “suicide.” *Id.* at 408–09. See Jane Meredith Adams, *Assisted Suicide Gains in Propriety Oregon Vote Confirms Years of Steadily Growing Public Support*, BOS. GLOBE, Nov. 9, 1997, at D3; William Claiborne, *Doctor-Aided Suicide Is Backed in Poll*, WASH. POST, July 30, 1998, at A3; Robert J. Blendon et al., *Should Physicians Aid Their Patients in Dying? The Public Perspective*, 267 J. AM. MED. ASS’N 2658, 2658 (1992); Peter A. Singer et al., *Public Opinion Regarding End-of-Life Decisions: Influence of Prognosis, Practice and Process*, 41 SOC. SCI. MED. 1517, 1517 (1995); Gary Libow, *Poll Finds Tentative, Conditional Support for Assisted Suicide*, HARTFORD COURANT, Apr. 12, 1998, at B5.

⁷⁴ Quill, *supra* note 3, at 691–94. See TIMOTHY E. QUILL, *DEATH AND DIGNITY: MAKING CHOICES AND TAKING CHARGE* 13 (1994). Dr. Quill’s decision to call for a new paradigm of end of life care through the narrative of a story is reminiscent of the role of storytelling in feminist legal scholarship. See also Kathryn Abrams, *Hearing the Call of Stories*, 79 CALIF. L. REV. 971, 971–82 (1991) (examining the emergence of feminist narrative scholarship as a distinctive form of critical legal discourse).

treatment options.⁷⁵ Dr. Quill eventually wrote Diane a prescription for sleeping pills. Four months later Diane killed herself.⁷⁶ Dr. Quill's new paradigm of death with dignity stressed the important role of the doctor-patient relationship in end-of-life decision-making.⁷⁷ This framing stands in sharp contrast to the early right to die framing espoused by Dr. Kevorkian who identified physician assisted suicide as a service and a right rather than as medical care.

Dr. Quill's call for death with dignity, in many ways echoes the early abortion cases as to the important role of the doctor-patient relationship in end-of-life decision making. Indeed, Dr. Quill's description of the relationship with his patient Diane and their ongoing conversation over the course of several years of treatment that ultimately led to her decision to end her life, was deeply reminiscent of the Court's characterization of the role of doctors in the early abortion cases. For example, in one early case, the Court described the role of the physician in the abortion decision:

[the] conscientious physician[']s . . . professional activity is concerned with the physical and mental welfare, the woes, the emotions, and the concern of his female patients. He, perhaps more than anyone else, is knowledgeable in this area of patient care, and he is aware of human frailty, so-called 'error,' and needs. The good physician . . . will have sympathy and understanding for the pregnant patient that probably are not exceeded by those who participate in other areas of professional counseling.⁷⁸

At the same time that Dr. Quill asserted the role of the physician in the end-of-life decision from the individualized choice of the Kevorkian "death machine," legislative and healthcare reform efforts sought to support patient decision-making through enhanced social support, healthcare access, and legal rights that ensured authentic decision-making for the most vulnerable in society.

The death with dignity movement sought to recast the perception of end-of-life decision-making from a lonely desperate act of assisted "suicide," to a more nuanced view that end-of-life decisions are made after thoughtful discussion within the context of a doctor-patient relationship.⁷⁹ Unlike the early Kevorkian-style framing

⁷⁵ Quill, *supra* note 3, at 691–94.

⁷⁶ *Id.* at 693.

⁷⁷ See, e.g., Timothy Quill, *Physician Assisted Death: After the U.S. Supreme Court Ruling*, 75 U. DET. MERCY L. REV. 481, 484 (1998) (stating that "we often teach our physicians, unfortunately, to treat the underlying disease . . . [Death with dignity] means finding out who is this person, what do they still want to achieve, what are their goals. We are going to try to give them as much choice and control as we can.").

⁷⁸ *Doe v. Bolton*, 410 U.S. 179, 196–97 (1973).

⁷⁹ See Tucker, *supra* note 1, at 1595 (noting the important evolution in terminology from "suicide" to describe the choice of a mentally competent, terminally ill person to choose death).

of the right-to-die, the movement for physician-assisted death emphasized that the decision to terminate life was made within the context of a doctor-patient relationship to assess the patient's mental state and offer different paths and treatments before reaching the conclusion to end one's life with the assistance of a physician.⁸⁰ The next section describes the successes of the AID movements that flowed from and reinforced the close nexus between AID and the doctor-patient relationship.

2. *Legislating the Healthcare Frame*

The AID movement's success in reframing death with dignity from a focus on rights to a focus on healthcare is reflected in legislative reform efforts. While most state laws still prohibit a licensed physician from writing a prescription for a lethal dose of medication to hasten the death of dying patients, beginning in 1990, nearly two dozen states sought to pass AID legislation.⁸¹ Oregon became the first state to pass a death-with-dignity law in 1994. Washington State passed a death-with-dignity law in 2008, and death-with-dignity legislation was introduced this year in the District of Columbia and at least twenty-three other states.⁸²

California is the most recent state to pass AID legislation. Governor Brown signed end-of-life legislation into law in October 2015.⁸³ Significantly, the California Medical Association (CMA) changed course after a twenty-eight year opposition to medical aid in dying to take a neutral stance to California's End of Life Option Act.⁸⁴ In so doing, CMA became the nation's first state medical organization to change position on the issue of AID.⁸⁵ The importance of the healthcare frame is evident in CMA president Dr. Luther Cobb's statement about the bill,

⁸⁰ BALL, *supra* note 2, at 73.

⁸¹ These states include Arizona, California, Connecticut, Hawaii, Maryland (2009), Massachusetts (2010), Montana (2009), Maine, Michigan, New Hampshire (2010), New Mexico (2010), New York (2010), Pennsylvania (2009), Oregon, Vermont, Washington and Wisconsin, Wyoming (2009). See *Living with Dying*, DEATH WITH DIGNITY NAT'L CTR., (August 2011), <http://www.deathwithdignity.org/take-action/> [<https://perma.cc/3745-CWWS>]; see also, Kevin O'Reilly, *Oregon Still Stands Alone: Ten Years of Physician Assisted Suicide*, AM. MED. NEWS, (May 12, 2008), <http://www.amednews.com/article/20080512/profession/305129970/4/> [<https://perma.cc/ER2P-YFJN>] (discussing the Death with Dignity Act in Oregon); Valerie Vollmar, *Recent Developments in Physician-Assisted Death*, OCTOBER 2005 RECENT DEVELOPMENTS REPORT (2005), <https://willamette.edu/law/pdf/pas/2005-10.pdf> [<https://perma.cc/8CTC-6HFS>] (providing updates on recent scholarship, legislation, and cases dealing with Death with Dignity).

⁸² *Id.*

⁸³ See CAL. HEALTH & SAFETY CODE § 443 (West, Westlaw through 2016 legislation).

⁸⁴ *California Medical Association Removes Opposition to Physician Aid in Dying Bill*, CAL. MED. ASS'N, (May 20, 2015), <http://www.cmanet.org/news/press-detail/?article=california-medical-association-removes> [<https://perma.cc/B8YT-4G92>].

⁸⁵ *Id.*

The decision to participate in the End of Life Option Act is a very personal one between a doctor and their patient, which is why CMA has removed policy that outright objects to physicians aiding terminally ill patients in end of life options. We believe it is up to the individual physician and their patient to decide voluntarily whether the End of Life Option Act is something in which they want to engage. Protecting that physician-patient relationship is essential.⁸⁶

The central focus on the doctor-patient relationship was again highlighted by Senator Bill Manning, co-author of the legislation, who described how CMA was actively involved throughout the bill's legislative process.⁸⁷

While early framing of the right to die used terms like “assisted suicide” and “mercy killing,” death with dignity legislation uses terms such as physician-assisted death in an attempt to recharacterize the issue within the context of dignity and compassionate choice. For example, the Oregon Death with Dignity Act (ODDA),⁸⁸ specifically provided that physician-assisted death “shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law.”⁸⁹ In response to the ODDA, the Oregon Department of Human Services announced that it would no longer use the term “physician-assisted suicide” to describe terminally ill patients who ask doctors to assist them in dying.⁹⁰ Thus, the ODDA went beyond the legal status of physician-assisted death to redefine the very language used to refer to AID and thereby helped reshape the public perception of the act.

Similarly, Montana's Terminally Ill Act—which protects physicians against prosecution for withholding or withdrawing life support for terminally ill patients—specifically prohibits referring to a patient's death “a suicide or homicide” “for any purpose.”⁹¹ It also charges the Montana Attorney General with creating a “declaration registry” and conducting a statewide campaign to educate Montanans about end-of-life decision-making.⁹² Medical experts,⁹³ legal experts, and the

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ OR. REV. STAT. ANN. §§ 127.800–.897 (West, Westlaw through 2016 Legis. Sess.).

⁸⁹ *Id.* § 127.880.

⁹⁰ Charles Fiegl, *Oregon Nixes Use of Term “Physician-Assisted Suicide,”* AM. MED. NEWS, (Nov. 6, 2006), <http://www.amednews.com/article/20061106/profession/311069952/7/> [<https://perma.cc/CS69-66SE>].

⁹¹ MONT. CODE ANN. § 50-9-205 (West 2015).

⁹² MONT. CODE ANN. § 50-9-205 (West, Westlaw through 2015 Legis. Sess.).

⁹³ Position Statement, Am. Med. Women's Ass'n, *Aid in Dying* (Sept. 9, 2009) https://www.amwa-doc.org/wp-content/uploads/2013/12/Aid_in_Dying1.pdf [<https://perma.cc/ED24-TQ4M>] (recognizing that the American Medical Women's Association's position statement, *Aid in Dying*, states, “The term ‘suicide’ is increasingly recognized as inaccurate and inappropriate in this context and we reject that term. We adopt the less emotionally charged, value-neutral, and accurate terms ‘Aid in Dying’ and ‘Physician Assisted Dying.’”); *see also*, Joseph B. Stratton, *Physician Assistance with*

American Psychological Association⁹⁴ have increasingly adopted this changed terminology.

By changing the terminology of AID, the movement sought to recast the issue in public perception. This change in terminology reflects a transition from conceptualizing AID as a “violent, lonely, despairing act” to the idea that “choice in dying is more than an individual need, private crisis, or hospital staff problem,”⁹⁵ rather it is a collective issue. As one commentator described it,

the word ‘suicide’ is well suited to the description of a distraught individual with his whole life ahead of him [who] . . . commits a completely senseless and utterly tragic act. In contrast, ‘suicide’ is not well suited to describe . . . [a terminally ill patient] who . . . simply wishes to avoid more needless suffering and indignity.”⁹⁶

The transformation from the right to die to death with dignity was more than an evolution of terminology, it was an important shift in public understanding of the nature of the right itself and acknowledged the underlying questions of dignity, compassion and autonomy that motivated the movement and the law.

3. *The Healthcare Frame Reflected in Court Opinions*

The AID healthcare framing is gaining traction in courts where the constitutional rights arguments have failed. While three states—Oregon, California and Washington—have legalized AID, Montana has held that a physician who provides a patient with lethal medications cannot be prosecuted for aiding a suicide.⁹⁷

Dying: Reframing the Debate; Restricting Access, 15 TEMP. POL. & CIV. RTS. L. REV. 475, 475 (2006) (asserting that “the process of permitting people to actively end their lives before their disease ends their lives” should be referred to as “physician assistance with dying” rather than “physician-assisted suicide”); Position Statement, Am. Acad. Of Hospice & Palliative Med., Physician-Assisted Death (Feb. 14, 2007), <http://www.aahpm.org/position/suicide.html> [<https://perma.cc/47T6-M42A>] (rejecting the term physician-assisted suicide as emotionally charged and inaccurate); Judith R. Gordon, *New WSPA Policy on Value-Neutral Language Regarding End-of-Life Choices*, WASH. ST. PSYCHOL. ASS’N, Jan. 8, 2007.

⁹⁴ Rhea K. Farberman, *Terminal Illness and Hastened Death Requests: The Important Role of the Mental Health Professional*, 28 PROF. PSYCHOL: RESEARCH & PRAC. 544 (1997) (stating that The American Psychological Association has recognized that “the reasoning on which a terminally ill person . . . bases a decision to end his or her life is fundamentally different from the reasoning a clinically depressed person uses to justify suicide.”).

⁹⁵ HILLYARD & DOMBRINK, *supra* note 55, at 241.

⁹⁶ James E. Dallner & D. Scott Manning, *Death with Dignity in Montana*, 65 MONT. L. REV. 309, 314–15 (2004).

