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Redefining the Lawyer's Role in Calls for a Dignified Death

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I. INTRODUCTION

Legal and medical decisions regarding death date back more than two millennia, revealing evolving ethical and jurisprudential concerns surrounding the right to die.[1] Constitutional inquiries are often clouded by longstanding opposition rooted in religious fundamentalism, ethical and evidentiary constraints, rigid textualism, and rudimentary conceptions of medical ethics codified in the Hippocratic Oath. The right to die movement continues to raise bioethical concerns about quality and value of life as well as the legal process of death. So, while the tools for euthanasia and physician-assisted suicide have evolved, "many fundamental questions have remained the same: who owns a life, and what are the ethical implications in advancing (or otherwise choosing not to delay) a death?"[2]

This centuries-long dispute is shaped by, among other interrelated principles, judicial decrees, federal and state legislation, social activism, and ethics. This Essay addresses important questions raised by the right to die movement in the legal and medical professions. It primarily applies the American Bar Association's Model Rules of Professional Conduct to physician-assisted suicide and, in doing so, discusses issues about the lawyer's obligations to the client, autonomy, competence, and the administration of justice in U.S. jurisdictions. Part II begins by providing a brief history of the development of the right to die movement, drawing an important distinction between euthanasia and physician-assisted suicide. It discusses the requirements for physician-assisted suicide and analyzes landmark U.S. Supreme Court decisions concerning the

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[1] Connor T. A. Brenna, *Regulating Death: A Brief History of Medical Assistance in Dying*, 27 INDIAN J. PALLIAT. CARE 448 (2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8655630 ("In Athens, 399 BCE, the Greek philosopher Socrates—imprisoned and sentenced to death by hemlock on the charges of impiety and corrupting Athenian youth—famously raised a cup of the poison to his lips.").

[2] *Id.*

right to die. Part III describes how attorneys and medics must balance legal and ethical obligations when faced with death. The critical factors are autonomy and competence. Last, Part IV comments on federal funding of physician-assisted suicide, racial disparities, and the potential for progress through jury nullification.

II. HISTORY OF EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE

The history of medical aid in dying begins in classical antiquity, centuries before the establishment of Christianity.[3] The attitudes toward infanticide, euthanasia, and suicide were tolerant, but there is little evidence such permissiveness was linked to concern for the terminally-ill.[4] However, by the twelfth through fifteenth centuries, the medical community overwhelmingly opposed euthanasia, and this shift in opinion can be attributed to religious views that condemned the ending of life as sinful.[5] This position was prevalent during the Renaissance and Reformation periods, which subsequently influenced U.S. colonial attitudes and invigorated Evangelical Christians during the Great Awakening of the mid-1700s to oppose euthanasia and suicide.[6] This culminated in New York passing a statute explicitly outlawing physician-assisted suicide in 1828, making it the first U.S. state to address the issue.[7]

Since the late-1800s, civilizations debated the morality of euthanasia and physician-assisted suicide in various situations, and these discussions are informed by other factors such as economic and military turmoil and liberalism.[8] Research demonstrates public approval of euthanasia and physician-assisted suicide increased during the Great Depression and in the 1960s

[3] *History of Medical Aid in Dying*, PROCON.ORG (Dec. 15, 2022), https://euthanasia.procon.org/historical-timeline (providing a comprehensive timeline of the right to die movement's development).
[4] Neil M. Gorsuch, *The Right to Assisted Suicide and Euthanasia*, 23 HARV. J.L. & PUB. POL'Y 599, 626-27 (2000) (noting that suicide was treated as a form of entertainment or a profitable venture for heirs).
[5] *History of Medical Aid in Dying*, *supra* note 3.
[6] *Id.*
[7] *Id.*
[8] *Id. See also* Joe Carter, *How Euthanasia Came to Europe*, ERLC (Dec. 29, 2016), https://erlc.com/resource-library/articles/how-euthanasia-came-to-europe.

when social movements opposed traditional authority structures in favor of more individual freedom and open-mindedness toward sex and drugs.[9] Conversely, support waned following World War II and reports of Nazi atrocities.[10] So whether a person has the right to die requires balancing nuanced views of self-determination against competing state interests concerned with preserving life, protecting third parties, and maintaining the medical profession's integrity.[11]

A. The Legality of Euthanasia and Physician-Assisted Suicide

The main difference between euthanasia and physician-assisted suicide is "who performs the final, fatal act."[12] Euthanasia requires the physician to take active measures to end the patient's life, whereas physician-assisted suicide requires the patient to self-administer a lethal medication prescribed by the physician.[13] This distinction explains the disparate treatment of the two procedures; presently, euthanasia is legal in eight countries and physician-assisted suicide is legal in ten countries and parts of the United States.[14] In most of these locations, to qualify for legal assistance, people who seek euthanasia or physician-assisted suicide must meet certain criteria, including having a terminal illness, demonstrating they are of sound mind, and freely expressing

[9] *History of Medical Aid in Dying*, *supra* note 3. Carter, *supra* note 8.
[10] *Id.*
[11] *Physician-Assisted Suicide and the Right to Die with Assistance*, 105 HARV. L. REV. 2021, 2022 (1992) (noting the right to die is limited by evidentiary and procedural requirements in cases involving incompetent patients, and further explaining the right to die depends on the patient's prognosis in many jurisdictions).
[12] Nicola Davis, *Euthanasia and Assisted Dying Rates Are Soaring. But Where Are They Legal?*, GUARDIAN (July 15, 2019, 1:00 AM), https://www.theguardian.com/news/2019/jul/15/euthanasia-and-assisted-dying-rates-are-soaring-but-where-are-they-legal.
[13] *Id.* ("Most, but not all, jurisdictions that allow some form of euthanasia or assisted suicide require the involvement of medical professionals."). Ewan C. Goligher et al., *Physician-Assisted Suicide and Euthanasia in the ICU: A Dialogue on Core Ethical Issues*, 45 CRIT. CARE MED. 149, 150 (2017).
[14] Avivah Wittenberg-Cox, *A Designed Death—Where and When the World Allows It*, FORBES (Oct. 22, 2022, 12:00 PM), https://www.forbes.com/sites/avivahwittenbergcox/2022/10/22/a-designed-death--where--when-the-world-allows-it/?sh=18cb3f107b3d. Euthanasia is legal in Belgium, Canada, Colombia, Luxembourg, the Netherlands, New Zealand, Spain, and all six states of Australia. *Id.* In the United States, physician-assisted suicide is legal in eleven states or districts: California, Colorado, Hawaii, Montana, Maine, New Jersey, New Mexico, Oregon, Vermont, Washington, and the District of Columbia. *Id.*

their wishes to die, but some countries like Canada and Switzerland allow voluntary euthanasia.[15] This Essay strictly applies U.S. criminal laws and ethics rules to physician-assisted suicide.

