NOTE

A Proposal for Proper Procedure: The Aid-in-Dying Process for Californians with Disabilities

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[*] Copyright © 2018 Michael Benassini. J.D. Candidate, University of California, Davis School of Law, 2018; M.A., University of Nevada, Las Vegas 2015; B.A., University of California, Santa Barbara. I deeply appreciate the support of the UC Davis Law Review, especially Russell Sternshein, in publishing this piece. I also thank Professor Jasmine Harris for her guidance from the start of this project, and my parents, Angelo and Susan, for supporting me in all my legal endeavors.

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INTRODUCTION

Six states have legalized procedures for physicians to administer aid-in-dying services to patients.[1] Oregon adopted the first physician-assisted suicide law in 1994, and the legal community quickly began grappling with the implications of allowing terminally ill patients to voluntarily end their lives.[2] Where a state allows, yet maintains influence over, an individual's decision to end his or her life, the state should proceed cautiously in order to respect the legal and constitutional rights implicated in such a decision.[3] The state should be even more cautious when the individual seeking aid-in-dying services has a developmental disability.[4] Relative to others, these individuals are more susceptible to coercion and agency problems in making the decision to end their lives and during the aid-in-dying process.[5] Existing safeguards, such as requiring informed

[1] Five states have done so by legislative act, and one by judicial decision. *See State-by-State Guide to Physician-Assisted Suicide*, PROCON.ORG, http://euthanasia.procon.org/view.resource.php?resourceID=000132 (last updated Feb. 21, 2017, 12:58 PM) (noting California, Colorado, Oregon, Vermont, and Washington have legalized physician-assisted suicide by legislation, and Montana by judicial decision).

[2] *Id. See generally, e.g.*, Raphael Cohen-Almagor, *Euthanasia and Physician-Assisted Suicide in the Democratic World: A Legal Overview*, 16 N.Y. INT'L L. REV. 1, 11-12 (2003) (describing the legal battles that ensued in the wake of the enactment of the Oregon physician-assisted suicide statute); Brett Kingsbury, Note, *A Line Already Drawn: The Case for Voluntary Euthanasia After the Withdrawal of Life-Sustaining Hydration and Nutrition*, 38 COLUM. J.L. & SOC. PROBS. 201, 213-14 (2004) (describing the prompt legal attacks and challenges to Oregon's physician-assisted suicide statute).

[3] *See* Charles Baron, *Physician Assisted Suicide Should Be Legalized & Regulated*, 41 BOS. B.J. 15, 28-29 (1997) (advocating for the regulation of physician-assisted suicide); Neil M. Gorsuch, *The Right to Assisted Suicide and Euthanasia*, 23 HARV. J.L. & PUB. POL'Y 599, 688-91 (2000) (cautioning against legalizing assisted suicide). The type of state influence over an individual's choice to die, contemplated in this Note, is where the individual is held in State custody. *See infra* Section I.A.

[4] *See* Mary E. Harned, *The Dangers of Assisted Suicide: No Longer Theoretical*, *in* DEFENDING LIFE 2013: DECONSTRUCTING ROE: ABORTION'S NEGATIVE IMPACT ON WOMEN 513, 517 (2013), http://www.aul.org/wp-content/uploads/2012/04/dangers-assisted-suicide.pdf; *Not Dead Yet Disability Activists Oppose Assisted Suicide as a Deadly Form of Discrimination*, NOT DEAD YET, http://notdeadyet.org/assisted-suicide-talking-points (last visited Jan. 25, 2018); *see also Some Oregon and Washington State Assisted Suicide Abuses and Complications*, DISABILITY RTS. EDUC. & DEF. FUND, http://dredf.org/public-policy/assisted-suicide/some-oregon-assisted-suicide-abuses-and-complications (last visited Jan. 25, 2018) [hereinafter *Assisted Suicide Abuses*]. This Note "uses 'people first' language consistent with the view within the U.S. disability rights movement that disabilities and medical diagnoses are not persons and do not define individuals." Jasmine E. Harris, *Processing Disability*, 64 AM. U. L. REV. 457, 459 n.4 (2015).

[5] *See infra* Sections II.C.1–2.

voluntariness when initiating the aid-in-dying process, may not be adequate because an individual's disability can impair their ability to make decisions of their own volition.[6] Additionally, some procedural safeguards impermissibly constrain the agency of individuals with disabilities without providing any corresponding benefit.[7] One example, analyzed in this Note, is California's refusal to administer aid-in-dying services to patients in state custody unless private service providers are locally unavailable.[8]

This Note argues that the emergency regulations adopted by the California Department of Developmental Services ("DDS"), in response to the California legislature passing the California End of Life Option Act ("ELOA"),[9] do not provide legally sufficient procedures to residential patients[10] who seek aid-in-dying services. Part I provides background information on the DDS, the ELOA, the DDS's emergency regulations, and three recent Supreme Court decisions.[11] Part II evaluates the legal sufficiency of the procedures enacted by the emergency regulations in light of those Supreme Court decisions, and lower court decisions.[12] Part III proposes a more robust procedure that the DDS should implement for residential patients who seek aid-in-dying services.[13] And Part IV addresses potential objections to the arguments of Parts II and III.[14]

I. State of the Law

A. *The California Department of Developmental Services*

The DDS is the state government entity responsible for providing services and support across California to children and adults with developmental disabilities.[15] The DDS provides some of these services

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[6] *See infra* Section II.C.2.

[7] *See* CAL. CODE REGS. tit. 17, § 51002 (2018) (requiring proof of unavailability of private aid-in-dying service providers in order to gain access to state-administered aid-in-dying services); *infra* Section II.A.

[8] *See* CAL. CODE REGS. tit. 17, § 51002; *infra* Sections I.C, II.A.

[9] CAL. HEALTH & SAFETY CODE § 443 (2018).

[10] A residential patient is an individual with a developmental disability who lives, and receives various support services, in a residential developmental center operated by the California Department of Developmental Services. *See infra* Section I.A.

[11] *See infra* Part I.

[12] *See infra* Part II.

[13] *See infra* Part III.

[14] *See infra* Part IV.

[15] *See Welcome to DDS*, CAL. DEP'T OF DEVELOPMENTAL SERVS., http://www.dds.ca.gov

in state-operated residential developmental centers, which employ physicians and other support staff and house residential patients.[16] The services available to residential patients range widely, from basic skills training, to educational, vocational, and specialized medical services.[17] On June 9, 2016, the DDS filed notice of proposed emergency regulations in response to the ELOA.[18] These regulations, as argued in this Note,[19] reflect the state refusing to administer end of life assistance to DDS patients except in special circumstances.[20] The ELOA gives DDS patients a right to access end of life services, while the DDS's refusal problematically presents a barrier to patients accessing those services.[21]

B. The California End of Life Option Act

The ELOA provides that a terminally ill adult with sufficient "capacity to make medical decisions" may request a prescription for an aid-in-dying drug from an "attending physician," if certain other criteria are met.[22] Having sufficient "capacity to make medical decisions" means the ability to understand the consequences of a health care decision, its significant benefits, risks, and alternatives, and the ability to make and communicate an informed decision to health care providers.[23] An individual's "attending physician" is defined as the physician with primary responsibility for the health care of the individual, and for treatment of that individual's terminal disease.[24] The DDS staff doctor primarily responsible for treating a terminally ill,

(last visited Jan. 25, 2018). DDS provides services under the legal mandate of the California Lanterman Developmental Disability Services Act. CAL. WELF. & INST. CODE §§ 4500-4846 (2018).

[16] *See Welcome to DDS*, *supra* note 15.

[17] *See Developmental Centers Home Page*, CAL. DEP'T OF DEVELOPMENTAL SERVS., http://www.dds.ca.gov/DevCtrs/Home.cfm (last updated Nov. 15, 2017).

[18] CAL. DEP'T OF DEVELOPMENTAL SERVS., NOTICE OF PROPOSED EMERGENCY ACTION — SUBJECT: END OF LIFE OPTION ACT (2016), https://www.dds.ca.gov/ProposedRegs/EOLOptionAct/NOPR.pdf.

[19] *See infra* Part II.

[20] *See infra* Section I.C.

[21] *See infra* Part II.

[22] *See* CAL. HEALTH & SAFETY CODE §§ 443.1-.5 (2018). Other criteria include that the patient requests the aid-in-dying drugs voluntarily, has established California residency, has the physical and mental ability to self-administer the drugs, and properly documents three requests, two oral and one written, at least fifteen days apart. *See id.*

[23] *Id.* § 443.1(e).

[24] *Id.* § 443.1(c).

residential patient is classified as that patient's attending physician under this statutory definition.[25] Before administering aid-in-dying services, an attending physician must, among other requirements, make several medical and mental health determinations, receive at least three requests directly from a patient, and keep detailed records before prescribing an aid-in-dying drug.[26]

C. The DDS Emergency Regulations

The DDS adopted emergency regulations in response to the ELOA, in order to prevent residential patients in DDS developmental centers from receiving aid-in-dying services in any state owned institution or from any state employed physician.[27] Instead, aid-in-dying services must be administered by private physicians in a community based setting.[28] Community based care consists of administering services to patients in their homes and in small scale facilities within their local communities, rather than in a centralized institution.[29] The DDS emergency regulation procedure mirrors that of several California State agencies, which may also receive requests to administer aid-in-dying services to individuals in their custody or care.[30] If an

[25] *See id.*; *supra* Section I.B.

