SELF-DEFEATING SELF-ADMINISTRATION: HOW STATE PHYSICIAN-ASSISTED SUICIDE LAWS VIOLATE THE AMERICANS WITH DISABILITIES ACT (ADA)

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ABSTRACT

On September 12, 2026, Illinois will become the thirteenth United States jurisdiction where it is legal for a patient with a terminal illness to receive physician-assisted suicide. Each jurisdiction that allows physician-assisted suicide also requires self-administration. Otherwise, the procedure would be considered voluntary euthanasia, which is illegal in every state in the United States. Self-administration is a defining component of physician-assisted suicide.

The self-administration requirement of physician-assisted suicide violates the ADA. Under Title II of the ADA, a service made available by a public entity may not discriminate against disabled individuals. The self-administration requirement discriminates against disabled individuals because it categorically excludes them. Further, the self-administration requires individuals who will be disabled in the future to make a premature decision to ensure eligibility.

States should repeal and resist physician-assisted suicide laws because the self-administration requirement violates the ADA. Under the Supremacy Clause, state law that conflicts with federal law is invalid. Removing self-administration from state physician-assisted suicide laws would collapse those laws into voluntary euthanasia, which is against public policy. Thus, states that already enacted physician-assisted suicide should repeal those laws. States that have not enacted such laws should resist physician-assisted suicide laws.

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I. INTRODUCTION

Susan, a California resident, has amyotrophic lateral sclerosis (ALS).[1] ALS, also called Lou Gehrig's disease, destroys nerve cells in the brain and spinal cord, causing progressive loss of muscle control.[2] It is incurable and fatal.[3]

Susan wants the option to take a life-ending drug under California's physician-assisted suicide law.[4] When she expresses her desire to her doctor, he explains to her that there are eligibility requirements under California's physician-assisted suicide law.[5] Specifically, he explains that California's physician-assisted suicide law requires self-administration.[6] In other words, Susan must take the life-ending drug herself.[7]

However, ALS is a neurodegenerative disease that causes the loss of muscle control and gets worse over time.[8]

Susan's doctor describes the choice she faces.[9] Her progressively deteriorative disease and the self-administration requirement create a question of massive implications for the end of her life.[10] Although she currently has the physical ability to self-administer the life-ending drug, she will eventually lose that ability.[11] For example, she will eventually lose the ability to hold the medicine cup and swallow the drug.[12] The question is not if she will lose the ability to self-administer the drug, but when.[13]

The doctor encourages her to, if she truly wants to avoid the final stages of her disease, choose to commit physician-assisted suicide before she loses her ability, even if it is earlier than she would prefer.[14]

California's self-administration requirement has presented Susan, and patients like her, with an impossible question: whether she should take the life-ending drug sooner than she would like to ensure she has the physical ability to do so, or wait and risk losing the ability to self-administer the drug

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1. Author's original thought.
2. *Amyotrophic Lateral Sclerosis (ALS)*, MAYO CLINIC (Apr. 10, 2024) https://www.mayoclinic.org/diseases-conditions/amyotrophic-lateral-sclerosis/symptoms-causes/syc-20354022 [https://perma.cc/R6ZE-TAJD].
3. *Id.*
4. Author's original thought (Physician-assisted suicide laws are also commonly called PAS, medical aid-in-dying (MAID), physician aid-in-dying (PAID), physician-assisted dying, or death with dignity laws. For consistency, this Comment will refer to such laws as physician-assisted suicide laws.); *see also* discussion *infra* Section II.A.
5. Author's original thought.
6. *Id.*
7. *Id.*
8. MAYO CLINIC, *supra* note 2.
9. Author's original thought.
10. *Id.*
11. *Id.*
12. *Id.*
13. *Id.*
14. *Id.*

and lose eligibility under state physician-assisted suicide laws.[15] A choice to wait may require Susan to endure the prolonged death she wishes to avoid.[16] Patients with terminal illnesses without these types of physical disabilities are not forced to make this choice.[17] They can freely choose when to take the life-ending drug.[18]

Susan has a friend, Bernard, who has been diagnosed with terminal cancer.[19] His cancer, while painful and deadly, does not affect his ability to self-administer.[20] Bernard tells his doctor that he has the same desire as his friend; he wants to commit physician-assisted suicide.[21] His doctor explains that there are eligibility requirements, but that he meets all of them and is free to choose when he would like to take the life-ending drug.[22] Bernard has the ability to fully enjoy the service of physician-assisted suicide.[23] Susan does not.[24]

In the future, Susan will lose the physical ability to self-administer.[25] Because of that disability, Susan will be ineligible for the service of physician-assisted suicide.[26] Such ability-based discrimination is a stark violation of the Americans with Disabilities Act (ADA).[27] The ADA provides that no individual, by reason of their disability, should be unable to fully enjoy a service such as physician-assisted suicide.[28] The problem is that state physician-assisted suicide laws, through their self-administration requirement, violate the ADA.[29] This violation should not be allowed to stand.[30]

State legislatures should repeal and resist physician-assisted suicide laws because they violate the ADA through the self-administration requirement.[31] Removal of the self-administration requirement from state physician-assisted suicide laws is not a viable option because it would allow voluntary euthanasia.[32]

First, this Comment will lay out a background for the discussion of how state physician-assisted laws violate the ADA by addressing terminology,

15. *Id.*
16. *Id.*
17. *Id.*
18. *Id.*
19. *Id.*
20. *Id.*
21. *Id.*
22. *Id.*
23. *Id.*
24. *Id.*
25. *Id.*
26. *Id.*
27. *See* discussion *infra* Section III.A.
28. *See* discussion *infra* Sections II.B, III.A.
29. *See* discussion *infra* Sections III.A.1, III.A.2.
30. *See* discussion *infra* Section III.A.3.
31. *See* discussion *infra* Section III.A.3.
32. *See* discussion *infra* Section III.A.3.

statutory law, case law, and general schools of thought relating to physician-assisted suicide.[33] Second, this Comment will analyze the violation.[34] Third, this Comment will argue that state legislatures should repeal and resist physician-assisted suicide laws.[35] Fourth, this Comment will address potential questions and counterarguments.[36] Fifth, the Comment will address how practical and policy considerations favor the repeal of state physician-assisted suicide laws.[37] Finally, it will conclude.[38]

II. BACKGROUND

The background of this Comment seeks to first establish the terminology used in this area of law to provide clarity and create consistency.[39] Second, the background will describe the relevant statutory law, including both state physician-assisted suicide laws and the ADA.[40] Third, the background will describe the federal cases that address the general area of physician-assisted suicide and euthanasia.[41] Fourth, the background will introduce two general schools of thought relating to physician-assisted suicide laws.[42]

A. Terminology

The topic of physician-assisted suicide has many relevant terms that can be confused.[43] Further, proponents and opponents of physician-assisted suicide dispute “the proper or most neutral terminology” for the topic.[44] This dispute is “possibly just as great as the ongoing debates over its legalization.”[45] This Comment seeks to provide the reader with a clear understanding of the terms.[46] Clarity requires specific terminology.[47] Thus, this Comment will use the terminology used by the Supreme Court and what

33. *See* discussion *infra* Part II.
34. *See* discussion *infra* Part III.
35. *See* discussion *infra* Section III.A.
36. *See* discussion *infra* Section III.B.
37. *See* discussion *infra* Section III.C.
38. *See* discussion *infra* Part IV.
39. *See* discussion *infra* Section II.A.
40. *See* discussion *infra* Sections II.B.1, II.B.2.
41. *See* discussion *infra* Section II.C.
42. *See* discussion *infra* Section II.D.
43. *See Glossary of Terms*, DEATH WITH DIGNITY, deathwithdignity.org/resources/assisted-dying-glossary/ [https://perma.cc/62FG-2YAS] (last visited Feb. 26, 2026)
44. Alyssa Thruston, *Physician-Assisted Death: A Selected Annotated Bibliography*, 111 L. LIBR. J. 31, 34 (2019).
45. *Id.*; *compare Glossary of Terms*, *supra* note 43, *with Physician-Assisted Suicide Disregards the Dignity of Human Life*, AM. UNITED FOR LIFE, https://aul.org/physician-assisted-suicide/ [https://perma.cc/2H8W-M43J] (last visited Feb. 26, 2025) (referring to physician-assisted suicide as suicide assistance).
46. Author’s original thought.
47. *Id.*

some scholars have determined is applicable and appropriate: "physician-assisted suicide."[48]

There are critical differences between physician-assisted suicide, voluntary euthanasia, and the refusal of life-saving care.[49]

The critical difference between physician-assisted suicide and voluntary euthanasia is the question of who administers the lethal drug.[50] In a physician-assisted suicide procedure, "mentally competent, adult patients with terminal illness[es] . . . request a prescription for life-ending medication from their physician. The patient must self-administer and ingest the medication without assistance."[51]