Physician-assisted suicide is an option afforded to individuals in the United States by law or court decision.[16] Requirements vary by jurisdiction, but there are certain uniform conditions that must be met: (1) the patient must be an adult with decision-making capacity, although courts have addressed the right to die in cases involving minors; (2) who has a poor prognosis of six months or less to live because of a terminal illness; and (3) who can self-ingest the medication, which typically functions like a sleeping pill.[17] The U.S. right to die movement is premised on the idea that a competent, terminally-ill person should have the right to choose their time and manner of death.[18]

This principle—autonomy—lays the foundation for three other medical options that are legally available to qualified patients, such as the right to terminate life-sustaining treatment, forego a blood transfusion on religious grounds, and voluntarily stop eating and drinking.[19] In theory, giving terminally-ill people the right to "obtain a prescription for a lethal medication that they can later self-ingest"[20] would not substantially deviate from existing U.S. jurisprudence on related issues. For example, the case of Karen Ann Quinlan, who inadvertently started the U.S. right to die movement in 1975, produced volumes of discussions regarding fundamental liberty

[15] *See, e.g.*, Holly Honderich, *Who Can Die? Canada Wrestles with Euthanasia for the Mentally Ill*, BBC NEWS (Jan. 14, 2023), https://www.bbc.com/news/world-us-canada-64004329.
[16] *Physician-Assisted Suicide Fast Facts*, CNN (May 26, 2022, 11:40 AM), https://www.cnn.com/2014/11/26/us/physician-assisted-suicide-fast-facts/index.html (noting which states enacted medical assistance in dying statutes through ballot initiatives and legislation).
[17] Thaddeus Mason Pope, *Legal History of Medical Aid in Dying: Physician Assisted Death in U.S. Courts and Legislatures*, 48 N.M. L. REV. 267, 271 (2018).
[18] Katherine A. Chamberlain, *Looking for a "Good Death": The Elderly Terminally Ill's Right to Die by Physician-Assisted Suicide*, 17 ELDER L.J. 61, 62 (2009).
[19] Pope, *supra* note 17, at 268.
[20] *Id.*

interests like freedom of religion, privacy, and self-determination.[21] These shifts in cultural consciousness occur in conjunction with congressional and judicial action, so availability of physician-assisted suicide depends on several factors that do not always align.

B. Supreme Court Jurisprudence

The U.S. Supreme Court considered the right to die in four landmark decisions. Its jurisprudence began in 1990 with *Cruzan by Cruzan v. Director, Missouri Department of Health*.[22] Nancy Cruzan was involved in a car accident that left her in an "irreversible vegetative state," a condition in which she exhibited motor reflexes but showed no signs of cognitive function.[23] The State of Missouri bore the healthcare costs, approximately $110,000 per year, while Cruzan's family fought to have the gastronomy tube removed so she could "be allowed to die a dignified death."[24] Despite the parents' repeat attempts to terminate the life-support system, hospital employees refused to honor the request without a court order.

A state trial court authorized the termination after concluding an individual has a state and federal constitutional right to refuse medical treatment. The Missouri Supreme Court reversed, holding state policy favors the preservation of life and an incompetent person's wishes regarding withdrawal of life-sustaining treatment must be proved by clear and convincing evidence.[25] Cruzan's parents appealed, but the U.S. Supreme Court affirmed the prior decision. It explained that under the Fourteenth Amendment's Due Process Clause, a competent person has a liberty

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[21] Robert D. McFadden, *Karen Ann Quinlan, 31, Dies; Focus of '76 Right to Die Case*, N.Y. TIMES (June 12, 1985), https://www.nytimes.com/1985/06/12/nyregion/karen-ann-quinlan-31-dies-focus-of-76-right-to-die-case.html (proponents of physician-assisted suicide argued that being "forced to function against all natural impulses" interfered with Quinlan's "religious belief that earthly existence is but one phase of a continuity of life, which reaches perfection after death" and constitutes cruel and unusual punishment in violation of the Eighth Amendment).

[22] 497 U.S. 261 (1990).

[23] Tamar Lewin, *Nancy Cruzan Dies, Outlived by a Debate Over the Right to Die*, N.Y. TIMES (Dec. 27, 1990), https://www.nytimes.com/1990/12/27/us/nancy-cruzan-dies-outlived-by-a-debate-over-the-right-to-die.html.

[24] *Id.*

[25] Tracy J. Edgerton, *Fundamental Rights and Physician-Assisted Suicide: Protecting Personal Autonomy*, 1 J. GENDER RACE & JUST. 283, 288 (1997).

interest in refusing treatment and hastening death, but because the common law right of informed consent is premised upon a capacity for reasoning, requiring evidence on an incompetent person's wishes in a situation where individual rights and state interests clash is not violative of the U.S. Constitution.[26] Following this decision, interest in living wills and advance directives surged as people sought to articulate their wants regarding future medical care should they lose decision-making abilities.[27]

In two related 1997 cases brought by physicians and terminally-ill patients since deceased, the U.S. Supreme Court considered the constitutionality of state laws banning physician-assisted suicide under the Due Process and Equal Protection Clauses of the Fourteenth Amendment. In *Washington v. Glucksberg*,[28] the Court analyzed Washington State's practice of criminalizing physician-assisted suicide to determine whether a ban on the procedure violates the Due Process Clause by denying competent, terminally-ill adult patients the liberty to choose death over life. The Court unanimously ruled for Washington State, holding the right to assisted suicide is not a fundamental liberty interest because it is offensive to national traditions and practices.[29] The Court further found the ban on physician-assisted suicide rationally related to the State's legitimate interests in preserving human life and protecting against systemic abuses of vulnerable individuals, such as disabled persons and those in guardianships.[30]

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[26] *Id.*

[27] Robert Steinbrook, *Comatose Woman Dies After Artificial Feedings Are Halted*, L.A. TIMES (Dec. 27, 1990), https://www.latimes.com/archives/la-xpm-1990-12-27-mn-10204-story.html. *See also* Ellen Goodman, *The Long Death of Nancy Cruzan*, WASH. POST (Dec. 29, 1990), https://www.washingtonpost.com/archive/opinions/1990/12/29/the-long-death-of-nancy-cruzan/7393a252-8ea9-4885-8c86-b08e2a1d4ff3 (mentioning that Cruzan's death occurred almost eight years after the car accident that left her unconscious, primarily because of the extensive litigation occasioned by this case).