[26] *See* HEALTH & SAFETY §§ 443.3, .5, .8.

[27] *See* CAL. CODE REGS. tit. 17, §§ 51000-51002 (2018); CAL. DEP'T OF DEVELOPMENTAL SERVS., INITIAL STATEMENT OF REASONS — SUBJECT OF PROPOSED REGULATIONS: END OF LIFE OPTION ACT 1, http://www.dds.ca.gov/proposedRegs/EOLOptionAct/ISOR.pdf (justifying the emergency regulations by stating that "[g]iven the intellectual and behavioral challenges of persons residing in a state developmental center or a state-operated facility, the Act's requirement to provide terminal patients with aid-in-dying drugs can constitute *a threat to the health and safety of the facilities' other residents and staff*" (emphasis added)).

[28] *See* CAL. CODE REGS. tit. 17, §§ 51000-51002.

[29] *See Frequently Asked Questions: Home and Community-Based Services Rules*, CAL. DEP'T OF DEVELOPMENTAL SERVS., http://www.dds.ca.gov/HCBS/docs/faqRules.pdf (last visited Jan. 25, 2018). Institutional or institution-based care shall be used in this Note to refer to the practice of housing an individual in a single facility, sequestering the patient in order to provide all necessary services within the single facility. Community based care shall refer to programs which focus on the State providing services within patients' own homes, as well as in diffuse small-scale facilities where patients have access to services which cannot easily be provided at their homes. *See id.*

[30] *See, e.g.*, CAL. CODE REGS. tit. 9, § 4600 (2018) (Department of State Hospitals); CAL. CODE REGS. tit. 12, § 509 (2018) (Veteran's Home of California). Both agencies also followed emergency regulation passage procedures, similar to that of the DDS, in adopting these policies. Insofar as these government agencies serve individuals with disabilities, some arguments in this Note should apply to them as well as the DDS. The Department of State Hospitals follows a similar appeals procedure, by which individuals in Department custody may demonstrate inability to find appropriate

appropriate community based care setting cannot be located for a given DDS residential patient, only then may the patient submit an appeal to the Director of the DDS.[31] The Director considers the totality of the circumstances in deciding whether to authorize administration of aid-in-dying services within a DDS residential center.[32] This procedure reflects an impermissible state-mandated accommodation of community based, rather than institution based, aid-in-dying services.[33]

D. Supreme Court Precedent

1. States Must Offer Community Based Care, but Patients Need Not Accept It

In *Olmstead v. L.C. ex rel. Zimring*, the Respondents, a pair of individuals with mental disabilities, brought suit against state officials under the Americans with Disabilities Act ("ADA").[34] They sought to challenge their confinement, or institutionalization, in a Georgia State hospital psychiatric ward after voluntarily admitting themselves.[35] They argued that state caretakers unjustifiably refused to transfer them to a community based setting, despite the determination that the state could appropriately administer Respondents' care outside of the psychiatric institution.[36] The Supreme Court ruled in favor of the patients and held that unjustified isolation in institutional facilities "is properly regarded as discrimination based on disability" under the ADA.[37] The Court considered several factors in determining whether a State's decision to institutionalize a given individual with a disability is sufficiently justified.[38] Additionally, the Court explicitly stated that the

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private based care and thereby receive aid-in-dying services from the State. *See* tit. 9, § 4601. The Veteran's Home of California does not offer an appeal, and flatly requires discharge from the facility before an individual may receive aid-in-dying services. *See* tit. 12, § 509.

[31] *See* tit. 17, § 51002.

[32] *Id.*

[33] *See infra* Sections I.D.1, II.A.

[34] Olmstead v. L.C. *ex rel.* Zimring, 527 U.S. 581, 593-94 (1999).

[35] *See id.* at 593.

[36] *See id.* at 593-94.

[37] *Id.* at 597; *see* 28 C.F.R. § 35.130(a) (2017).

[38] *Olmstead*, 527 U.S. at 597 ("[T]he District Court must consider, in view of the resources available to the State, not only the cost of providing community-based care to the litigants, but also the range of services the State provides others with mental disabilities, and the State's obligation to mete out those services equitably.").

ADA does not require states to provide community based services as an accommodation to individuals with disabilities who would rather receive institution based services.[39] The Court rejected the State's argument that providing community based services would not be a "reasonable modification" of current state services, and that doing so would entail "fundamenta[l] alter[ation] of the States' services and programs."[40] Although the Court held that refusing to provide a community based setting violated the ADA, its reasoning demonstrates that the DDS's mandate of community based aid-in-dying services also runs contrary to the purposes of the ADA.[41] Indeed, the Court held unnecessary institutional confinement to be a violation of the ADA, but still sought to protect the Respondents' agency and liberty interests by emphasizing that "nothing in the ADA or its implementing regulations condones termination of institutional settings for persons unable to handle or benefit from community settings."[42]

2. The State Owes a Positive Duty to Individuals in Involuntarily Custody

In *DeShaney v. Winnebago County Department of Social Services*, the mother of a young child brought suit on the child's behalf under 42 U.S.C. § 1983 because his father, her ex-husband, beat the child into a life-threatening coma.[43] The mother alleged that state officials violated the child's liberty rights by failing to intervene prior to the beating.[44] State officials had previously found evidence of abusive injuries to the child while in the father's custody, but nonetheless granted the father full custody of the child.[45] The Supreme Court held that although the child's fate was tragic, "nothing in the language of the Due Process Clause itself requires the State to protect the life, liberty, and property of its citizens against invasion by private actors."[46] The Court went on to note at least one exception, where "the State takes a person into its custody and holds him there against his will, the Constitution imposes upon it a corresponding duty to assume some responsibility for his

[39] *See id.* at 602; *see also* 28 C.F.R. § 35.130(e)(1).

[40] *See Olmstead*, 527 U.S. at 603 (citing 28 C.F.R. § 35.130(b)(7)).

[41] *See infra* Section II.A.

[42] *Olmstead*, 527 U.S. at 601-02; *see infra* Section II.A.

[43] *See* 42 U.S.C. § 1983 (2018); DeShaney v. Winnebago Cty. Dep't of Soc. Servs., 489 U.S. 189, 191-93 (1989).

[44] *See DeShaney*, 489 U.S. at 191.

[45] *Id.* at 191-92.

[46] *Id.* at 195.

safety and general well-being."[47] This exception is significant because it creates a duty of care to DDS residential patients that are involuntarily held in California State custody.[48] This duty of care requires some degree of positive action on the part of DDS officials to ensure involuntary patient safety throughout the aid-in-dying process.[49]

3. The Due Process Balancing Test

In *Mathews v. Eldridge*, the Respondent challenged the constitutionality of the administrative procedure responsible for terminating his Social Security disability benefits.[50] The Court's decision rested on balancing the Respondent's procedural due process right against the government's interest in not changing the procedural status quo.[51] In determining whether additional procedures were warranted, the Court considered the importance of the private interest to be affected, the value of the proposed additional procedure relative to the current procedure, and the government's interest in fiscal and administrative efficiency.[52] The Court ruled against the Respondent and held that this balancing test does not require an evidentiary hearing prior to the termination of disability benefits.[53] The Court's test has since been developed in lower courts and analyzed by legal scholars as one of the main standards for assessing the requirements of procedural due process.[54] This Note will apply the test announced in

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[47] *Id.* at 199-200.

[48] *See* Campbell v. Wash. Dep't of Soc. & Health Servs., 671 F.3d 837, 842-43 (9th Cir. 2011) (explaining that, when a state institutionalizes an individual, the Due Process clause imposes a duty to assume responsibility for the person's safety and general well-being "because it has 'render[ed] him unable to care for himself'" (citing *DeShaney*, 489 U.S. at 200)).

[49] *See infra* Section II.B.

[50] Mathews v. Eldridge, 424 U.S. 319, 323-25 (1976).

[51] *See id.* at 335.

[52] *See id.*

[53] *See id.* at 349.

[54] *See, e.g.*, D.B. v. Cardall, 826 F.3d 721, 741-42 (4th Cir. 2016) (applying *Eldridge* to analyze a procedural due process claim in the juvenile immigration context); Rodriguez v. Robbins, 804 F.3d 1060, 1077 (9th Cir. 2015) (applying *Eldridge* to analyze a procedural due process claim in the adult immigration context); Jason Parkin, *Adaptable Due Process*, 160 U. PA. L. REV. 1309, 1320 (2012) ("Then, six years after deciding *Goldberg*, the Court in *Mathews v. Eldridge* adopted what remains the general approach for determining what process is due when the government seeks to deprive an individual of a constitutionally protected interest."); Linda Lee Reimer Stevenson, Comment, *Fair Play or a Stacked Deck?: In Search of a Proper Standard of Proof in Juvenile Dependency Hearings*, 26 PEPP. L. REV. 613, 619 (1999) (analyzing the

Eldridge to evaluate the constitutional sufficiency of the current DDS emergency procedures.[55]

E. The Legality of the DDS Emergency Regulations

The DDS emergency regulations, as written, are in tension with the previously discussed Supreme Court decisions in two ways.[56] First, the *Olmstead* Court announced that community based care is an accommodation required by the ADA, but it is not the *sine qua non* of compliance with federal disability anti-discrimination law.[57] Accordingly, the DDS's policy of transferring patients to local community based care, unless such care cannot be located, runs contrary to *Olmstead*'s interpretation of the ADA.[58] Based on the text of the ADA, DDS residential patients who wish to receive aid-in-dying services under the ELOA should be able to remain in their institutional care setting.[59] If community based care is an accommodation, then DDS residential patients should have the option of declining that accommodation where doing so will not detract from the other services that the DDS offers to both residential and non-residential patients.[60] The *Olmstead* Court focused on the utter denial of community based care as violating the ADA, but did not mandate that community based care was necessary or appropriate in all cases.[61]

Second, the DDS abdicates any direct responsibility for the well-being of residential patients once they transfer to private community

standard of proof in juvenile dependency hearings under the *Eldridge* test); Bradley J. Wyatt, Note, *Even Aliens Are Entitled to Due Process: Extending* Mathews v. Eldridge *Balancing to Board of Immigration Appeals Procedural Reform*, 12 WM. & MARY BILL RTS. J. 605, 605 (2004) (arguing that the analysis in *Eldridge* dictates an expansion of the due process offered by the U.S. Board of Immigration Appeals).