However, euthanasia is defined as the "practice or an instance of causing or hastening the death of a person who suffers from an incurable or terminal disease or condition . . . ."[52] If the patient requests euthanasia, it is considered voluntary euthanasia.[53] However, in the United States, it is not relevant whether the patient has given consent to a physician, nurse, or family member because "[a]ll forms of euthanasia are illegal in the United States."[54] Voluntary euthanasia is discussed in detail later in this Comment.[55]

On the other hand, the refusal of life-saving care is when a patient with a terminal illness refuses active life-sustaining treatments or drugs.[56] For example, Bernard could refuse the continuation of his grueling chemotherapy, a life-sustaining regimen.[57] This would be distinct from his request to take a prescribed life-ending drug, which would be physician-assisted suicide, or to have his physician inject the life-ending drug into him, which would be voluntary euthanasia.[58] All would result in death, but each is categorically distinct.[59] The Supreme Court recognizes this distinction, as this Comment analyzes below.[60]

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48. *See* Washington v. Glucksberg, 521 U.S. 702, 717 (1997) (using the term "physician-assisted suicide"); *see also* Katherine Drabiak, *The Harms of Expanding Physician-Assisted Suicide*, 35 HEALTH MATRIX 1, 9 (2025) ("Despite this effort at rebranding, multiple scholars note that the plain dictionary definition of "suicide" is the intentional and voluntary taking of one's own life.").

49. *See Glossary of Terms*, *supra* note 43.

50. *Id.*

51. *Id.*

52. *Id.*; *see also Euthanasia*, BLACK'S L. DICTIONARY (12th ed. 2024) (defining euthanasia as "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.").

53. *Euthanasia*, BLACK'S L. DICTIONARY (12th ed. 2024) (defining voluntary euthanasia as being "performed with the terminally ill person's consent").

54. *Glossary of Terms*, *supra* note 43; *see also Euthanasia*, BLACK'S L. DICTIONARY (12th ed. 2024) ("Euthanasia is sometimes regarded by the law as second-degree murder, manslaughter, or criminally negligent homicide.").

55. *See* discussion *infra* Section III.B.2.

56. *Glossary of Terms*, *supra* note 43.

57. Author's original thought.

58. *Id.*

59. *See Glossary of Terms*, *supra* note 43.

60. *See* discussion *infra* Section II.C.2.

As a group, physician-assisted suicide, voluntary euthanasia, and the refusal of life-saving care are considered different options within end-of-life care.[61]

When this Comment discusses physician-assisted suicide, it does not analyze voluntary euthanasia, which is illegal in all fifty states, or removal of life-saving care, which is legal in all fifty states.[62] This Comment discusses physician-assisted suicide, which, on September 12, 2026, will be legal in thirteen U.S. jurisdictions but is affirmatively prohibited in thirty-eight states.[63]

B. Statutory Law

This Comment will analyze one of the ways state physician-assisted suicide laws violate the ADA.[64] Before that analysis, this Comment will establish the background for state physician-assisted suicide laws and the requirement for self-administration.[65] This Comment will then discuss the ADA itself.[66]

1. State Physician-Assisted Suicide Laws

On September 12, 2026, Illinois will become the thirteenth U.S. jurisdiction where it is legal for a patient with a terminal illness to receive physician-assisted suicide.[67] All thirteen jurisdictions that have legalized physician-assisted suicide require self-administration.[68]

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61. *Glossary of Terms*, *supra* note 43.

62. *Id.*

63. *In Your State*, DEATH WITH DIGNITY, https://deathwithdignity.org/states/ [https://perma.cc/BWC6-XDQS] (last visited Jan. 30, 2026) (listing the jurisdictions: California, Colorado, Delaware, District of Columbia, Hawaii, Illinois, Maine, Montana, New Jersey, New Mexico, Oregon, Vermont, and Washington); 2025 Ill. Legis. Serv. 104-441 (West).

64. *See* discussion *infra* Section III.A.

65. *See* discussion *infra* Section II.B.1.

66. *See* discussion *infra* Section II.B.2.

67. *In Your State*, *supra* note 63 (listing the jurisdictions: California, Colorado, Delaware, District of Columbia, Hawaii, Illinois, Maine, Montana, New Jersey, New Mexico, Oregon, Vermont, and Washington); 2025 Ill. Legis. Serv. 104-441 (West) (prescribing September 12, 2026 as the effective date for Illinois's physician-assisted suicide law).

68. *Compare* CAL. HEALTH & SAFETY CODE § 443.2(a)(5) (West 2018) ("The individual has the physical and mental ability to self-administer the aid-in-dying drug."), *with* COLO. REV. STAT. § 25-48-102(5) (2024) (requiring "the qualified individual" to "self-administer to bring about death"), *and* DEL. CODE ANN. tit. 16, § 2501C(a) (2025) (providing a right for a terminally ill patient to "self-administer medication to end their life"), *and* HAW. REV. STAT. § 327L-1 (2023) (defining prescription for the purpose of physician-assisted suicide to require "that the qualified patient may self-administer to end the qualified patient's life"), *and* 2025 Ill. Legis. Serv. 104-441 (West) (requiring self-administration), *and* ME. REV. STAT. ANN. tit. 22, § 2140(2)(K) (describing that a qualified patient will "obtain a prescription for medication that the qualified patient may self-administer to end the qualified patient's life"), *and* Baxter v. State, 224 P.3d 1211, 1222 (Mont. 2009) (reasoning the self-administration requirement keeps physician-assisted suicide from violating public policy), *and* N.J. REV. STAT. § 26:16-4 (2025) (requiring self-administration), *and* N.M. STAT. ANN. § 24-7C-2(E) (West 2021) (requiring the patient to

As an example of such a requirement, the California End of Life Option Act (EOLOA) requires that "[t]he individual has the physical and mental ability to self-administer the aid-in-dying drug."[69] Compared to other laws, the California EOLOA has the clearest, most direct requirement that the patient has the physical ability to self-administer the life-ending drug.[70] Thus, the language from the California EOLOA will be used as an example that represents all self-administration requirements for state physician-assisted suicide laws.[71]

The purpose of self-administration requirements is twofold: to protect autonomy and to prevent abuse.[72] Stated another way:

> [T]his final protection [of self-administration] is the only way to ensure beyond any doubt that ingestion is a voluntary act. A person seeking to end their life pursuant to the [EOLOA] can opt out at any point—after requesting or receiving the prescription, after the drugs are in their hand, after the feeding tube has been installed, after saying goodbye.[73]

The final choice lies with the patient and no one else.[74] This self-administration requirement is intended to create a distinction between physician-assisted suicide and voluntary euthanasia.[75] In fact, it is the primary characteristic of physician-assisted suicide that allows proponents to distinguish it from voluntary euthanasia.[76] Voluntary euthanasia is illegal in all fifty states.[77] Without self-administration, a doctor's permission to

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"self-administer that medication to bring about . . . death"), *and* OR. REV. STAT. ANN. § 127.815(1)(b)(D) (West 2023) (describing the physician's duty to inform the patient of "[t]he probable result of *taking* the medication to be prescribed") (emphasis added), *and* VT. STAT. ANN. tit. 18, § 5283 (West 2023) (requiring "the physician prescribes to a patient with a terminal condition medication to be self-administered for the purpose of hastening the patient's death"), *and* WASH. REV. CODE § 70.245.010(7) (2023) (requiring self-administration), *and* D.C. CODE § 7-661.03(a)(2)(D) (2017) (describing the physician's duty to inform the patient of "[t]he potential risks associated with *taking* a covered medication") (emphasis added).

69. CAL. HEALTH & SAFETY CODE § 443.2(a)(5) (West 2018).

70. *See* sources cited *supra* note 68.

71. *See* Part III.

72. *Frequently Asked Questions*, DEATH WITH DIGNITY, https://deathwithdignity.org/resources/faqs/ [https://perma.cc/D2HG-FXPC] (last visited Nov. 26, 2025) (presenting that safeguards—like the ability to self-administer—protects patients from abuse and coercion).

73. Shavelson v. Bonta, 608 F. Supp. 3d 919, 928 (N.D. Cal. 2022); *see also* Washington v. Glucksberg, 521 U.S. 702, 747 (1997) (O'Connor, J., concurring) (listing "coercion and abuse" as state interest in preventing physician-assisted suicide).

74. *See Shavelson*, 608 F. Supp 3d at 928.

75. Megan S. Wright, *Equality of Autonomy? Physician Aid in Dying and Supported Decision-Making*, 63 ARIZ. L. REV. 157, 164–65 (2021) (citing OR. REV. STAT. ANN. § 127.880.) ("Patients must also be able to self-administer the medication, making . . . [physician-assisted suicide] distinct from euthanasia.").