[28] 521 U.S. 702 (1997).

[29] *See id.* at 710-16 (discussing the history of state and common law bans on assisted suicide, and noting that for over 700 years, Anglo-American traditions have punished or disapproved of suicide and assisted suicide). The Court explained that a substantive due process analysis weighs fundamental rights and liberties which are objectively "deeply rooted in this Nation's history and tradition" against narrowly-tailored restrictions on these rights to serve a compelling state interest. *Id.* at 721-22.

[30] *Id.* at 728-32.

Similarly, in *Vacco v. Quill*,[31] the Court considered whether New York violated the Equal Protection Clause by allowing competent, terminally-ill adult patients to withdraw their life support while simultaneously denying that same right to patients physically unable to do so unassisted. In yet another unanimous decision, the Court articulated a distinction between individual refusal of life-saving treatment (letting someone die) and physician-assisted suicide (making someone die), highlighting the latter involves the criminal elements of causation and intent.[32] The Court implicitly connected this discussion to *primum non nocere* ("first, do no harm"), a phrase appearing in the Hippocratic Oath that counsels against a physician's efforts to cause or hasten a patient's death, regardless of the righteousness or morality of the physician's motives.[33] The Court found criminalizing physician-assisted suicide was rationally related to a legitimate interest in preventing the State from starting down the path to voluntary and involuntary euthanasia,[34] a slippery slope argument the Court initially posited in *Washington v. Glucksberg*.[35]

Last, *Gonzales v. Oregon*[36] gave the Court the opportunity to interact with the first state law authorizing physicians to prescribe lethal doses of controlled substances to terminally-ill patients, Oregon's Death with Dignity Act. The Court found the Controlled Substances Act does not allow the United States Attorney General to prohibit physicians from prescribing regulated drugs for use in physician-assisted suicide under state law authorizing the procedure.[37] The Court's

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[31] 521 U.S. 793 (1997).
[32] *Id.* at 800-03. The Court explained that when a patient refuses life-sustaining treatment, the patient dies from the underlying disease. *Id.* at 801. But in situations involving assisted suicide, the patient ingests and is killed by lethal medication prescribed by a physician. *Id.* Furthermore, a doctor who assists a suicide must intend that "the patient be made dead." *Id.* at 802. Interestingly, the Court highlighted that a patient who refuses life-saving treatment does not necessarily have the specific intent to die; rather, the patient may "fervently wish to live, but to do so free of unwanted medical technology, surgery, or drugs." *Id.*
[33] *See generally* T. A. Cavanaugh, *Why the Hippocratic Oath Prohibits Physician-Assisted Suicide*, PUB. DISCOURSE (Nov. 20, 2019), https://www.thepublicdiscourse.com/2019/11/57243.
[34] 521 U.S. at 809.
[35] 521 U.S. at 732-36.
[36] 546 U.S. 243 (2006).
[37] Tom Rosentiel, *High Court Rejects Federal Regulation of Physician-Assisted Suicide*, PEW RSCH. CENTER (Jan. 31, 2006), https://www.pewresearch.org/2006/01/31/supreme-courts-decision-in-igonzales-v-oregoni ("The "Ashcroft

decision ultimately rested on statutory interpretation and deference to congressional intent. The Court noted the Controlled Substances Act "bars doctors from using their prescription-writing powers as a means to engage in illicit drug dealing and trafficking as conventionally understood[,]" but it does not seek to regulate the practice of medicine generally.[38] Indeed, states have historically been entrusted with defining medical standards under the structure and limitations of federalism, which provide states with "great latitude under their police powers to legislate as to the protection of the lives, limbs, health, comfort, and quiet of all persons."[39] Although regulation of physician-assisted suicide at an administrative or federal level remains unclear, the law at the center of this case served as a model for other states that introduced their own end-of-life legislation.[40]

III. ETHICAL CONSIDERATIONS

The right to die movement has forced lawyers and physicians to grapple with competing ethical considerations for decades.[41] On the one hand, the client-patient has the final say regarding the objectives of representation and care, including the right to plead guilty and refuse life-saving treatment.[42] On the other, these interests may conflict with the professionals' convictions or state laws. This Part discusses autonomy and competence at length. Subpart A describes self-determination and the lawyer's duty to effectuate the client's objectives. If the lawyer disagrees with the morality of the client's choices and is unable to withdraw, the lawyer must proceed in support of human dignity. Subpart B addresses concerns about competence because of mental

Directive," as it came to be known, stated that physician-assisted suicide was not a "legitimate medical purpose," as defined by the CSA.").

[38] 546 U.S. at 270.

[39] *Id.*

[40] *See generally* Emily Knox, *Death with Dignity: A Right to Death?*, 24 PUB. INT. L. REP. 109 (2019).

[41] *See generally* Avivah Wittenberg-Cox, *Slippery Slope or Wise Demise? The Pros and Cons of Medically Assisted Dying*, FORBES (Nov. 1, 2022, 12:22 PM), https://www.forbes.com/sites/avivahwittenbergcox/2022/11/01/slippery-slope-or-wise-demise-the-pros-and-cons-of-medically-assisted-dying/?sh=2a23659118c9.

[42] *See* 42 C.F.R. § 482.13; MODEL RULES OF PRO. CONDUCT r. 1.2 (AM. BAR ASS'N 2020).

impairment or age and provides tests courts use to determine whether a person has decision-making capacity. Last, this Part examines the role of the prosecutor.

