

Illinois Death with Dignity Act: A Case for
Legislating Physician Assisted Suicide and Active
Euthanasia

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I. INTRODUCTION

Over the past century, the average life expectancy of Americans increased by about twenty-five years.¹ Specifically in Illinois, the death rate is on a steady decrease since 2000.² For Illinois patients that qualify for state-provided insurance, end-of-life-care can become extremely expensive.³ With the average life expectancy rising, the amount of people covered by health insurance growing, and the continual advancement of medical technology, the cost of end-of-life-care is likely to remain a growing public financial burden.⁴ Even though people are living longer, they are still burdened by painful diseases and ailments, and some people in Illinois would desire to end their lives if it were legally allowed.⁵

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1. See DeWitt C. Baldwin, Jr. MD, *The Role of the Physician in End-of-Life Care: What More Can We Do?*, 2 J. HEALTH CARE L. & POL'Y 258, 259 (1998-99) (explaining that due to advancements of science and technology the average life expectancy has jumped from approximately 50 years in 1900 to about 75.8 years in 1995).

2. *Deaths by County of Residence: Illinois, 2000-2009*, ILL. DEPT. OF PUB. HEALTH, http://www.idph.state.il.us/health/bdmd/death_00-09.htm (last updated Dec. 4, 2012).

3. Dan Gorenstein, *How Doctors Die*, N.Y. TIMES, Nov. 20, 2013, at F1, available at <http://www.nytimes.com/2013/11/20/your-money/how-doctors-die.html>. Seventeen percent of Medicare's \$550 billion annual budget is spent on patients' last six months of life. *Id.*

4. See *id.* ("Between 2007 and 2010, Medicare spending on patients in the last two years of life jumped 13 percent, to nearly \$70,000 per patient.").

5. See Claire Andre & Manuel Velasquez, *Assisted Suicide: A Right or a Wrong?*, Santa Clara Univ., <http://www.scu.edu/ethics/publications/iie/v1n1/suicide.html> (last visited May 5, 2014) ("[T]here are many who want to die, but whose disease, handicap, or condition renders them unable to end their lives in a dignified manner. When such people ask for

This article will argue that the Illinois legislature should propose a Death with Dignity Act modeled after Oregon's Death with Dignity Act (DWDA)⁶; however, Illinois should go a step further and also legalize active euthanasia. First, this article will define the key terms needed to have an informed conversation about this issue. The article will differentiate between such terms as active and passive euthanasia, as well as, unassisted and assisted euthanasia. The second part of this article will explain what the Oregon DWDA entails.⁷ It will explain what procedural safeguards the Oregon DWDA has in place to ensure that its patients are not being coerced or unduly influenced into making a decision to end their life. Finally, this article will argue that Illinois should model legislation after Oregon's DWDA, and it should also legislate active euthanasia. It will support this argument by showing that Illinois does not have an unqualified interest in extending the lives of its residents⁸ and that it is more humane to let a terminally-ill patient die on his own terms rather than spend his last moments of life needlessly suffering.⁹

II. DEFINING THE TERMS

In order to have a constructive discussion about the morality of euthanasia and physician-assisted suicide, one should possess a working knowledge of the key terms. Physician-assisted suicide is when a doctor facilitates a patient in their request to commit suicide by giving them either the drugs necessary or the medical knowledge necessary to commit the act.¹⁰ Euthanasia is similar, but distinct; it is the act of causing, or speeding

assistance in exercising their right to die, their wishes should be respected.”).

6. OR. REV. STAT. §§ 127.800-97 (2013).

7. *See infra* Part III.

8. *See infra* Part IV.A.

9. *See infra* Part IV.B.

10. *See* BLACK'S LAW DICTIONARY 1475 (8th ed. 2004) (“The intentional act of providing a person with medical means or the medical knowledge to commit suicide.”) [hereinafter BLACK’S].

up, the death of a patient who suffers from either a terminal illness or an especially incurable painful illness in order to alleviate the patient's suffering.¹¹ Voluntary active euthanasia is where a competent person makes a decision or a request to be assisted in dying.¹² Nonvoluntary active euthanasia occurs when an incompetent and mentally incapable person is given medications or other interventions that cause death.¹³ Involuntary active euthanasia occurs when a competent person is put to death without making a request to die or without consent.¹⁴ Passive euthanasia occurs when a terminally ill person is allowed to die by either withholding or withdrawing life-sustaining support.¹⁵