⁹⁷ *Baxter v. State*, 224 P.3d 1211, 1222 (Mont. 2009).

The Montana Supreme Court in *Baxter v. Montana* considered a challenge to the application of Montana’s homicide statutes to physicians who provide aid in dying to mentally competent, terminally ill patients.⁹⁸ The court specifically declined to consider the question of whether a competent, terminally ill person has a constitutional right to die with dignity under the Montana Constitution.⁹⁹ Instead, the court addressed the issue of patient decision-making and held that the defense of consent could shield a physician from homicide liability based on the nature of the doctor-patient relationship. The court stated that “the act of a physician handing medicine to a terminally ill patient, and the patient’s subsequent peaceful and private act of taking the medicine, are not comparable to the violent, peace-breaching conduct [of homicide.]”¹⁰⁰ The decision omitted constitutional considerations and focused exclusively on the issues of healthcare, the doctor-patient relationship, and dignity in reaching its conclusion: “Each stage of the physician-patient interaction is private, civil, and compassionate. The physician and terminally ill patient work together to create a means by which the patient can be in control of his own mortality.”¹⁰¹ The court stated “the Montana Rights of the Terminally Ill Act indicates legislative respect for a patient’s autonomous right to decide if and how he will receive medical treatment at the end of his life.”¹⁰² Legislative reform in the *Baxter* case was important in shaping judicial analysis, beyond a constitutional rights frame to the context of dignity, privacy, autonomy, and access to healthcare.¹⁰³

4. Addressing Vulnerability through Enhanced Social Support, Legal Rights, and Healthcare Access

The AID movement has been successful in transforming the way healthcare is delivered to people at the end of life through a legislative and healthcare agenda that was responsive to critics’ arguments that the availability of AID would disproportionately impact those who face multiple forms of oppression. As described above, the Supreme Court in *Washington v. Glucksberg* summed up this opposition by describing that “[t]he risk of harm is greatest for the many individuals in our society whose autonomy and well-being are already compromised by poverty,

⁹⁸ *Id.*

⁹⁹ *Id.* at 1214.

¹⁰⁰ *Id.* at 1216.

¹⁰¹ *Id.* at 1217.

¹⁰² *Id.* at 1222.

¹⁰³ A similar challenge worked its way through the courts in New Mexico. In 2014 a New Mexico district court in *Morris v. Brandenburg*, held that sections of the New Mexico Constitution protecting rights to liberty, safety and happiness protects the right of a physician to administer aid in dying to a terminally ill mentally competent patient. No. D-202-CV 2012-02909 (N.M. Dist. 2014) (citing N. MEXICO CONST. art. II, § 4). The case was reversed on appeal, *Morris v. Brandenburg*, 356 P.3d 564 (N.M. Ct. App. 2015), and was reversed and remanded before the Supreme Court of New Mexico, *Morris v. Brandenburg*, 376 P.3d 836, 857 (2016).

lack of access to good medical care, advanced age, or membership in a stigmatized social group.”¹⁰⁴ The Court went on to further echo the position of organized opposition to AID, stating, “If physician-assisted suicide were permitted, many might resort to it to spare their families the substantial financial burden of end-of-life health-care costs.”¹⁰⁵

The Roman Catholic Church’s argument against AID also addresses the social conditions that affected the choice of terminally ill patients. A daily fact sheet issued to supply talking points to priests and parishioners to lobby their legislators against AID stressed that “[l]egalizing physician-assisted suicide . . . puts incredible pressure on [the terminally ill] to ‘choose to die’—especially those who are uninsured, ill, disabled, old or poor.”¹⁰⁶ As one writer for *Christianity Today* argued,

Instead of seeking legal protection for euthanasia, we would do better as a society to develop our present resources. The hospice movement, for example, needs volunteers, money, and facilities to provide a less costly and more caring context for dying. And there is room for better use of our present knowledge for managing and eliminating pain. If we put our energies into these approaches, we may discover once again that we are all connected and that agony can have meaning.¹⁰⁷

The AID movement responded to these concerns by pursuing a legislative and healthcare agenda that sought to address the conditions in which end of life decisions are made with respect to healthcare access, dignity, compassion, and autonomy. This section details some of the legislative and healthcare reform successes of the AID movement that address patient vulnerability. Each of these reforms seeks to alleviate the underlying healthcare and social causes that may lead an individual to choose AID, including pain, suffering, loss of dignity, lack of social support, and lack of healthcare access.

The death with dignity movement pushed for significant changes in the way physicians are trained to care for the dying, and the way healthcare is delivered to patients at the end of life.¹⁰⁸ In 1961, physicians received no training in treating

¹⁰⁴ *Washington v. Glucksberg*, 521 U.S. 702, 732 (1997) (citing N.Y. STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 120 (1994)).

¹⁰⁵ *Id.*

¹⁰⁶ California Catholic Conference (CCC), “*No on AB 374: California Compassionate Choices Act*,” www.cacatholic.org (the CCC was one of the major organizations that opposed California’s Compassionate Choices Act, AB 374, and published daily fact sheets for Roman Catholic priests and parishioners who were encouraged to use these fact sheets as talking points to lobby their legislators).

¹⁰⁷ David Neff, *The Wrong Way to Go*, 35 CHRISTIANITY TODAY, Oct. 28, 1991, at 15.

¹⁰⁸ Palliative care is intended to reduce the severity of pain caused by illness, but not to cure the illness. Hospice is palliative care for terminally ill patients and is provided at the end stages of life. See BALL, *supra* note 2, at 106–07.

patients facing death.¹⁰⁹ For example, in that year the *Journal of the American Medical Association* published a study of physicians' practices in cancer and found that 90% of the respondents preferred not to tell their patients of their diagnosis or prognosis.¹¹⁰ By comparison, in 1997, the American Hospital Association reported that 70% of deaths occurred after discussion to forgo or withdraw treatment.¹¹¹ Sponsors of death with dignity legislation argued for changes in the law to rectify a lack of medical school training for physicians in how to support a patient who is dying.¹¹² Studies have found that AID improves communication between physicians and patients regarding end-of-life options.¹¹³

In addition, the AID movement pushed for significant changes in training doctors in pain management in end-of-life care. Critics of AID, such as amici for the medical and nursing associations in *Glucksberg*, called for improved palliative care rather than AID, fearing that some would choose AID to end suffering, arguing that "[AID] is not the right answer to the problem of inadequate care."¹¹⁴ In 1999,

¹⁰⁹ HILLYARD & DOMBRINK, *supra* note 55, at 16.

¹¹⁰ *Id.*; Donald Oken, *What to Tell Cancer Patients: A Study of Medical Attitudes*, 175 J. AM. MED. ASS'N 86, 86–94 (1961).

¹¹¹ HILLYARD & DOMBRINK, *supra* note 55, at 17 (citation omitted).

¹¹² One of the sponsors of ODDA, Dr. Peter Goodwin, along with his co-sponsor Barbara Coombs Lee, argued in support of the law by drawing attention to the lack of medical school training for physicians in assisting dying patients to die. Dr. Goodwin asserted that, "Traditionally, patients were generally given very high doses of morphine and left to die. . . . Physicians were trained that it is harmful to give the family the bad news until it is over. These medical practices were deplorable." HILLYARD & DOMBRINK, *supra* note 55, at 15 (quoting Dr. Peter Goodwin, physician and co-sponsor of the ODDA); Timothy E. Quill et al., *The Debate Over Physician-Assisted Suicide: Empirical Data and Convergent Views*, 128 ANNALS OF INTERNAL MED. 552, 552–58 (1998).

¹¹³ A Government Accountability Office (GAO) report found that physicians working with hospice-based palliative care providers in Oregon "are more comfortable with discussing end-of-life issues with their patients since the 1997 enactment in Oregon of the Death with Dignity Act, which focused attention in the state on end-of-life care and the options available to individuals." U.S. GOV'T ACCOUNTABILITY OFF, GAO-08-66, END-OF-LIFE CARE: KEY COMPONENTS PROVIDED BY PROGRAMS IN FOUR STATES (2007) at 14 (examining key components of end-of-life care programs in Arizona, Florida, Oregon, and Wisconsin). The GAO report found that the Death with Dignity Act had created an environment where end-of-life issues were discussed more openly between doctors and patients. *See also*, 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 J. AM. MED. ASS'N 2363, 2368 (2001) (finding that physicians perceived that more patients found conversations regarding the death with dignity to be helpful than upsetting, regardless of how the physician felt about AID).

¹¹⁴ Brief for American Medical Association et al. as Amici Curiae Supporting Petitioners at 1, *Washington v. Glucksberg*, 521 U.S. 702 (1997) (No. 96-110). Additionally, the briefs of surviving family members in *Glucksberg* argued in favor of AID, citing inadequate palliative care and physicians who were reluctant to prescribe adequate pain relief medication, care that resulted in "a slow, deteriorating death [that] often leads to loss of

Congress passed the Pain Relief Promotion Act that codifies protection of physicians for hastening a patient's death as the result of pain management.¹¹⁵ Growing data out of Oregon's and Washington's death with dignity acts suggests that AID leads to enhanced pain management practices.¹¹⁶ These changes in healthcare practices around pain management sought to enhance human dignity while at the same time to ensure patients make authentic choices about end-of-life decisions, rather than merely choosing AID to end pain.

The AID movement also sought to increase familial and social support of dying patients in response to critics' concerns that, as the Supreme Court described, the most vulnerable might resort to AID "to spare their families the substantial financial burden of end-of-life health-care costs."¹¹⁷ The movement sought to increase social and financial support of the dying process through developing a system of hospice

dignity and self-respect for the dying person." Brief Amicus Curiae of Surviving Family Members in Support of Physician-Assisted Dying, in Support of Respondents at 10, *Washington v. Glucksberg*, 521 U.S. 702 (1997) (Nos. 96-110, 95-1858).

¹¹⁵ This issue is one that is being widely discussed among healthcare policymakers. For example, an August 2010 editorial in the *New England Journal of Medicine* called upon the medical profession to change its "long-held paradigm that has limited access to palliative care to patients who were predictably and clearly dying" to a new one which begins palliative care at the time of diagnosis. Amy S. Kelley, Editorial, *Palliative Care—A Shifting Paradigm*, 363 *NEW ENG. J. MED.* 781, 782 (2010); see also, Jennifer S. Termel et al., *Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer*, 363 *NEW ENG. J. MED.* 733, 733–42 (2010).

¹¹⁶ For example, a University of Wisconsin Study of pain management practices in Oregon rated Oregon's pain policy at a C+ in the years 2000–2003, and an A in the years since 2008 after Oregon's Death with Dignity Act. CARBON CANCER CTR, UNIV. OF WIS. SCH. OF MED. AND PUB. HEALTH, *ACHIEVING BALANCE IN STATE PAIN POLICY: A PROGRESS REPORT CARD 14* (2nd ed. 2006), http://www.michigan.gov/documents/mdch/Wisc.Edu.PolicyReportCard2006_211447_7.pdf [<https://perma.cc/TUK5-RSHD>]; CARBON CANCER CTR, UNIV. OF WIS. SCH. OF MED. AND PUB. HEALTH, *ACHIEVING BALANCE IN STATE PAIN POLICY: A PROGRESS REPORT CARD 19* (2014), <http://acscan.org/content/wp-content/uploads/2014/07/PRC-2013.pdf> [<https://perma.cc/ZK5D-F3EN>].

Another study in Oregon found that 76% of physicians reported that they took measures to improve their knowledge of the use of pain medication for the terminally ill and 79% of physicians reported that their confidence in prescribing pain medications had improved since passage of the Oregon Death with Dignity Act (ODDA). The Oregon study also found that a third of physicians increased referrals to hospice following the availability of aid in dying under the ODDA. Ganzini, *supra* note 113, at 2366. Another study found that since passage of the ODDA, hospice nurses and social workers observed an increase in physicians' knowledge of palliative care and an increase in physician's willingness to refer patients to hospice and to care for hospice patients. Elizabeth R. Goy et al., *Oregon Hospice Nurses and Social Workers' Assessment of Physician Progress in Palliative Care Over the Past Five Years*, 1 *PALLIATIVE & SUPPORTIVE CARE* 215, 217 (2003).