[55] *See infra* Sections III.B–C.

[56] *See supra* Sections I.C–E.

[57] *See generally* Olmstead v. L.C. *ex rel.* Zimring, 527 U.S. 581 (1999) (holding that the plaintiff/patients qualified for community-based treatment, but states can take into account the available resources in determining whether patients are entitled to immediate community placement).

[58] *See* CAL. CODE REGS. tit. 17, § 51002 (2018); *Olmstead*, 527 U.S. at 602; *supra* Sections I.C–D.1.

[59] *See* U.S. CONST. amend. XIV (prohibiting states from depriving citizens of rights without due process of law); *Olmstead*, 527 U.S. at 602; *supra* Sections I.C–D.

[60] *See Olmstead*, 527 U.S. at 597 (holding that courts must consider "the range of services the State provides others with mental disabilities, and the State's obligation to mete out those services equitably"); *infra* Section III.B; *see also* 28 C.F.R. § 35.130(d) (2017).

[61] *See Olmstead*, 527 U.S. at 601-02.

based care for aid-in-dying services.[62] Since the State owes DDS residential patients a positive duty of care in cases of involuntary commitment, this abdication conflicts with the constitutional principles described in *DeShaney*.[63] In other words, the Fourteenth Amendment may give rise to a state duty to affirmatively prevent harm to involuntary DDS patients after they transfer to private community based care.[64] On both counts, if an alternative procedure satisfies the Fourteenth Amendment balancing test outlined in *Eldridge*, then the DDS's emergency regulations enacted a constitutionally suspect procedure.[65]

II. PRECEDENT AND POLICY

A. *The Conflict with the Americans with Disabilities Act as Interpreted in* Olmstead

The U.S. Supreme Court's reasoning in *Olmstead* provides a useful framework for analyzing the potential conflict between the ADA and the DDS emergency regulations as an impermissible state-mandated accommodation for individuals with disabilities. In *Olmstead*, the Respondents argued that the ADA guaranteed them the option of community based mental health services.[66] In response to the State's contrary argument, the Court engaged in a textual interpretation of the ADA.[67] The Court explicitly stated that "nothing in the ADA . . . condones termination of institutional settings for persons unable to handle or benefit from community settings."[68] This interpretation clarifies that an individual cannot be forced to accept an accommodation that they do not wish to receive.[69] The *Olmstead* Court found further guidance on the issue in then-codified Appendix A to the Federal Regulations implementing the ADA, which clearly

[62] *Supra* Section I.E; *see* tit. 17, §§ 51000-51002; *supra* Section I.C.

[63] *See* DeShaney v. Winnebago Cty. Dep't of Soc. Servs., 489 U.S. 189, 199-200 (1989); *supra* Sections I.C, I.D.2.

[64] *See DeShaney*, 489 U.S. at 199-200 (explaining that involuntary restraint of an individual gives rise to an affirmative state duty to care for the individual); Mathews v. Eldridge, 424 U.S. 319, 335 (1976) (delineating the three factors to be analyzed in determining whether a particular claim of insufficient procedural due process warrants a finding of constitutional violation); *infra* Sections II.B, III.A, III.C.

[65] *See Eldridge*, 424 U.S. at 335; *infra* Part III.

[66] *Olmstead*, 527 U.S. at 594.

[67] *See id.* at 601-03.

[68] *Id.* at 601-02.

[69] 28 C.F.R. § 35.130(e)(1) (2017); *see Olmstead*, 527 U.S. at 602.

stated that individuals with disabilities must be given the option to decline a particular accommodation.[70]

The *Olmstead* Court correctly interpreted the ADA to mandate the elimination of discrimination against individuals with disabilities by forcing states to provide services in "the most integrated setting appropriate to the needs" of individuals with disabilities.[71] Thus, the Court ruled against Georgia's argument that providing the option of community based care would constitute a "fundamental alteration" to state services, which would not be required under ADA.[72] Critically, this was a ruling against the State's flat denial of community based services, which the Court found would be the most integrated setting appropriate to the needs of the Respondents.[73] The Court sought to account for the differing circumstances of individuals with disabilities by carefully limiting the community based care mandate to cases where community based care is most appropriate to patient needs, and exempting cases where there would be no benefit to the patient.[74] Therefore the Court's reasoning supports construal of community based care as an accommodation which must be offered by States, rather than a form of service which is flatly required for all patients in all cases by the ADA.[75] The Court sought to eliminate segregation of individuals with disabilities by mandating the option of community based care as an integrated setting, but did not seek to supplant institutional care altogether.[76]

The legality of the DDS's mandated appeals process thus depends upon whether providing aid-in-dying services without an appeals process would fundamentally alter the nature of the services that the DDS currently provides.[77] The DDS allows a residential patient to

[70] *See Olmstead*, 527 U.S. at 602; 28 C.F.R. pt. 35 app. A (2017) (re-codified as app. B).

[71] *Olmstead*, 527 U.S. at 588-92; 28 C.F.R. § 35.130(d) (2017); Loretta Williams, *Long Term Care After* Olmstead v. L.C.*: Will the Potential of the ADA's Integration Mandate Be Achieved?*, 17 J. CONTEMP. HEALTH L. & POL'Y 205, 206-10 (2000) (exploring the impact of *Olmstead* "on the delivery of publicly-funded long term care" for individuals with disabilities).

[72] *See Olmstead*, 527 U.S. at 594-95, 597, 607; 28 C.F.R. § 35.130(b)(7)(i).

[73] *Olmstead*, 527 U.S. at 594-95, 597, 607.

[74] *Id.* at 599-602.

[75] *See id.*

[76] *See id.*

[77] Like the decision to institutionalize a particular individual, the legitimacy of the decision to require an appeal depends on whether the State has sufficient resources to offer aid-in-dying services without an appeal, and can do so without unduly detracting from the other services California currently offers to individuals with disabilities. *See Olmstead*, 527 U.S. at 587; 28 C.F.R. § 35.130(b)(7)(i); *supra* Section I.D.2.

appeal for institutional aid-in-dying services only if appropriate community based aid-in-dying services cannot be located for that patient.[78] But upon a successful appeal, the Director of DDS may freely authorize a residential patient's receipt of aid-in-dying services at a DDS residential center.[79] Since the DDS is willing to offer these services after a successful appeal, doing so without the appeals process would not likely be considered a "fundamenta[l] alter[ation] of the States' services."[80] It would merely entail respecting the agency of DDS residential patients by allowing free choice of an aid-in-dying services setting.[81] Therefore, the procedures under the DDS emergency regulations constitute an unjustified state-mandated accommodation of community based care.[82] DDS's own publications indicate that community based care is correctly considered an accommodation, meant to provide the utmost access to state services without the negative effects of institutionalization.[83] So long as community based care is considered an accommodation, the emergency regulations run contrary to *Olmstead*'s interpretation of the ADA.[84]

Thus, the Supreme Court left no question as to the anti-discriminatory utility of community based care; it is to be used as a tool for inclusion under the ADA, but not as a mandate against individuals who would prefer institution based care.[85] Herein lies the

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78 CAL. CODE REGS. tit. 17, § 51002 (2018).

79 *Id.*

80 *Olmstead*, 527 U.S. at 603 (citing 28 C.F.R. § 35.130(b)(7)). Giving patients the option of receiving aid-in-dying services at DDS residential centers presents a stronger case for legally required procedure than that of the patients in *Olmstead*. There, patients sought transfer to community based care, whereas DDS patients would be seeking the right *not* to transfer to community based care.

81 *See* tit. 17, § 51002; *cf. Olmstead*, 527 U.S. at 602 ("[P]ersons with disabilities must be provided the option of declining to accept a particular accommodation." (citing 28 C.F.R. pt. 35, App. A, p. 450 (1998))); *infra* Section III.B (arguing that free choice of aid-in-dying care setting is required by the balancing test announced in *Mathews v. Eldridge*).

82 *See* tit. 17, §§ 51000-51002; *Olmstead*, 527 U.S. at 601-03 ("Nor is there any federal requirement that community-based treatment be imposed on patients who do not desire it.").