A. Active versus Passive Euthanasia

On the surface, the distinction between active and passive euthanasia seems to be rather simple. Active euthanasia requires a person to take affirmative measures, such as administering a lethal injection, whereas passive euthanasia occurs when a person refuses to prevent an individual's

11. See *Id.* at 594 (“The act or practice of causing or hastening the death of a person who suffers from an incurable or terminal disease or condition, esp. a painful one, for reasons of mercy.”). Euthanasia is sometimes regarded by the law as second-degree murder, manslaughter, or criminally negligent homicide. *Id.* In 2001, the Netherlands became the first nation to legalize euthanasia. *Id.*

12. ROBERT YOUNG, *MEDICALLY ASSISTED DEATH 2* (2007); see also KEVIN YUILL, *ASSISTED SUICIDE: THE LIBERAL, HUMANIST CASE AGAINST LEGALIZATION 11* (2013) (defining voluntary euthanasia as ending another person's life at his or her own “explicit request”); see, e.g., Lawrence M. Hinman, *An Introduction to the Moral Issues, in Contemporary Moral Issues: Diversity and Consensus 102, 103* (Lawrence M. Hinman ed., 3rd ed. 2006).

13. See YUILL, *supra* note 12, at 11 (defining nonvoluntary euthanasia as ending an incompetent and mentally incapable person's life without “explicitly requesting it”); see, e.g., Hinman, *supra* note 12, at 103-104.

14. See YUILL, *supra* note 12, at 11 (defining involuntary euthanasia as ending competent person's life without an “explicit request” or without “full informed consent”); see, e.g., Hinman, *supra* note 12, at 104. Involuntary active euthanasia is essentially murder because a person that wants to live is intentionally killed. See Young, *supra* note 12, at 2 (“[N]o matter how honourable the perpetrator's motive is in bringing about such death, it constitutes homicide.”).

15. BLACK'S at 594. A good example of litigation regarding passive euthanasia is the case of Karen Ann Quinlan in *In re Quinlan* 348 A.2d 801, *modified and remanded*, 355 A.2d 647, the parents of Karen Ann Quinlan were allowed to remove artificial respiration, allowing her to die from her illness. YOUNG, *supra* note 12, at 6.

death.¹⁶ In a hospital setting, the most common form of passive euthanasia is a Do Not Resuscitate (DNR) order.¹⁷

The distinction between active and passive euthanasia is particularly crucial in the field of medical ethics.¹⁸ The crucial distinction between active and passive euthanasia lies in a doctor's act¹⁹ or omission²⁰ because some find it acceptable to withhold life-sustaining treatment and allow a patient to die, but unacceptable to take active measures to kill a patient.²¹

The ordinary assessment of ethicists is that active euthanasia is more morally questionable than passive euthanasia because active euthanasia requires taking an affirmative action to bring about the death of another person.²² However, this distinction might not be black and white, because passive euthanasia does in fact require an affirmative action to turn off life-sustaining equipment or an active choice to not administer drugs that would prolong a patient's life.²³ If a doctor switches off a patient's respirator and the patient dies as a result of the doctor turning off the respirator, it is true that the doctor is the immediate cause of the patient's death.²⁴ Thus,

16. Hinman, *supra* note 12, at 102.

17. *Id.*

18. James Rachels, *Active and Passive Euthanasia*, 292 NEW ENG. J. MED. 78 (1975), available at http://www.qcc.cuny.edu/socialSciences/ppecorino/DeathandDying_TEXT/Active%20and%20Passive%20Euthanasia.pdf.

19. An act is "something done or performed." *See* BLACK'S at 26.

20. An omission is "a failure to do something." *See id.* at 1121.

21. *See* Rachels, *supra* note 18. The distinction between active and passive euthanasia is important because in some cases it is permissible to withhold life-sustaining treatment, but it is never permissible for a doctor to take active measures designed to kill a patient. *Id.* *See also* *Active and Passive Euthanasia*, BBC, http://www.bbc.co.uk/ethics/euthanasia/overview/activepassive_1.shtml (last visited Feb. 24, 2014). Some medical professionals agree with this distinction because it allows them to provide for a patient who prefers death to life-sustaining treatment while allowing them to avoid the ethical and legal problems they would face if they were to actively kill a patient that wished to die. *Id.* ("They think it allows them to provide a patient with the death they want without having to deal with the difficult problems they would face if they deliberately killed that person.")

