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Dignity in Choice: A Terminally Ill Patient's Right to Choose

Cody Bauer

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DIGNITY IN CHOICE: A TERMINALLY ILL PATIENT'S RIGHT TO CHOOSE

Cody Bauer†

I. INTRODUCTION................................................................. 1025

II. MEDICAL AID IN Dying ..................................................... 1026
   A. An Overview ............................................................... 1026
   B. United States Supreme Court Holdings Regarding Medical Aid
      in Dying ..................................................................... 1029
   C. States That Permit Medical Aid in Dying ....................... 1029
      1. Oregon ..................................................................... 1029
      2. Washington............................................................. 1032
      3. Vermont..................................................................... 1034
      4. California................................................................... 1035
      5. Colorado.................................................................... 1036
      6. Hawaii....................................................................... 1037
      7. The District of Columbia............................................ 1038
      8. Montana..................................................................... 1039
   D. States That Prohibit Medical Aid in Dying ..................... 1040
   E. An Examination of Physicians’ Opinions ....................... 1041
   F. The American Push for Medical Aid in Dying ............... 1045

III. MEDICAL AID IN Dying IN MINNESOTA ......................... 1047
    A. Legislation in Minnesota ............................................. 1047
       1. Prior Legislation ..................................................... 1047
       2. Current Legislation .................................................. 1049
    B. The Minnesota Public’s Opinion ................................. 1049

IV. THE PRACTICE OF MEDICAL AID IN Dying
    INTERNATIONAL............................................................. 1050
    A. The Netherlands, Belgium, Luxembourg, Switzerland,
       Colombia, and Canada............................................... 1050

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I. INTRODUCTION

At just twenty-nine years of age, Brittany Maynard was diagnosed with terminal brain cancer and given a mere six months to live. The cancer caused Maynard to suffer from debilitating seizures, head and neck pain, and stroke-like symptoms. In November 2014, after exhausting all available medical options and treatments, Maynard decided to end her life by drinking a lethal mixture of water, sedatives, and respiratory-system depressants prescribed by her physician. Maynard stated, “I’m not killing myself. Cancer is killing me.” According to Maynard, she chose “to go in a way that is less suffering and less pain.” Maynard’s death reignited a decades-long national debate about the right of terminally ill patients to access medical aid in dying.

This Note focuses on five related areas. First, this Note provides an overview of medical aid in dying. Then, it discusses two landmark

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2. Death With Dignity Advocate Brittany Maynard Dies in Oregon, supra note 1.
3. Id. In an interview with NBC News, Maynard stated, “I’m not killing myself. Cancer is killing me.” Id.
4. Id.
5. Id.
7. See infra Part II.A.
Supreme Court cases on the topic. The Note next analyzes the practice in the eight United States jurisdictions where it is permitted, by both statute and common law, and advocates for the legalization of medical aid in dying in Minnesota. Next, the Note discusses the practice internationally. Finally, the Note examines two recent cases involving Final Exit Network, a controversial non-profit that provides guidance to patients with terminal illnesses on how to end their lives on their own terms.

II. MEDICAL AID IN DYING

A. An Overview

“Medical aid in dying,” also known as “death with dignity” and “physician-assisted death,” is a term that describes when “a physician facilitates a patient’s death by providing the necessary means and/or information to enable the patient to perform the life-ending act.” The term medical aid in dying, however, is somewhat of a misnomer, as a physician does not provide actual aid in the act. Instead, statutes permitting medical aid in dying require the patient, of sound mind and discretion, to administer the medication himself or herself. After passing a series of examinations and evaluations, the physician merely assists by prescribing lethal medication for the patient. For the purposes of this Note, medical aid in dying must be distinguished from the term “euthanasia.” Euthanasia describes the

8. See infra Part II.B.
9. See infra Part II.C.
10. See infra Part III.
11. See infra Part IV.
12. See infra Part V.
16. Id. at 491 (providing Oregon law as an example, which requires “that patients must be terminally ill and mentally sound, must be capable of administering the medication themselves, and two different doctors must approve”).
17. Id. at 472.
“act of deliberately causing the death of another person who may suffer from an incurable disease or condition, commonly performed with a lethal injection.” Thus, the primary distinction between medical aid in dying and euthanasia is in who “pulls the trigger.” With medical aid in dying, the patient is the individual who takes the prescribed lethal medication or takes an action intended to cause the patient’s death. Euthanasia, on the other hand, involves an individual other than the patient taking such action. Specifically, euthanasia involves a physician injecting a patient with a substance meant to painlessly bring on death. No jurisdictions in the United States have allowed the legalization of euthanasia, and cases involving euthanasia are prosecuted under general homicide laws.