¹¹⁷ *Washington v. Glucksberg*, 521 U.S. 702, 732 (1997) (citing New York State Task Force on Life and the Law, *When Death Is South: Assisted Suicide and Euthanasia in the Medical Context* at 120 (May 1994)).

care facilities. In 1974, there was just one palliative care hospice facility in America. By 2010, there were nearly five thousand palliative care hospice programs available in all fifty states. In less than forty years, medical treatment for the dying has moved from a minimum number of patients treated in hospice to nearly 42% of all deaths occurring in a hospice program.¹¹⁸ Hospice and palliative care is centered on a philosophy that people facing end of life have the right to receive medical care, emotional and spiritual support to die a pain-free and dignified death.¹¹⁹ Hospice programs receive governmental funding in many states and are covered by Medicare, Medicaid, and most private insurance programs.¹²⁰

The death with dignity movement sought not only to change the medical practices and social support for the dying, but also sought to pass laws to advance the legal rights of people facing the end of life. The early legislative reform efforts enacted advance directive statutes and Do-Not-Resuscitate (DNR) statutes nationwide with the result that all but six states allow for some sort of living will and DNR provisions.¹²¹

For example, while AID supporters in California were unable to pass AID legislation because of well-funded opposition mounted by the Roman Catholic Church, legislators focused instead on the underlying issues facing patients at the end of life.¹²² In February 2008, legislators passed the California Right to Know End-of-Life Options Act that did not mention physician assistance in dying but rather, required that healthcare providers give terminally ill patients information and counseling regarding end-of-life options such as hospice care, withholding or withdrawing life-sustaining treatment, voluntarily stopping eating and drinking, and “palliative sedation.”¹²³ Similarly, despite defeat of AID legislation in Maine, in 2001 the Maine legislature passed two end-of-life care bills; one designed to

¹¹⁸ BALL, *supra* note 2, at 3. Hospice advocates, for example, have successfully changed the way care is administered to people at the end of life. They assert that, “the last interval before death can also be the culmination of the shaping of a human being, even as it transforms everyone else involved.” MARIE DE HENNEZEL, *INTIMATE DEATH: HOW THE DYING TEACH US HOW TO LIVE* xiv (Carol Brown Janeway trans., 1997); *see also*, IRA BYOCK, *DYING WELL: THE PROSPECT FOR GROWTH AT THE END OF LIFE* 38 (1997). Amici from the National Hospice Association argued for increased social and familial support in the dying process through hospice care facilities, arguing that the final stage of life “may be a time of profound opportunity for terminally-ill individuals and their families Given proper support, dying can become an important, valued life event.” Brief for the National Hospice Organization as Amicus Curiae Supporting Petitioners, at 6–7, *Washington v. Glucksberg*, 521 U.S. 702 (1997) (Nos. 95-1858, 96-110), 1996 WL 656338.

¹¹⁹ *Hospice Care*, NHPCO.ORG, <http://www.nhpc.org/about/hospice-care> (last updated Apr. 10, 2016) [<https://perma.cc/AWG2-HXC4>].

¹²⁰ *See infra* notes 121–124 and accompanying text.

¹²¹ JAMES M. HOEFLER & BRIAN KAMOIE, *DEATHRIGHT: CULTURE, MEDICINE, POLITICS AND THE RIGHT TO DIE* 145 (1994).

¹²² Vollmar, *supra* note 81.

¹²³ *See Death with Dignity as an End-of-Life Option*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/faqs/> [<https://perma.cc/449N-ZL4K>].

improve end-of-life care and the other to fund a Medicaid hospice benefit. The bills not only established a Medicaid hospice benefit—funded at 23% above the Medicare rate—it also mandated private insurance to cover hospice and increased the threshold of care from six to twelve months, provided funding to hospice centers, and funding to develop and implement a study of professional entry-level and continuing education requirements related to end-of-life care for all licensed health care professionals.¹²⁴

Thus, despite the fact that bills failed to give patients the ultimate right to choose AID, other bills passed that enhanced the quality of patient care throughout the dying process by increasing healthcare access, social support, and better medical training for doctors treating dying patients.

Death with dignity advocates undertook legislative and healthcare reform efforts that addressed the underlying social conditions that affect decision-making for people facing the end of life such as poverty, disability, and lack of social support or access to healthcare.¹²⁵ This shift in the way healthcare is provided to the dying reflects a fundamental shift in the understanding of healthcare access itself, from a narrow view of healthcare as a doctor-patient relationship of two people to an enhanced notion of dignity-related healthcare that considers how broader issues of social support, healthcare access, legal rights, and social structures enhanced healthcare for the dying.

As described in the next section, while AID transitioned to the realm of healthcare and the doctor-patient relationship, abortion moved in the opposite direction. In abortion cases, women seeking abortion were reconceptualized by the Court from healthcare consumers to individualized rightsholders while at the same time their legal rights, healthcare access and social support were sharply curtailed. Moreover, while there was robust debate in the AID movement that acknowledged the impact of poverty, disability, and healthcare access on end-of-life decision-making, the reproductive rights experienced significantly less dynamic range, from the early grassroots call for reproductive freedom as an aspect of women's equality to a narrow focus on "choice."

¹²⁴ *Id.*

¹²⁵ Many of these issues had been raised by the amici curiae and the justices at oral argument in *Washington v. Glucksberg*. In the *Glucksberg* and *Vacco* cases, a combined forty-one amicus briefs were filed in opposition to the constitutional right of AID and nineteen in support of the respondents. The large number of amici represented a wide array of interests in the issue of AID from organizations representing disability rights, religious organizations, medical organizations, hospice organizations, politicians, bioethicists, civil rights groups, and in two cases, the families of the deceased in the two cases. *Washington v. Glucksberg*, 521 U.S. 702, 736 (1997); *Vacco v. Quill*, 521 U.S. 793, 808 (1997).

B. Abortion: From Healthcare to “Choice”

1. “Choice” Framing of the Abortion Right

Roe was decided against the backdrop of a robust grassroots feminist movement that demanded reproductive rights as one aspect of a larger call for women’s equality. Activists argued that the abortion right was essential to “full human dignity and personhood of women.”¹²⁶ However, in the years following *Roe*, the expansive feminist call for abortion as an aspect of women’s equality began to retract and narrow, emphasizing instead the constitutional basis of the right of choice. Scholars have suggested various reasons for this. Professor Reva Siegel described how in an effort to disentangle abortion from the contentious fight for the Equal Rights Amendment, pro-choice advocates consciously chose to distance abortion from the women’s rights claims that characterized the early abortion movement.¹²⁷ Others have argued that after *Roe* the grassroots political mobilization that had been forged by a broader feminist agenda of equality was later forced to narrow its message to a single “choice” issue in response to countermovement pressure by the subsequent pro-life mobilization.¹²⁸

Thus, while abortion began as one part of the broad-based feminist movement’s call for women’s equality, those broader aspirations narrowed over time to that of choice.¹²⁹ This trend foreclosed a more robust articulation of the right beyond constitutional rights framing. While *Roe v. Wade* had the immediate impact of allowing access to abortion for many women, in the long term the abortion rights movement after *Roe* had less success in transitioning beyond the constitutional rights

¹²⁶ Lindgren, *supra* note 7, at 392.

¹²⁷ See Siegel, *Roe’s Roots*, *supra* note 68, at 1901 (stating that, “with conservative backlash burgeoning, feminists came to rely on privacy reasoning as a way to *separate* the ERA from their support for abortion and gay rights, until the women’s movement abandoned hope of the ERA’s ratification in the 1980s.”); Siegel, *Constitutional Culture*, *supra* note 69, at 1395.

¹²⁸ SUZANNE STAGGENBORG, *THE PRO-CHOICE MOVEMENT: ORGANIZATION AND ACTIVISM IN THE ABORTION CONFLICT 70–72* (1991) (noting that by 1975, institutionalized tactics in defense of legal abortion had become central to the pro-choice movement as these organizations became formalized and professionalized); Ruth Bader Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to Roe v. Wade*, 63 N.C. L. REV. 375, 376–77 (suggesting that *Roe* undercut a grassroots legalization movement and invited backlash). *But see*, Greenhouse & Siegel, *Before (and After) Roe v. Wade*, *supra* note 65; Robert Post & Reva Siegel, *Roe Rage: Democratic Constitutionalism and Backlash*, 42 HARV. C.R.-C.L. L. REV. 373, 431 (2007).

¹²⁹ While some in the larger women’s movement tried to engage broader concerns such as rights to contraceptives and child care, abortion was treated in practice as a single issue. STAGGENBORG, *supra* note 128, at 107. The focus on abortion’s legal status, to the exclusion of broader issues of reproductive rights and justice is highlighted by the fact that in 1980, NARAL changed their mission statement from “keep abortion safe and legal” to simply “keep abortion legal.” *Id.*

paradigm to engage the broader feminist concerns that had animated the early movement. To date, abortion continues to reside almost exclusively in the realm of constitutional rights.¹³⁰

Similarly, the Supreme Court's early articulation of abortion through a healthcare frame also began to recede.¹³¹ The Court's transition away from abortion as a right related to healthcare toward a right solely conceptualized as a choice first appeared in a series of cases challenging restrictions on federal and state funding for abortions for low-income women.¹³² In 1977, the majority in *Maheer v. Roe*¹³³ upheld limits on public funding for abortions that were not medically necessary.¹³⁴ The Court explained that the

regulation places no obstacles—absolute or otherwise—in the pregnant woman's path to an abortion The State may have made childbirth a more attractive alternative, *thereby influencing the woman's decision*, but it has imposed no restriction on access to abortions that was not already there. The indigency that may make it difficult—and in some cases, perhaps, impossible—for some women to have abortions is neither created nor in any way affected by the . . . regulation.¹³⁵

The majority refused to acknowledge that funding restrictions on abortion affected the right of access and instead framed the issue in terms of how the effect of funding influenced a pregnant woman's *decision-making*.¹³⁶

Three years later in *Harris v. McRae*¹³⁷ the majority upheld the Hyde Amendment, which denied public funding for certain medically necessary abortions.¹³⁸ The majority described that the abortion right “protects the woman from unduly burdensome interference with her freedom *to decide whether to terminate her pregnancy*’ . . . [and does not prevent the state] from making a ‘value

¹³⁰ See *infra* Sections II.B.(i) & (ii); Lindgren, *supra* note 7.

¹³¹ See Lindgren, *supra* note 7, at 385 (providing analysis that serves as a basis for this section).

¹³² See, e.g., *Harris v. McRae*, 448 U.S. 297, 326–27 (1980) (upholding Hyde Amendment's restriction on the use of federal funds for medically necessary abortions under Medicaid program); *Beal v. Doe*, 432 U.S. 438, 447 (1977) (upholding limits on state funding for non-therapeutic abortions); *Maheer v. Roe*, 432 U.S. 464, 480 (1977) (upholding prohibitions on state funding for non-medically necessary abortions); *Poelker v. Doe*, 432 U.S. 519, 521 (1977) (upholding a city's refusal to provide publicly financed hospital services for nontherapeutic abortions).

¹³³ 432 U.S. 464 (1977).

¹³⁴ *Id.* at 480.

¹³⁵ *Id.* at 474 (emphasis added).

¹³⁶ See *id.*

¹³⁷ 448 U.S. 297 (1980).

¹³⁸ *Id.* at 326–27; see Jill E. Adams & Jessica Arons, *A Travesty of Justice: Revisiting Harris v. McRae*, 21 WM & MARY J. OF WOMEN & L. 5, 31 (2014).

judgment favoring childbirth over abortion and . . . implement[ing] that judgment by the allocation of public funds.”¹³⁹ In the Court’s analysis, abortion was a right to choose to terminate a pregnancy and limits on access to healthcare that resulted from funding restriction were characterized simply as the state expressing a preference for childbirth.¹⁴⁰ The majority characterized women seeking abortion as rightsholders who were not harmed by the lack of funding for abortion healthcare because their right of choice remained intact.

The dissent in these funding cases consistently pushed back and sought to reassert abortion through the frame of healthcare. The dissent in *Maier v. Roe*, for example, stated that “indigency makes access to competent licensed physicians not merely ‘difficult’ but ‘impossible.’ As a practical matter, many indigent women will feel they have no choice but to carry their pregnancies to term because the State will pay for the associated medical services.”¹⁴¹ The *Maier* dissent highlighted that choice and access to healthcare services are integrally linked and that the practical effect of burdening an individual’s right of access to the means of effectuating choice is in effect to unconstitutionally burden the choice itself.¹⁴²

Similarly, in *Beal v. Doe*,¹⁴³ which denied Medicaid funding for nontherapeutic abortions, the dissent framed the funding issue specifically by asserting abortion as healthcare:

[O]ur abortion cases compel the conclusion that elective abortions constitute medically necessary treatment for the condition of pregnancy . . . Pregnancy is unquestionably a condition requiring medical services. Treatment for the condition may involve medical procedures for its termination, or medical procedures to bring the pregnancy to term, resulting in a live birth. ‘Abortion and childbirth, when stripped of the sensitive moral arguments surrounding the abortion controversy, are simply two alternative medical methods of dealing with pregnancy.’¹⁴⁴

The dissent highlights the tension in the Court’s alternative views of the abortion right between healthcare and decision-making. The dissent in *Harris v. McRae* highlighted the fundamental distinction in the way the majority characterized the nature of the right of abortion:

¹³⁹ *Harris*, 448 U.S. at 314 (quoting *Maier*, 432 U.S. at 473–74) (second alternation in original) (emphasis added).