22. *See* Hinman, *supra* note 12, at 103.

23. *See* *Active and Passive Euthanasia*, *supra* note 21 ("But some people think this distinction is nonsense, since stopping treatment is a deliberate act, and so is deciding not to carry out a particular treatment.")

24. *See id.* Even though the disease of the patient is an underlying factor in the patient's death, it cannot be argued that the doctor's act of turning off life-sustaining equipment is the

passively letting a patient die by removing life-support is just as much of an act as is administering a lethal injection to a patient.²⁵ Therefore, there is no material difference between active and passive euthanasia because in both instances the patient dies from an affirmative action that was taken for humanitarian reasons.²⁶

At times active euthanasia is preferable to passive euthanasia.²⁷ Active euthanasia is often more compassionate than passive euthanasia.²⁸ The typical case is one in which a patient is dying of an incurable disease and his pain and suffering can no longer be alleviated by the present treatment.²⁹ The patient will inevitably die within the next few days, but he cannot bear to go on living because of the excruciating pain.³⁰ The patient asks the doctor to end his life, and his family supports his request.³¹ At this point in time, a doctor can withhold treatment and let the patient die, passive

proximate cause of the patient's death.

25. See *id.* (“[T]he act of removing life-support is just as much an act of killing as giving a lethal injection.”).

26. *Id.*

27. See Rachels, *supra* note 18 for a good distinction between active and passive euthanasia. Throughout the article Rachels suggests that there is no moral difference between active and passive euthanasia because the end result is the same: the patient dies. *Id.* “The bare difference between killing [active euthanasia] and letting die [passive euthanasia] does not, in itself make a moral difference. If a doctor lets a patient die, for humane reasons, he is in the same moral position as if he had given the patient a lethal injection for humane reasons.” *Id.* In the early 1970's AMA policy stated that intentional termination of a patient's life was wrong and then goes on to deny that removing life-sustaining treatment was the intentional termination of a life. *Id.* Yet, it is a mistake to deny that the cessation of treatment is the “intentional termination of the life of one human being by another.” *Id.* Therefore, there can be no moral distinction between active and passive euthanasia. “If one simply withholds the treatment, it may take the patient longer to die, and so he may suffer more than he would if more direct action were taken and a lethal injection given.” *Id.* at 121.

28. Hinman, *supra* note 12, at 103.

29. *Id.*

30. *Id.*

31. See Rachels, *supra* note 18. Suppose a patient is going to die in a few days and the current treatment is not alleviating any pain. The doctor can withhold treatment. *Id.* However, the patient's agony will continue on needlessly. *Id.* If the doctor simply withholds treatment, the patient would suffer more than if a more direct action, such as lethal injection were taken. *Id.* This is a strong reason for thinking that once the decision to not continue treatment has been made, that active euthanasia is preferable, more humane and compassionate than passive euthanasia. See also Hinman, at 103. (“It is not uncommon for situations to occur in which patients will undoubtedly die . . . their remaining time will be filled . . . with extreme pain or unconsciousness In such situations, passive euthanasia seems to be *crueler* than active euthanasia and therefore morally less preferable.”).

euthanasia, or he can take steps to end the patient's suffering, active euthanasia.³² Currently, only the former is legal in Illinois.³³

B. Assisted versus Unassisted Euthanasia

It is also important to highlight the distinction between assisted and unassisted euthanasia. The difference is important because state initiatives that call for physician assisted suicide that have been accepted have legislated a form of unassisted euthanasia.³⁴ The states conditioned their laws on the patients' ability to personally take the death causing medication himself.³⁵ While the state initiatives that call for physician assisted suicide that have failed attempted to legislate a form of active euthanasia.³⁶ These initiatives have failed because if a patient is unable to self-administer the death-hastening medication, a physician cannot actively assist the patient, because this act would be illegal.³⁷ Therefore, physician-assisted suicide is a misnomer because the only physician assistance comes writing a prescription for a death-hastening medication.³⁸

32. Rachels, *supra* note 18.

33. Compare *In re Longeway*, 549 N.E.2d 292, 321 (Ill. 1989) (holding that guardian of an incompetent patient who is terminally ill and diagnosed as irreversibly comatose may exercise right to refuse artificial nutrition and hydration on behalf of the patient), and *Ficke v. Evangelical Health Sys.*, 674 N.E. 2d 888, 889 (Ill. App. Ct. 1996) (“As a general principle of Illinois law, competent adults have the right to refuse any type of medical care, including life-sustaining treatment. The right to refuse medical care has been recognized under constitutional right-to-privacy principles and is deeply ingrained in common law principles of individual autonomy, self-determination, and informed consent.”), with 720 Ill. Comp. Stat. Ann. 5/12-34.5 (2012) (making it a crime for someone to aid another person in the physical act of committing suicide).