A distinction between the two terms is further drawn around the patient’s mindset. For example, medical aid in dying allows a patient to end his or her life on his or her own terms, while euthanasia takes the power out of the patient’s hands. Yet, some opponents of both medical aid in dying and euthanasia fail to see a difference between the two acts and think that any steps taken to end another person’s life should be prosecuted under the jurisdiction’s appropriate homicide statute. This distinction is important to note because no states have or advocate for euthanasia, which effectively takes power out of the patients’ hands. Instead, medical aid in dying gives patients a choice and allows them to end life on their own terms.

Medical aid in dying presents a unique problem where a state’s political sovereignty collides with an individual citizen’s autonomy. The medical aid in dying debate often presents moral, legal, and

18. Id.
20. See Busscher, supra note 19, at 124.
21. Id.
22. Id. at 136–37.
23. Id. at 137; see also Council on Ethical & Judicial Affairs, Decisions Near the End of Life, 267 JAMA 2229, 2230 (1992).
ethical dilemmas because a patient’s choice to end his or her life conflicts with the state’s interest in preserving human life.\textsuperscript{26} Seven states currently allow medical aid in dying: Oregon, Washington, Vermont, California, Montana, Colorado,\textsuperscript{27} and most recently, Hawaii.\textsuperscript{28} The District of Columbia joined these states in 2017 with its Death with Dignity Act.\textsuperscript{29} Montana is the only state that permits medical aid in dying without having an actual statute legalizing it—instead, the state did so through common law.\textsuperscript{30} More states may legalize medical aid in dying in the coming years as evidenced by an increase in proposed legislation. In 2015, twenty-six state legislatures introduced bills to legalize medical aid in dying, with seventeen of those states taking up the issue for the first time.\textsuperscript{31} Minnesota was one of those states, and its proposed legislation will be discussed later in this Note.\textsuperscript{32} There are also two Supreme Court opinions on the issue.

\textsuperscript{26} Id. at 599–600.

\textsuperscript{27} Neelam Chhikara, Note, Extending the Practice of Physician-Assisted Suicide to Competent Minors, 55 FAM. CT. REV. 430, 431 (2017).


\textsuperscript{31} Chhikara, supra note 27, at 431. Legislatures that introduced legalizing medical aid in dying in 2015 include: Alaska, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Iowa, Kansas, Maine, Maryland, Massachusetts, Minnesota, Missouri, Montana, Nevada, New Hampshire, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Utah, Wisconsin, and Wyoming. Id. at 431 n.12 (citing Death with Dignity Around the U.S., supra note 30).

\textsuperscript{32} See infra Part III.A.
B. United States Supreme Court Holdings Regarding Medical Aid in Dying

In 1997, two landmark Supreme Court opinions regarding medical aid in dying came out of New York and Washington.33 These cases illustrate the Supreme Court’s interpretation of medical aid in dying and its evolution in the United States. The New York case was brought by a cohort of physicians.34 The Washington case was also brought by a group of physicians, patients, and a right-to-die nonprofit organization.35 The issue in both cases involved challenges under the Fourteenth Amendment, with the petitioners claiming their respective states’ bar on medical aid in dying violated their constitutionally guaranteed due process.36 Despite admittedly persuasive arguments, the Supreme Court held, in both cases, that state restrictions on medical aid in dying did not violate due process or an individual’s Fourteenth Amendment rights.37 While the Supreme Court was unwilling to permit medical aid in dying by common law ruling, it left room for individual states to craft and pass their own death with dignity legislation.38

C. States That Permit Medical Aid in Dying

1. Oregon

Oregon became the pioneer in the medical aid in dying pursuit when it authorized the practice, by ballot, in November 1994.39

34. Vacco, 521 U.S. at 793.
35. Washington, 521 U.S. at 702.
36. Vacco, 521 U.S. at 798 (acknowledging that aiding another individual to commit or attempt suicide is prohibited, but patients may refuse lifesaving medication); Washington, 521 U.S. at 706.
37. Vacco, 521 U.S. at 793 (“We hold that it [New York’s prohibition on assisting suicide] does not [violate the Fourteenth Amendment].”); Washington, 521 U.S. at 702 (“Washington’s prohibition against caus[ing] or aid[ing] a suicide does not violate the Due Process Clause.”) (internal quotations omitted).
38. See Washington, 521 U.S. at 735–36 (“Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society.”).
Oregon’s Death with Dignity Act passed narrowly, with 51% in support and 49% opposed.\textsuperscript{40} By 1997, the Act gained more support. That year, a measure to repeal the Act was rejected by voters, with 60% in support of the Act compared to 40% in opposition.\textsuperscript{41}