A. Client-Patient Autonomy

The legal and medical professions operate under the assumption that people are autonomous beings who possess the right to make decisions affecting their lives. This concept of self-determination is "based on the conviction that one owns one's body and that one can do with it as one pleases."[43] Model Rule 1.2(a) requires the lawyer to abide by the client's decisions regarding the objectives of the representation. These considerations operate in tandem with the ethic of zeal, a professional responsibility that informs the lawyer's other ethical obligations.[44] Thus, once a lawyer commits to a client, the lawyer is duty-bound to seek these objectives through available means permitted by law and "take whatever lawful and ethical measures are required to vindicate a client's cause or endeavor."[45] The contentious topic of physician-assisted suicide tests the boundaries of legal representation and zealous advocacy, but ultimately, the lawyer's purpose should be reimagined as advancing dignity rather than blind adherence to rules.

As Monroe Freedman and Abbe Smith explain, "the issue is whether a lawyer… may disregard the client's instructions… on the ground that the lawyer disapproves of either the means or the end."[46] The Model Rules of Professional Conduct are not clear on the issue, but as the client's fiduciary, the lawyer must "preserve and foster the client's autonomy within the law."[47] Indeed, listening to clients is essential to competent, client-centered lawyering.[48] In cases of

[43] J. Donald Boudreau & Margaret A. Somerville, *Euthanasia and Assisted Suicide: A Physician's and Ethicist's Perspectives*, 4 MEDICOLEGAL & BIOETHICS J. 1, 5 (2014) (this concept is recognized in the Fourteenth Amendment right to privacy and the Georgetown Mantra of Bioethics).
[44] MONROE H. FREEDMAN & ABBE SMITH, UNDERSTANDING LAWYERS' ETHICS 67 (5th ed. 2017).
[45] MODEL RULES OF PRO. CONDUCT r. 1.3 cmt. [1] (AM. BAR ASS'N 2020).
[46] FREEDMAN & SMITH, *supra* note 44, at 45.
[47] *Id.* at 50.
[48] *Id.* at 51.

physician-assisted suicide, listening to the client-patient entails filing the necessary paperwork with the appropriate authority, collecting documentation that reduces end-of-life directives to writing, and obtaining medical diagnoses and approvals for the procedure from independent physicians. If the client is a physician charged with violating an assisted suicide statute, then the lawyer should proceed, under Model Rule 3.1 and Rule 11 of the Federal Rules of Civil Procedure, by asserting a defense that is "warranted by… a nonfrivolous argument for extending, modifying, or reversing existing law or for establishing new law."[49] At its core, the right to die movement is a fight for dignified death, and the lawyer is in a unique position to change the legal status of physician-assisted suicide through court proceedings and oral advocacy.

Model Rules 1.7(a)(2) and 1.16(a)(1) provide for withdraw on grounds of conflict of interest if the lawyer's sense of personal repugnance regarding the subject matter critically impairs the lawyer's ability to serve the client.[50] Lawyers who work physician-assisted suicide cases may see their beliefs impede the quality of representation they afford clients in states that require a court order to die. Relatedly, asking healthcare professionals to approve people for assisted death or to carry out the procedure could alter their values, cause psychological harm, or conflict with their objective to preserve life.[51] But as the Model Rules and accompanying Comments establish, a lawyer has the option to withdraw only if it can be accomplished without a material adverse effect on the client's interests.[52] Given the quick progression of a terminal illness, the high-profile

[49] *Id.* at 92.
[50] MODEL RULES OF PRO. CONDUCT r. 1.16 cmt. [7] (AM. BAR ASS'N 2020) ("The lawyer may also withdraw where the client insists on taking action that the lawyer considers repugnant or with which the lawyer has a fundamental disagreement.").
[51] Michael Gryboski, *Doctor, Christian Medical Group Sue New Mexico Over Physician Assisted Suicide Law*, CHRISTIAN POST (Dec. 16, 2022), https://www.christianpost.com/news/doctor-sues-new-mexico-over-assisted-suicide-law.html (describing a recent lawsuit challenging the legality of the End-of-Life Options Act, which petitioners allege unlawfully compels physicians to speak a certain message about assisted suicide, even if doing so contradicts the physicians' religious, moral, and ethical convictions).
[52] MODEL RULES OF PRO. CONDUCT r. 1.16 cmt. [7].

status of such cases, and a state's compelling interest in preventing and punishing deliberate killings, a lawyer may be unable to withdraw by reason of substantial prejudice to the client.

In the event the lawyer is unable to avoid involvement in conduct that is morally offensive, the lawyer's relationship with the client must be reimagined as affirming the dignity of the client because "[t]o define legal representation in terms of autonomy rather than human dignity is to celebrate procedure over substance, or decision-making over decisions."[53] Thus, the lawyer must be a partisan for the human dignity of the client, and should ascertain whether the objectives of the representation are consistent with that dignity.[54] The right to die is essentially a right to self-determination, and states with such laws protect "the patient's status as a human being."[55] Furthermore, because the end result of medical involvement for many people remains death, the role of healthcare professionals at a certain point is not to save life, but to sustain it only so long as is reasonable.[56] Terminally-ill client-patients deserve the right to receive legal and medical aid in achieving the best possible end. And irrespective of the lawyer's beliefs, the lawyer must counsel the client about the consequences of pursuing or performing the procedure in accordance with basic tenets of the criminal legal system and Model Rule 2.1, which mandates the lawyer render candid advice.[57]

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[53] Teresa Stanton Collett, *Life and Death Lawyering: Dignity in the Absence of Autonomy*, 1 JISLE 177, 192 (1996).
[54] *Id.* at 190.
[55] *Physician-Assisted Suicide and the Right to Die with Assistance*, *supra* note 11, at 2025.
[56] Rod D. MacLeod et al., *Assisted or Hastened Death: The Healthcare Practitioner's Dilemma*, 4 GLOB. J. HEALTH SCI. 87, 92-3 (2012).
[57] MODEL RULES OF PRO. CONDUCT r. 2.1 (AM. BAR ASS'N 2020) ("In rendering advice, a lawyer may refer not only to law but to other considerations such as moral, economic, social and political factors, that may be relevant to the client's situation."). For example, a physician who assists a suicide may have their license revoked. Alexandra Sifferlin, *Maryland Board Revokes Doctor's Medical License for Involvement in Assisted Suicides*, TIME (Dec. 30, 2014, 3:46 PM), https://time.com/3649959/maryland-doctor-assisted-suicide. Such a decision implicates not only legal issues but economic and reputational considerations as well.