83 *See Frequently Asked Questions: Home and Community-Based Services Rules*, *supra* note 29 (indicating that the intent of the DDS community based services rules "is to ensure that states receiving federal Medicaid funds meet the needs of consumers who *choose* to get their long-term services and supports in their home or community, *rather than* in institutions" (emphasis added)).

84 *See Olmstead*, 527 U.S. at 601-03 (explaining that the ADA was meant to open community-based care as an option to individuals institutionalized by the state, not to force that form of care on individuals who do not desire it).

85 *Id.*

conflict between the DDS emergency regulations and the Court's interpretation of the ADA. The regulations leave no room for DDS residential patients to freely exercise their legal rights under the ELOA while in their current institutional setting.[86] To receive institution based aid-in-dying services from the DDS, a patient must show that there are no local community based aid-in-dying service programs available to them.[87] If there are local community based services available for a DDS patient, then they cannot request to receive the services in their DDS residential center.[88] After *Olmstead*'s call for deinstitutionalization, more community based disability care centers are developing, some of which are not as reliable as institutional care centers.[89] Furthermore, many individuals with disabilities may reasonably choose institution based care over the less reliable systems of community based care. Therefore, insofar as the DDS is forcing residential patients to seek community based care against their will, the DDS emergency regulations do not adhere to the Court's interpretation of community based care as an accommodation under the ADA.[90]

Attempts to distinguish *Olmstead* on the grounds that the Respondents sought mental health services, rather than aid-in-dying services, does not secure the legality of the DDS emergency regulations. The Court in *Olmstead* described the value of community based care as an accommodation *per se* under the ADA, and did not explicitly limit its evaluation to a specific context of services.[91] The

[86] *See* tit. 17, §§ 51000-51002 ("Except as provided in section 51002, the Department of Developmental Services shall not provide aid-in-dying drugs under the End of Life Option Act . . . to any terminally ill resident in a developmental center or state-operated facility, and shall not permit its employees, independent contractors, or other persons to provide the end-of-life option on the premises of any Department facility . . . .").

[87] *Id.* § 51002.

[88] *See id.* §§ 51000-51002.

[89] *See* Tamie Hopp, *People as Pendulums: Institutions and People with Intellectual and Developmental Disabilities*, NONPROFIT Q. (July 16, 2014), https://nonprofitquarterly.org/2014/07/16/people-as-pendulums-institutions-and-people-with-intellectual-and-developmental-disabilities (arguing that after the decline of federally sponsored institutional care in the wake of *Olmstead*, "the service landscape created a vacuum that lured nonprofit and for-[profit] providers into the business of human services," which led to "problems created by an unchecked expansion of providers rushing in to fill a need" including "poor quality of care, questionable and even criminal management practices by service providers, and lackluster monitoring by public health and welfare agencies").

[90] *See* tit. 17, §§ 51000-51002; *Olmstead*, 527 U.S. at 602; *infra* Section III.A.

[91] *See Olmstead*, 527 U.S. at 601-02.

Court's ruling for the Respondents did not turn on the type of services they sought, but instead on whether providing those services would constitute a fundamental alteration of the currently offered state services.[92]

Another important fact to consider throughout this analysis is that the DDS commits to a "person-centered planning approach" in identifying and meeting the service and treatment needs of residential patients.[93] A person-centered planning approach is meant to respect the particular medical decisions of each individual patient. Therefore, the DDS should support a patient's decision to institutionally exercise their right to physician-assisted suicide to the greatest extent possible.[94]

B. *The State's Duty of Care Under* DeShaney

In *DeShaney*, the Court interpreted the Due Process Clause of the Fourteenth Amendment.[95] The Petitioner unsuccessfully argued that the State had a positive duty to maintain the general well-being of minors against the acts of private custodians, where the government grants custody to individuals known to be abusive to children.[96] Although the Court rejected this argument, it explained that the State does have a duty of care under the Fourteenth Amendment to any person who the State involuntarily holds in custody.[97] Many DDS patients fit the definition of this exception, as the DDS houses individuals who have been ordered into California State custody under the label of civil commitment.[98] The Supreme Court and the Ninth

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[92] *Id.* at 602-03; 28 C.F.R. § 35.130(b)(7)(i) (2017).

[93] *Developmental Centers Home Page*, *supra* note 17.

[94] *See infra* Section III.B.

[95] U.S. CONST. amend. XIV, § 1 ("No State shall . . . deprive any person of life, liberty, or property, without due process of law . . . ."); DeShaney v. Winnebago Cty. Dep't of Soc. Servs., 489 U.S. 189, 199-200 (1989).

[96] *DeShaney*, 489 U.S. at 193-94. The government knew of the potential harm to the minor in this case because, post-divorce, the court granted the abusive father custody of the child victim and subsequently received allegations of paternal abuse.

[97] *Id.* at 199-200.

[98] *See* CAL. CODE REGS. tit. 17, § 51001(a)(2) (2018); *Mental Health/Developmental Services Collaborative*, *Meeting of January 22, 2013 Minutes*, CAL. DEP'T OF DEVELOPMENTAL SERVS. (Feb. 2, 2013), https://www.dds.ca.gov/HealthDevelopment/docs/CollaborativeMeetingMinutes_1_22_2013.pdf ("AB 1472 allows for the civil commitment of a person with a developmental disability who is determined to be dangerous to self or others."). Civil commitment refers to the process by which an individual with a "grave disability" may be confined to a state institution against their will. CAL WELF. & INST. CODE § 5008(h)(1)-(2) (2018). Grave disability is defined as

Circuit both explicitly acknowledge the application of the *DeShaney* exception to individuals in state developmental disability care programs if commitment to the program is involuntary.[99]

The DDS mandates the use of private physicians in community based settings for the administration of aid-in-dying services to involuntarily committed residential patients.[100] Therefore, under *DeShaney*, the DDS has a responsibility to maintain the safety and general well-being of its patients while in private community based aid-in-dying care programs.[101] This responsibility is especially important because individuals with disabilities are susceptible to many risks when seeking aid-in-dying services.[102] The Court's interpretation of the Fourteenth Amendment in *DeShaney* indicates that the DDS should take positive actions to mitigate those risks.[103]

For example, in *Campbell v. Washington Department of Social and Health Services*, the Ninth Circuit recognized that state custodial entities are required to monitor the safety and general well-being of involuntarily committed patients after transfer to community based care.[104] The Plaintiff brought suit alleging, *inter alia*, a violation of her daughter's constitutional rights under the *DeShaney* exception.[105] Plaintiff's thirty-three-year-old daughter was found unconscious in her bathtub and died a week later while under the supervision of a Washington State community based developmental services

"[a] condition in which a person, as a result of a mental health disorder [or impairment by chronic alcoholism], is unable to provide for his or her basic personal needs for food, clothing or shelter." *Id.*

[99] *See* Youngberg v. Romeo, 457 U.S. 307, 324-25 (1982) (recognizing "constitutionally protected interests in conditions of reasonable care and safety, reasonably nonrestrictive confinement conditions, and such training as may be required by these interests" for individuals involuntarily committed to state institutions based on diagnosis with a disability); Campbell v. Wash. Dep't of Soc. & Health Servs., 671 F.3d 837, 842-43 (9th Cir. 2011) (recognizing that institutionalization is an example of a restraint of personal liberty that triggers the Due Process Clause protections). California passed extensive legislation protecting the right of individuals with disabilities to services which facilitate their participation in public society at the same level as individuals without disabilities. *See* Lanterman Developmental Disabilities Services Act, CAL. WELF. & INST. CODE §§ 4500-4884 (2018).

[100] *See* tit. 17, §§ 51001-51002.

[101] *DeShaney*, 489 U.S. at 199-200.

[102] *See infra* Section II.C.

[103] *See infra* Section III.C (describing what procedural actions the law requires of the DDS).

[104] *Campbell*, 671 F.3d at 842-43.

[105] *Id.* at 839.

program.[106] The Ninth Circuit found that the *DeShaney* exception did not apply because the patient's enrollment in the program was voluntary.[107] However, the structure of the Ninth Circuit's reasoning indicates that the state would owe a duty if the patient's commitment to the program was involuntary.[108] Thus, patients who are involuntarily housed in DDS residential centers are owed positive state duties of care, even after transfer to a community based setting.[109]

Additionally, a claim that State responsibility terminates once a residential DDS patient is transferred to private, rather than public, aid-in-dying care lacks support.[110] The DDS is still responsible because all patients maintain a right of return to the DDS residential center if they decide, after transfer, that they do not wish to end their lives.[111] Plus, patients may request to delay transfer until they are ready to ingest the aid-in-dying drugs.[112] Involuntarily committed individuals have both of these rights, in addition to the requirement that the committing court approve the initial transfer.[113] This structure suggests that the DDS does not intend to fully relinquish custody of any patient, but merely to temporarily waive responsibility during the period that aid-in-dying drugs are actually administered.[114] Regardless of the emergency regulation procedure, the right of return provision indicates that the transfer (because it is potentially temporary) is not sufficient grounds for terminating the DDS's constitutionally required duty to ensure the safety and well-being of their involuntary patients.[115]

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[106] *Id.*

[107] *Id.* at 842-45.

[108] *Id.*

[109] *See* CAL. CODE REGS. tit. 17, §§ 51001-51002 (2018); DeShaney v. Winnebago Cty. Dep't of Soc. Servs., 489 U.S. 189, 199-200 (1989).