¹⁴⁰ *Id.* at 314–15; see also *Maier*, 432 U.S. at 474 (“The State may have made childbirth a more attractive alternative, thereby influencing the woman’s decision, but it has imposed no restriction on access to abortions that was not already there.”).

¹⁴¹ *Maier*, 432 U.S. at 483 (Brennan, J., dissenting).

¹⁴² See *id.* at 487.

¹⁴³ 432 U.S. 438 (1977).

¹⁴⁴ *Id.* at 449 (citations omitted).

the Court suggests that a withholding of funding imposes no real obstacle to a woman deciding whether to exercise her constitutionally protected procreative choice . . . [F]or a poor person attempting to exercise her ‘right’ to freedom of choice, . . . [the funding restrictions] have precisely the same effect as an outright prohibition.¹⁴⁵

Thus, for the dissent, not only was abortion recognized as an aspect of healthcare, but the abortion right included access to abortion-related healthcare services. This led to the conclusion that laws that restricted access also restricted the right itself.

The Courts continued to transition away from a healthcare frame of the abortion right in its analysis in *Planned Parenthood of Southeastern Pennsylvania v. Casey*.¹⁴⁶ Relying upon the undue burden analysis first developed in Justice O’Connor’s dissent in *City of Akron v. Akron Center for Reproductive Health*,¹⁴⁷ the Court’s analysis in *Casey* specifically separated the decisional right to choose abortion from access to abortion-related healthcare, stating,

The fact that a law which serves a valid purpose, one not designed to strike at the right itself, has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it. Only where state regulation imposes an undue burden on a woman’s ability to make this *decision* does the power of the State reach into the heart of the liberty protected by the Due Process Clause.¹⁴⁸

The opinion identified the decision to terminate a pregnancy as a liberty right that was not related to one’s ability to “procure” an abortion. Under the Court’s analysis, limits on the health care necessary for abortion were identified as merely having “incidental effects” on the abortion right:

What is at stake is the woman’s right to make the ultimate decision, not a right to be insulated from all others in doing so. Regulations which do no more than create a structural mechanism by which the State . . . may express profound respect for the life of the unborn are permitted, if they are not a substantial obstacle to the woman’s exercise of the right to choose.¹⁴⁹

Again, the abortion right was cast in terms of decision-making, referring to abortion as “the ultimate decision” and “the right to choose.” The Court’s reasoning sought to limit abortion to a decisional right, unconnected from healthcare, to terminate a

¹⁴⁵ *Harris v. McRae*, 448 U.S. 297, 347 (1980) (Marshall, J., dissenting).

¹⁴⁶ 505 U.S. 833, 846 (1992).

¹⁴⁷ 462 U.S. 416, 453 (1983) (O’Connor, J., dissenting).

¹⁴⁸ *Casey*, 505 U.S. at 874 (emphasis added).

¹⁴⁹ *Id.* at 877.

pregnancy. The Court asserted “the right protects the woman from unduly burdensome interference with her *freedom to decide whether to terminate her pregnancy*.”¹⁵⁰

Finally, in *Gonzales v. Carhart*,¹⁵¹ the Court upheld for the first time an outright ban on an abortion procedure known as intact D & E and also upheld for the first time an abortion restriction that did not contain an exception for the health of the woman.¹⁵² The *Carhart* Court isolated intact D & E from women’s healthcare by omitting any discussion of the healthcare contexts in which pregnant women would seek a second-trimester abortion despite briefing on this issue by amici curiae.¹⁵³ This deliberate decision to omit the healthcare issues that gave rise to second-trimester abortions furthered the fiction that such procedures were “choices” that occurred in isolation of women’s health care. The Court dismissed the decision to use the intact D & E by stating that “expectant mothers, and society as a whole [will be better informed] of the consequences that follow from a decision to elect a late-term abortion.”¹⁵⁴ This carefully chosen language ignored the medical necessity that drove the decision to seek a second-trimester abortion and instead sought to present women who underwent this procedure merely as rightsholders who “elected” the procedure.

2. Retracting Legal Rights, Social Support, and Healthcare Access to Abortion

In contrast to AID, legal rights related to abortion have been retracting dramatically in recent years. Indeed, more state abortion restrictions were enacted in the years between 2011 and 2013 than in the entire previous decade combined.¹⁵⁵ There have been many laws passed that diminish the legal rights of women and girls to obtain abortion-related healthcare such as parental consent provisions for

¹⁵⁰ *Id.* at 874 (emphasis added) (quoting *Maher v. Roe* 432 U.S. 464, 473–74 (1977)).

¹⁵¹ 550 U.S. 124 (2007).

¹⁵² *See id.* at 167–68; *cf. Stenberg v. Carhart*, 530 U.S. 914, 921–22 (2000) (invalidating an almost identical abortion restriction because it lacked an exception for the health of the mother).

¹⁵³ *See Gonzales v. Carhart*, 550 U.S. 124, 146–67 (2007); *cf.* Brief for American Medical Women’s Ass’n et al. as Amici Curiae Supporting Respondents at 15, n. 10, *Gonzales*, 550 U.S. 124 (No. 05-1382) (describing that the benefit of choosing the intact D & E procedure was that it allowed these patients, “to see and hold the fetus, and mourn its death.”).

¹⁵⁴ *Gonzales*, 550 U.S. at 160.

¹⁵⁵ GUTTAMACHER INST., *supra* note 17. In fact, more than one-quarter of the state abortion restrictions since *Roe v. Wade* were enacted between 2011 and 2015. *More Than One-Quarter of the 1,074 State Abortion Restrictions Since Roe v. Wade Were Enacted Between 2011 and 2015*, GUTTAMACHER INST. (Jan. 2016), <https://www.guttmacher.org/image/2016/more-one-quarter-1074-state-abortion-restrictions-roe-v-wade-were-enacted-between-2011> [https://perma.cc/J3EE-8UZH].

minors,¹⁵⁶ restrictions on federal and state funding of abortion,¹⁵⁷ as well as regulations designed to restrict and discourage abortions such as twenty-four hour waiting periods,¹⁵⁸ prohibiting nontherapeutic abortions in public hospitals,¹⁵⁹ requiring all post first-trimester abortions be performed in hospitals,¹⁶⁰ and requiring informed written consent before an abortion could be performed.¹⁶¹

While the AID movement has had many successes in changing the way doctors are trained and improving medical practices around dying, abortion-related healthcare has remained unchanged and has been restricted. For example, the number of abortion providers is declining,¹⁶² abortion-related healthcare is delivered primarily through stand-alone clinics,¹⁶³ and abortion practice is taught in only a handful of medical teaching programs.¹⁶⁴ After 1973, the medical profession failed to make a concerted effort to train doctors in abortion practice and to encourage doctors to integrate abortion into ordinary practice.¹⁶⁵ Rather, in the years since *Roe*, abortion-related medical practice has been marginalized by the medical community and has isolated providers in stand-alone clinics.¹⁶⁶ As a result, over the last thirty years, abortion training has been steadily disappearing from residency programs that

¹⁵⁶ *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52, 81 (1976) (invalidating use of parental consent forms in the abortion context); *Bellotti v. Baird*, 443 U.S. 622, 651 (1979) (holding parental consent provisions unconstitutional). *But see* *Planned Parenthood Ass'n of Kan. City, Mo, Inc. v. Ashcroft*, 462 U.S. 476, 494 (1983) (upholding laws requiring minors to secure parental consent or judicial consent before obtaining an abortion); *Ohio v. Akron Center for Reproductive Health*, 497 U.S. 502, 519–20 (1990) (upholding laws making it a crime for a physician to perform an abortion without providing timely notice to a minor's parents).

¹⁵⁷ *Maheer v. Roe*, 432 U.S. 464, 480–81 (1977) (upholding a Connecticut regulation that provided financial assistance for childbirth but not for abortions unless “medically necessary”); *Beal v. Doe*, 432 U.S. 438, 447–48 (1977) (holding that state accepting Medicaid funding were not required to perform abortions); *Harris v. McRae*, 448 U.S. 297, 326–27 (1980) (upholding the Hyde Amendment that barred use of federal funds for medically necessary abortions); *Webster v. Reproductive Health Services*, 492 U.S. 490, 521–22 (1989) (upholding a ban on the use of public employees and facilities for non-therapeutic abortions).

¹⁵⁸ *But see* *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 449–51 (1983) (holding the twenty-four hour waiting period unconstitutional).

¹⁵⁹ *Poelker v. Doe*, 432 U.S. 519, 521 (1977) (upholding the ban by the city of St. Louis on non-therapeutic abortions in its municipal hospitals).

¹⁶⁰ *But see* *City of Akron*, 462 U.S. at 452 (holding that the provision at issue unreasonably infringes upon a woman's constitutional right to an abortion).

¹⁶¹ *Danforth*, 428 U.S. at 67.

¹⁶² Emily Bazelon, *The New Abortion Providers*, N.Y. TIMES, (July 14, 2010), <http://www.nytimes.com/2010/07/18/magazine/18abortion-t.html?pagewanted=all> [<https://perma.cc/QBR9-GJR7>].

¹⁶³ *Id.*

¹⁶⁴ *Id.*

¹⁶⁵ *Id.*

¹⁶⁶ *Id.*

produce new doctors.¹⁶⁷ A 1985 survey of obstetric and gynecology residency programs found that 28% of them offered no training at all, half of the programs made training available as an option, and only 23% included it routinely.¹⁶⁸ In 1995, the number of OB-GYN residencies offering abortion training fell 12%.¹⁶⁹

Further, while the AID movement has transformed the end-of-life experience for patients by changing the way doctors are trained, emphasizing palliative care, and increasing hospice, there has been comparatively little change in the way abortion care is delivered in the United States since *Roe v. Wade*. In the years immediately following *Roe*, women health activists began to set up freestanding abortion clinics which were seen as the quickest and most economical way to offer low cost, medically safe abortion services to the largest number of women.¹⁷⁰ At the same time, after the Supreme Court decision in *Roe*, many hospitals, both public and private, refused to perform abortions. By 1976, for example, the vast majority of public and private hospitals had never performed an abortion.¹⁷¹ By 1985, only 17% of public hospitals and 23% of private hospitals performed any abortions.¹⁷² As a result, the majority of abortions are performed in stand-alone clinics—such as Planned Parenthood—rather than in hospitals. In 1973, hospitals made up 80% of the country’s abortion facilities and by 1996, 90% of abortions in the United States were performed at clinics.¹⁷³ By 1985, a dozen years after *Roe*, 82% of all U.S. counties had no identified abortion service provider.¹⁷⁴

AID’s transition to a healthcare frame was accompanied by changes in healthcare practices around dying such as palliative care, hospice care, and increased legal rights in medical decision-making. In addition, two courts have upheld the right of AID based on protection of the doctor-patient relationship, rather than based on constitutional claims. By contrast, the Supreme Court’s abortion opinions have gradually narrowed the scope of the abortion right to a constitutional right of decision-making. At the same time that the abortion right has been isolated as a constitutional claim, abortion-related healthcare, social support, and legal rights

¹⁶⁷ GERALD N. ROSENBERG, *THE HOLLOW HOPE* 194 (2d ed. 2008).

¹⁶⁸ Philip D. Darney et al., *Abortion Training in U.S. Obstetrics and Gynecology Residency Programs*, 19 *FAMILY PLANNING PERSPECTIVES* 158, 160 (1987).

¹⁶⁹ Bazelon, *supra* note 162.

¹⁷⁰ Garrow, *supra* note 66, at 838 (noting that abortion activists chose the model of the free-standing clinic because it was the lowest-cost method for providing medically-safe abortions to a large number of women, most of whom would not have been able to afford the dramatically higher fees charged by hospitals).

¹⁷¹ ROSENBERG, *supra* note 167, at 189–90.

¹⁷² *Id.* at 190.