B. Competence

The desire to end one's life is antithetical to the concept of self-preservation and implicates Model Rule 1.14 because the client-patient, it is argued, possesses diminished capacity and is legally incapable of making a decision affecting their rights. Specifically, Model Rule 1.14(a) states a client can lack the requisite capacity because of minority, mental impairment, or some other reason. In physician-assisted suicide cases, the client's competence is primarily questioned on mental impairment grounds because the "relatively common end-of-life symptoms of hopelessness, [depression], loss of meaning, and existential distress" increase the likelihood of suicidal thoughts or desire for a hastened death.[58] This issue is further complicated in situations concerning terminally-ill people under the age of eighteen who lack capacity because of age. But as the Comments to Model Rule 1.14 make clear:

> In determining the extent of the client's diminished capacity, the lawyer should consider and balance such factors as: the client's ability to articulate reasoning leading to a decision, variability of state of mind and ability to appreciate consequences of a decision; the substantive fairness of a decision; and the consistency of a decision with the known long-term commitments and values of the client. In appropriate circumstances, the lawyer may seek guidance from an appropriate diagnostician.[59]

This totality of the circumstances test requires the lawyer or court to weigh multiple factors and, as previously discussed, the possible evidentiary hurdles and burden of proof issues make advance directives and living wills attractive alternatives to years of litigation.[60] Often, medical directives

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[58] *Id.* at 90.

[59] MODEL RULES OF PRO. CONDUCT r. 1.14 cmt. [6] (AM. BAR ASS'N 2020).

[60] Mayo Clinic Staff, *Living Wills and Advance Directives for Medical Decisions*, MAYO CLINIC (Aug. 2, 2022), https://www.mayoclinic.org/healthy-lifestyle/consumer-health/in-depth/living-wills/art-20046303 (describing types of advance directives and living wills, including power of attorney and DNR (do not resuscitate) and DNI (do not intubate) orders). For example, the Terri Schiavo controversy refers to a series of cases between 1990 and 2005 that highlighted poignant considerations in the right to die movement, particularly family disagreements and the absence of advance directives or living wills. Radhika Chalasani, *A Look Back: The Terri Schiavo Case*, CBS NEWS (Mar. 31, 2016, 11:51 AM), https://www.cbsnews.com/pictures/look-back-in-history-terri-schiavo-death. It took eleven years to resolve the dispute between Schiavo's parents and husband, who wanted to disconnect the feeding tube. *Id.* President Bush commented on Schiavo's death, stating: "The essence of civilization is that the strong have a duty to

regarding end-of-life care are made well before the onset of a debilitating disease, which argues against a finding of undue influence or irrational reasoning. Furthermore, patients make decisions after consulting with their physicians, who are professionals specially trained to assess medical conditions and outcomes. Contrary to opponents' characterizations, end-of-life planning requires great reflection and adherence to extensive administrative formalities.

1. Informed Consent

The doctrine of informed consent is intimately connected to autonomy and competence. Judicial opinions dealing with informed consent do not generally articulate tests for competence, but the Washington Supreme Court established a rebuttable presumption in *Grannum v. Berard*.[61] By focusing on the person's capacity to comprehend the situation, risks, and alternatives, a court should ask whether the person, at the time of the act, possessed sufficient reason to understand the nature, terms, and effect of the agreement.[62] As scholars on the issue have remarked:

> It might be argued that a decision by a terminal patient to refuse treatment provides prima facie evidence of mental incompetency or is itself so irrational that it should be disregarded. However, given the patient's implicit choice between prolonged dying or more rapid death, a decision to die may be quite reasonable even if other individuals or groups in our society judge it unacceptable for themselves.[63]

The competency standard, as articulated by the U.S. Supreme Court in *Dusky v. United States*,[64] is low. This case is instructive in the present matter because the defendant was found competent to stand trial despite suffering from schizophrenia, and mental health considerations are at the forefront of debates in physician-assisted suicide cases. But in fact, informed consent is a higher standard than competency to stand trial because it requires more than a rational understanding of

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protect the weak…. In cases where there are serious doubts and questions, the presumption should be in favor of life." *Id.*

[61] 422 P.2d 812 (Wash. 1967).

[62] *Informed Consent and the Dying* Patient, 83 YALE L.J. 1632, 1653 (1974).

[63] *Id.* at 1656.

[64] 362 U.S. 402 (1960).

the trial proceedings and ability to consult with counsel. To give informed consent, one must understand the nature of the action being sought, which in the medical context will include possible risks, potential side effects, and available alternatives.[65] The idea that one might competently consent to a treatment but not be competent to refuse it has been critiqued as "palpable nonsense."[66]

In cases involving minors, who are deemed incompetent because of age, their legal representative (relative) or guardian ad litem (court-appointed attorney) represent the best interests of the minor. Section 402 of the Uniform Marriage and Divorce Act provides several factors for a court to consider in determining the minor's best interests, including the parents' and child's wishes and the mental and physical health of all involved.[67] However, states would benefit by utilizing the mature minor doctrine more often to make case-specific determinations of a minor's maturity because it is similar to the informed consent doctrine applied to adult patients and would allow certain minors to make decisions traditionally reserved for those of majority age.[68] A proper analysis would consider:

> [The] age, ability, experience, education, training, and degree of maturity or judgment obtained by the child, as well as upon the conduct and demeanor of the child at the time of the procedure or treatment … [and] whether the minor has the capacity to appreciate the nature, risks, and consequences of the medical procedure to be performed, or the treatment to be administered or withheld.[69]

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[65] John Harris, *Consent and End of Life Decisions*, 29 J. MED. ETHICS 10, 12 (2003).
[66] *Id. See generally* John W. Dalbey Donahue, *Physician-Assisted Suicide: A "Right" Reserved for Only the Competent?*, 19 VT. L. REV. 795 (1995) (discussing prevalent doctrines within the right to die movement, such as the common law right of self-determination and the constitutional right to accept or refuse treatment as well as current decision-making standards employed by courts to determine if incompetent persons should be allowed to refuse life-sustaining treatment, such as the substituted-judgment doctrine and the best interests standard).
[67] Carl E. Schneider, *Discretion, Rules, and Law: Child Custody and the UMDA's Best-Interest Standard*, 89 MICH. L. REV. 2215, 2219 (1991).
[68] Shawna Benston, *Not of Minor Consequence?: Medical Decision-Making Autonomy and the Mature Minor Doctrine*, 13 IND. HEALTH L. REV. 1, 3 (2016).
[69] *Id.* at 4.