Under Oregon’s Act, a patient must meet four criteria to qualify: (1) be at least eighteen years of age; (2) have residency in the state of Oregon; (3) be “capable of making and communicating health care decisions for him/herself;” and (4) be “diagnosed with a terminal illness that will lead to death within [six] months.”\textsuperscript{42} A patient must then take seven steps to obtain a prescription from a participating physician, including: making multiple requests for the prescription (separated by at least fifteen days); consulting with multiple physicians; consulting with a psychologist to screen for mental health issues; and attending an informational session about alternatives to end-of-life care, including hospice and palliative care.\textsuperscript{43} Oregon’s Act also places an affirmative duty on physicians to report all prescriptions that they write for lethal medications to the Oregon Health Division.\textsuperscript{44}

In 1999, Dr. Arthur Chin and others conducted a case study on the impact of Oregon’s Death with Dignity Act in the first years of its application.\textsuperscript{45} The case study examined patients with similar terminal illnesses, dividing the group into cohorts consisting of patients who did not receive prescriptions for lethal medications and patients who did.\textsuperscript{46} The case study found that as of January 1, 1999, of the 23 patients who received medication prescribed under the Death with Dignity Act, 15 died after ingesting the medication, 6 died as a result of their terminal illness, and 2 were still living when the researchers conducted their study.\textsuperscript{47} The case study further examined the demographics of those who requested medical aid in

\footnotesize{eathwithdignityact/pages/faqs.aspx#whatis [https://perma.cc/7J89-4EAY] (last visited June 20, 2018).}

\textsuperscript{40} Id.

\textsuperscript{41} Id.

\textsuperscript{42} Id. The attending physician determines whether the criteria have been met, and that decision gets reviewed by another physician. Id.

\textsuperscript{43} Id.

\textsuperscript{44} Id.


\textsuperscript{46} Id. The cohort consisting of patients who received medication prescribed under the Death with Dignity Act was comprised of 23 individuals. Id. at 577.

\textsuperscript{47} Id.
dying compared with those who did not.\textsuperscript{48} Those who requested end-of-life medication did not have demographic factors of more “vulnerable” populations—factors like low education levels and lack of medical insurance.\textsuperscript{49} Instead, those requesting this medication had at least a high school diploma and had medical insurance, thus contradicting critics’ argument that medical aid in dying exploits vulnerable populations.\textsuperscript{50}

Significantly, the Chin study indicates “that the choice of [medical aid in dying] was not associated with level of education or health insurance coverage.”\textsuperscript{51} This refutes the argument that uneducated, uninsured patients have greater potential to be exploited by the Act.\textsuperscript{52} Instead, the Act allows patients diagnosed with a terminal illness to end their life on their own terms without prolonged suffering from the effects of their illnesses.\textsuperscript{53}

More recently, the Oregon Public Health Division reported that in 2016, 204 patients received medication under the state’s Death with Dignity Act.\textsuperscript{54} Of those 204 patients, 133 individuals ingested the medication and subsequently died.\textsuperscript{55} A 2017 report by the Oregon Health Authority revealed that 93.6% of the deaths occurring from the Oregon Act took place after approved patients