¹⁷³ Bazelon, *supra* note 162. This trend is changing with a new push by pro-choice physicians to open residency and fellowship programs in contraception and abortion practice in medical schools across the country in an effort to integrate abortion as a seamless part of health care for women.

¹⁷⁴ ROSENBERG, *supra* note 167, at 193; Stanley K. Henshaw et al., *Abortion Services in the United States, 1984 and 1985*, 19 *FAM. PLAN. PERSP.* 63, 63 (1987).

remained unchanged or have been retracting. The next section suggests that while identifying AID exclusively in the context of healthcare has resulted in successes in courts and legislatures, the history of the abortion right offers a cautionary tale about the limitations of framing AID within the context of the doctor-patient relationship.

C. Abortion's Cautionary Tale: Healthcare and the Doctor-Patient Relationship

The Supreme Court in the early abortion cases clearly identified the abortion right as a decision shared between doctor and patient. To be sure, informed consent litigation has largely replaced the degree of medical paternalism evident in the early abortion cases.¹⁷⁵ However, despite the evolution in patient rights and informed consent, an inherent imbalance of power persists in the doctor-patient relationship.¹⁷⁶ Indeed, the courts have identified the doctor-patient relationship as a fiduciary relationship in recognition of the degree to which patients must trust in and rely upon the doctor's knowledge and judgment.¹⁷⁷ Therefore it is still important to consider the impact of framing rights, in abortion and AID, within the context of the doctor-patient relationship due to the unique nature of the relationship and the degree to which both patients and courts defer to doctors in healthcare decision-making.¹⁷⁸

¹⁷⁵ See George J. Annas, *The "Right to Die" in America: Sloganeering from Quinlan and Cruzan to Quill and Kevorkian*, 34 DUQ. L. REV. 875, 876–77 (1996) (describing the informed consent cases that brought about changes in the paternalistic model of the doctor-patient relationship).

¹⁷⁶ *Id.* at 876.

¹⁷⁷ *Id.*

¹⁷⁸ Indeed, the important role of the doctor-patient relationship is evidenced by the numerous state laws that require doctors treating patients seeking abortion-related healthcare to read informed consent “scripts” designed to dissuade them from their abortion decision. A report by the Guttmacher Institute indicates that as of 2006, seven states mandated that doctors provide “negative and unscientific information about abortion and its implications,” either by supplying doctors with a script or by requiring doctors to provide state-sponsored brochures to patients seeking abortions. Chinué Turner Richardson & Elizabeth Nash, *Misinformed Consent: The Medical Accuracy of State-Developed Abortion Counseling Materials*, 9 GUTTMACHER POL’Y REV., 6, 11 (Fall 2006) (“[P]olicymakers and public health officials frequently disregard the basic principles of informed consent in favor of furthering a highly politicized antiabortion goal.”); Robert Post, *Informed Consent to Abortion: A First Amendment Analysis of Compelled Physician Speech*, 2007 U. ILL. L. REV. 939, 940–41; Carol Sanger, *Seeing and Believing: Mandatory Ultrasound and the Path to a Protected Choice*, 56 UCLA L. REV. 351, 375–79, 375 n.112 (2008) (“Although couched in the protective terms of informed consent, these statutes are unabashedly meant to transform the embryo or fetus from an abstraction to a baby in the eyes of the potentially aborting mother.”). For discussions of the role of the doctor-patient relationship in the abortion decision, see Nan Hunter, *Justice Blackmun, Abortion, and the Myth of Medical Independence*, 72 BROOK. L. REV. 147, 196 (2006) (tracing the Court’s deference to medical authority in the abortion cases and arguing that, “the expansion and contraction of deference to medicine in the abortion cases has been an epiphenomenon of ideological shifts.”); Peter

Scholars have resoundingly criticized the Supreme Court's early framing of the abortion right as a decision shared between pregnant women and their doctors because it subordinated women's constitutional rights to the judgment of their healthcare providers.¹⁷⁹ As previously discussed, the Court identified the abortion right as a qualified right to make the abortion decision within the context of the doctor-patient relationship.¹⁸⁰ For example, the *Roe* Court described the abortion right as "the right of the physician to administer medical treatment according to his professional judgment . . . [and] the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician."¹⁸¹ The Court framed the right of abortion as the right of doctors to practice medicine according to their professional judgment rather than recognizing abortion as a right of women to access the healthcare necessary to terminate a pregnancy. Professor Reva Siegel, for example, has argued that the decision in *Roe v. Wade* straddled the women's rights and the medical models of abortion rights, and gave only "confused expression" to women as constitutional rightsholders.¹⁸² As a result, the abortion decision gave greater protection to doctors' rights to make medical decisions than to women's rights to control reproduction.¹⁸³ The deference to the judgment of doctors in abortion decision-making reinforced traditional notions

M. Ladwein, *Discerning the Meaning of Gonzales v. Carhart: The End of the Physician Veto and the Resulting Change in Abortion Jurisprudence*, 83 NOTRE DAME L. REV. 1847, 1847 (2008) (arguing that *Carhart* signals the end of the "physician's veto," defined to mean the autonomy and judgment of physicians in the abortion context); Theodore W. Ruger, *Health Law's Coherence Anxiety*, 96 GEO. L. J. 625, 640–42 (2007–08) (discussing the de-emphasis of the doctor-patient relationship in a series of contexts, including abortion).

¹⁷⁹ See, e.g., Appleton, *supra* note 64, at 197–201 (discussing the Court's approach to the constitutional questions raised by abortion cases); Ginsburg, *supra* note 64, at 1199–200 (citations omitted) ("The idea of the woman in control of her destiny and her place in society was less prominent in the *Roe* decision itself, which coupled with the rights of the pregnant woman the free exercise of her physician's medical judgment. The *Roe* decision might have been less of a storm center had it . . . homed in more precisely on the women's equality dimension of the issue."); Greenhouse, *supra* note 60, at 42 (discussing "*Roe*'s paternalistic assumption" about doctors knowing what is best for their patients); Siegel, *supra* note 64, at 273–79 (providing an account of the *Roe* decision).

¹⁸⁰ Appleton, *supra* note 64, at 197–98; LUKER, *supra* note 68, at 94–100; Siegel, *supra* note 68, at 1879–80.

¹⁸¹ *Roe v. Wade*, 410 U.S. 133, 165–66 (1973).

¹⁸² Siegel, *supra* note 68, at 1897. See Siegel, *supra* note 64, at 273–79; Appleton, *supra* note 64, at 197–201; Greenhouse, *supra* note 60, at 42. See also Jessie Hill, *Reproductive Rights as Healthcare Rights*, 18 COLUM. J. GENDER & L. 501, 519 (2009) (describing that international human rights norms and the constitutions of most other countries create affirmative rights to health services and arguing for a similar human rights framing of abortion as a healthcare right in the United States).

¹⁸³ Appleton, *supra* note 64, at 200–03.

of women as dependent on men rather than in control of her own destiny.¹⁸⁴ As Justice Ruth Bader Ginsberg noted, “The idea of the woman in control of her destiny and her place in society was less prominent in the *Roe* decision itself, which coupled with the rights of the pregnant woman the free exercise of her physician’s medical judgment.”¹⁸⁵

Similarly, protecting the right of AID by identifying the right as a decision between doctor and patient, as the Montana Supreme Court did in *Baxter v. Montana*, raises the possibility of creating an incomplete right in which end-of-life decision-making is a shared decision between doctors and patients, rather than one that rests exclusively with the patient.¹⁸⁶ As was experienced in the early days before *Roe v. Wade*, this leaves patients vulnerable to finding cooperative doctors to access the right to both abortion and AID. Further, patients seeking AID, like those seeking abortion, will find it increasingly difficult to find willing doctors to assist them in AID as Catholic-owned hospitals merge with or purchase nonsectarian hospitals around the country.¹⁸⁷ Both abortion and physician-assisted deaths are prohibited by the directives that guide Catholic hospital protocol.¹⁸⁸ As Catholic-owned hospitals consolidate across the country, it raises the possibility that patients who live in the communities served by these hospitals will not have access to AID.

Further, protecting AID within the confines of the doctor-patient relationship favors those patients with health insurance and financial resources that allow them to forge a relationship with a private family physician. By contrast, patients who are poor or uninsured often lack the resources to receive ongoing healthcare from a private family physician and often receive healthcare services from public hospitals.¹⁸⁹ In these contexts, patients facing the end of life are much less likely to have formed the doctor-patient relationship necessary to exercise the AID decision within the type of doctor-patient relationship described by the Montana case or by Dr. Quill in his relationship with Diane.

¹⁸⁴ See *TRIBE*, *supra* note 64, at 45 (arguing that the medical model, which emphasized the role of doctors in the abortion decision, reinforced the traditional role of women as dependent and not in control of their destiny).

¹⁸⁵ Ginsburg, *supra* note 64, at 1199–200 (citations omitted).

¹⁸⁶ See *Baxter v. State*, 224 P.3d 1211, 1222 (Mont. 2009).

¹⁸⁷ U.S. CONFERENCE OF CATHOLIC BISHOPS, *ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES* 36 (5th ed. 2009).

¹⁸⁸ See generally Susan Berke Fogel & Lourdes A. Rivera, *Saving Roe Is Not Enough: When Religion Controls Healthcare*, 31 *FORDHAM URB. L.J.* 725, 732–33 (2003) (discussing the reproductive health services provided by Catholic hospitals); Lori R. Freedman et al., *When There’s a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 *AM. J. OF PUB. HEALTH* 1774, 1774 (2008) (describing medical practice guidelines for Catholic-owned hospitals); Monica Sloboda, *The High Cost of Merging with a Religiously-Controlled Hospital*, 16 *BERKELEY WOMEN’S L.J.* 140, 155 (2013) (discussing access to reproductive health services).

¹⁸⁹ See KHIARA M. BRIDGES, *REPRODUCING RACE: AN ETHNOGRAPHY OF PREGNANCY AS A SITE OF RACIALIZATION* 9–10 (2011) (discussing the public hospital system and reproductive justice).

As AID moves into the legal territory of the early abortion case law that protected the right as an aspect of the doctor-patient relationship, abortion's history should serve as a caution to the AID movement: continue to press for constitutional rights recognition at the state level. While the development of the jurisprudence of the abortion right has shown that identifying abortion solely as a constitutional right is inadequate to protect the healthcare access necessary to effectuate that right, it will provide, at a minimum, the legal protection necessary to anchor the right of AID for individual patients.

Part III considers what lessons can be drawn from the AID movement's transformation from what is identified as the individual rights frame of Dr. Kevorkian to the contextualized choice of Dr. Quill. Part III draws upon the two movements to develop the notion of dignity-related healthcare. It begins with a discussion of the role of dignity as an animating principle in the law generally and how dignity has been invoked in AID cases specifically. Next, Part III explores how both dignity and healthcare are concepts that have been threaded through the jurisprudence of abortion, drawing upon the death with dignity movements to argue that dignity-related healthcare addresses how decision-making in these contexts—both AID and reproductive health—occurs within a systemic set of values, social, economic, and governmental structures. The lesson to be drawn from the death with dignity movements is that healthcare must be reframed from a decision between doctors and patients to a fundamental shift in the way death is perceived, supported, and addressed in the healthcare system in response to patient vulnerability. Part III concludes that a similar shift, in the context of reproductive rights, would suggest a shift from a focus on abortion decision-making to a broader framing of reproductive healthcare, rights, and justice.