In addition to the fact that "[c]onstitutional rights do not mature and come into being magically only when one attains the state-defined age of majority[,]"[70] society allows minors to confront issues of life or death in other forms, such as the ability to enlist in the military or be tried as an adult in a murder trial.[71] Thus, to adequately protect minors, the legal system must consider the ability of mature minors or legal representatives to make well-informed medical decisions.

2. Prosecution of Physician-Assisted Suicide

Suicide is not a crime in any U.S. state,[72] but restrictions on assisting someone in committing suicide exist in most jurisdictions. Criminal liability turns on the mental competence of the person requesting assisted suicide, so "[d]epending on their level of involvement, someone who assists a competent person to commit suicide is more likely to be charged with the crime of assisted suicide, whereas someone who actively assists an incompetent patient is more likely to be prosecuted for homicide (murder or manslaughter)."[73] Progressive prosecution is a recent phenomenon wherein district attorneys exercise discretion to refrain from prosecuting certain crimes, such as Andrew Warren's decision not to pursue abortion-related charges in Florida. Many progressive prosecutors face extensive backlash from conservative officials who staunchly oppose the abortion and right to die movements,[74] so proponents should not rely on the benevolence of prosecutors to advance their objectives.

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[70] *Id.* at 14.
[71] *Id.*
[72] *Physician-Assisted Suicide and the Right to Die with Assistance*, *supra* note 11, at 2024.
[73] Cameron Stewart et al., *A Test for Mental Capacity to Request Assisted Suicide*, J. MED. ETHICS 1, 1 (2010) https://www.researchgate.net/profile/Carmelle-Peisah/publication/49629115_A_test_for_mental_capacity_to_request_assisted_suicide/links/5b5f75b90f7e9bc79a702a3a/A-test-for-mental-capacity-to-request-assisted-suicide.pdf.
[74] Adam Edelman, *Prosecutor Fired by Ron DeSantis Hits GOP Attacks on the Manhattan DA: 'Part of the Authoritarian Playbook'*, NBC NEWS (Mar. 30, 2023, 3:40 PM), https://www.nbcnews.com/politics/politics-news/ron-desantis-fired-prosecutor-andrew-warren-now-speaking-rcna76983 (reporting that Governor DeSantis stated: "While a prosecutor can decline to prosecute cases, such declination must be the result of an individualized determination about the merits of the individual case, not due to a blanket policy of non-enforcement.").

In jurisdictions where physician-assisted suicide is illegal, prosecutors may charge the healthcare professionals responsible for approving or prescribing life-ending medications to terminally-ill patients under criminal statutes penalizing assisted suicide, manslaughter, and murder.[75] The charging decision is informed by Prosecution Function Standard 3-1.2(b), which states:

> The primary duty of the prosecutor is to seek justice within the bounds of the law, not merely to convict. The prosecutor serves the public interest and should act with integrity and balanced judgment to increase public safety both by pursuing appropriate criminal charges of appropriate severity, and by exercising discretion not to pursue criminal charges in appropriate circumstances. The prosecutor should seek to protect the innocent and convict the guilty, consider the interests of victims and witnesses, and respect the constitutional and legal rights of all persons, including suspects and defendants.

Because physician-assisted suicide is illegal in most U.S. jurisdictions, and states have a compelling interest in preventing death, there is a strong presumption prosecutors will file charges, and some may seek the maximum sentence permitted by the relevant law.

i. Ineffective Assistance of Counsel

Overturning a conviction based on an ineffective assistance of counsel claim is unlikely. In *Strickland v. Washington*,[76] the U.S. Supreme Court stated that to prove ineffective assistance, a defendant must show: (1) their trial lawyer's performance fell below an objective standard of reasonableness; and (2) "a reasonable probability that, but for counsel's unprofessional errors, the result of the proceeding would have been different." In *Strickland*, the Court made clear that the reasonableness standard is easily met, even in cases where the defendant faces capital

[75] Christian M. Wade, *High Court Takes Up Physician-Assisted Suicide*, SALEM NEWS (Feb. 3, 2022), https://www.salemnews.com/news/high-court-takes-up-physician-assisted-suicide/article_0d3d8b5c-8474-11ec-80df-5394b9bff2ca.html (explaining that while state prosecutors are sympathetic to end-of-life issues, they argue physician-assisted suicide is not immune from prosecution). "A physician's act of writing a lethal prescription for a patient who uses it to commit suicide constitutes wonton or reckless conduct causing death and therefore may result in prosecution under the common law of involuntary manslaughter." *Id.*

[76] 466 U.S. 668 (1984).

punishment.[77] Thus, in physician-assisted suicide cases, overturning convictions based upon a violation of *Strickland* is improbable given extensive evidence documenting the procedure, such as medical diagnoses and prescriptions, laws explicitly outlawing the procedure, and the state's compelling interest in preserving life.

ii. Capital Punishment

Sometimes a state's interest in retributive justice outweighs its interest in preserving life. Twenty-seven states and the federal government designate capital punishment as an appropriate sentence for certain criminal offenses, such as manslaughter and murder.[78] A state can, despite victim recantations, exculpatory evidence, and expressions of remorse by the defendant, mandate the involuntary execution of a person. A state is legally permitted to go so far as to forcibly medicate death row defendants to achieve competency for execution because the U.S. Supreme Court held it is unconstitutional to kill an insane person in *Ford v. Wainwright.*[79]

The Fourteenth Amendment's Due Process Clause states that no state shall "deprive any person of life, liberty, or property, without due process of law." A competent, terminally-ill person is not readily afforded the right to voluntarily end a life that will be filled with immense suffering, and those who are given access to physician-assisted suicide go through an arduous and detailed process.[80] The paradoxical distinction in treatment of death row prisoners and terminally-ill

[77] *Id.* at 697 ("An ineffectiveness claim, however, as our articulation of the standards that govern decision of such claims makes clear, is an attack on the fundamental fairness of the proceeding whose result is challenged.").
[78] *State by State*, DEATH PENALTY INFO. CENTER, https://deathpenaltyinfo.org/state-and-federal-info/state-by-state (last visited May 1, 2023).
[79] *See generally* Caitlin Steinke, *How the Medicate-to-Execute Scheme Undermines Individual Liberty, Offends Societal Norms, and Violates the Constitution*, HOFSTRA L. SCHOLARLY COMMONS (2013), https://scholarlycommons.law.hofstra.edu/cgi/viewcontent.cgi?article=1007&context=hofstra_law_student_works; 477 U.S. 399, 406 (1986) (noting that executing a prisoner who lost his sanity has consistently been branded as "savage and inhuman").
[80] *See generally* Meredith Martin Rountree, *Criminals Get All the Rights: The Sociolegal Construction of Different Rights to Die*, 105 J. CRIM. & CRIMINOLOGY 149 (2015) (comparing the ability of death-sentenced prisoners to enlist assistance in dying with the more circumscribed right held by people with serious illnesses).