76. *See Glossary of Terms*, *supra* note 43.

77. *Id.*; *see also* Thruston, *supra* note 44 ("Physician-administered euthanasia is illegal throughout the United States.").

administer a life-ending drug could be abused, either intentionally or unknowingly.[78]

2. The Americans with Disabilities Act

In 1990, Congress passed the ADA to eliminate discrimination faced by individuals with disabilities.[79] Title II of the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."[80]

The ADA and the Code of Federal Regulations (CFR) provide definitions and further explanations for this prohibition.[81]

Under the CFR, Title II of the ADA "applies to all services, programs, and activities provided or made available by public entities."[82] The ADA defines a public entity as "any State or local government [or] any department, agency, special purpose district, or other instrumentality of a State or States or local government . . . ."[83]

The CFR defines a disability, under Title II of the ADA, as "a physical or mental impairment that substantially limits one or more of the major life activities of such individual . . . ."[84] Such a definition is intended to "be construed broadly in favor of expansive coverage, to the maximum extent permitted by the terms of the ADA."[85]

The CFR specifically provides that physical or mental impairment includes any "physiological disorder or condition . . . affecting one or more body systems, such as neurological [and] musculoskeletal . . . ."[86] Major life activities include "[c]aring for oneself [and] performing manual tasks . . . ."[87] "[W]hether an impairment substantially limits a major life activity should not demand extensive analysis."[88] Stated another way, a disability under Title II is not a restrictive definition but is quite lenient and inclusive.[89]

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78. *See* Shavelson, 608 F. Supp. 3d at 928.
79. PGA Tour, Inc. v. Martin, 532 U.S. 661, 674 (2001) ("Congress enacted the ADA in 1990 to remedy widespread discrimination against disabled individuals.").
80. The Americans with Disabilities Act of 1990, 42 U.S.C. § 12132.
81. 42 U.S.C. §§ 12131, 12134(a); Nondiscrimination on the Basis of Disability in State and Local Government Services, 28 C.F.R. § 35.101(a) (2025).
82. 28 C.F.R. § 35.102 (2025).
83. 42 U.S.C. § 12131(1)(A)–(B).
84. 28 C.F.R. § 35.108(a)(1)(i) (2025).
85. *Id.* § 35.108(a)(2)(i) (2025).
86. *Id.* § 35.108(b)(1)(i) (2025).
87. *Id.* § 35.108(c)(1)(i) (2025).
88. *Id.* § 35.108(d)(1)(ii) (2025).
89. *Id.* § 35.108(a)-(d) (2025).

C. Two Principles from Case Law

In *Washington v. Glucksberg*, the Supreme Court concluded that there "is not a fundamental liberty interest [to physician-assisted suicide] protected by the Due Process Clause" of the Constitution.[90] Under a historical analysis of the nation's traditions, the Court ruled that physician-assisted suicide, as a fundamental right, is inconsistent with centuries of legal doctrine and practice.[91] "More specifically, for over 700 years, the Anglo-American common-law tradition has punished or otherwise disapproved of both suicide and assisting suicide."[92]

Without an established fundamental right, the Court has left the policymaking surrounding physician-assisted suicide to the states.[93] The Court held that the states have "an 'unqualified interest in the preservation of human life.'"[94] In short, the states may, without violating the Constitution, prohibit or allow for doctors to administer physician-assisted suicide.[95]

The Court's reasoning rests on the observation that "the States are currently engaged in serious, thoughtful examinations of physician-assisted suicide and other similar issues."[96] Further, the Court has ruled that "States have a legitimate interest 'in protecting the integrity and ethics of the medical profession.'"[97]

Thus, states may prohibit or allow physician-assisted suicide in the interests of democracy and their own power to create such laws.[98]

Further, the Court has continually distinguished between physician-assisted suicide and the refusal of life-saving care based on intent.[99] Consistently in the law, the actor's intent—not the result—may distinguish between two acts which appear similar.[100] Here, with physician-assisted suicide, it is no different.[101]

The Court has looked to the doctor's intent to make such a distinction.[102] In *Vacco v. Quill*, the Court concluded that "a physician who withdraws . . . life-sustaining medical treatment purposefully intends . . . 'to

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90. Washington v. Glucksberg, 521 U.S. 702, 728 (1997).
91. *Id.* at 723.
92. *Id.* at 711 (citing Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 294–95 (1990)).
93. *See id.*
94. *Id.* at 728 (citing *Cruzan*, 497 U.S. at 282).
95. *Id.*
96. *Id.* at 719.
97. United States v. Skrmetti, 605 U.S. 495, 539 (2025) (quoting *Washington*, 521 U.S. at 702).
98. *Washington*, 521 U.S. at 735 ("Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society.").
99. *Id.* at 723; Vacco v. Quill, 521 U.S. 793, 807 (1997) (recognizing "at least implicitly, the distinction between letting a patient die and making that patient die").
100. *Vacco*, 521 U.S. at 802.
101. *See id.*
102. *Id.* at 801.

cease doing useless and futile or degrading things to the patient when [the patient] no longer stands to benefit from them.'"[103] The Court reasoned that the same would be "true when a doctor provides aggressive palliative care" such as painkilling drugs which "may hasten a patient's death, but the physician's purpose and intent is, or may be, only to ease his patient's pain."[104]

However, the Court contrasted this intent with the intent required a "doctor who assists a suicide . . . 'must, necessarily and indubitably, intend primarily that the patient be made dead.'"[105] Stated another way, a doctor's intent to remove lifesaving but degrading care is distinct from a doctor's intent to affirmatively end a patient's life.[106]

Similarly, the Court has looked to the patient's intent to reveal further differences.[107] A patient who seeks to voluntarily refuse life-saving care might not seek to end their own life.[108] That patient may simply want to stop fighting the inevitable and allow their disease to run its natural course.[109] Such desire can coexist with wanting and wishing to be better.[110] In contrast, "a patient who commits suicide with a doctor's aid necessarily has the specific intent to end their own life . . . ."[111]

This principle is best exemplified through a brief hypothetical.[112] Recall Bernard, the cancer patient who is Susan's friend.[113] Rather than seeking physician-assisted suicide, he has told his doctor that he is tired of fighting his cancer, and although he wishes to be healed, he would prefer to stop his chemotherapy to have a better quality of life in his remaining few months.[114] His decision is not necessarily to end his own life; it is to progress towards the end of his life without choosing to take medication that is hurting his body as it attacks his cancer.[115] Thus, he does not have the specific intent to die.[116]

103. *Id.* (quoting Assisted Suicide in the United States, Hearing before the Subcommittee on the Constitution of the House Committee on the Judiciary, 104th Cong., 2d Sess., 368 (1996) (testimony of Dr. Leon R. Kass)).

104. *Id.* at 802.

105. *Id.* (quoting Assisted Suicide in the United States, Hearing before the Subcommittee on the Constitution of the House Committee on the Judiciary, 104th Cong., 2d Sess., 368 (1996) (testimony of Dr. Leon R. Kass)).

106. *See id.* at 801–02.

107. *Id.* at 802.

108. *Id.* (quoting State School v. Saikewicz, 373 Mass. 728, 743, n. 11 (1977) ("In refusing treatment the patient may not have the specific intent to die")).

109. *See id.*

110. *See id.*

111. *Id.*

112. Author's original thought.

113. See *supra* text accompanying notes 19–23.

114. Author's original thought.

115. *Id.*

116. *Id.*

If Bernard requested physician-assisted suicide, however, as in the original hypothetical, he would have the specific intent to end his own life.[117]

This difference in specific intent is how the Court distinguishes between physician-assisted suicide, which may be outlawed or legalized, and the refusal of potentially life-saving care, which is an inherent right.[118] There exists a fundamental right to the refusal or removal of life-saving care, but there does not exist a fundamental right to physician-assisted suicide.[119]

Thus, physician-assisted suicide should be treated differently under the American legal framework.[120]

D. Two Schools of Thought on Physician-Assisted Suicide

There are two major schools of thought on how to treat physician-assisted suicide in the American legal framework, however both rely on the same word: dignity.[121] The largest proponent of physician-assisted suicide laws, Death with Dignity, frames physician-assisted suicide as an issue of choice, autonomy, and dignity.[122] Conversely, Americans United for Life, an opponent of physician-assisted suicide, argues that physician-assisted suicide disregards the inherent dignity of human life.[123]

Death with Dignity refers to physician-assisted suicide as "assisted death" and claims that "'suicide'" is an example of an "inappropriate term[] for describing death with dignity."[124] This position exemplifies the argument surrounding the terminology mentioned above.[125]

The advocacy of Death with Dignity depends on where a physician-assisted suicide law stands within each state.[126] For a state like Florida, where physician-assisted suicide is not legal but occasionally considered by the state legislature, Death with Dignity advocates for the introduction of bills in each legislative session.[127] For a state like California, where physician-assisted suicide is legal, the organization advocates

117. *Id.*

118. *See* Vacco v. Quill, 521 U.S. 793, 802 (1997).