III. TOWARD DIGNITY-RELATED HEALTHCARE

A. *The Jurisprudence of Dignity*

Dignity is a theme that runs throughout United States jurisprudence.¹⁹⁰ Applied in the human rights context and constitutions of countries throughout the world,

¹⁹⁰ See, e.g., THE CONSTITUTION OF RIGHTS, HUMAN DIGNITY AND AMERICAN VALUES 1–9 (Michael J. Meyer & William A. Parent eds., Cornell Univ. Press 1992) (providing commentary on the idea of human dignity). Indeed, *The Federalist Papers* urged adoption of a Constitution in order to ensure the “liberty,” “dignity” and “happiness” of U.S. citizens. ALEXANDER HAMILTON, THE FEDERALIST NO. 1, 3. See also *Rosenblatt v. Baer*, 383 U.S. 75, 92 (1966) (Stewart, J., concurring) (stating that “the essential dignity and worth of every human being [is] a concept at the root of any decent system of ordered liberty.”); William J. Brennan, Jr., *The Constitution of the United States: Contemporary Ratification*, 27 S. TEX. L. REV. 433, 438 (1986) (stating that the Constitution “is a sublime oration on the dignity of man, a bold commitment by a people to the ideal of libertarian dignity protected through law.”).

dignity functions as normative value from which positive rights flow.¹⁹¹ In contrast, the U.S. Constitution sets forth a system of negative rights, or the right to be *free from* government interference.¹⁹² As a result, in the U.S. context of negative rights, dignity functions as a norm that guides other constitutional rights.¹⁹³ Many commentators have highlighted how dignity is infused throughout the interpretation of constitutional rights.¹⁹⁴ It has been suggested that dignity is a value that animates the moral foundations of all constitutional rights.¹⁹⁵ Some commentators have argued that the term dignity is so pervasive in constitutional law that the Supreme Court has “changed the content of U.S. constitutional law to name dignity as a distinct and core value.”¹⁹⁶ Indeed, the central role of dignity in U.S. law has led some to argue for its inclusion as a foundational principle of law.¹⁹⁷

¹⁹¹ See G.A. Res. 217(III), at 72 (Dec. 10, 1948) (providing, “[a]ll human beings are born free and equal in dignity and rights.”). See generally MYRES S. MCDUGAL ET AL., *HUMAN RIGHTS AND WORLD PUBLIC ORDER* xvii (1980) (discussing human rights with respect to human dignity); Neomi Rao, *Three Concepts of Dignity in Constitutional Law*, 86 NOTRE DAME L. REV. 183, 193–96 (2011) (discussing different conceptions of dignity); Christopher McCrudden, *Human Dignity and Judicial Interpretation of Human Rights*, 19 EUR. J. INT’L L. 655, 656 (2008) (recounting the development of human rights and dignity).

¹⁹² See Rao, *supra* note 191, at 187; see, e.g., ISAIAH BERLIN, *FOUR ESSAYS ON LIBERTY* 122–34 (1969) (describing the origins and consequences of negative and positive rights).

¹⁹³ See Rex D. Glensy, *The Right to Dignity*, 43 COLUM. HUM. RTS. L. REV. 65, 71 (2011).

¹⁹⁴ See *id.* at 81–82; Walter F. Murphy, *An Ordering of Constitutional Values*, 53 S. CAL. L. REV. 703, 758 (1980); see also Maxine D. Goodman, *Human Dignity in Supreme Court Constitutional Jurisprudence*, 84 NEB. L. REV. 740, 743 (2006) (noting that the Supreme Court has repeatedly recognized human dignity as giving meaning to constitutional rights, and advocating for the consistent recognition of the value in the application of existing constitutional standards).

¹⁹⁵ See RONALD DWORKIN, *TAKING RIGHTS SERIOUSLY* 272–78 (1977); see also Ronald Dworkin, *The Coming Battles Over Free Speech*, THE N.Y. REV. OF BOOKS, June 11, 1992 (discussing, as one justification for free speech, the idea that speech is valuable because it is essential in a just political society, for government to treat its adult members as “responsible moral agents.”).

¹⁹⁶ See Judith Resnik & Julie Chi-hye Suk, *Adding Insult to Injury: Questioning the Role of Dignity in Conceptions of Sovereignty*, 55 STAN. L. REV. 1921, 1941 (2003).

¹⁹⁷ See, e.g., RONALD DWORKIN, *FREEDOM’S LAW: THE MORAL READING OF THE AMERICAN CONSTITUTION* 2 (1996) (explaining that the U.S. Constitution embodies the protection of abstract human values such as dignity); Goodman, *supra* note 194, at 789 (advocating that the Supreme Court should expressly recognize human dignity as underlying certain constitutional rights); Maxine Eichner, *Families, Human Dignity, and State Support for Caretaking: Why the United States’ Failure to Ameliorate the Work-Family Conflict Is a Dereliction of the Government’s Basic Responsibilities*, 88 N.C. L. REV. 1593, 1596 (2010) (arguing that “the respect for human dignity [is] at the root of the United States’ liberal democratic understanding of itself”); Murphy, *supra* note 194, at 758 (specifying that “[t]he fundamental value that constitutionalism protects is human dignity.”); Resnik & Suk, *supra*

Dignity is particularly well-suited to function as a guiding value in the context of rights related to healthcare as it is most frequently invoked by the courts to describe aspects of liberty, autonomy, and self-determination.¹⁹⁸ While its meaning is imprecise and often inconsistent,¹⁹⁹ its most fundamental or basic premise requires that dignity attaches to each individual by virtue of being human and relates to human agency.²⁰⁰ Courts have interpreted dignity as the autonomy and liberty of the individual to be free from interference in the most fundamental decisions.²⁰¹ The Supreme Court frequently uses the term in contexts that involve certain personal choices that are so central to individual liberty and autonomy, including those intimate choices that define personal identity and beliefs, as to be protected under the Fourteenth Amendment.²⁰² In light of the central role that dignity plays as a guiding principle and normative background in U.S. law, it is an apt term for purposes of setting forth a concept of healthcare that is grounded in autonomy and respect for human dignity.

The term dignity appears in a wide variety of constitutional case law.²⁰³ For example, the Court stated that the Fourth Amendment “guarantees the privacy,

note 196, at 1941 (arguing that the Supreme Court has “changed the content of United States constitutional law to name dignity as a distinct and core value.”).

¹⁹⁸ See Rao, *supra* note 191, at 207–17 (setting forth a taxonomy of dignity in Supreme Court jurisprudence).

¹⁹⁹ See, e.g., Zachary R. Calo, *Human Dignity and Health Law: Personhood in Recent Bioethical Debates*, 26 NOTRE DAME J.L. ETHICS & PUB. POL’Y 473, 473–74 (2012) (noting that “human dignity is a notoriously malleable term for which there is no agreed upon meaning.”); John D. Castiglione, *Human Dignity Under the Fourth Amendment*, 2008 WIS. L. REV. 655, 662 (noting that dignity is “admittedly [an] ethereal concept.”); Glensy, *supra* note 193, at 67; Rao, *supra* note 191, at 201–208.

²⁰⁰ Immanuel Kant, for example, describes dignity in terms of human agency by stating that, “autonomy is the ground of dignity of human nature and of every rational nature.” IMMANUEL KANT, *GROUNDING FOR THE METAPHYSICS OF MORALS* 41 (James W. Ellington trans., Hackett Publ’g Co., Inc. 3d ed. 1993).

²⁰¹ See Berlin, *supra* note 192, at 122; JOHN STUART MILL, *ON LIBERTY* 9 (Elizabeth Rapaport ed., Hackett Publ’g Co., Inc. 1978) (1859) (discussing autonomy and liberty of individuals).

²⁰² See, e.g., *Obergefell v. Hodges*, 135 S. Ct. 2584, 2604–05 (2015) (“The fundamental liberties protected by the Fourteenth Amendment’s Due Process Clause extend to certain personal choices central to individual dignity and autonomy, including intimate choices defining personal identity and beliefs.”); *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972) (“It is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.”); *Griswold v. Connecticut*, 381 U.S. 479, 484–486 (1965) (“ . . . a ‘governmental purpose to control or prevent activities constitutionally subject to state regulation may not be achieved by means which sweep unnecessarily broadly and thereby invade the area of protected freedoms.’”).

²⁰³ See Glensy, *supra* note 193, at 71; Rao, *supra* note 191, at 193–96; see, e.g., Jordan J. Paust, *Human Dignity as a Constitutional Right: A Jurisprudentially Based Inquiry into Criteria and Content*, 27 HOW. L.J. 145, 158 (1984) (noting that between 1925 and 1982 the

dignity, and security of persons against certain arbitrary and invasive acts by officers of the Government or those acting at their direction.”²⁰⁴ The Court has described that, “[t]he basic concept underlying the Eighth Amendment is nothing less than the dignity of man.”²⁰⁵ Dignity has been used by the Court to articulate values underlying freedom from race and gender discrimination. For example, the Court described that being excluded from jury service on the basis of gender injures “personal dignity and . . . the individual’s right to participate in the political process.”²⁰⁶ On race-based classifications, the Court stated “[o]ne of the principal reasons race is treated as a forbidden classification is that it demeans the dignity and worth of a person to be judged by ancestry instead of by his or her own merit and essential qualities.”²⁰⁷

Dignity also featured prominently in the recent same sex marriage case, *Obergefell v. Hodges*, in which the Supreme Court held that under the Due Process and Equal Protection Clauses of the Fourteenth Amendment, couples of the same-sex may not be deprived of the right to marry.²⁰⁸ The majority opinion closed by saying,

No union is more profound than marriage, for it embodies the highest ideals of love, fidelity, devotion, sacrifice, and family. In forming a marital union, two people become something greater than once they were. As some of the petitioners in these cases demonstrate, marriage embodies a love that may endure even past death. It would misunderstand these men and women to say they disrespect the idea of marriage. Their plea is that they do respect it, respect it so deeply that they seek to find its fulfillment for themselves. Their hope is not to be condemned to live in loneliness, excluded from one of civilization’s oldest institutions. They ask for equal *dignity* in the eyes of the law. The Constitution grants them that right.²⁰⁹

Supreme Court used the term human dignity or its equivalent in 187 opinions); Goodman, *supra* note 194, at 756 (declaring that from 1980 to 2000, the Supreme Court used equivalent terms in 91 opinions).

²⁰⁴ *Skinner v. Railway Labor Execs.’ Ass’n*, 489 U.S. 602, 613–14 (1989); *see also* *Schmerber v. California*, 384 U.S. 757, 767 (1966) (“The overriding function of the Fourth Amendment is to protect personal privacy and dignity against unwarranted intrusion by the State.”).

²⁰⁵ *Trop v. Dulles*, 356 U.S. 86, 100 (1958).

²⁰⁶ *J.E.B. v. Alabama*, 511 U.S. 127, 153 (1994) (Kennedy, J., concurring); *see also* *Nguyen v. INS*, 533 U.S. 53, 83 (2001) (O’Connor, J., dissenting) (noting the potential for injury to dignity “that inheres in or accompanies so many sex-based classifications.”).

²⁰⁷ *Rice v. Cayetano*, 528 U.S. 495, 517 (2000).

²⁰⁸ *Obergefell v. Hodges*, 135 S. Ct. 2584, 2599 (2015).

²⁰⁹ *Id.* at 2608 (emphasis added). The opinion earlier asserted that “There is dignity in the bond between two men or two women who seek to marry and in their autonomy to make such profound choices.” *Id.* at 2599. *See also* *In re Marriage Cases*, 183 P.3d 384, 400 (Cal. 2008) (recognizing that preventing gay couples from entering into marriages fails to

Dignity has been used in a wide variety of cases ranging from Second Amendment gun rights, to campaign finance, and the death penalty.²¹⁰ Thus, dignity is a powerful value at play, not only in individualized decision-making, but as a value that animates the other rights related to treatment by the state and the community.

B. AID and Dignity-Related Healthcare

Dignity has long played a central role in the fields of healthcare and bioethics, and has been especially prominent in questions of euthanasia and AID.²¹¹ For example, the U.S. Supreme Court has invoked questions of dignity in cases involving the right to refuse medical treatment for the terminally ill. In *Cruzan v. Director, Missouri Dep't of Health*,²¹² Justice O'Connor stated in her concurring opinion that requiring a competent adult to endure the procedures of being fed artificially by means of a tube against her will "burdens the patient's liberty, dignity, and freedom to determine the course of her own treatment."²¹³

In *Baxter v. Montana*, the Montana Supreme Court, upholding the right of AID, invoked dignity as a central concern and phrased the issue as whether "competent,

recognize the dignity of gay couples), superseded by constitutional amendment, CAL. CONST. art. 1, § 7.5, as recognized in *Strauss v. Horton*, 207 P.3d 48, 122 (Cal. 2009); *Kerrigan v. Comm'r of Pub. Health*, 957 A.2d 407, 466 (Conn. 2008) (same).

²¹⁰ See *McDonald v. City of Chicago*, 561 U.S. 742, 791 (2010) (addressing dignity in the Second Amendment context); *Citizens United v. FEC*, 558 U.S. 310, 329 (2010) (discussing whether corporate finance restrictions limit the dignity of free expression); *Wellons v. Hall*, 558 U.S. 220, 220 (2010) (per curiam) (stating that judicial proceedings related to death penalty cases must be conducted with "dignity").