\textsuperscript{48}. Id.
\textsuperscript{49}. Id.
\textsuperscript{50}. Id. The authors indicate the cohort that received the medication did not statistically differ from the cohort that did not in terms of education level, race, sex, or urban or rural residence. Id. at 580. But, the authors acknowledge their sample size was relatively small and more research is needed. Id.
\textsuperscript{51}. Id. at 577.
\textsuperscript{52}. See George J. Annas, Legal Issues in Medicine: Death by Prescription, 331 NEW ENG. J. MED. 1240, 1240–43 (1994) (arguing that uninsured patients will be pressured to use medical aid in dying as a way to avoid costs of medical care).
\textsuperscript{53}. See Robert A. Lindsay, Oregon’s Experience: Evaluating the Record, 9 AM. J. BIOETHICS 19, 22 (2009) (arguing that palliative care has improved in Oregon since the implementation of the OWDA).
\textsuperscript{55}. Id. Further, 80.5% of the patients were aged 65 or older and 78.9% had some form of terminal cancer. See Rebecca Boyle, Assisted Suicide is Now Legal in Colorado, Thanks to Overwhelming Voter Support, POPULAR SCI. (Nov. 9, 2016), https://www.popsci.com/new-way-to-die-in-west [http://perma.cc/GA6W-5VRG] (stating that while patients who receive medication under the Medical Aid in Dying Act may never take it, having it allows those patients “the option of a quick escape”).
took an overdose of either prescribed secobarbital or pentobarbital. The three concerns most frequently mentioned by these patients were a loss of autonomy, a decreasing ability to participate in activities that once made life enjoyable, and a loss of dignity. The data reveals no information that would indicate the exploitation of vulnerable groups, such as the financial cost of continued medical treatment for terminal diseases. Instead, the data reveals that the true motivating factor in seeking this treatment is patients ending their lives on their own terms without prolonged suffering.

2. Washington

Washington, following in Oregon’s footsteps some fifteen years later, passed its own Death with Dignity Act in November 2008, with the law becoming effective in March 2009. Washington’s Act requires terminally ill adults to consult with at least two physicians and make both oral and written requests for medication (to be self-administered by the patient) at least fifteen days apart. This Act places no affirmative duty on physicians, pharmacies, or hospitals to participate in such requests. A physician or hospital with a moral

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56. PUB. HEALTH DIV., supra note 54, at 10 (finding that of those patients using the Act, 59.3% died by prescribed secobarbital and 34.3% died by pentobarbital); see also Boyle, supra note 55 (describing pentobarbital and secobarbital as drugs that depress central nervous system function that can be used as anti-convulsants or anesthetics, and at high doses, the two drugs cause death).

57. PUB. HEALTH DIV., supra note 54, at 10. Specifically, 89.5% of the patients were concerned with loss of autonomy, 89.5% were concerned with losing enjoyment in prior activities, and 65.4% were concerned with loss of dignity. Id.

58. See id.


60. WASH. REV. CODE. ANN. §§ 70.245.090, 70.245.110(1) (West, Westlaw through Ch. 3 of the 2018 Reg. Sess.). According to the Act, the patient must also have a prognosis of six months to live and be a resident of Washington. Id. §§ 70.245.010(13), 70.245.130. The Act defines residency as including, but not limited to, possession of a Washington driver’s license, registration to vote in Washington, or evidence that the qualified patient owns or leases property in Washington. Id.

or ethical aversion to prescribing lethal medication may decline to fulfill the patient’s request.\textsuperscript{62}

As of December 2011, 255 patients had utilized Washington’s Death with Dignity Act.\textsuperscript{63} Of those patients, approximately 78% had a form of terminal cancer.\textsuperscript{64} The number of patients receiving medication remained somewhat stable over the next 5 years, as indicated by Washington’s 2016 Death with Dignity Act Report, issued by the Washington Department of Health.\textsuperscript{65} The report revealed that lethal medication was dispensed to 248 patients in 2016.\textsuperscript{66} Of those patients, 192 died after ingesting the medication, 36 died without having ingested the medication, and the ingestion status of the remaining 12 prescriptions was unknown.\textsuperscript{67} If certain groups were truly being exploited by these laws, the data would show more patients from vulnerable groups requesting end-of-life medication. But that is not the case. Washington’s data—like Oregon’s data and Chin’s study—shows that patients requesting this medication are not who critics consider “vulnerable.”\textsuperscript{68} They are not uninsured, people of color, or those with mental illness or severe depression. Instead, the vast majority of these patients were white (97%), had terminal cancer (77%), and had some sort of health insurance coverage (92%).\textsuperscript{69} Washington’s data reveals that a patient ending his or her life is entirely the decision of that patient. The Act merely provides the patient with the option to do so in a dignified manner.

(last visited June 20, 2018) (calling participation “entirely voluntary,” and noting that “health care providers are not required to provide prescriptions or medications to qualified patients”).

\textsuperscript{62} See \textit{WASH. Death with Dignity Act: Frequently Asked Questions, supra note 61.}

\textsuperscript{63} See Elizabeth T. Loggers, \textit{Implementing a Death with Dignity Program at a Comprehensive Cancer Center}, 368 NEW. ENG. J. MED. 1417, 1418 (2013).