119. *See id.*

120. Author's original thought.

121. *Compare* DEATH WITH DIGNITY, https://deathwithdignity.org/ [https://perma.cc/3RUE-5EWV] (last visited Nov. 26, 2025) ("we should all have the right to die with dignity") (emphasis in original) *with* AM. UNITED FOR LIFE, *supra* note 45 ("physician-assisted suicide disregards the dignity of human life") (emphasis added).

122. DEATH WITH DIGNITY, *supra* note 121.

123. AM. UNITED FOR LIFE, *supra* note 45.

124. *Glossary of Terms*, *supra* note 43.

125. *See supra* notes 43–48 and accompanying text.

126. *See In Your State*, *supra* note 63.

127. *See Florida*, DEATH WITH DIGNITY, https://deathwithdignity.org/states/florida/ [https://perma.cc/2JNY-NUK6] (last visited Nov. 26, 2025).

lowering the requirements for eligibility for physician-assisted suicide "to help more patients access [physician-assisted suicide] in California."[128]

In contrast, organizations such as Americans United for Life advocate for the repeal of state physician-assisted suicide laws in the United States.[129] They argue that physician-assisted suicide "takes and devalues human life, hinders authentic life-affirming medicine, and compromises the integrity of the medical profession."[130] In short, Americans United for Life seeks to return to the understanding of end-of-life care before Oregon legalized physician-assisted suicide in 1994.[131]

While Death with Dignity and Americans United for Life, along with their respective allies, battle out the ethical issues of physician-assisted suicide in state legislatures, neither raises the issue of how the self-administration requirement interacts with the ADA in legal scholarship.[132] Pointing out this violation and raising it as the basis for an argument that states should repeal and resist physician-assisted suicide laws is an original contribution to legal scholarship.[133]

III. ARGUMENT

First, the analysis will establish that state physician-assisted suicide laws violate the ADA both on their face and in effect.[134] Second, it will conclude that repeal and resistance are the only viable solutions to the problem.[135] Third, the analysis will address common questions and counterarguments to this solution.[136] Fourth, the analysis will address practical and public policy considerations that favor repealing physician-assisted suicide.[137]

A. State Legislatures Should Repeal and Resist Physician-Assisted Suicide Laws Because They Violate the ADA Through Their Self-Administration Requirement

State physician-assisted suicide laws violate the ADA through their self-administration requirement because the ADA prohibits state law from

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128. *See California*, DEATH WITH DIGNITY, https://deathwithdignity.org/states/california/ [https://perma.cc/337R-VYNH] (last visited Nov. 26, 2025).

129. *See generally* Carolyn McDonnell, *A Time to Choose: Suicide Assistance or Suicide Prevention*, AMS. UNITED FOR LIFE 22 (May 2023) https://aul.org/wp-content/uploads/2023/04/2023-05-A-Time-to-Choose-Suicide-Assistance-or-Suicide-Prevention-Web.pdf [https://perma.cc/LS57-PSU6].

130. *Id*.

131. *Id.*

132. Author's original thought.

133. *Id.*

134. *See* discussion *infra* Sections III.A.1, III.A.2.

135. *See* discussion *infra* Section III.A.3.

136. *See* discussion *infra* Section III.B.

137. *See* discussion *infra* Section III.C.

making such a categorical distinction.[138] Furthermore, state physician-assisted suicide laws violate the ADA because they require disabled individuals to make decisions that they would not otherwise make.[139] The removal of the self-administration requirement is an unsustainable solution because it would result in voluntary euthanasia.[140]

1. State Physician-Assisted Suicide Laws Violate the ADA on Their Face Because Disabled Individuals Are Categorically Discriminated Against

Title II of the ADA restricts the actions of a public entity.[141] Every state is a public entity.[142] Every public entity or state that has a physician-assisted suicide law has a self-administration requirement.[143]

Title II of the ADA protects individuals with disabilities, who are defined broadly.[144] Despite a broad construction, the CFR has explicitly carved out a definition for a disability which includes "[a]ny physiological disorder or condition . . . affecting one or more body systems, such as neurological [and] musculoskeletal . . . ."[145]

Here, a condition, such as ALS, would impede a patient, such as Susan, from having the physical ability to self-administer a life-ending drug.[146] By not meeting the self-administration requirement, a patient would be ineligible for physician-assisted suicide.[147] Thus, the self-administration requirement creates a categorical distinction between two types of terminally ill patients who seek physician-assisted suicide: those who are physically disabled and those who are not.[148]

Such categorical discrimination made by reason of a disability should not be allowed to stand.[149] The self-administration requirement of state physician-assisted suicide laws violates the ADA on its face because the requirement strikes at the heart of the ADA to protect individuals and classes of individuals who are marginalized.[150]

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138. *See* discussion *infra* Section III.A.1.
139. *See* discussion *infra* Section III.A.2.
140. *See* discussion *infra* Section III.A.3.
141. *See* discussion *supra* Section II.B.2.
142. 42 U.S.C. § 12131(1)(A)–(B); The Americans with Disabilities Act of 1990, 42 U.S.C. § 12131(1)(A)–(B).
143. *See* sources cited *supra* note 68.
144. *See* discussion *supra* Section II.B.2; 28 C.F.R. § 35.108(a)–(b) (2025).
145. 28 C.F.R. § 35.108(b)(1)(i) (2025).
146. Author's original thought.
147. *E.g.*, CAL. HEALTH & SAFETY CODE § 443.2 (a)(5) (West 2018) (requiring self-administration).
148. *See id.*
149. *See* 42 U.S.C. § 12131.
150. PGA Tour, Inc. v. Martin, 532 U.S. 661, 674 (2001) ("Congress enacted the ADA in 1990 to remedy widespread discrimination against disabled individuals.").

2. State Physician-Assisted Suicide Laws Violate the ADA in Effect by Forcing Premature Decisions on Individuals Who Have Yet to Lose Mobility

Proponents of physician-assisted suicide often present the purpose of the life-ending drug as focused on reducing patient pain and suffering.[151] However, "pain and symptoms appear to play much less of a role in contributing to terminally ill persons' decisions to end their lives than one might expect."[152]

Terminal illnesses, especially as they progress, can lead to "feelings of anger, impotence, desperation, and hopelessness," which serve as "primary contributors to [the patients'] decisions to end their lives."[153] Many patients see physician-assisted suicide as an escape from these existential circumstances.[154]

A patient with a terminal disease such as ALS, which directly impacts physical ability, would likely lead to the same feelings of impotence, desperation, and hopelessness.[155] Those feelings would be magnified in a patient who expects to lose eligibility under a state's physician-assisted suicide law.[156]

Patients like Susan are faced with a tough decision: either take the life-ending drug sooner than she would like to ensure her physical ability to self-administer, or wait, risking losing the ability to self-administer the drug, thus losing eligibility under state physician-assisted suicide laws.[157] If Susan's disease progressed so that she developed a disability, she would no longer be eligible for physician-assisted suicide under state law because every U.S. jurisdiction requires self-administration.[158]

Bernard's case is tragic, yet he will not face such a decision.[159] His terminal cancer will not interfere with his ability to self-administer the drug, and thus his eligibility for physician-assisted suicide will persist until the latest stages of his disease.[160]

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151. Drabiak, *supra* note 48, at 17.

152. Phoebe Friesen, *Medically Assisted Dying and Suicide: How Are They Different and How Are They Similar?*, 50 HASTINGS CTR. REP. 32, 36 (2020).

153. *Id.* (discussing what family members report as patient's motivating factors for choosing to request physician-assisted suicide).

154. Drabiak, *supra* note 48, at 22 ("Both categories [of people who commit suicide and undergo physician-assisted suicide] are not necessarily seeking death, but rather trying to escape what they view as intolerable circumstances.").

155. *See* Shavelson v. Bonta, 608 F. Supp. 3d 919, 925 (N.D. Cal. 2022) ("While [the patient with ALS] currently has the physical ability to self-administer the aid-in-dying medication without assistance, she will likely lack the hand strength and coordination to take the medication on her own in the near future.").

156. *Id.*; Author's original thought.

157. *See Shavelson*, 608 F. Supp. at 924–25; Author's original thought.

158. *See* discussion *supra* Section III.A.1.