[110] *Cf. Campbell*, 671 F.3d at 842-45. In *Campbell*, the patient's community based care facility was state-operated. *See id.* at 839-40. However, the Court's reasoning indicates that the relevant source of the State's duty of care is the State's involuntary physical restraint of patients, not its ownership of the patients' treatment facility. *See id.* at 842-44.

[111] tit. 17, § 51001(a)(1).

[112] *Id.*

[113] *Id.* § 51001(a)(2)-(3).

[114] *See id.* §§ 51001-51002.

[115] *See Campbell*, 671 F.3d at 842-45 ("[I]t is the State's affirmative act of restraining the individual's freedom to act on his own behalf — through incarceration, institutionalization, or other similar restraint of personal liberty — which is the 'deprivation of liberty' triggering the protections of the Due Process Clause . . . ." (citing DeShaney v. Winnebago Cty. Dep't of Soc. Servs., 489 U.S. 189, 200 (1989))).

The DDS's justification for enacting the process of mandatory transfer to private aid-in-dying care (*sans* a successful appeal)[116] is that the current services provided to residential patients, including hospice and palliative care, constitute "appropriate and necessary medical care for [each patient's] condition."[117] The "Statement of Reasons" for the emergency regulations goes on to note that since some residential patients present "intellectual and behavioral challenges," administering aid-in-dying drugs in DDS facilities would pose a "threat to the health and safety of the facilities' other residents and staff."[118] It is hard to imagine what the DDS finds threatening to others about allowing a patient to voluntarily end their life, as the aid-in-dying process does not typically involve the exacerbation of any behavioral or intellectual conditions.[119] Early studies of physician-assisted suicide and euthanasia in the Netherlands revealed that the most commonly reported medical complication is failure of the aid-in-dying drugs to take full effect, resulting in severe trauma or pain, but not death.[120] Therefore, the greatest risk presented by the administration of aid-in-dying drugs is borne by the patient seeking to end their life, not the administrators of the aid-in-dying services or other residents.[121] The DDS's justification for the regulations does not reflect the current medical understanding of the aid-in-dying process, which suggests that the DDS may have an alternative, perhaps more publicly reprehensible, justification for enacting the current regulatory scheme.[122]

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[116] *See* tit. 17, §§ 51001-51002; INITIAL STATEMENT OF REASONS — SUBJECT OF PROPOSED REGULATIONS: END OF LIFE OPTION ACT, *supra* note 27, at 2.

[117] INITIAL STATEMENT OF REASONS — SUBJECT OF PROPOSED REGULATIONS: END OF LIFE OPTION ACT, *supra* note 27, at 1.

[118] *Id.*

[119] *See Complications with Assisted Suicide*, LIFE, http://www.life.org.nz/euthanasia/euthanasiakeyissues/complications-and-euthanasia (last visited Jan. 31, 2018).

[120] *See id.*

[121] *See id.*

[122] For instance, the DDS may simply want to avoid California government liability for any medical complications arising during the aid-in-dying process for their residential patients. Or the DDS may not wish to expose itself to liability via a state doctor incorrectly authorizing a patient to receive aid-in-dying services. *See id.*; INITIAL STATEMENT OF REASONS — SUBJECT OF PROPOSED REGULATIONS: END OF LIFE OPTION ACT, *supra* note 27, at 2.

C. The Case for Cautious Aid-in-Dying Care for Individuals with Disabilities

Since the advent of legalized physician-assisted suicide, scholars have debated the potential risks associated with allowing people to choose to end their lives.[123] These risks bear particularly upon the community of individuals with disabilities.[124] One specific risk is that ELOA eligible individuals with disabilities are particularly susceptible to others' attempts to coerce them to end their lives.[125] Another risk derives from the fear that some ELOA eligible individuals with disabilities are still not sufficiently competent to give meaningful consent in requesting aid-in-dying services.[126] The following two sections address the real dangers of each of these risks to illustrate why a state duty of care is necessary to ensure the safety and well-being of DDS residential patients seeking private aid-in-dying care.[127]

1. The Coercion Problem

Perhaps the most disturbing form of coercion is present in cases where an individual is encouraged to end their life because their caretaker, whether a family member or a contracted individual,

[123] *See, e.g.*, Carol J. Gill, *Health Professionals, Disability, and Assisted Suicide: An Examination of Relevant Empirical Evidence and Reply to Batavia*, 6 PSYCHOL. PUB POL'Y & L. 526 (2000) (analyzing the propriety of allowing physicians to "referee requests for assisted suicide"); Kelly Lyn Mitchell, *Physician-Assisted Suicide: A Survey of the Issues Surrounding Legalization*, 74 N.D. L. REV. 341, 360-74 (1998) (analyzing the sufficiency of various procedural safeguards used in laws such as the ELOA).

[124] *See* Baron, *supra* note 3, at 29 ("Special means must be found for protecting the disabled from discrimination."). *But see* Gill, *supra* note 123 (offering a critical analysis of the disability-rights activist argument against physician-assisted suicide, partially to respect the autonomy of individuals with disabilities).

[125] *See, e.g.*, James L. Underwood, *The Supreme Court's Assisted Suicide Opinions in International Perspective: Avoiding a Bureaucracy of Death*, 73 N.D. L. REV. 641, 649 (1997) (stating that "[t]he unspoken implication of [a Canadian Supreme Court decision] was that disabled terminally ill people are vulnerable to pressure to speed their death and deserve[] special government protection").

[126] *Cf.* Stephanie Graboyes-Russo, *Too Costly to Live: The Moral Hazards of a Decision in* Washington v. Glucksburg *and* Vacco v. Quill, 51 U. MIAMI L. REV. 907, 918-25 (1997) (arguing that the typical procedural safeguard requirements of voluntariness, consent, and competency in statutes like the ELOA do not effectively prevent individuals who have been unduly influenced from seeking aid-in-dying services). In contradistinction, another risk is that regulation of aid-in-dying services for individuals with disabilities will constitute undue state restraint upon the agency of those individuals. *See infra* Section IV.B.

[127] *See supra* Sections II.C.1–2.

perceives them as a burden.[128] In 2010, at least one fourth of the patients seeking aid-in-dying services in Oregon and Washington State indicated that they sought the drugs, at least in part, because they did not want to "be a 'burden' on family members."[129] Although this is not proof of coercion, it illustrates the significant influence that caretakers have over an individual's decision to end their life. Insurance companies also have an incentive to encourage individuals to seek aid-in-dying services, since the treatment of individuals' terminal illness and palliative care typically costs far more than aid-in-dying services.[130] The case of Barbara Wagner illustrates such a form of coercion.[131] In 2008, Ms. Wagner's insurance company denied her request for cancer treatment coverage, but also explicitly offered to pay for aid-in-dying services without prior solicitation from Ms. Wagner.[132]

The Disability Rights Education and Defense Fund created a collection of individual profiles describing cases of personal and economic coercion under the Oregon and Washington State physician-assisted suicide statutes.[133] The case of Thomas Middleton is illustrative of the potential economic motivation for coercion created by physician-assisted suicide statutes.[134] Mr. Middleton, suffering from Lou Gehrig's disease, decided to move from a house he owned into Tami Sawyer's home in July 2008.[135] Mr. Middleton named Ms. Sawyer his estate trustee shortly after moving in with her, and deeded his home to the trust.[136] In the same month that Mr. Middleton died via physician-assisted suicide, Ms. Sawyer sold Mr. Middleton's house, and the proceeds went to her own personal businesses.[137] After a federal real estate fraud investigation, Ms. Sawyer was indicted on counts of first-degree criminal mistreatment and first-degree aggravated theft.[138] This case illustrates one way in which a private care provider, in charge of a former DDS residential patient, could be economically motivated to coerce that patient to end their life.

[128] *See* Harned, *supra* note 4, at 516.
[129] *Id.*
[130] *Id.*
[131] *Id.*
[132] *Id.*
[133] *Assisted Suicide Abuses*, *supra* note 4.
[134] *See id.*
[135] *Id.*
[136] *Id.*
[137] *Id.*
[138] *Id.*

Without any supervision by the government post-transfer, emerging private care providers could have similar opportunities to develop financial interests in patients' deaths, as in the case of Mr. Middleton.[139] Currently, the ELOA does not impose any burden on the California government to screen for any of the forms of coercion discussed above.[140]

2. The Agency Problem

The debate regarding the degree of agency which the law should ascribe to individuals with disabilities, and the manner in which that agency should best be protected, is very much alive.[141] Many scholars espouse the belief that individuals with disabilities cannot give effective consent for aid-in-dying services if they are concurrently suffering from certain mental health conditions, such as depression.[142] For this reason, states attempt to limit individuals seeking aid-in-dying services by requiring that patients request the aid-in-dying drugs voluntarily, as medically assessed by their physicians.[143] However, the case of Michael Freeland illustrates the break down in this protection.[144] Mr. Freeland sought aid-in-dying services at age sixty-four, after having a forty-three year history of acute depression and suicide attempts.[145] However, the doctor he requested a lethal prescription from did not believe a psychiatric consultation was necessary in order to ensure Mr. Freeland was acting voluntarily.[146] Despite his doctor's belief, Mr. Freeland chose to seek mental health

[139] *See id.*; *infra* Section III.C.