34. See YULL, *supra* note 12, at 29. One major difference between Oregon's successful Measure 16 and the defeated Washington initiative 119 and California's Proposition 161, was that the Oregon proposal explicitly prohibited euthanasia: it was reasonable ‘prescribing only’ measure that barred any kind of lethal injection or other direct action on a dying patient by the physician. This difference was critical to the bill's success because it silenced the euthanasia threat to certain groups fostered by the opposition by exclusively endorsing the death-by-prescription model.

35. See OR. REV. STAT. §§ 127.800-127.897 (2013) (requiring a terminally ill patient to be able to self-administer a DWDA prescription).

36. See *supra* note 34 and accompanying note.

37. See *supra* note 35.

38. Oregon Health Authority, *Death With Dignity Act*, OREGON.GOV,

III. OREGON'S DEATH WITH DIGNITY ACT

In 1997, Oregon became the first state to legalize physician-assisted suicide³⁹ when it enacted the DWDA.⁴⁰ The DWDA allows terminally-ill patients to end their lives through voluntary self-administration of lethal medications that are prescribed by a physician.⁴¹ Oregon's DWDA is a form of physician-assisted suicide and not a form of voluntary active euthanasia.⁴² The distinguishing feature of physician-assisted suicide is that the drugs are to be self-administered by the patient.⁴³ This distinction allows a physician to distance himself from a patient's action and be legally protected from liability for assisting in his suicide.⁴⁴

A. How the DWDA Works

If an Oregon resident is a capable adult who is confirmed terminal by his attending and consulting physicians, and voluntarily expressed his wish to die, then he may make a written request for medication that will end his life in a humane and dignified matter.⁴⁵ The DWDA qualifies and defines what it means to be a capable adult⁴⁶; the patient must be determined to be able to make and communicate his healthcare decisions to his healthcare providers.⁴⁷ Furthermore, the DWDA defines what it means to be terminally

<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/index.aspx> (last visited Feb. 25, 2014) ("Death with Dignity Act which allows terminally-ill Oregonians to end their lives through the voluntary self-administration of lethal medications, expressly prescribed by a physician for that purpose.").

39. See *Euthanasia*, PROCON.ORG, <http://euthanasia.procon.org/view.resource.php?resourceID=000132> (last updated Dec. 13, 2013). Currently four states have legalized physician-assisted suicide: three states, Oregon, Virginia, and Washington, have done so by enacting legislation, and; one state, Montana, has done so via court ruling. *Id.*

40. OR. REV. STAT. §§ 127.800-127.897 (2013).

41. See Oregon Health Authority, *supra* note 38.

42. See *supra* Part II for a discussion about the differences between physician-assisted suicide and euthanasia.

43. Young, *supra* note 12, at 45.

44. *Id.*

45. OR. REV. STAT. § 127.805.

46. *Id.* at § 127.800(3).

47. See *id.* at § 127.800. The court or the patient's attending or consulting physician,

ill⁴⁸; a patient will be diagnosed terminal if he suffers from an incurable or irreversible disease that has been medically confirmed and the patient, within reasonable medical judgment, will die within six months.⁴⁹

B. Procedural Safeguards

The DWDA sets out numerous procedural safeguards to ensure that the patient's request to die is well-informed, his own, and has not been made in a rash or hasty manner.⁵⁰ In order to provide adequate protection for a competent terminally-ill patient, the DWDA requires that the patient must make a valid request for life-ending medication.⁵¹ The patient must make the request in front of two witnesses, and the witnesses must be able to attest that the patient signed his written request free from coercion and volitionally.⁵² To further ensure that a patient has not been coerced in any way, the DWDA limits the qualifications of valid witnesses to a patient's written request.⁵³ The witness cannot be a relative, by blood or adoption, cannot be entitled to any portion of the patient's estate, cannot be the owner, operator or employee of the center in which the patient is receiving medical care and cannot be the patient's attending physician.⁵⁴

The DWDA also protects a patient from making a rash decision by requiring him to make an oral request, followed by a written request, followed by a second oral request, all within fifteen days.⁵⁵ After the patient makes his second oral request, his attending physician must offer the patient

psychiatrist or psychologist can determine if the patient has the ability to express his wishes.
Id.