159. Author's original thought.

160. *Id.*

Susan represents a small minority of disabled patients who are required to make an exclusive, tough decision.[161] The minority of the underlying diseases for patients who sought physician-assisted suicide in the United States between 1998 and 2020 were neurological diseases, like ALS, at 10.9%.[162] During that same time, the majority had a cancer diagnosis at 74%.[163]

Despite being a minority, the ADA protects individuals with disabilities because society has historically tended to isolate and segregate them.[164] Here, a patient is being discriminated against because her disability—not her intent, residency, or the nature of an underlying non-terminal illness—is the effective reason that she is being forced to make a decision to end her life prematurely when her nondisabled counterparts are not.[165] This decision is forced upon her by the self-administration requirement.[166]

Thus, the self-administration requirement of every state physician-assisted suicide law violates the ADA.[167]

3. The Violation Is Irreparable Because Removing the Self-Administration Requirement Would Effectively Convert These Laws into Voluntary Euthanasia

Under the Supremacy Clause of the United States Constitution, "state laws that conflict with federal law are 'without effect.'"[168] Stated another way, the ADA "'requires preemption of inconsistent state law' when necessary to comply with its command . . . ."[169] Thus, if state physician-assisted suicide laws conflict with the ADA, they are preempted.[170]

Here, state physician-assisted suicide laws violate the ADA both on their face and in their effect.[171] This conclusion leaves policymakers with two options: either amend the state law to conform with the federal law or repeal the statute.[172]

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161. *See* Elissa Kozlov et al., *Aggregating 23 Years of Data on Medical Aid in Dying in the United States*, 70 J. AM. GERIATRIC SOC'Y 3040, 3041 (2022).

162. *Id.*

163. *Id.*

164. PGA Tour, Inc. v. Martin, 532 U.S. 661, 674–75 (2001) ("In studying the need for such legislation, Congress found that 'historically, society has tended to isolate and segregate individuals with disabilities . . . .'") (quoting 42 U.S.C. § 12101(a)(2)); *see also* 42 U.S.C. § 12101(a)(3) ("discrimination against individuals with disabilities persists in such critical areas as . . . health services.").

165. Author's original thought.

166. *Id.*

167. *Id.*

168. Altria Grp., Inc. v. Good, 555 U.S. 70, 76 (2008) (quoting Maryland v. Louisiana, 451 U.S. 725, 746 (1981); U.S. CONST. art. VI, cl. 2.).

169. Shavelson v. Bonta, 608 F. Supp. 3d 919, 926 (N.D. Cal. 2022).

170. *Id.*

171. *See* discussion *supra* Sections III.A.1, III.A.2.

172. Author's original thought.

These violations and conflicts have been pointed out to the courts before.[173] In *Shavelson v. Bronta*, a California resident with ALS challenged the EOLOA's self-administration requirement because it put her in a position much like Susan's.[174] She had to choose between acting sooner, while physically able to self-administer the life-taking medication, or waiting and risking eligibility because she would lose the physical ability to self-administer the drug.[175] There, the plaintiff argued that the self-administration requirement should be removed because it discriminated against her as a disabled person.[176]

However, the District Court decided that such an exception for patients with physical disabilities would "'fundamentally alter the nature of the service, program, or activity.'"[177] The court opined that to remove the restriction would be following the prediction of the Supreme Court in *Washington v. Glucksberg*, when the Court argued that permitting physician-assisted suicide "may start a state 'down the path to voluntary and perhaps even involuntary euthanasia . . . .'"[178] The court ultimately found that any accommodation for physically disabled, yet otherwise eligible, patients would compromise the program's fundamental nature and undermine the purpose of the self-administration requirement.[179]

The district court in *Shavelson v. Bonta* was right about one thing: "[t]he final protection [of self-administration] is the requirement at issue here . . . ."[180] However, the court chose an option that is not viable.[181] The court reasoned that the removal of the exception of the self-administration requirement would blur the state physician-assisted suicide law into euthanasia.[182] The court's conclusion, however, allows for physically disabled patients to be discriminated against by reason of their disability and for a state law to remain effective without being consistent with federal law.[183] The court's non-conclusion allows discrimination and the resulting ADA violation to continue.[184] This violation of the ADA and the Supremacy Clause is not sustainable; policymakers must choose.[185] If the self-administration requirements of state physician-assisted laws violate the

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173. *See, e.g., Shavelson*, 608 F. Supp. 3d at 919.
174. *Id.*; *see also* discussion *supra* Part I.
175. *Shavelson*, 608 F. Supp.3d at 925.
176. *Id.*
177. *Id.* at 927 (quoting 28 C.F.R. § 35.130(b)(7)(i)).
178. *Id.* (quoting Washington v. Glucksberg, 521 U.S. 702, 733 (1997)).
179. *Id.* at 927–28.
180. *Id.* at 928.
181. Author's original thought.
182. *Shavelson*, 608 F. Supp. 3d at 927.
183. Author's original thought.
184. *Id.*
185. *Id.*

ADA, something must go: either the self-administration requirement or the laws themselves.[186]

Removing the self-administration requirement would effectively convert the laws into permitting voluntary euthanasia, which is illegal and contrary to the intention of state legislatures.[187] Self-administration is a central requirement of physician-assisted suicide.[188] In fact, it is the defining characteristic that separates physician-assisted suicide from voluntary euthanasia.[189] Thus, there is no solution to remove the self-administration requirement while keeping the law.[190]

The remaining option is to repeal and resist current state physician-assisted suicide laws because their self-administration requirements violate federal law, the ADA.[191]

State legislatures, not courts, are the most effective means of bringing state law into harmony with federal law on this issue.[192] The Supreme Court has consistently held that states have an unqualified interest in the preservation of human life.[193] The Court has deferred to the democratic process to create policy "about the morality, legality, and practicality of physician-assisted suicide."[194] Thus, the Court will likely continue to avoid making determinations about physician-assisted suicide, so the best avenue for change is through state legislatures.[195]

State legislatures in states such as California, Oregon, and Washington, where physician-assisted suicide is legal, should repeal those statutes because their laws violate the ADA, and removing the self-administration requirement would convert the law into a legalization of voluntary euthanasia.[196] Similarly, states such as North Carolina, Pennsylvania, and Arizona, where Death with Dignity is advocating for state physician-assisted suicide laws, should resist the enactment of such laws.[197]

Thus, states with physician-assisted suicide laws should repeal and resist them to come into harmony with federal law.[198]

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186. Altria Grp., Inc. v. Good, 555 U.S. 70, 76 (2008); Shavelson 608 F. Supp. 3d at 926–27.

187. *Shavelson*, 608 F. Supp. at 927 ("The [EOLOA] was the culmination of a multi-year process . . . [and the] . . . resulting framework draws a sharp boundary, allowing a person to take their own life with aid-in-dying medication, but forbidding the taking of anyone else's."); Alyssa Thruston, *supra* note 44 ("Physician-administered euthanasia is illegal throughout the United States.").

188. *See* discussion *supra* Section II.A.

189. *See* discussion *supra* Section II.A.

190. *See Shavelson*, 608 F. Supp. at 927–28; *see also* discussion *infra* Section III.B.2.

191. *Shavelson*, 608 F. Supp. at 926 ("The ADA therefore requires preemption of inconsistent state law when necessary to comply with its command."); U.S. CONST. art. VI, cl. 2.

192. Author's original thought.

193. Washington v. Glucksberg, 521 U.S. 702, 728 (1997) (citing *Cruzan*, 497 U.S. at 282).

194. *Id.* at 735.

195. *Id.*

196. *See In Your State*, *supra* note 64; *see* discussion Sections III.A.1, III.A.2.

197. *See In Your State*, *supra* note 64.

198. Author's original thought.

B. Can the State Physician-Assisted Suicide Law Violation of the ADA Be Resolved?

This Comment proposes one solution to the problem of state physician-assisted suicide laws violating the ADA.[199] The solution is for state legislatures to repeal and resist such laws.[200] The following sections of this Comment address relevant counterarguments and questions contrary to the analysis above.[201] The first question is how physician-assisted suicide falls under Title II of the ADA as a service of a public entity when doctors prescribe the life-ending drug.[202] The second question analyzes what is wrong with voluntary euthanasia.[203]

1. How Does Physician-Assisted Suicide Fall Under Title II of the ADA as a Service of a Public Entity When Doctors Prescribe the Life-Ending Drug?