²¹¹ Calo, *supra* note 199, at 473–75 (noting that while dignity continues to maintain a significant role within human rights, in bioethics human dignity has acquired particular prominence). Many have written on the bioethics of dignity in the abortion and end-of-life contexts. See, e.g., FRANCIS FUKAYAMA, *OUR POSTHUMAN FUTURE* 174 (2002) (explaining how modern ethical controversies by biotechnology raise questions regarding human dignity to groups of people such as the unborn, infants, the terminally ill, and the elderly); LEON R. KASS, *LIFE, LIBERTY AND THE DEFENSE OF DIGNITY* 251 (2002) (discussing the ethical controversies surrounding the right to die); RAPHAEL COHEN-ALMAGOR, *THE RIGHT TO DIE WITH DIGNITY* 17 (2001) (describing that the concept of dignity "refers to a worth or value that flows from an inner source. It is not bestowed from the outside but rather is intrinsic to the person."); DWORKIN, *supra* note 18, at 238–38 (explaining that, "[a] true appreciation of dignity argues decisively . . . for individual freedom, not coercion, for a regime of law and attitude that encourages each of us to make mortal decisions for himself."); 2 NATIONAL COMMISSION FOR THE PROTECTION OF HUMAN SUBJECTS OF RESEARCH, APPENDIX TO THE BELMONT REPORT: ETHICAL PRINCIPLES AND GUIDELINES FOR THE PROTECTION OF HUMAN SUBJECTS OF RESEARCH 22–28 (1979).

²¹² 497 U.S. 261 (1990).

²¹³ *Id.* at 289.

terminally ill patients have a constitutional right to die with dignity.”²¹⁴ Justice Wayne’s concurrence expanded upon the importance of dignity in AID when he stated,

Society does not have the right to strip a mentally competent, incurably ill individual of her inviolable human dignity when she seeks aid in dying from her physician. Dignity is a fundamental component of humanness; it is intrinsic to our species; it must be respected throughout life; and it must be honored when one’s inevitable destiny is death from an incurable illness.²¹⁵

Moreover, his concurrence specifically relied upon the dignity interest expressed in an earlier abortion opinion in which the Montana Supreme Court struck down a statute prohibiting certified physician assistants from performing abortions. Quoting that case, Justice Wayne described that “[r]espect for the dignity of each individual . . . demands that people have for themselves the moral right and moral responsibility to confront the most fundamental questions about the meaning and value of their own lives and the intrinsic value of life in general, answering to their own consciences and convictions.”²¹⁶

As occurred in the AID context, using the term dignity in conjunction with healthcare similarly signals a shift in framing from rights of individualized decision-making to a concern with the impact of social, economic, and political structures on autonomy, dignity, and self-determination more broadly. As described above, the dignity frame transitioned AID from a rights frame to a healthcare frame. This shift brought about an expanded view of AID that considered the impact on dignity when external forces such as poverty, disability, lack of state support of family and

²¹⁴ *Baxter v. State*, 224 P.3d 1211, 1213–14 (Mont. 2009).

²¹⁵ *Id.* at 1233 (Nelson, J., concurring). Montana is one of a handful of states, including Illinois and Louisiana, which enumerates dignity as a protected right in their constitution. The Montana Constitution provides,

Individual Dignity: The dignity of the human being is inviolable. No person shall be denied the equal protection of the laws. Neither the state nor any person . . . shall discriminate against any person in the exercise of his civil or political rights on account of race, color, sex, culture, social origin or condition, or political or religious ideas.

MONT. CONST. art. II, § 4 (West, Westlaw through Oct. 2015 amendments).

²¹⁶ *Baxter*, 224 P.3d at 1230 (Nelson, J., concurring) (quoting *Armstrong v. State*, 989 P.2d 364, 389 (Mont. 1999)). Dignity was also an important aspect of the New Mexico district court opinion *Morris v. Brandenburg*. *Morris v. Brandenburg*, No. D-202-CV 2012-02909 (N.M. Dist. 2014), *rev’d*, *Morris v. Brandenburg*, 356 P.3d 564 (N.M. Ct. App. 2015), *aff’d* 2016-NMSC-027 (2016). There, District Court Judge Nan Nash described that, “patients who choose aid in dying typically choose to die at home, in familiar surroundings, with loved ones present. These are peaceful, dignified deaths.” *Id.* at ¶ 30.

healthcare, and healthcare training, deprive individuals of dignity in the context of end-of-life decision-making. By employing the term dignity-related healthcare, this Article seeks to engage similar discussions and concerns to consider how social, political, and economic structures and relationships come to bear upon dignity in many healthcare contexts, including abortion-related healthcare, a place where such considerations have not commonly taken hold outside of the reproductive justice framework.²¹⁷

C. Abortion as a Right Related to Healthcare and Dignity

Establishing the abortion right as a right related to healthcare grounded in dignity brings together disparate strands of existing Supreme Court jurisprudence on abortion rights.²¹⁸ The language of dignity was first invoked by the Court in the abortion context in *Thornburgh v. American College of Obstetricians and Gynecologists*.²¹⁹ The Court placed the case squarely within the tradition of liberty cases related to individual decision-making.²²⁰ Writing for the majority, Justice

²¹⁷ It is important to note again that while the impact of social, political and economic systems on reproductive health and rights has not been part of mainstream discourse around reproductive rights, this framework has been integral to the reproductive justice framework for decades. See, e.g., DOROTHY ROBERT, *KILLING THE BLACK BODY* 7 (1997) (discussing the interplay between race, social problems, and reproduction); JAE SILLMAN ET AL., *UNDIVIDED RIGHTS: WOMEN OF COLOR ORGANIZE FOR REPRODUCTIVE JUSTICE* 11 (2004) (“Women of color in the US negotiate their reproductive lives in a system that combines various interlocking forms of oppression.”); ASIAN COMMUNITIES FOR REPROD. JUST., *A NEW VISION FOR ADVANCING OUR MOVEMENT FOR REPRODUCTIVE HEALTH, REPRODUCTIVE RIGHTS AND REPRODUCTIVE JUSTICE* 1 (2005) http://www.apirh.org/download/ACRJ_A_New_Vision.pdf. [<https://perma.cc/978K-VLVC>] (discussing the levels on which to effect change for reproductive justice).

²¹⁸ See Rao, *supra* note 191, at 183; Victoria Barantesky, *Abortion Dignity: The Abortion Doctrine After Gonzales v. Carhart*, 36 HARV. J.L. & GENDER 123, 167–68 (2013); Leslie Meltzer Henry, *The Jurisprudence of Dignity*, 160 U. PENN. L. REV. 169, 208–12 (2011); Glensy, *supra* note 193, at 91; Reva B. Siegel, *Dignity and the Politics of Protection: Abortion Restrictions Under Casey/Carhart*, 117 YALE L.J. 1694, 1696 (2008) (arguing that gender-paternalistic views of dignity underscore *Gonzales v. Carhart* based on harm to women as mothers and contrasting with the dignity of decisional autonomy expressed by the Court in *Planned Parenthood v. Casey*); Vicki C. Jackson, *Constitutional Dialogue and Human Dignity: States and Transnational Constitutional Discourse*, 65 MONT. L. REV. 15, 16 (2004).

²¹⁹ 476 U.S. 747, 772 (1986), *overruled by* *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992).

²²⁰ See *Eisenstadt v. Baird*, 405 U.S. 438, 440, 454–55 (1972) (upholding the right of unmarried couples to access contraceptives); *Griswold v. Connecticut*, 381 U.S. 479, 485–86 (1965) (prohibiting the state from interfering with married couples’ right to use contraceptives); *Meyer v. Nebraska*, 262 U.S. 390, 400–03 (1923) (recognizing the right to direct the education and upbringing of one’s children).

Blackmun stated that “[f]ew decisions are more personal and intimate, more properly private, or more basic to individual dignity and autonomy, than a woman’s decision . . . whether to end her pregnancy. A woman’s right to make that choice freely is fundamental.”²²¹

The notion of dignity runs through both *Gonzales v. Carhart*²²² and *Planned Parenthood v. Casey*.²²³ In *Casey* the Supreme Court explicitly connected dignity to autonomy in the abortion decision stating “[t]hese matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment.”²²⁴ Justice Stevens’ separate opinion also engaged notions of dignity in support of the abortion right: “The authority to make such traumatic and yet empowering decisions is an element of basic human dignity . . . a woman’s decision to terminate her pregnancy is nothing less than a matter of conscience.”²²⁵ The Supreme Court in *Carhart* specifically relies on human dignity as the basis of its opinion to *allow* government restrictions on abortion. In upholding the federal Partial-Birth Abortion Ban Act, the Court reasoned that the ban “expresses respect for the dignity of human life”²²⁶ and thereby “the State’s interest in respect for life is advanced by the dialogue that better informs the political and legal systems, the medical profession, expectant mothers, and society as a whole”²²⁷ At the same time, the *Casey* opinion relies on a rationale of dignity to prohibit governmental interference in a woman’s decision whether to become a parent.²²⁸ Indeed, as Professor Siegel argues, “[A] commitment to dignity structures the undue burden test itself.”²²⁹

In addition, there have been gestures toward identifying abortion as a right of healthcare as opposed to a fundamental right founded in marriage and procreation case law. For example, in his concurring opinion in *Doe v. Bolton*,²³⁰ Justice Douglas argued that abortion was a right of health that was related to privacy, describing the medical privacy right as “the right to care for one’s health and person and to seek out a physician of one’s own choice.”²³¹ His concurrence identified abortion specifically as a right of privacy related to healthcare, rather than as a right of privacy related to procreation, marriage and childrearing.²³² He described this right of healthcare by stating, “[t]he right to seek advice on one’s health and the right to

²²¹ *Thornburgh*, 476 U.S. at 772.

²²² 550 U.S. 124 (2007).

²²³ 505 U.S. 833 (1992); see Siegel, *supra* note 218, at 1696.

²²⁴ *Casey*, 505 U.S. at 851.

²²⁵ *Id.* at 916 (Stevens, J., concurring in part and dissenting in part).

²²⁶ *Carhart*, 550 U.S. at 157.

²²⁷ *Id.* at 160.

²²⁸ *Casey*, 505 U.S. at 851.

²²⁹ Siegel, *supra* note 218, at 1696.

²³⁰ *Doe v. Bolton*, 410 U.S. 179 (1973) (Douglas, J., concurring).

²³¹ *Id.* at 219.

²³² *Id.* at 211.

place reliance on the physician of one's choice are basic to Fourteenth Amendment values."²³³ He argued in *Doe* that the term "liberty" in the Fourteenth Amendment included, "the freedom to care for one's health and person, freedom from bodily restraint or compulsion, freedom to walk or stroll or loaf."²³⁴ This characterization associated privacy with healthcare and protected women as rightsholders exercising a choice to access this healthcare.

Further, Justice Blackmun's concurring opinion in *Planned Parenthood of Southeastern Pennsylvania v. Casey* also identified abortion as a right of choice that is related to healthcare, stating,

this Court has recognized the vital liberty interest of persons in refusing unwanted medical treatment. Just as the Due Process Clause protects the deeply personal decision of the individual to *refuse* medical treatment, it also must protect the deeply personal decision to *obtain* medical treatment, including a woman's decision to terminate a pregnancy.²³⁵

Thus, the tension between identifying abortion as a right related to healthcare versus decision-making has threaded through the abortion decisions in much the same way that these two conceptual frameworks have vied for dominance in AID. Once again, it is this shift between framings of healthcare and choice in these two movements that this Article seeks to examine, rather than the comparison between the ethical and moral implications presented by abortion and AID.²³⁶

The AID movement's trending successes suggests that there is a benefit to be gained by pulling together these two strands of thinking on the abortion right to identify abortion as a right of healthcare specifically anchored in dignity of pregnant women. It is important to note that recently the dignity argument has been used effectively by the antiabortion movement. For example, woman-protective abortion legislation²³⁷ seeks to restrict abortion based on the assertion that abortion harms women because women who have abortions will come to regret their decision and will suffer psychological distress.²³⁸ This trend makes it ever more important for the

²³³ *Id.* at 219–20.

²³⁴ *Id.* at 213.

²³⁵ *Planned Parenthood of Se. Penn. v. Casey*, 505 U.S. 833, at 927 n.3 (Blackmun, J., concurring) (emphasis in the original).

²³⁶ *See supra* Introduction.

²³⁷ The woman-protective anti-abortion legislation is based upon the premise that abortion harms women. For example, the South Dakota legislature used this reasoning to pass legislation banning abortion. *See* H.B. 1215, 2006 Leg., 81st Sess. (S.D. 2006) (repealed by voter referendum Nov. 7, 2006) (stating the act's interest was "to fully protect the rights, interests, and health of the pregnant mother . . . and the mother's fundamental natural intrinsic right to a relationship with her child"). *See*, Reva B. Siegel, *The New Politics of Abortion*, 2007 U. ILL. L. REV. 991, 992 (2007).