[140] *See* CAL. HEALTH & SAFETY CODE § 443 (2018); *infra* Section III.C. The only screening required by the statute is certification by an independent physician that a patient possesses mental capacity, requests an aid-in-dying drug voluntarily after making an informed decision, and shows no indication of mental illness. *See* HEALTH & SAFETY § 443.5.

[141] *See, e.g.*, Licia Carlson, *Who's the Expert? Rethinking Authority in the Face of Intellectual Disability*, 54 J. INTELL. DISABILITY RES. 58, 59 (2010) (discussing two forms of authority that are putting forth knowledge claims about people with intellectual disabilities); Amy S.F. Lutz, *Who Decides Where Autistic Adults Live?*, ATLANTIC (May 26, 2015), https://www.theatlantic.com/health/archive/2015/05/who-decides-where-autistic-adults-live/393455.

[142] *See, e.g.*, Eric Chevlen, *The Limits of Prognostication*, 35 DUQ. L. REV. 337, 347-49 (1996); Graboyes-Russo, *supra* note 126, at 918-24; *Assisted Suicide Abuses*, *supra* note 4.

[143] *See, e.g.*, HEALTH & SAFETY § 443.

[144] *See Assisted Suicide Abuses*, *supra* note 4.

[145] *Id.*

[146] *Id.*

and suicide prevention services, and he was able to make amends with his estranged daughter and live for an additional two years with his terminal condition.[147] Mr. Freeland's case was not exceptional, as no more than three percent of aid-in-dying services patients in Oregon between 2011 and 2014 were referred to a psychological evaluation before being prescribed a lethal drug.[148] Although Mr. Freeland ended up seeking a psychological evaluation and refrained from taking the lethal prescription, other patients may not question their doctor's judgment that an evaluation is unnecessary. As in the case of Mr. Freeland, the private care provider accepting former DDS residential patients could easily fail to screen for mental health problems without California government supervision.[149]

III. SOLUTION

A. *Compliance with* Olmstead, DeShaney, *and the Americans with Disabilities Act*

The DDS should adopt a procedure that conforms to the legal and constitutional principles announced in *Olmstead* and *DeShaney*.[150] Therefore, the DDS procedure directing residential patients on how to invoke their rights under the ELOA should be amended in two ways. First, residential patients must have an uninhibited choice to receive aid-in-dying services in either their current DDS public institutional setting or an appropriate private community based setting.[151] Under *Olmstead*, the ADA requires that DDS-employed physicians fulfill the role of attending physicians under the ELOA without an appeals process.[152] Second, when an involuntary residential patient is transferred to private community based care for aid-in-dying services, the DDS must ensure the safety and well-being of that patient throughout the aid-in-dying process.[153] This requirement can be achieved by tasking a staff member to vet available community based

[147] *Id.*

[148] *Id.* (citing the Oregon Death with Dignity Annual Reports, published by the Oregon Health Authority, Public Health Division).

[149] *See id.*; *cf. supra* Section II.C.1.

[150] *See supra* Sections II.A–B.

[151] *See supra* Section II.A.

[152] *See supra* Section II.A.

[153] *See supra* Section II.B.

programs for instances of coercion or legally deficient medical evaluation.[154]

B. First Satisfaction of the Eldridge *Test*

An application of the test announced in *Eldridge* determines whether either of the previously mentioned amendments to the DDS emergency regulations are legally required.[155] The *Eldridge* test indicates whether due process requires the DDS to offer patients the free choice to receive aid-in-dying services in either an institution or community based setting.[156]

First, this analysis entails evaluating the nature of the private interest abridged by the DDS emergency regulations.[157] The DDS emergency regulations force patients to physically transfer to community based care, unless such care is unavailable in their community and the Director of DDS grants approval.[158] Thus, the private interest abridged is an agency interest in freely choosing the setting in which to receive aid-in-dying services.[159] If community based care is considered an accommodation, the ELOA and ADA together grant patients an interest in freely choosing their aid-in-dying care setting, but the DDS emergency regulations inhibit free choice.[160]

Second, the *Eldridge* test asks whether allowing residential patients to freely choose their aid-in-dying setting more adequately protects DDS patients' agency interest than the current emergency regulations.[161] Removing the appeals process from current DDS regulations alleviates a direct burden on the agency of DDS patients, thereby granting them free choice for their care setting.[162]

Third, the *Eldridge* test asks whether allowing residential patients to freely choose their aid-in-dying setting will unduly increase the financial and administrative burden on the government, relative to current procedure.[163] This burden is low because the DDS is already willing and able to administer aid-in-dying services upon a successful

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[154] *See supra* Sections II.B–C.

[155] *See supra* Sections I.D.3–E, III.A.

[156] *See* Mathews v. Eldridge, 424 U.S. 319, 335 (1976); *supra* Sections I.E, III.A.

[157] *See Eldridge*, 424 U.S. at 335; CAL. CODE REGS. tit. 17, § 51002 (2018).

[158] *See* tit. 17, § 51002.

[159] *See* 28 C.F.R. § 35.130(d)-(e)(1) (2017).

[160] *See* Olmstead v. L.C. *ex rel.* Zimring, 527 U.S. 581, 602 (1999); 28 C.F.R. § 35.130(d)-(e)(1); *supra* Section II.A.

[161] *See Eldridge*, 424 U.S. at 335.

[162] *See* tit. 17, § 51002; *supra* Section II.A.

[163] *Eldridge*, 424 U.S. at 335.

appeal.[164] The ELOA merely requires that attending physicians keep records, counsel patients, and write aid-in-dying drug prescriptions.[165] Therefore, the only way the proposed amendment increases financial and administrative burdens on the government is by a few extra hours of wages to physicians who already provide other medical services to DDS residential patients.[166]

Therefore, under this test, the DDS is required to remove the current appeals process for residential patients seeking aid-in-dying services.[167] Patients have a substantial agency interest in maintaining their autonomy under the ADA, as described in *Olmstead*.[168] Current procedure does not further this interest, whereas the removal of the appeals process would immediately restore DDS patients' freedom of choice in treatment setting.[169] Removing the appeals process would result in minimal additional salary costs to the California government. Even if the State pays for the entire process, aid-in-dying drugs can be acquired for as low as $450 to $500.[170] The ELOA, in most cases, should require no more than ten extra hours of record keeping and counseling by attending physicians.[171] At an estimated rate of $2,000 per patient, the cost of providing approximately 900 DDS residential patients with aid-in-dying services, were they all to be ELOA-eligible, would likely not exceed $1.8 million.[172] This amount is a small fraction of the entire DDS budget, which exceeds $7 billion, and represents a highly unlikely scenario.[173] Thus, the deprivation of DDS

[164] *See* tit. 17, § 51002.

[165] CAL. HEALTH & SAFETY CODE § 443.6 (2018).

[166] Any terminally ill patients who are eligible for aid-in-dying care, but do not choose to seek aid-in-dying care, are still eligible for other forms of medical care so long as they are enrolled in a DDS residential center. *See supra* Section I.A.

[167] *See Eldridge*, 424 U.S. at 335; tit. 17, § 51002.

[168] *See* Olmstead v. L.C. *ex rel.* Zimring, 527 U.S. 581, 601-02 (1999) (affirming a patient's right under the ADA to accept or decline a particular accommodation); 28 C.F.R. § 35.130(d) (2017); *supra* Section II.A (describing a patient's agency interest under *Olmstead*).

[169] *See* tit. 17, § 51002; *supra* Section II.A.

[170] *FAQs*, DEATH WITH DIGNITY, https://www.deathwithdignity.org/faqs (last visited Jan. 21, 2018).

[171] *See* CAL. HEALTH & SAFETY CODE §§ 443.6-.7 (2018) (requiring, at most, one consultation with a physician to confirm the terminal prognosis and prescribe the drug, one consultation with a mental health specialist to ensure voluntariness, review of the patient's medical records, and completion of a small amount of paperwork).

[172] *See* INITIAL STATEMENT OF REASONS — SUBJECT OF PROPOSED REGULATIONS: END OF LIFE OPTION ACT, *supra* note 27, at 1 (approximating the number of residential patients at 900).

[173] *See* DEP'T OF DEVELOPMENTAL SERVS., GOVERNOR'S BUDGET HIGHLIGHTS (2018),

patients' agency interests outweighs the minimal cost to the California government of removing the appeals process required for access to institutional aid-in-dying care.[174]

Furthermore, the Court's reasoning in *Olmstead* shows that relinquishing custody of patients seeking aid-in-dying services is not based on a legitimate state interest.[175] Courts must balance the cost of providing the community based services, against the burden that providing such services places on the State's administration of other services, to decide whether the ADA requires the State to offer community based services.[176] The *Olmstead* Court found that providing community based care was required because the cost of doing so, albeit substantial, would not significantly detract from the State's other services.[177] If this same reasoning were applied to a DDS residential patient's request to receive institution, rather than community based services, a court would likely find that providing aid-in-dying services without the current appeals process would not detract from the DDS's other services provided to patients.[178] This reasoning further detracts from the legitimacy of the current appeals process required by the DDS.

C. *Second Satisfaction of the* Eldridge *Test*

Due process may also require the DDS to provide a staff member to maintain the safety and general well-being of involuntary DDS patients who transfer to private community based care for aid-in-dying services.[179] As explained in *DeShaney*, involuntarily detained individuals have a private interest in the custodial state ensuring their personal safety, which is abridged by DDS inaction after transfer.[180] The DDS emergency regulations potentially leave patients with disabilities open to harm from private, community based aid-in-dying services providers.[181] *DeShaney* explains that each involuntary patient

http://www.dds.ca.gov/Budget/Docs/2018_2019DDSBudgetHighlights.pdf.