patients is startling, particularly when considering prisoners may expedite executions by competently waiving their right to appeal.[81] Many do not have medical conditions that will lead to death within six months, but some are at an increased risk for suicide, which right to die opponents offer as prima facie evidence of incompetence.[82] Yet even where there are doubts concerning a defendant's guilt or mental health, a state can medicate to kill, but will prevent a person whose fate is determined to a reasonable degree of medical certainty from exercising the most fundamental and private of all choices—when and under what terms to die.

IV. POSSIBLE PATHS MOVING FORWARD

This Part provides hypothetical developments in the right to die movement. Subpart A considers the likelihood federal funds would be used to cover the costs of physician-assisted suicide. In doing so, it discusses abortion because the two procedures implicate similar fundamental liberty interests and are frequently mentioned together. Subpart B addresses and counters the slippery slope argument articulated in *Washington v. Glucksberg* that greater access to physician-assisted suicide will lead to involuntary euthanasia. Subpart C suggests that jury nullification may be an avenue through which progress can be made.

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[81] John H. Blume, *Killing the Willing: "Volunteers," Suicide and Competency*, 103 MICH. L. REV. 939, 950 (2005); Stephen Skaff, *Chapman v. Commonwealth: Death Row Volunteers, Competency, and "Suicide by Court"*, 53 ST. LOUIS U. L.J. 1353, 1366 (2009) ("[I]f the court is satisfied that the death penalty is just in the particular case, it should then conduct a second, subjective inquiry: Why does the volunteer want to waive his appeals? If the answer is that, with due regard for individual variation in phrasing, he accepts that death is the appropriate punishment for his crime, then he should be permitted to waive his appeals. If, on the other hand, the motivation appears suicidal, then waiver should not be permitted.").

[82] Rountree, *supra* note 80, at 154-70. *See also* Mills v. Rogers, 457 U.S. 291, 303 (1982) (granting certiorari to determine whether an involuntarily committed mental patient has a constitutional right to refuse treatment with antipsychotic drugs, and noting that "it is distinctly possible that Massachusetts recognizes liberty interests of persons adjudged *incompetent* that are broader than those protected directly by the Constitution of the United States") (emphasis added).

A. The Assisted Suicide Funding Restriction Act of 1997

The Assisted Suicide Funding Restriction Act of 1997 prohibits health centers from using federal funds to provide or pay for an item, service, or benefit coverage for the purpose of causing the death of any individual, including mercy killing, euthanasia, and physician-assisted suicide.[83] This Act prevents Medicaid and Medicare funds from being used in specific end-of-life programs.[84] This restriction disproportionately impacts the elderly, who are likely to seek physician-assisted suicide and require government assistance. One way to increase terminally-ill patients' access to physician-assisted suicide would be to overturn the Assisted Suicide Funding Restriction Act of 1997.

Given the U.S. Supreme Court's current political composition, if a case about financing end-of-life procedures were to come before it, it is unlikely the Court would rule in favor of allowing a monetary scheme to operate government-sponsored death centers. A majority of the Justices are members of the conservative party, which supports traditional family and societal structures as well as Christian values. These beliefs certainly played a role in the past year when the Court issued an extraordinary decision, *Dobbs v. Jackson Women's Health Organization*,[85] that impacted more than half the U.S. population overnight and dealt a devastating blow to human rights activists; indeed, what the Justices characterized as respect for the words of the U.S. Constitution was in reality an exercise of predatory judicial activism.[86]

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[83] H.R. 1003, 105th Cong. (1997).
[84] *See generally* Joy Fallek, *The Pain Relief Promotion Act: Will It Spell Death to "Death with Dignity" or Is It Unconstitutional?*, 27 FORDHAM URB. L.J. 1739 (2000).
[85] 597 U.S. ___ (2022).
[86] Jia Tolentino, *We're Not Going Back to the Time Before Roe. We're Going Somewhere Worse*, THE NEW YORKER (June 24, 2022), https://www.newyorker.com/magazine/2022/07/04/we-are-not-going-back-to-the-time-before-roe-we-are-going-somewhere-worse. Interestingly, the U.S. Supreme Court recently declined to decide whether fetuses are entitled to the due process and equal protection rights conferred by the Fourteenth Amendment. Nate Raymond, *U.S. Supreme Court Rebuffs Fetal Personhood Appeal*, REUTERS (Oct. 12, 2022, 11:38 AM), https://www.reuters.com/legal/us-supreme-court-rebuffs-fetal-personhood-appeal-2022-10-11.

Justice Brandeis famously remarked in his dissent in *New State Ice Co. v. Liebmann* that, "a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the county."[87] This same logic was at play in *Dobbs*. There, the Court expressed that overruling *Roe v. Wade* merely returned the authority to legislate on abortion to the states as federalism intended.[88] But despite high levels of approval for both procedures by the U.S. population,[89] states continue to implement laws outlawing or severely restricting access to abortion, thereby chilling respect for bodily autonomy. So even if the Court were to allow a state-financing scheme to offer physician-assisted suicide, the states that banned or curtailed abortion would use the same moral and textualist arguments to attack the right to die.[90]

B. Racism and Healthcare Inequalities

Given the documented racial healthcare disparities in the United States, opponents of the right to die movement point to the "disproportionately low usage of the practice by patients of color as evidence of unfounded fears that vulnerable persons would be coerced into an early death or exploited by the availability of the legalized practice."[91] There are more people in poor health within low socio-economic groups and, as such, assisted suicide might disproportionately be seen as a "way out." The slippery slope argument posits that vulnerable groups might become targets

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[87] 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

[88] The Tenth Amendment to the U.S. Constitution reads: "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." *Dobbs*, 597 U.S. at 6 ("It is time to heed the Constitution and return the issue of abortion to the people's elected representatives. "The permissibility of abortion, and the limitations, upon it, are to be resolved like most important questions in our democracy: by citizens trying to persuade one another and then voting." That is what the Constitution and the rule of law demand.") (internal citations omitted). In addition, the Court employed this rationale in *Washington v. Glucksberg*, arguing that decisions regarding the legalization of physician-assisted suicide should be left to the states as experimenting laboratories.