48. *Id.* at § 127.800(12).

49. *Id.*

50. *See id.* at §§ 127.805-127.850.

51. *See id.* at §§ 127.805-127.810.

52. *Id.* at § 127.810.

53. *See id.*

54. *Id.*

55. *Id.* at § 127.840.

the opportunity to rescind his request.⁵⁶ No less than fifteen days may elapse between the patient's initial oral request and the writing of a prescription for medicine that will end the patient's life in a humane and dignified manner, and no less than forty-eight hours shall elapse between the patient's written request and the writing of a prescription.⁵⁷ In the interim, the patient's attending physician must fully inform the patient of his decision⁵⁸ and must recommend that the patient notify his next of kin that he made a request for life-ending medication.⁵⁹ The last protection that the DWDA provides to a patient is that he must self-administer the medication⁶⁰; this protection prevents a doctor or a family member from administering the death-hastening drug to the patient.⁶¹ If the patient wants to die, then he must self-administer the drug.⁶²

IV. PROPOSED ILLINOIS DEATH WITH DIGNITY ACT

The Illinois legislature should propose a Death with Dignity Act that models after Oregon's DWDA⁶³; however, Illinois should go a step further and also legalize active euthanasia. Illinois lacks a legitimate state interest in forcing a capable, terminally-ill adult, who wishes to be aided in the act of committing suicide, to live the rest of his days in agony and despair.⁶⁴ Additionally, terminally-ill patients' choices have grave impacts on those that are intimately connected to them, and therefore any decision relating to a terminally-ill patient's final requests should be between him and his

56. *Id.* at §§ 127.840-127.845.

57. *Id.* at § 127.850.

58. *Id.* at § 127.830.

59. *Id.* at § 127.835.

60. *See* Oregon Health Authority, *supra* note 38 (“[A]llows terminally ill Oregonians to end their lives through the voluntary self-administration of lethal medications . . .”).

61. *Id.*

62. *Id.*

63. OR. REV. STAT. §§ 127.800-127.897 (2013).

64. *But see* Washington v. Glucksberg, 521 U.S. 702, 728-36 (1997) (in holding that Washington's assisted suicide ban does not violate the Constitution, the Court stated that Washington asserted several legitimate reasons for banning assisted-suicide).

family and not a concern of the State.⁶⁵

A. Illinois Does Not Have an Unqualified Interest in Extending the Lives of its Residents

Illinois does not have an unqualified interest in preserving the lives of its residents despite the holding of *Washington v. Glucksberg*, in which the Supreme Court found that Washington did have this interest.⁶⁶ Washington had a legitimate interest because the patients in *Washington* were asserting an interest absent a state statute; however, if Illinois were to propose a statute allowing for physician-assisted suicide and active euthanasia, then that statute would qualify Illinois' interests in its terminally ill patients.⁶⁷ A state may have an interest in preserving the lives of citizens that are still productive to society, but this interest must be weighed against the medical conditions and the wishes of patients.⁶⁸ This balancing approach is better because end-of-life care is costly⁶⁹; an uninsured terminally-ill patient who wishes to die may end up needlessly costing the state thousands of dollars in order to prolong the patient's life for a few more days or weeks.⁷⁰ Further, if a patient requests medication to end his life and Illinois law continues to forbid it, then it appears that Illinois is mandating the suffering of terminally ill patients.⁷¹

65. See *infra* Part IV.B.

66. *Glucksberg*, 521 U.S. at 728 ("First, Washington has an 'unqualified interest in the preservation of human life.' *Id.* The State's prohibition on assisted suicide, like all homicide laws both reflects and advances its commitment to this interest." [citations omitted]).