²³⁸ *See* Susan Frelich Appleton, *Reproduction and Regret*, 23 YALE J.L. & FEMINISM 255, 261 (2011); Maya Manian, *The Irrational Woman: Informed Consent and Abortion*

reproductive rights, health, and justice movements to reclaim this framing. Opponents have used woman-protective antiabortion legislation to change the terminology around the procedure. While traditional abortion laws refer to abortion as the termination of pregnancy, the woman-protective model recasts abortion as the termination of a relationship between a pregnant woman and her child.²³⁹ The Supreme Court incorporated the woman-protective reasoning in *Gonzales v. Carhart*, to argue that the decision to undergo a so-called partial birth abortion harmed women by fundamentally breaking the bond between mother and child.²⁴⁰

This broader vision opens the possibility of finding common cause in enhancing the rights and dignity of pregnant women more generally, to healthy deliveries, to reducing the number of unwanted pregnancies, lowering the cost of parenting and demanding greater support for caregiving.²⁴¹ For example, fetal personhood legislation has been defeated nationwide, even in those states that consistently support abortion restrictions by reconnecting abortion to larger issues of pregnancy care, contraception, fertility, and women's health.²⁴² As was the case

Decision-Making, 16 DUKE J. GENDER L. & POL'Y. 223, 225 (2009); REVA SIEGEL, *The Right's Reasons: Constitutional Conflict and the Spread of Woman-Protective Anti-Abortion Argument*, 57 DUKE L.J. 1641, 1653 (2008).

²³⁹ The South Dakota legislature introduced a woman-protective anti-abortion bill in 2011 that identifies abortion as, "the decision of a pregnant mother considering termination of her relationship with her child by an abortion." See Siegel, *supra* note 237, at 992 (discussing South Dakota's legislation). The bill followed an earlier bill passed in 2005 by the South Dakota legislature based on the same woman-protective reasoning that, "by having an abortion, her existing relationship and her existing constitutional rights with regards to that relationship will be terminated." *Id.* (discussing HB 1166, 80th Leg. Assem., Reg. Sess. (S.D. 2005) (codified in S.D.L.C. §34-23A-10.1). The bill was halted by preliminary injunction, *see* *Planned Parenthood Minn. v. Rounds*, 530 F.3d 724, 726 (8th Cir. 2008) (en banc), and is currently on appeal in the Eighth Circuit, 662 F.3d 1072 (8th Cir. S.D. Dec 07, 2011) (NO. 09-3231, 09-3233, 09-3362)).

²⁴⁰ *Gonzales v. Carhart*, 550 U.S. 124, 159 (2007); *see* Chris Guthrie, *Carhart, Constitutional Rights, and the Psychology of Regret*, 81 S. CAL. L. REV. 877, 879 (2008) (arguing that states will use the psychology of regret from the *Carhart* decision to justify wide-ranging constraints on the abortion right generally); Robin Toner, *Abortion Foes See Validation for New Tactic*, N.Y. TIMES, May 22, 2007, at A1 (arguing that the Court's regret analysis will "galvaniz[e] anti-abortion forces and set[] the stage for an intensifying battle over new abortion restrictions in the states.").

²⁴¹ See, Lynn M. Paltrow, *Towards a Real Culture of Life* (March 12, 2007), <http://rhrealitycheck.org/article/2007/03/14/towards-a-real-culture-of-life/> [<https://perma.cc/WR3K-X4U3>]; Robin West, *From Choice to Reproductive Justice: De-Constitutionalizing Abortion Rights*, 118 YALE L.J. 1394, 1427 (2009).

²⁴² Professor Maya Manian has argued, the potential for success in this type of coalition building can be seen in the successful defeat of fetal personhood statutes despite a landscape of dramatic restrictions in abortion related healthcare nationwide. Reproductive rights advocates in fetal personhood battles have successfully argued that fetal personhood would impact women's healthcare decision-making more broadly by subjecting pregnant women to wide-ranging regulation from criminalizing behavior during pregnancy, restrictions in

in AID, this recognition offers the opportunity for proponents of reproductive justice to find common ground with opponents of abortion who nonetheless seek to support issues that will decrease the likelihood of abortion, such as reducing poverty and increasing governmental or private social support for parenting, increasing healthcare access for women's reproductive health, and passing legislation designed to eradicate discrimination against pregnant and parenting women. Indeed, there is much opportunity to find common ground in the social support of pregnancy, working mothers, and families in the context of reproductive justice more generally rather than solely in the context of the abortion debate.²⁴³ Instead, abortion continues to be almost exclusively conceptualized within the framework of an individual right of choice to terminate a pregnancy that occurs in isolation of these social forces.

Transitioning from a rights framing of abortion to a dignity and healthcare framing requires contextualizing the experiences of women who have abortions, who birth and raise children, and who decide not to have children, to demonstrate that reproductive choice serves to enhance dignity, compassion, and healthcare in the lives of women, their families, and their communities. Studying the AID debate from the alternative framings of Dr. Kevorkian and Dr. Quill reveals how the AID movement transformed the "right to die" into a new paradigm of thoughtful decisions made within the context of healthcare, with social and legal support designed to enhance dignity and compassion in the lives of the terminally ill and their families. Reproductive decision-making should be reframed in a similar way.²⁴⁴

CONCLUSION

The death with dignity movement has successfully maneuvered from an early right to die, framed by constitutional rights, to a broad redefinition of death with dignity. This has transformed the way patients experience the dying process and the

women's employment opportunities, and potentially granting spousal control over healthcare-decision-making during pregnancy. Maya Manian, *Lessons from Personhood's Defeat: Abortion Restrictions and Side Effects on Women's Health*, 74 OHIO ST. L.J. 75, 77 (2013).

²⁴³ See Paltrow, *supra* note 241; West, *supra* note 241, at 1426 (noting that a fair amount of pro-life feminist scholarship is now focused on increasing public support for parenting); Elizabeth R. Schiltz, *Should Bearing the Child Mean Bearing All the Cost? A Catholic Perspective on the Sacrifice of Motherhood and the Common Good*, 10 LOGOS 15, 17 (2007) (arguing for a combination of Catholic and feminist thought on support for child raising); Jacqueline L. Salmon, *Some Abortion Foes Shifting Focus from Ban to Reduction*, WASH. POST, Nov. 18, 2008, at A1; MomsRising, <http://www.momsrising.org> (seeking to organize both pro-choice and pro-life mothers around issues affecting parenting such as paid maternity leave and publicly-funded childcare).

²⁴⁴ Professor Maya Manian has demonstrated how fetal personhood statutes across the nation have been successfully defeated by reconnecting abortion to pregnancy care, contraception, and women's health and arguing that this reframing should be applied to resist abortion restrictions more broadly. Manian, *supra* note 242, at 77.

way doctors treat the dying.²⁴⁵ Fifty years ago, the vast majority of people faced the end of life in hospital rooms under the care of doctors who had received no training in end-of-life care, with 90% of doctors preferring not to tell terminal patients of their prognosis.²⁴⁶ Today, palliative hospice care programs are available in all fifty states,²⁴⁷ almost half of deaths occur in a hospice setting.²⁴⁸ Doctors are trained in offering palliative care and patients have dramatically enhanced legal rights to make healthcare decisions at the end of life.²⁴⁹ The death with dignity movement has many successes in transitioning its agenda from a focus on the right to die to one that addresses the dignity of the terminally ill through enhancing healthcare access and legal rights.

The abortion right has been comparatively less successful in moving from a rightsframing to addressing the reproductive healthcare needs of women and girls, especially those who face multiple forms of oppression. As a result of the cleave that separates abortion-related healthcare from the mainstream medical care establishment discussed above, the current framing of the abortion right is more analogous to Dr. Kevorkian than to Dr. Quill. Abortion providers have been relegated to the role of providing services in isolation of healthcare contextualized in women's reproductive lives. Abortion has been identified exclusively in terms of constitutional rights, which conceptualizes abortion as a right to make the abortion decision free of undue burdens of state interference but unsupported in any other way. Public perception, state-level legislation, case law, and the lack of training of doctors in medical school, all reinforce the narrative of abortion as a right of decision-making rather than as an aspect of women's healthcare. As a result, the abortion right has been given minimal effective protection, with the right being recognized so long as women's decision-making has nominally been preserved.

The comparison with the death with dignity movement suggests ways of thinking differently about reproductive rights. For example, how reproductive rights, healthcare, and justice can transition from an abortion-centric constitutional rights framing toward a broader framing that seeks to enhance the support, respect, and dignity of choices made by pregnant and parenting people as well as those who

²⁴⁵ Professor Sylvia Law explains that this transformation in the rights of dying patients tracks similar trends in the movement to reform child birth to shift decision-making from doctors to patients to enhance a patients' right to control the conditions of how they experience birth and, in the case of AID, death. See Sylvia A. Law, *Birth and Death: Doctor Control vs. Patient Choice*, 82 MINN. L. REV. 1045, 1059–61 (1998).

²⁴⁶ HILLYARD & DOMBRINK, *supra* note 55, at 16.

²⁴⁷ DE HENNEZEN, *supra* note 118.

²⁴⁸ By 2010, nearly 42% of all deaths occurred in hospice care. HOEFLER & KAMOIE, *supra* note 121.

²⁴⁹ Professor Sylvia Law has argued that the movement for patient-centered treatment at the end of life, especially in the area of pain management, can learn much from the earlier movement for patient-centered birth and control of reproduction. Law, *supra* note 245, at 1059–61.

choose not to parent.²⁵⁰ By expanding its approach from the current focus on the right of abortion to embrace a broader approach seeking to address underlying conditions that effectively limit choice in this context—conditions such as poverty, lack of healthcare access, race, age, disability, and immigration status, to name a few—the movement could similarly broaden the scope of abortion from individualized decision-making to contextualized choice. Further, this shift may offer opportunities for recognizing other forms of justice beyond simply effective access to abortion. And these areas are ones where opponents of abortion may find common ground.

At the same time, the history of the abortion right cautions against narrowly identifying the healthcare of AID as that which exists exclusively within the boundaries of the doctor-patient relationship. While this version of the healthcare frame may win legislative and court victories in the short term, it runs a serious risk of eroding the decisional autonomy of patients in favor of the decision-making of their doctors. The current language found in the opinion by the Montana Supreme Court that asserts the privacy of the doctor-patient relationship in the context of AID, is almost identical to the language employed by the Supreme Court in the early abortion cases. While the healthcare framing was effective to gain support of physician organizations in the fight for abortion rights and was integral to the Court's analysis, it ultimately subordinated the decision-making of pregnant women to the authority of their doctors.

When the histories and discursive developments of these two movements are seen together, the potential for developing a more robust right of abortion and AID framed as healthcare and grounded in human dignity emerges. This conceptualization of healthcare related to dignity recognizes that healthcare practices and access, legal rights, and social support are integral aspects of healthcare. Further, it broadens the field of view from a narrow focus on healthcare as the doctor-patient relationship to a broader commitment to healthcare that ensures that all people have the social, economic, and political power to exercise meaningful autonomy in healthcare contexts. Finally, this renewed right of healthcare based on dignity looks beyond decision-making that occurs at the threshold of the abortion decision or death, to think more broadly about healthcare within the continuum of people's lives. The death with dignity movement reframed the issue of end-of-life decision-making from a decision between doctors and patients, and recast it as a

²⁵⁰ This framework is often referred to as reproductive justice. Specifically, the movement for reproductive justice contextualizes decision-making to consider how lack of social support, access to healthcare, poverty, race, disability, age and rural location, for example, affect decision-making. For further description of “reproductive justice,” see the Reproductive Justice Virtual Library at <https://www.law.berkeley.edu/php-programs/centers/crrj/zotero/library.php>. See Jael Silliman et al., *The Political Context for Women of Color Organizing*, in UNDIVIDED RIGHTS: WOMEN OF COLOR ORGANIZE FOR REPRODUCTIVE JUSTICE (2004); ASIAN COMMUNITIES FOR REPROD. JUSTICE, A NEW VISION FOR ADVANCING OUR MOVEMENT FOR REPRODUCTIVE HEALTH, REPRODUCTIVE RIGHTS, AND REPRODUCTIVE JUSTICE (2005); SISTERSONG WOMEN OF COLOR REPROD. HEALTH COLLECTIVE, REPRODUCTIVE JUSTICE BRIEFING BOOK (2007).

fundamental shift in the way death is perceived, supported, and addressed in the healthcare system. A similar shift is possible, and necessary, in the context of abortion to a broader framing of reproductive healthcare, rights, and justice.