[89] *Abortion*, GALLUP, https://news.gallup.com/poll/1576/abortion.aspx (last visited Apr. 30, 2023); Paula Span, *Physician Aid in Dying Gains Acceptance in the U.S.*, N.Y. TIMES (Jan. 16, 2017), https://www.nytimes.com/2017/01/16/health/physician-aid-in-dying.html.

[90] *Tracking the States Where Abortion Is Now Banned*, N.Y. TIMES (Apr. 28, 11:00 AM), https://www.nytimes.com/interactive/2022/us/abortion-laws-roe-v-wade.html.

[91] Terri Laws, *How Race Matters in the Physician-Assisted Suicide Debate*, RELIG. & POLITICS (Sept. 3, 2019), https://religionandpolitics.org/2019/09/03/how-race-matters-in-the-physician-assisted-suicide-debate.

of involuntary euthanasia disguised as physician-assisted suicide.[92] The autonomy of some patients would allegedly be compromised because of pressure to commit suicide by family members or "social or economic forces,"[93] such as being burdened by the astronomical costs of living.

This argument is unpersuasive based solely on the fact that a person seeking to end their life can do so through less formal, and perhaps more violent, means. And as situations in states like Oregon, Washington, and Montana make clear, proper legislation and judicial gatekeeping can and do prevent misuse of the system.[94] A related argument cautions against offering non-residents access to physician-assisted suicide based on the assertion that "suicide tourism" to these states will increase.[95] These contentions fail to substantively oppose availability of the procedure to terminally-ill patients because death can be effectuated outside the legal and medical systems, and states offering the right to die to foreigners still mandate compliance with stringent requirements.

C. Court House Efforts: "Not Guilty"

An alternative path toward increased access to physician-assisted suicide potentially includes jury nullification.[96] While this effort would not alter the legal status of physician-assisted suicide, it would impact the ability of a physician to be found guilty and sentenced. Jury nullification is the process through which jurors refuse to convict despite overwhelming evidence

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[92] Chamberlain, *supra* note 18, at 83.

[93] Eric A. Johnson, *Assisted Suicide, Liberal Individualism, and Visceral Jurisprudence: A Reply to Professor Chemerinsky*, 20 ALASKA L. REV. 321, 330-31 (2003).

[94] Pope, *supra* note 17, at 277-81 (documenting the extensive procedures a patient seeking physician-assisted suicide must satisfy, including making one written and two oral requests for medication to end their life that are witnessed by two persons, notifying next of kin, reporting to state authorities, and participating in a waiting period).

[95] Deepa Shivaram, *Physician-Assisted Death in Oregon Is No Longer Limited to Just State Residents*, NPR (Mar. 30, 2022, 12:15 PM), https://www.npr.org/2022/03/30/1089647368/oregon-physician-assisted-death-state-residents. *See also* Nick Reynolds, *Vermont Bill Sparks Fear of 'Suicide Tourism'*, NEWSWEEK (Feb. 18, 2023, 6:00 AM), https://www.newsweek.com/vermont-bill-sparks-fear-suicide-tourism-1782148 (commenting on suicide tourism in Oregon and Switzerland). Amelia Gentleman, *Inside the Dignitas House*, GUARDIAN (Nov. 17, 2009), https://www.theguardian.com/society/2009/nov/18/assisted-suicide-dignitas-house (discussing the world's first assisted suicide center, Dignitas in Switzerland).

[96] Pope, *supra* note 17, at 269.

of guilt.[97] With regard to physician-assisted suicide, jurors may refuse to convict because even though a defendant is legally guilty, the jurors do not consider the act to be morally wrong.[98] In the case of Dr. Jack Kevorkian, portrayed as "Dr. Death" in the media, the jury cleared him of charges that he violated state law criminalizing physician-assisted suicide, and experts subsequently commented that, "[i]t sends a message to prosecutors that juries in Michigan are not willing to convict a doctor who helps a terminally-ill person implement a decision to hasten inevitable death."[99]

V. CONCLUSION

The right to die has captivated people for thousands of years, and literature on the subject deals with philosophical, moral, and legal theories about the concept of life and its value. This Essay presents but a fraction of available material. Given law's prominence in society, prosecutors and defense attorneys are in unique positions to develop the right to die through exercises of discretion and zealous advocacy. Issues concerning autonomy and competence are difficult to address, but the objective of this Essay has been to vehemently argue for repurposing the lawyer's role to advance dignity and allow terminally-ill persons the right to leave this world according to their own terms.

Patricia Bober[*]

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[97] Yale Kamisar, *Physician-Assisted Suicide: The Problems Presented by the Compelling, Heartwrenching Case*, 88 J. CRIM. L. & CRIMINOLOGY 1121, 1125 n.17 (1998) ("To be more precise, it seems that no American jury has ever convicted a physician of homicide for performing active voluntary euthanasia, but in the last half-century at least four physicians have been prosecuted for engaging in such an act.").

[98] Daniel Bell, Manner of Death and Willingness to Nullify in a Euthanasia Case 16 (July 21, 2017) (M.S. thesis, Rochester Institute of Technology), https://scholarworks.rit.edu/cgi/viewcontent.cgi?article=10665&context=theses.

[99] David Margolick, *Jury Acquits Dr. Kevorkian of Illegally Aiding a Suicide*, N.Y. TIMES (May 3, 1994), https://www.nytimes.com/1994/05/03/us/jury-acquits-dr-kevorkian-of-illegally-aiding-a-suicide.html.

[*] J.D. Candidate 2023, Maurice A. Deane School of Law at Hofstra University; B.A. in Political Science and Theology, Fordham University 2017. I would like to thank Professor Yaroshefsky for her inspiring passion for ethics and the opportunity to write this Essay on such a personal issue. To my mother and father, I would not be in this position if it were not for your unwavering support. Last, I dedicate this Essay to my grandfather who passed at a time when the world was less compassionate than it is now. Human life has intrinsic value. We honor life when we respect dignity and recognize each person is the master of their destiny.