67. *Id.* The holding *Washington v. Glucksberg* was valid and can be distinguished from what I am proposing because in *Washington* the plaintiffs were asserting that the patients had a right to die absent a state statute; therefore the standard for review was that Washington had a compelling state interest. *Id.* If Illinois were to pass a DWDA, then the compelling state interest is legislated into the Act. *Id.*

68. See *id.* at 729 ("[T]he State has a real interest in preserving the lives of those who can still contribute to society and have the potential to enjoy life."). The court of appeals went on to say that Washington's interests must be weighed against the "medical condition and the wishes of the person whose life is at stake." *Id.*

69. See Gorenstein, *supra* note 3 and accompanying text.

70. *Id.*

71. See Rita L. Marker & Kathi Hamlon, *Euthanasia and Assisted Suicide: Frequently*

Critics of this assertion and defenders of banning physician-assisted suicide and active euthanasia argue that the laws are in place to prevent abuse and protect the patient.⁷² In response to critics, the Oregon DWDA has procedural safeguards in place to ensure that a patient wishing to die is not taken advantage of by unscrupulous doctors or being coerced by family members.⁷³ Meanwhile, the DWDA allows a patient to have full autonomy in making the critical decision on how to spend his final moments.⁷⁴ If Illinois legislated physician-assisted suicide, modeled after Oregon's DWDA and all of the procedural safeguards that come with it, it would ensure that a patient in Illinois would not be taken advantage of.⁷⁵ Additionally, if Illinois were to give a terminal patient the choice to end his life with dignity, it does not necessarily follow that he will choose to end his life.⁷⁶

B. A Terminally-Ill Patient's Care Impacts Those Who are Connected to Them

Illinois' terminally-ill patients should have the option to be assisted in suicide by their physician or be actively administered life-ending drugs if they are unable to physically act themselves because their choices and decisions have a grave impact on those around them.⁷⁷ As people get older

Asked Questions, PATIENTS RIGHTS COUNCIL, <http://www.patientsrightscouncil.org/site/frequently-asked-questions/> (last visited Feb. 26, 2014) ("Activists often claim that laws against euthanasia and assisted suicide are government mandated suffering.").

72. *Id.* ("Laws against euthanasia and assisted suicide are in place to prevent abuse and to protect people from unscrupulous doctors and others. They are not, and never have been, intended to make anyone suffer.").

73. *See infra* Part IV.B.

74. *Id.*

75. *See supra* Part III.B.

76. *See* OREGON PUBLIC HEALTH DIVISION, 2013 DWDA REPORT (2014), available at <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/yeay16.pdf>. Since the DWDA was passed in Oregon, a total of 1,173 people have received prescriptions written under the DWDA, while only 752 patients have died from taking the medications. *Id.*

77. *See* John Hardwig, *Is There a Duty to Die?*, 27 *Hastings Ctr. Report* 34 (1997), reprinted in *Contemporary Moral Issues: Diversity and Consensus* 110 (Lawrence M.

and are closer to dying, many have reported that their last goal in life is to not be a burden to their loved ones.⁷⁸

The lives of a terminally-ill patient's loved ones are impacted in many ways and can be seriously compromised by the patient's need for medical attention.⁷⁹ The burden and stress of providing around-the-clock-care can be overwhelming and often leaves the caregiver emotionally and physically exhausted.⁸⁰ There are severe economic consequences that can affect a patient's family.⁸¹ End of life care can be very expensive⁸² and it also results in many lost opportunities such as quitting a job or losing money to fund college.⁸³

*C. A Death with Dignity Act in Illinois Would be More Humane Than
Having Patients Needlessly Suffer*

When a patient cannot self-administer his own drugs it would be more humane to allow the doctor to administer the life-ending drugs than to let

Hinman ed., 3rd ed. 2006). (Explaining that end-of-life decisions have an impact on the patient, the family and society as a whole). In this essay, Hardwig goes on to say that under certain circumstances a person has a duty to die. I do not go to this extreme, but I use his reasoning on being a burden to loved ones to support my argument that physician-assisted suicide and active euthanasia should be legislated. *Id.*

78. *Id.*

79. *Id.* at 111.

80. *Id.* When I was in college, my maternal grandmother became bed bound. *Id.* She was never terminally ill, but my parents had to hire a live-in caregiver to feed, bath and cloth my grandmother. *Id.* In addition to this financial burden, my parents, younger brother and my uncle had a rotating schedule in which they would assist the caregiver in changing my grandmother's diapers daily. *Id.* The duties of my family in caring for my grandmother went on for three years and took an emotional and financial toll on everyone involved. *Id.* When my grandmother passed away in May 2010, the family was relieved, not because they were cruel and heartless, but because my grandmother died peacefully with the dignity that she deserved as the matriarch of the family. *Id.*

81. *See id.* ("We must also acknowledge that the lives of our loved ones can be devastated just by having to pay for health care for us."); *see also* Amanda Bennett, *End-of-Life Warning at \$618,616 Makes Me Wonder Was It Worth It*, BLOOMBERG (Mar. 4, 2010, 00:01 EST), http://www.bloomberg.com/apps/news?pid=newsarchive&sid=avRFGNF6Qw_w ("In just the last four days of trying to keep him alive—two in intensive care, two in a cancer ward—our insurance was charged \$43,711 for doctors, medicines, monitors, X-rays and scans. Two years later, the only thing I know for certain that money bought was confirmation that he was dying.").