Title II of the ADA applies to "the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."[204] Under the CFR, Title II of the ADA "applies to all services, programs, and activities provided or made available by public entities."[205] Put simply, state physician-assisted suicide laws make the service available to patients.[206]

As an example, the California EOLOA allows a capable adult with a terminal disease to request a prescription for a life-ending drug if certain conditions are met.[207] Of course, one condition is self-administration, but the EOLOA also requires a terminal diagnosis, the patient's voluntary consent, the patient's residency in California, and a specific method of patient request.[208]

Typically, under California law, it is a felony to deliberately aid, advise, or encourage another to commit suicide.[209] However, the EOLOA carves an exception in the penal code, allowing "a person whose actions are compliant with the provisions of the [EOLOA to] not be prosecuted under this section."[210]

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199. *See* discussion *supra* Section III.A.
200. *See* discussion *supra* Section III.A.
201. *See* discussion *infra* Sections III.B.1–4.
202. *See* discussion *infra* Section III.B.1.
203. *See* discussion *infra* Section III.B.2.
204. 42 U.S.C. § 12132–12165.
205. 28 C.F.R. § 35.102 (2025).
206. *See, e.g.*, EOLOA, CAL. HEALTH & SAFETY CODE § 443.2(a) (West 2018); *see also* 42 U.S.C. § 12131(1)(A)–(B) (making states public entities).
207. CAL. HEALTH & SAFETY CODE § 443.2(a) (West 2018).
208. *Id.* § 443.2(a)(1)–(5).
209. CAL. PENAL CODE § 401(a) (West 2019) ("any person who deliberately aids, advises, or encourages another to commit suicide is guilty of a felony.").
210. *Id.* § 401(b) (West 2019).

Thus, California authorizes the prescription of life-ending drugs for patients who meet its eligibility requirements.[211] It is irrelevant that a private doctor may be prescribing the medicine; the doctor is following a statutory scheme created by a public entity to avoid prosecution.[212] Physician-assisted suicide is only available because of a state's action.[213] Thus, Title II of the ADA applies.[214]

2. What Is So Wrong with Voluntary Euthanasia?

Removing the self-administration requirement, which violates the ADA, from state physician-suicide laws would effectively convert those laws into permitting voluntary euthanasia.[215] Voluntary euthanasia is euthanasia which "occurs at the request of the person who dies."[216] However, some proponents of physician-assisted suicide would argue that physician-assisted suicide laws should be broadened to allow physically disabled individuals to be voluntarily euthanized.[217] Thus, the problems with voluntary euthanasia need to be explored.[218]

Euthanasia in any form is illegal in all fifty states.[219] Defendants have been convicted of murder when they, in an attempt to assist another to commit suicide, carry out the physical act which results in the death of the deceased.[220] A doctor who commits the final act resulting in the death of the patient commits murder.[221] It is irrelevant if the patient gives the doctor consent.[222]

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211. *See* sources cited *supra* notes 204–10 and accompanying text.

212. Author's original thought.

213. *See* 28 C.F.R. § 35.102. Even if policymakers were to find this reasoning unpersuasive, Title III of the ADA protects disabled individuals against discrimination by public accommodations, which specifically include health care providers, hospitals, and pharmacies. 42 U.S.C. § 12182(a); § 12181(7)(F).

214. *See* 42 U.S.C. § 12132.

215. *See* discussion *supra* Section III.A.3.

216. See *Glossary of Terms*, *supra* note 43.

217. Cyndi Bollman, *A Dignified Death? Don't Forget About the Physically Disabled and Those Not Terminally Ill: An Analysis of Physician-Assisted Suicide Laws*, 34 S. ILL. UNIV. L. J. 395, 410 (2010) ("there is always the option of permitting the physician to actually administer the drugs."); *see also* Shavelson v. Bonta, 608 F. Supp. 3d 919, 925 (N.D. Cal. 2022) (originating from a plaintiff seeking the court to remove the self-administration requirement so that she can be effectively euthanized if she loses her ability to self-administer); *see also* AN ACT REGARDING PARIENT-DIRECTED CARE AT THE END OF LIFE, 126th ME Leg. H.P. 758, 1st Sess. (2013) (proposing permitting a patient to accept care delivered by a physician that may hasten or bring about death).

218. *See* sources cited *supra* note 217.

219. Thruston, *supra* note 44 ("Physician-administered euthanasia is illegal throughout the United States.").

220. 40A AM. JUR. 2d *Homicide* § 560.

221. *See id.*

222. *Id.*

These principles arise out of the common law understanding of suicide and assisted suicide.[223] Under common law, as summarized by Sir William Blackstone, "the law has therefore ranked [suicide] among the highest, crimes" despite it being "a felony committed on oneself."[224] Further, Blackstone reasoned that although "[m]urder is an injury to the life of an individual . . . the law of society considers principally the loss which the state sustains by being deprived of a member . . . ."[225] The state loses a citizen regardless of whether a person kills themselves, is assisted to kill themselves, or is murdered.[226] Thus, under common law, someone may not consent to their own death because society is deprived, despite the individual loss.[227]

While states generally do not punish suicide due to impracticality, many states have continued to punish the act of assisting a suicide, particularly when the person affirmatively takes the final step to end another's life.[228] For example, the California penal code makes it a felony for a "person who deliberately aids, advises, or encourages another to commit suicide" with the exception of the EOLOA.[229] Thus, even states with physician-assisted suicide laws recognize the dangers of legalizing voluntary euthanasia.[230]

Further, even if a patient voluntarily requests that their physician assist in their death, they will not be making that decision because of pain and suffering.[231] In fact, the motivating factors are often shared with those who seek regular suicide: loneliness, hopelessness, feeling like a burden to others, and a lack of control.[232] Both a traumatized or depressed young person who attempts suicide and an individual seeking physician-assisted suicide—when terminally ill—"feel the future is not worth living for . . . ."[233] Both a terminally ill patient and a psychologically suffering person feel hopeless, but the law and society in some states treat them differently.[234]

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223. Washington v. Glucksberg, 521 U.S. 702, 711–12 (1997) (reasoning that United States common law understanding of suicide and assisting suicide come from English common law).

224. 4 WILLIAM BLACKSTONE, COMMENTARIES *189.

225. *Id.* at *4.

226. *See id.*

227. *See id.*

228. *See* Washington v. Glucksberg, 521 U.S. 702, 774–75 (1997) (O'Connor, J., concurring); *see also* MAYO CLINIC, *supra* note 2 (listing Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersy, New Mexico, New York, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhodie Island, South Dakota, Tennessee, Texas, Washington, Wisconsin, and Puerto Rico as states with statues which prohibit a suicide in 1997).

229. CAL. PENAL CODE § 401(a)–(b) (West 2019).

230. *See id.*

231. Friesen, *supra* note 152, at 36.

232. *Id.* ("A significant number of themes are common across the contexts of medically assisted dying and suicide. These include the central place of loss, loneliness, hopelessness, the experience of burdening others, a dissolution of one's identity, a lack of control, and feeling that one has no future prospects.").

233. *Id.*

234. *See id.* at 37–38.

If voluntary euthanasia, physician-assisted suicide, and suicide all share the same motivating intent, the law should treat them similarly.[235] The law should discourage voluntary euthanasia because it is motivated by the same feelings that motivate suicide.[236] States already discourage suicide.[237]

C. Practical and Public Policy Considerations Favor Repealing Physician-Assisted Suicide

The first public policy consideration that favors the repeal of physician-assisted suicide is that there is a steady growth trend in the usage of physician-assisted suicide, which will lead to greater disparity in the future.[238] The second public policy factor that favors resistance to physician-assisted suicide laws is that proponents of physician-assisted suicide advocate for the lowered requirements once physician-assisted suicide laws pass in states.[239] Finally, this Comment looks at lessons that can be learned from other nations' usage of physician-assisted suicide and euthanasia.[240] These policy concerns are by no means an exhaustive list.[241]

1. As the Prevalence of Physician-Assisted Suicide Grows, the Effect of the Violation of the ADA Will Grow Proportionally

Few patients elect to partake in physician-assisted suicide in the United States.[242] Between 1998 and 2020, only 5,329 patients died by physician-assisted suicide, while 8,451 received a prescription.[243] In contrast, in 2020 alone, 45,979 people died by standard suicide in the United States.[244]

Regardless of its relatively limited effect, as physician-assisted suicide laws mature in a state, use of physician-assisted suicide steadily increases

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235. *See* Vacco v. Quill, 521 U.S. 793, 801–02 (1997) (looking to intent to decide how the law should react to end-of-life choices).

236. Author's original thought.

237. *See* Washington v. Glucksberg, 521 U.S. 702, 713–14 (1997) ("Nonetheless, although States moved away from Blackstone's treatment of suicide, courts continued to condemn it as a grave public wrong.").

238. *See* discussion *infra* Section III.C.1.

239. *See* discussion *infra* Section III.C.2.

240. *See* discussion *infra* Section III.C.3.

241. *See Opinion 5.7 Physician-Assisted Suicide*, AMA CODE OF MED. ETHICS, https://code-medical-ethics.ama-assn.org/sites/amacoedb/files/2025-1/AMA%20Code%20of%20Medical%20Ethics5.7_0.pdf [https://perma.cc/F589-VK5R] (last visited Feb. 10, 2026) (opining that "[p]hysician-assisted suicide is fundamentally incompatible with the physician's role as a healer"); *see also* McDonnell, *supra* note 129 (addressing how legalization of physician-assisted suicide undermines suicide prevention policies).