174 *See* Mathews v. Eldridge, 424 U.S. 319, 335 (1976); *supra* Section II.A.

175 *See* Olmstead v. L.C. *ex rel.* Zimring, 527 U.S. 581, 597 (1999).

176 *See id.* ("[T]he District Court must consider, *in view of the resources available to the State*, not only *the cost of providing community-based care* to the litigants, but *also the range of services the State provides others with mental disabilities*, and the *State's obligation to mete out those services equitably*." (emphasis added)).

177 *See id.* at 605-07.

178 This was analyzed earlier in this section, Section III.B, as well as in Section II.A.

179 *See Eldridge*, 424 U.S. at 335.

180 DeShaney v. Winnebago Cty. Dep't of Soc. Servs., 489 U.S. 189, 199 (1989).

181 *Cf. supra* Section II.B (arguing that DDS has an affirmative responsibility to

has a constitutionally guaranteed right to at least some procedures which mitigate that risk of harm to them.[182] The Fourteenth Amendment would not likely require overly extensive process, so long as the State takes some affirmative action to prevent patients from transferring to potentially harmful private care settings.[183] As further elaborated below, this procedure could be executed by a DDS staff member that evaluates acceptable private aid-in-dying services providers in the vicinity of each DDS residential treatment center. The DDS already advocates for coordination with private community based services providers. For example, the DDS's "Task Force on the Future of the Developmental Centers," recommends a public and private partnership in the face of declining DDS developmental centers.[184]

This procedural individual interest is likely stronger than the agency interest discussed in Section III.B because it derives from a constitutional amendment, rather than from Federal and California State legislation.[185] If the procedural interest in mitigating risks during the aid-in-dying process is stronger than the agency interest in free choice of care setting, then the government should be required to bear a relatively higher financial and administrative burden to protect the procedural interest.[186] This relative strength justifies requiring higher burdens on the DDS than those required by the procedure in Section III.B.[187] Hiring additional employees, or creating new job roles,

ensure the safety of patients placed with community based aid-in-dying providers).

[182] *See DeShaney*, 489 U.S. at 199-200; *supra* Section II.B.

[183] *Cf. DeShaney*, 489 U.S. at 199-200. "[W]hen the State by the affirmative exercise of its power so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs — *e.g.*, food, clothing, shelter, medical care, and reasonable safety — it transgresses the substantive limits on state action set by the Eighth Amendment and the Due Process Clause." *Id.* at 200 (citations omitted). This suggests that the State's duty to act is limited to protecting the basic human needs of individuals, insofar as the State's limit on the individual's liberty detracts from those needs.

[184] CAL. DEP'T OF DEVELOPMENTAL SERVS., THE FUTURE OF STATE DEVELOPMENTAL CENTERS: 2015 MAY REVISION (2015), http://www.dds.ca.gov/budget/Docs/DCClosures-2015MayRevision.pdf (describing the "Task Force on the Future of the Developmental Centers" as comprised of various public and private actors).

[185] *See supra* Section III.B (proposing that the ELOA and ADA grant patients an interest in freely choosing their aid-in-dying setting). *Compare supra* Section II.A (discussing an individual's agency interest under the ADA), *with supra* Section II.B (discussing the State's duty of care under the Fourteenth Amendment to any person it voluntarily holds in custody).

[186] *See* Mathews v. Eldridge, 424 U.S. 319, 334-35 (1976).

[187] *See id.*; *supra* Section III.B (advocating for abolition of the appeal requirement for institution based aid-in-dying services based on the patient's agency interest as described in *Olmstead*).

represents a higher burden than requiring current DDS physicians to provide a novel type of medical service, but this burden is offset by the relative strength of the State interest in minimizing risk imposed by *DeShaney*.[188] Accordingly, the cost of creating a few additional administrative employee roles would likely not outweigh the State's duty of care.[189]

Under the second prong of *Eldridge*, States are required to change standard procedure if such change will more effectively ensure the safety and well-being of DDS patients, relative to the current DDS emergency procedure.[190] The current emergency regulations do not require any care or action on the part of the DDS once a patient is transferred to community based care.[191] In contrast, if the DDS were to appoint staff members to coordinate with private aid-in-dying service vendors, then involuntary DDS residential patients would more likely receive safe and ethical treatment.[192] Under the third prong of *Eldridge*, any new procedural requirements must be tempered by the financial and administrative burden that the procedure places on the California government.[193] Admittedly, the burden of providing a new type of staff member is higher than requiring current physician employees to offer an additional type of medical service.[194] However, the responsibilities of this new staff position could be minimized to decrease the burden of the new procedure. Most importantly, the job would be limited to conducting inspections and keeping records to ensure that any program offering aid-in-dying services to involuntary DDS residential patients will not coerce or fail to diagnose the potential involuntariness of patients.[195] Individually assigned case

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188 *Compare supra* Section III.B (weighing additional costs of eliminating the appeals process), *with supra* Section III.C (explaining the State's interest in guaranteeing the safety of involuntarily detained patients).

189 *See* DeShaney v. Winnebago Cty. Dep't of Soc. Servs., 489 U.S. 189, 199 (1989) (explaining that the State has a duty to involuntarily detained patients to mitigate any risk of harm).

190 *See Eldridge*, 424 U.S. at 335 (explaining that "identification of the specific dictates of due process generally requires consideration of . . . the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards"); *supra* Section III.B (applying the second prong of the *Eldridge* test to ask whether allowing residential patients to freely choose their aid-in-dying setting more adequately protects their agency interest than current procedure).

191 *See* CAL. CODE REGS. tit. 17, §§ 51000-51002 (2018).

192 *See supra* Sections II.B–C, III.A.

193 *See Eldridge*, 424 U.S. at 335.

194 *See supra* Sections III.A–B.

195 *See supra* Section II.C (discussing potential coercion and failure to diagnosis

managers are likely too high a financial and administrative burden on the government, but hiring staff to compile and vindicate a list of approved aid-in-dying services vendors would likely only require one additional staff member per DDS facility. If a single employee is in charge of all aid-in-dying referrals to private care from a single DDS residential center, this solution will have the added benefit of providing the same procedural protections to voluntary, as well as involuntary, residential patients.

Therefore, although hiring a new type of staff is burdensome, the minimal cost of approximately four additional employees (one per each DDS residential center currently in operation) is likely outweighed by the state duty of care toward involuntary DDS patients.[196] The DDS does not currently take any positive actions to ensure the safety and well-being of its patients once they are in private community based care, which represents constitutionally suspect procedure.[197] The DDS is not limited to solving the problem by hiring new employees. The agency could potentially allocate these new responsibilities to current administrative employees, or the California government could establish a licensing and review board for all private aid-in-dying service providers independent of the DDS. At least some form of additional procedure as proposed in this Note is legally required to ensure that California maintains its duty of care as prescribed in *DeShaney*.[198]

Hiring staff members to monitor the aid-in-dying process for DDS patients is meant to directly address the coercion and agency problems described above.[199] The DDS should task its new staff members foremost with ensuring that all private aid-in-dying services available to DDS patients are carried out by service providers who have no opportunity or incentive to coerce DDS patients into death.[200] The second most important responsibility of the staff members would be to ensure only aid-in-dying service providers with a highly qualified

patient involuntariness as real risks in the right-to-die context).

[196] *See Eldridge*, 424 U.S. at 335; *Developmental Centers Home Page*, *supra* note 17; *supra* Sections II.B, III.A.

[197] *See* CAL. CODE REGS. tit. 17, §§ 51000-51002 (2018).

[198] *See* DeShaney v. Winnebago Cty. Dep't of Soc. Servs., 489 U.S. 189, 199-200 (1989) (holding that the State must provide involuntarily detained mental patients with services that meet their basic needs); *Eldridge*, 424 U.S. at 335; *supra* Sections II.B, III.A.

[199] *See supra* Section II.C.

[200] *See supra* Section II.C.1.

medical staff, willing and able to assess the voluntariness of the patient's decision, are available.[201]

IV. COUNTER-ARGUMENTS

A. *Lack of Undue Burden*

The Supreme Court often characterizes state regulation that places an undue burden on an individual's exercise of their legal or constitutional rights as a violation of due process.[202] In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the determinative question was whether a given regulation on abortion procedures "has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus."[203] One could argue that the current DDS emergency regulations do not place such an undue burden on individuals with disabilities seeking to exercise their ELOA rights, and therefore due process does not require the emergency procedure to be changed.[204] Proponents of this argument would hold that forcing DDS patients to relocate to private community based care for aid-in-dying services does not constitute a substantial obstacle in the way of physician-assisted suicide.[205]

The emergency regulations burden a legal, rather than a constitutional right.[206] Even if there is no undue burden presented by the emergency regulations, the State arguably has no legitimate interest in forcing patients into private care, rather than administering aid-in-dying services in public institutions.[207] In *Casey*, Pennsylvania was allowed to impose some burdens, so long as not undue, because of the compelling state interest in protecting the potential lives of unborn children.[208] If the California government passed the ELOA and is

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201 *See supra* Section II.C.2.