82. Bennett, *supra* note 81 and accompanying text.

83. *See* Hardwig, *supra* note 77, at 111.

the patient needlessly suffer.⁸⁴ Some believe that active euthanasia is more common than what is actually reported. When the final hours or days of a patient's life are affected by pain and suffering, it is common for his doctor to try and alleviate suffering based on his experience with the progression of a particular disease.⁸⁵ The doctor is in a privileged position to end the patient's suffering in accordance with the patient's wishes.⁸⁶ In a minority of situations, continued living means needless suffering.⁸⁷

A doctor's active euthanasia of a patient is already more common than people think, regardless of its legality, because it is a private action that will rarely be known to anybody outside of the deathbed scene.⁸⁸ When a doctor sees a patient in extreme agony and pain, he should try and do whatever is possible to alleviate the patient's suffering in accordance with the patient's wishes.⁸⁹ In Illinois, and countless other jurisdictions, if a physician were to administer a death-hastening drug to his patient it would be considered murder⁹⁰; however, this scenario does not seem more humane than allowing patients to suffer needlessly for their last days. Illinois should legalize active euthanasia in order to let a patient die on his terms rather than needlessly suffer.

84. This statement presupposes the condition that all the procedural safeguards of the DWDA have been met.

85. Yuill, *supra* note 12, at 27-28.

86. *Id.* at 28. Yuill suggests that this is "akin to the soldier who is begged by his comrade, who has just had his legs and lower torso blown off, to shoot him."

87. *Id.*

88. *Id.*

89. Peter Tyson, *The Hippocratic Oath Today*, PBS.ORG (Mar. 27, 2001), <http://www.pbs.org/wgbh/nova/body/hippocratic-oath-today.html>. The modern Hippocratic Oath takes into account the personal nature of a patient. *Id.* The modern oath also acknowledges the delicacy that must be acknowledged in end of life situations. *Id.*

90. 720 ILL. COMP. STAT. 5/12-34.5 (2012)

V. CONCLUSION

There is no moral or ethical difference between passive and active euthanasia⁹¹; however, legally there is a difference.⁹² Passive euthanasia is an accepted medical treatment in some jurisdictions, whereas active euthanasia constitutes murder in all jurisdictions.⁹³ Several states passed legislation that allows terminally-ill residents to make a choice to die on their own terms.⁹⁴ In Oregon, the DWDA allows a terminally-ill patient's doctor to prescribe them barbiturates to peacefully end their life⁹⁵; however, the physician cannot actively administer the drugs to their patients.⁹⁶

Illinois should model a law after Oregon's DWDA.⁹⁷ In addition, the state should legislate active euthanasia to allow a doctor to actively administer lethal drugs to its patients who cannot self-administer the drugs.⁹⁸ It would be more humane to allow a doctor to actively administer a death-hastening drug to a consenting patient than to allow the patient to suffer needlessly.⁹⁹ If Illinois modeled its own version of Oregon's DWDA, then a terminally ill patient will be legally protected from coercion by his doctors or family.¹⁰⁰ If a terminally ill patient can consent to any treatment that would prolong his life, it seems logical to allow him to consent to a treatment that would end his life.¹⁰¹

91. See *supra* Part II.A.

92. See *supra* note 14 and accompanying text.

93. See *supra* note 90.

94. See *supra* note 39 and accompanying text.

95. See YOUNG, *supra* note 12, at 45.

96. See Oregon Health Authority, *supra* note 38.

97. See U.S. CONST. amend. X. granting this power to the states.

98. See *supra* Part IV.C.

99. See *supra* note 27, and accompanying text.

100. See *supra* Part III.B.

101. See Andre, *supra* note 5 (“Supporters of legislation legalizing assisted suicide claim that all persons have a moral right to choose freely what they will do with their lives as long as they inflict no harm on others. This right of free choice includes the right to end one’s life when we choose.”).