242. *See* Kozlov et al., *supra* note 161, at 3041.

243. *Id.*

244. Sally C. Curtin et al., *Provisional Numbers and Rate of Suicide by Month and Demographic Characteristics*, NCHS VITAL STAT. RAPID RELEASE, 1, 5 (2022) https://stacks.cdc.gov/view/cdc/120830 [https://perma.cc/89C6-6GFG].

within that state.[245] For example, in California, the EOLOA doubled from 407 deaths in its first full year of use in 2017 to 853 deaths in 2022.[246] California is consistent with how the usage of physician-assisted suicide steadily increases in states after its legalization.[247]

Further, physician-assisted suicide is relatively new in the United States.[248] Although Oregon legalized physician-assisted suicide in 1998, Washington, as the second state, did not legalize it until 2008.[249] As a new end-of-life option, its prevalence is likely to increase in the coming years as more states legalize it—e.g., Illinois—and as more patients learn about and become comfortable with it.[250]

As physician-assisted suicide laws mature, their use becomes more prevalent.[251] As more people use, learn of, and become more comfortable with physician-assisted suicide, more people will be discriminated against because the ineligible group will grow proportionally to the eligible group.[252]

The time is now for states to repeal and resist physician-assisted suicide laws before the prevalence grows and the self-administration requirement discriminates against more disabled people, violating the ADA.[253]

2. As Physician-Assisted Suicide Laws Mature, Proponents Advocate for Relaxed Requirements, Including Self-Administration

Proponents of physician-assisted suicide often advocate for relaxing eligibility requirements after using limited eligibility to get a statute initially passed in a state.[254] "Recently, multiple states have amended their laws to increase access to [physician-assisted suicide], including by expanding provider eligibility, reducing waiting periods, and eliminating residency requirements."[255]

Legislators and other proponents of physician-assisted suicide use eligibility requirements to strategically gain public acceptance of their proposed legislation by implying that physician-assisted suicide would be

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245. Kozlov et al., *supra* note 161, at 3041; *see also id* at 3043 fig. 1.

246. *California End of Life Option Act 2022 Data Report*, CALI. DEP'T. OF PUB. HEALTH, 1, 3 fig. 1 (July 2023) https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CDPH_End_of_Life%20_Option_Act_Report_2022_FINAL.pdf [https://perma.cc/DVE3-9R6L].

247. *See* Kozlov et al., *supra* note 161, at 3043 fig. 1.

248. *See id.*

249. *See id.*

250. *See id.*; *see also* 2025 Ill. Legis. Serv. 104-441 (West) (prescribing September 12, 2026 as the effective date for Illinois's physician-assisted suicide law).

251. *See* Kozlov et al., *supra* note 161, at 3043 fig. 1.

252. Author's original thought.

253. *Id.*

254. Drabiak, *supra* note 48, at 60–61 ("Proponents originally extolled the stringent eligibility criteria as safeguards to garner public support . . . . Proponents relabeled these safeguards as barriers and have worked to actively erase them through legislative and judicial challenges to expand potential providers, reduce waiting periods, and eliminate residency requirements.").

255. *Id.* at 3.

utilized narrowly and rarely.[256] Then, when legislators and advocacy groups see that resistance has subsided, they seek to implement broader access to physician-assisted suicide.[257]

For example, the Oregon Death with Dignity Act was passed in 1994.[258] In 2019, Oregon lawmakers gave physicians permission to waive the fifteen-day requirement for patients who are imminently dying.[259] In 2023, Oregon removed its residency requirement.[260] In 2025, proponents of physician-assisted suicide attempted to reduce the waiting period from fifteen days to seven days, but the amendment did not pass.[261]

Similarly, in 2022, California reduced the required duration between oral requests for physician-assisted suicide from fifteen days to forty-eight hours.[262] Such a reduction in eligibility requirements is made possible by proponents of physician-assisted suicide.[263]

Further, law journal comments and articles often encourage a relaxation of eligibility requirements.[264] For example, published legal scholarship has advocated for making physician-assisted suicide more accessible by removing self-administration and terminal illness requirements.[265] Other proponents argue that physician-assisted suicide should be extended to competent minors regardless of parental consent.[266]

Each of these proposed or successful erosions of state eligibility requirements for physician-assisted suicide has one chief effect: it broadens the applicability and thus increases the use of the service.[267] For example, while physician-assisted suicide has steadily increased in Oregon, the usage spiked in 2020 and 2023 when eligibility requirements were relaxed.[268]

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256. *Id.* at 35–36 (citing Scott Y.H. Kim, *What Does True Equality in Assisted Dying Require?*, 23 AM. J. BIOETHICS 1, 1 (2023)).

257. *Id.*

258. *Oregon*, DEATH WITH DIGNITY, https://deathwithdignity.org/states/oregon/ [https://perma.cc/7P5P-3QJS] (last visited Feb. 10, 2026).

259. *Id.*

260. *Id.*

261. *Id.*

262. *California*, *supra* note 128.

263. Drabiak, *supra* note 48, at 60–61.

264. *See generally* Thruston, *supra* note 44, at 34 (listing many law journal articles and comments which advocate for relaxed eligibility requirements).

265. *E.g.*, Bollman, *supra* note 217, at 415 (2010).

266. *E.g.*, Neelam Chhikara, *Extending the Practice of Physician-Assisted Suicide to Competent Minors*, 55 FAM. CT. REV. 430, 437 (providing that parental consent will not be required).

267. Tate Thielfoldt, *The Ethical and Legal Considerations of Physician-Assisted Dying for Individuals Living with Disabilities*, 18 U. ST. THOMAS J.L. & PUB. POL'Y 300, 312 (2024) ("Repealing safeguards is usually justified as expanding access to physician-assisted [suicide].").

268. *Oregon*, *supra* note 258; *Oregon Death with Dignity Act 2023 Data Summary*, OR. HEALTH AUTH., 16 tbl. 2, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year26.pdf [https://perma.cc/V6DX-L87W].

Eligibility requirements are described as safeguards but are used as a Trojan Horse to pass state physician-assisted suicide laws.[269] Many of the jurisdictions that have legalized physician-assisted suicide have deregulated the safeguards within the initial bills.[270] As proponents push deregulation, many of these changes have occurred within the last few years.[271]

As physician-assisted suicide becomes more accessible, its use becomes normalized, which in turn contributes to increased use.[272] Increased use creates more discrimination against disabled individuals.[273] Proponents of physician-assisted suicide should not be allowed to encourage the passage of their bills using eligibility requirements as safeguards and then characterize those eligibility requirements as restrictions.[274] State legislatures should avoid the progressively slippery slope that erodes physician-assisted suicide into something that can be abused.[275] States should repeal and resist physician-assisted suicide laws.[276]

3. There Are Important Lessons from Other Nations About the Effects of Physician-Assisted Suicide and Euthanasia

An analysis of the effect of physician-assisted suicide and euthanasia laws reinforces the two practical and policy considerations described above.[277] While the laws discussed in this section mostly legalize euthanasia, the two are linked and distinguished only by the self-administration requirement.[278] The Netherlands shows the validity of a slippery slope concern when it comes to such end-of-life laws.[279] Belgium reinforces the conclusion that the usage of euthanasia and physician-assisted suicide becomes more prevalent as time goes on.[280] Canada exemplifies that the eligibility requirements and restrictions are removed as the laws mature.[281]

In 2001, the Netherlands became the first country to legalize euthanasia.[282] As far as requirements, the law requires that the request for

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269. Thielfoldt, *supra* note 267, at 312 ("Safeguards have historically been used as a Trojan Horse to pass litigation with the intent of broadening access down the line.").
270. *Id.* at 308 (listing Oregon, Vermont, Washington, Colorado, California, Colorado, and Hawaii).
271. *Id.*
272. *See* discussion *supra* Section III.C.1.
273. *See* discussion *supra* Section III.C.1.
274. Author's original thought.
275. *Id.*
276. *See* discussion *supra* Sections III.A, III.B.
277. *See* discussion *supra* Sections III.C.1, III.C.2.
278. *See* discussion *supra* Sections II.A.1, III.B.2.
279. Jean-Paul Van De Walle & Sophia Kuby, *The Legalization of Euthanasia and Assisted Suicide: An Inevitable Slippery Slope*, ADF INT'L 36 (2022) https://adfinternational.org/wp-content/uploads/2022/02/Euthanasia-White-Paper_2022_DIGITAL.pdf [http://perma.cc/24J5-SNGE].
280. *Id.*
281. *Id.*
282. *Id.*

euthanasia is made with a voluntary and well-considered request.[283] Even minors may request euthanasia.[284] Between the ages of twelve and sixteen, parental consent is required; between sixteen and eighteen, it is not.[285] From 2009 to 2019, the number of euthanasia and assisted suicide cases has more than doubled in the Netherlands.[286] While the underlying conditions of the patients who seek physician-assisted suicide are typical, a growing number of patients have sought physician-assisted suicide because of early diagnoses of dementia.[287]