202 *See* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 876-77 (1992) (holding that a State's imposition of a substantial obstacle in the path of a woman seeking an abortion is an undue burden and therefore unconstitutional).

203 *See id.* at 877.

204 *See id.*

205 *See id.*

206 The right to physician-assisted suicide in California is derived from the End of Life Option Act, rather than the United States Constitution. *See* CAL. HEALTH & SAFETY CODE §§ 443-443.22 (2018).

207 *See supra* Section III.B (arguing that the Court's reasoning in *Olmstead* shows that relinquishing custody of patients seeking aid-in-dying services is not based on a legitimate state interest).

208 Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 875-76 (1992).

willing to allow public institution based aid-in-dying services where there is no private alternative, then California seems to assign a low priority to preserving human life in the case of ELOA patients.[209] In the absence of any other strong state interest, there is no justification for the appeals process other than fiscal efficiency and limiting state liability, which are not compelling interests.[210] Therefore, any burden on a DDS patient's free choice of where to receive aid-in-dying services would seem to be undue.

B. Equal Opportunity Objections

The Equal Protection Clause of the U.S. Constitution states that no government action can enforce unequal treatment of different individuals under the same law.[211] This Note proposes that the DDS actively screen potentially abusive private programs from providing aid-in-dying services to involuntary DDS patients.[212] Opponents may argue that this procedure will make it significantly more difficult for DDS patients to exercise their legal rights under the ELOA, as opposed to other individuals without disabilities or voluntary DDS residential patients.[213] This argument is supported by anti-discrimination legislation for individuals with disabilities.[214] Under this argument, the regulations proposed in this Note are impermissible violations of the Equal Protection Clause of the Fourteenth Amendment.[215]

[209] *See supra* Section III.B (describing the appeals process required under the ELOA to receive aid-in-dying care in a public institution). The State's justification for such a procedure cannot rest on the preservation of human life, as the end result under either private or public aid-in-dying care is death.

[210] *See supra* Section III.B (arguing that California's current procedure that obligates DDS aid-in-dying patients to seek services in community based settings is not based on a legitimate state interest).

[211] *See* U.S. CONST. amend. XIV, § 1.

[212] *See supra* Sections II.B–C, III.A, III.C.

[213] *See* U.S. CONST. amend. XIV, § 1; *supra* Section III.C (arguing that the individual procedural interest derived from the Constitution requires the government to bear a higher financial and administrative burden to ensure its protection). The proponent of this argument would claim that since DDS patients could be barred from patronizing certain private aid-in-dying services providers, the State would be effectively constraining patients' autonomy as medical consumers.

[214] *See, e.g.*, 28 C.F.R. § 35.130(a) (1998) (providing that a public entity may not exclude an individual with a disability from the benefits of its services, programs, or activities).

[215] *See* U.S. CONST. amend. XIV, § 1; *cf. supra* Section III.C (proposing DDS hire staff members to ensure that community based programs will not coerce or fail to diagnose the potential involuntariness of patients).

Although this argument has prima facie weight, it ignores the fact that the DDS screening process is but one element of the procedures proposed in this Note.[216] Were the DDS to require patients to seek private aid-in-dying care *and* constrain patients' choice of the local private care facilities, then this regulation would indeed limit individual agency more than the current DDS emergency regulations.[217] However, this Note also proposes that DDS patients be allowed to receive aid-in-dying services from state-employed physicians in DDS residential centers.[218] When considered as a whole, the procedures proposed in this Note have the combined effect of expanding the array of safe settings in which a DDS patient may seek aid-in-dying services, not constraining it.[219]

C. Contrary Characterizations of the Private Aid-in-Dying Services Sector

Opponents of the procedures proposed in this Note could argue that Section II.C mischaracterizes the current state of the private aid-in-dying services sector as presenting significant risk to aid-in-dying patients with disabilities.[220] While the aid-in-dying medical field is young, six states have already legalized the practice in some form since 1994.[221] Many reputable institutions and scholars advocate for aid-in-dying services as safe and procedurally protective when executed according to the given authorizing state statute.[222] The state statutes

[216] *See supra* Sections III.A–B (proposing extending availability of aid-in-dying services to DDS patients within the state residential services).

[217] Compare this type of regulation, with those proposed *supra* Section III.A (arguing that under *Olmstead* and *Eldridge*, the DDS may not force residential patients to access end-of-life services in private facilities rather than while remaining in state care, and has a responsibility to monitor the provision of services to its patients who do transfer to private care). *See* CAL. CODE REGS. tit. 17, §§ 51000-51002 (2018) (setting forth emergency regulations which deny patients access to aid-in-dying services within state institutions).

[218] *See supra* Sections III.A–B.

[219] *See supra* Part III (proposing a robust procedure that the DDS should implement for residential patients who seek aid-in-dying services).

[220] *See supra* Section II.C (arguing that the risk of coercion and risk of incompetence are real dangers in the aid-in-dying context).

[221] *See State-by-State Guide to Physician-Assisted Suicide*, *supra* note 1.

[222] *See, e.g.*, Baron, *supra* note 3, at 28-29 (advocating for the legalization and regulation of physician-assisted suicide); *About Compassion & Choices*, COMPASSION & CHOICES, https://www.compassionandchoices.org/who-we-are (last visited Jan. 21, 2018) (advocating for physician-assisted suicide from the nation's oldest, largest, and most active non-profit for end-of-life care); Editorial, *Giving Patients Aid in Dying Is Compassionate Care*, L.A. TIMES (June 9, 2016, 5:00 AM), http://www.latimes.com/

that authorize aid-in-dying services contain numerous legal requirements designed to minimize any potential abuses of those services.[223] Therefore, the argument goes, the individual interest in procedure based on the State's duty of care under *DeShaney* should carry far less weight than assigned above, when considered as part of an *Eldridge* balancing test.[224]

Although this position is legitimate from a technical standpoint, it does not pay heed to the seriousness with which the decision to end a life must be handled. From abortion to aid-in-dying medical services, the Supreme Court has consistently recognized the need for caution when allowing human life, potential or otherwise, to be extinguished.[225] Common sense dictates that whenever a decision involves ending a human life, extensive steps to prevent erroneous outcomes are warranted.[226] Therefore, states should be required to err on the side of caution where they allow individuals held involuntarily in state custody to decide to end their lives.[227]

CONCLUSION

This Note argued that the current DDS emergency procedures are legally and constitutionally deficient because they are in tension with Supreme Court precedent.[228] There are risks inherently present and especially dangerous to individuals with disabilities in the nascent field of private, community based aid-in-dying services in

opinion/editorials/la-ed-right-to-die-20160608-snap-story.html (noting that Kaiser Permanente, Sutter Health, and UCLA cover the cost of the right-to-die medication).

[223] *See, e.g.*, CAL. HEALTH & SAFETY CODE §§ 443.1-.22 (2018); OR. REV. STAT. §§ 127.815, .820, .825, .830 (2018); VT. STAT. ANN. tit. 18, § 5283 (2018); WASH. REV. CODE §§ 70.245.020-.220 (2018).

[224] *Cf. supra* Section II.B (describing the State's duty of care to involuntarily detained individuals); Section III.C (considering the patient's procedural interest under the *Eldridge* balancing test).

[225] *See, e.g.*, Washington v. Glucksberg, 521 U.S. 702, 729 (1997) (affirming that in the aid-in-dying context, the State has a real interest in preserving the lives of those who can still contribute to society); Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 876-77 (1992) (affirming that the State has an important and legitimate interest in protecting potential human life).

[226] *Cf.* Dina Fine Maron, *Many Prisoners on Death Row Are Wrongfully Convicted*, SCI. AM. (Apr. 28, 2014), https://www.scientificamerican.com/article/many-prisoners-on-death-row-are-wrongfully-convicted (concluding that twice as many prison inmates were wrongly convicted and sentenced to death than have been exonerated and freed).

[227] *Cf. supra* Section II.C (arguing that the risk of coercion and risk of incompetence are real dangers in the aid-in-dying context).

[228] *See supra* Sections II.A–B.

California.[229] Therefore, the DDS should rescind the current emergency regulations in favor of a regulatory scheme that seeks to prevent any private care provider, representing those risks, from providing services to involuntary DDS patients.[230] Additionally, this new scheme should not resurrect the appeals process currently required in order to receive aid-in-dying services in DDS residential centers.[231] This appeals process runs contrary to the respect for agency espoused in *Olmstead* and advocated for in the disability rights movement.[232] As a whole, the procedural scheme proposed in this Note would have the effect of increasing the number of safe and humane settings in which individuals with disabilities, held in state custody, may seek to end their lives under the ELOA.[233]

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229 *See supra* Section II.C.

230 *See supra* Sections III.A, III.C.

231 *See supra* Sections III.A–B (arguing for a solution that complies with *Olmstead* and *DeShaney*, and suggesting that *Eldridge* requires removal of the current appeals process).

232 *See* Jerry Alan Winter, *The Development of the Disability Rights Movement as a Social Problem Solver*, 23 DISABILITY STUD. Q., no.1, Winter 2003, at 33, 37-38 (explaining the disability rights movement's goal to facilitate disabled people to "take control of their own lives"); *supra* Sections III.A–B (explaining how the current appeals process does not uphold the agency interest described in *Olmstead* and proposing a solution that complies).

233 *See supra* Part III (proposing a robust procedure that the DDS should implement for residential patients who seek aid-in-dying services).