In the Netherlands, where euthanasia and physician-assisted suicide have become normalized, "euthanasia is offered as an ordinary medical service with a provider specialized in . . . 'euthanasia care . . . .'"[288] A Dutch ethicist, Professor Theo Boer, writes that there is "'a network of travelling euthanizing doctors . . . . On average, these physicians see a patient three times before administering drugs to end their life.'"[289] This normalized system of traveling doctors goes against what Professor Boer believes the Dutch "law presupposes (but does not require) an established doctor-patient relationship."[290]

Professor Boer, an initial proponent of euthanasia and a member of a regional euthanasia review committee in the Netherlands, believed in 2007 that "'there does not need to be a slippery slope when it comes to euthanasia . . . .'"[291] However, in 2014, he changed his opinion and "wrote a public appeal to the British House of Lords, warning: 'We were wrong, terribly wrong.'"[292] In 2023, he predicted to the British House of Commons that "any law that allows assisted dying will come to be experienced as an injustice and will be challenged in the courts."[293] He changed his view because his position as an established ethicist allows him to see that there is a valid slippery slope concern with euthanasia laws and physician-assisted suicide laws.[294] Once physician-assisted suicide or euthanasia is permitted

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283. *Id.*
284. *Id.*
285. *Id.* at 37.
286. *Id.*
287. *Id.*
288. *Id.*
289. *Id.* (citing Steve Doughty, *Don't Make Our Mistake: As Assisted Suicide Bill Goes to Lords, Dutch Watchdog Who Once Backed Euthanasia Warns UK of 'Slippery Slope' to Mass Deaths*, DAILY MAIL (July 9, 2014, at 18:40 EST), https://www.dailymail.co.uk/news/article-2686711/Dont-make-mistake-As-assisted-suicide-bill-goes-Lords-Dutch-regulator-backed-euthanasia-warns-Britain-leads-mass-killing.html [https://perma.cc/R353-FAQP]).
290. *Id.*
291. *Id.*
292. *Id.*
293. Theo Boer, *Written Evidence Submitted Professor Theo Boer (ADY0484)*, UK PARLIAMENT 2 (Jan. 2023) https://committees.parliament.uk/writtenevidence/117110/pdf/ [https://perma.cc/PZ8G-U4XU].
294. *See id.*

for one class or group of people, its availability is broadened, increasing its use.[295]

In 2002, Belgium joined the Netherlands in legalizing euthanasia.[296] The law serves as a defense to the intentional end of someone's life, providing that the patient meets certain requirements.[297] The Belgian euthanasia law requires that the Control Commission present a report to the legislature every two years.[298] This report shows that euthanasia, since its legalization, has grown in prevalence.[299]

The report produced by the Belgian Euthanasia Control Commission shows that euthanasia consistently increases in a country as the legalization of euthanasia matures.[300] For instance, in 2024, the commission reviewed 3,991 euthanasia registration documents, a 16.6% increase from the previous year.[301] Further, euthanasia cases reported in 2023 increased by 15% when compared with 2022.[302] When taken as a whole, the data show a steady year-over-year increase in the average number of cases.[303] In the first years since its legalization, an average of 493 euthanasia cases were reported, but that average jumped to 1,450 cases per year during the 2010–2014 period and jumped again to 2,275 cases per year during the 2015–2019 period.[304]

The only year of decrease during the first twenty years of euthanasia legalization in Belgium was 2020.[305] A spokesperson for the Control Commission assigned responsibility for the decrease to a criminal case involving euthanasia, which was tried early in the year, and a period of lockdown because of the COVID pandemic.[306] Thus, barring extraneous circumstances, the usage of euthanasia grows in the years after its legalization, as shown by the example of Belgium.[307]

In 2016, Canada legalized euthanasia.[308] However, subsequent amendments show that proponents of euthanasia and physician-assisted

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295. *See id.*

296. Van De Walle & Kuby, *supra* note 279.

297. *Id.* (listing as requirements: "as a result of a severe pathology or accident, in a condition of durable and unbearable physical or mental suffering that cannot be alleviated. The request must be voluntary and made without any external pressure.").

298. *Id.*

299. *See id.*

300. *See id.*

301. *Press Release from the Federal Commission for the Control and Evaluation of Euthanasia*, FCCEE (2024) https://consultativebodies.health.belgium.be/sites/default/files/documents/fccee-pressrelease_20250319-figureseuthanasia2024_.pdf [https://perma.cc/8NSM-94NN].

302. *Id.*

303. *See* Van De Walle & Kuby, *supra* note 279.

304. *Id.*

305. *Id.*

306. *Id.* (citing Hanne Decré, *2.444 Mensen Kregen Vorig Jaar Euthanasie, een Opvallende Daling: "Door het Euthanasieproces en de Lockdown"*, [2,444 People Received Euthanasia Last Year, a Striking Decrease: Through the Euthanasia Process and the Lockdown] VRT NWS (Mar. 2, 2021) https://www.vrt.be/vrtnws/nl/2021/03/02/ [https://perma.cc/A7W9-TQSH]. euthanasiecijfers-2020/).

307. *See id.*

308. *Id.*

suicide will push for the expansion of state laws and the decrease of requirements.[309] Initially, the law required that the person be suffering from "'a grievous and irremediable medical condition' . . . with 'natural death . . . reasonably foreseeable.'"[310] However, the Canadian Parliament passed an act to amend the regulation and remove the requirement that persons have a natural death that is foreseeable.[311] Stated another way, the law made it possible for a person without a foreseeable natural death to resort to euthanasia or physician-assisted suicide.[312] Canada is another example of when proponents of euthanasia and physician-assisted suicide successfully decreased requirements and broadened the applicability of those laws.

IV. CONCLUSION

For Susan and patients like her, a problematic question lies before her.[313] She must choose one of two options: either take a life-ending drug before she wants it in order to ensure her eligibility for the California EOLOA, or take it later and risk losing her ability to self-administer the life-ending drug, making her ineligible under the EOLOA.[314] By reason of her disability, Susan is not able to fully enjoy the services made available by the state.[315] This plainly violates the ADA.[316]

The self-administration requirement of state physician-assisted suicide laws violates the ADA.[317] Under the Supremacy Clause of the Constitution, state laws, like physician-assisted suicide laws with self-administration requirements, which conflict with federal laws, such as the ADA, are invalid.[318] Thus, state physician-assisted suicide laws are invalid because of the self-defeating self-administration requirement.[319]

Removing the self-administration requirement is an inappropriate solution because it would collapse physician-assisted suicide into voluntary euthanasia.[320] Self-administration is the defining distinction between euthanasia and physician-assisted suicide.[321] Euthanasia is illegal and not a

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309. *See id.*
310. *Id.* (citing Criminal Code, S.C. 2016, c. 3, s. 3 (Can.)).
311. *Id.* (citing An Act to Amend the Criminal Code (medical assistance in dying), S.C. 2021, c. 2, s. 2 (Can.)).
312. *Id.*; *see* Criminal Code, S.C. 2021, c. 2, s. 2 (Can.).
313. *See* discussion *supra* Part I.
314. *See* discussion *supra* Part I.
315. *See* discussion *supra* Part I.
316. *See* discussion *supra* Part I.
317. *See* discussion *supra* Part II.
318. *See* discussion *supra* Part II.
319. *See* discussion *supra* Part II.
320. *See* discussion *supra* Sections III.A.3, III.B.2.
321. *See* discussion *supra* Sections II.A, III.A.3.

policy that should be allowed by the states because of ethical concerns and historical precedent.[322]

Further, there are practical and public policy concerns that should encourage state legislatures to repeal and resist physician-assisted suicide laws.[323] Namely, that as physician-assisted suicide laws mature, proponents advocate and successfully remove eligibility requirements that protect the vulnerable from coercion and were crucial to the initial passage of the state law.[324] In turn, the prevalence grows, which allows for greater discrimination for physically disabled individuals.[325] These patterns are also observed in other nations, particularly the Netherlands, Belgium, and Canada.[326]

Thus, states that have already legalized physician-assisted suicide should repeal those laws as they are inconsistent with the ADA.[327] States that have not legalized physician-assisted suicide should resist the efforts of proponents of physician-assisted suicide to legalize it because the self-administration requirement violates the ADA.[328]

322. *See* discussion *supra* Sections III.A.3, III.B.2.
323. *See* discussion *supra* Section III.C.
324. *See* discussion *supra* Section III.C.2.
325. *See* discussion *supra* Section III.C.1.
326. *See* discussion *supra* Section III.C.3.
327. *See* discussion *supra* Part III.A.3.
328. *See* discussion *supra* Part III.A.3.