\textsuperscript{64} Id. Loggers found that 81% of patients in Oregon who received physician aid in dying also had a form of terminal cancer. \textit{Id.}


\textsuperscript{66} \textit{Id.}

\textsuperscript{67} \textit{Id.} Of the 192 who died from ingesting the prescribed medication, the youngest patient was 33 years old, and the oldest was 98 years. \textit{Id.}

\textsuperscript{68} \textit{Id.}

\textsuperscript{69} \textit{Id.} These patients primarily reported concerns to their care providers about loss of autonomy (87%), loss of the ability to participate in enjoyable activities (84%), and loss of dignity (66%). \textit{Id.} at 1–2.
3. Vermont

Vermont enacted its Patient Choice and Control at the End of Life Act, termed Act 39, into law on May 20, 2013. Vermont’s Act sets forth many of the same Oregon-style requirements, including consultations with multiple physicians, separate written requests, and protection from criminal liability for physicians engaging in the Act. The Act came under fire in 2016 when the Vermont Alliance for Ethical Healthcare initiated a lawsuit challenging the Act. Despite the Act only resulting in about 12 requests statewide per year, the plaintiffs claimed that physicians morally opposed to medical aid in dying were being forced to refer patients to other doctors. The plaintiffs claimed that this alleged obligation violated the free speech and equal protection rights of these doctors.
The United States District Court for the District of Vermont found for the defendants, stating that there were “no affirmative obligations under Act 39,” which meant that “plaintiffs’ Vermont members may not need the court’s protection.” Critics of the opinion believe that doctors who do not want to practice medical aid in dying “face a very real conflict in this situation.” Yet, the court’s interpretation of the Act made it clear that physicians are under no obligation or duty to engage in medical aid in dying.

4. California

California became the fourth state to permit medical aid in dying after passing its End of Life Option Act in October 2015. California’s Act went into effect in June 2016. It has many of the same requirements of the previously discussed state acts, including the approval of two physicians, a requirement that the patient have six months or less to live as the result of a terminal illness, and the patient’s affirmation of his or her choice in writing no more than forty-eight hours before ingesting the medication.

California’s Act had a profound impact for Elizabeth Wallner, a terminally ill fifty-two-year-old mother of two. When the Act passed, Wallner had “great peace of mind,” knowing that she would not have to die painfully from her terminal cancer, and her children and family would not have to watch her suffer her unwinnable battle with cancer. Wallner’s relief indicates a common concern for terminally ill patients—they do not want their loved ones to watch a disease

77. Id. at 234. The court’s opinion also stated that “Vermont members are not at risk, even when they care for a terminally ill patient otherwise eligible for assisted suicide and fail to inform their patient because the Act contains no duty to counsel or prescribe a lethal dose of medication.” Id.

78. Mansfield, supra note 74 (quoting an attorney for the plaintiffs in Vt. All. for Ethical Healthcare, Inc.).


80. CAL. HEALTH & SAFETY CODE § 443 (West 2016).


82. Chhikara, supra note 27, at 434.

83. Aliferis, supra note 81. Wallner has stage 4 colon cancer spreading throughout her body. Id. Wallner said California’s passing of the End of Life Option Act has given her “great comfort to know that the agonizingly traumatic image of me suffering will not be my family’s last memory of me.” Id.
consume them, and instead would rather choose to end their life when they feel comfortable.84

In 2017, the California Department of Health released its 2016 report on the use of the End of Life Option Act.85 The report indicated that during its first six months, 258 California residents requested medication under the Act.86 Of those patients, 191 received their requested prescriptions, which 59 chose not to ingest.87 The fact that 59 individuals chose not to use the medication shows that the Act does not force anyone to use the end-of-life medication. Instead, the Act gives the terminally ill the ability to pass away with personal control and peace of mind.88

5. Colorado

Colorado’s End of Life Options Act, termed Proposition 106, was passed on November 8, 2016, by a majority vote of 65%.89 Closely mirroring legislation in other states, Colorado’s Act requires a patient be eighteen years or older, communicate an informed

84. See id.
86. Id. at 3.
87. Id. The average age of the 111 patients who took the medication was 73, with ages ranging from 41 to 99 years old. Id. at 4. Most patients (96.4%) had some form of health insurance and most were receiving hospice or palliative care when they died (83.3%). Id. at 5. For 21 individuals, their illness overcame them prior to ingesting the lethal medication. Id. at 3.
89. See Colorado End of Life Options Act, Proposition 106 (2016), BALLotpEDIA (2016), https://ballotpedia.org/Colorado_End_of_Life_Options_Act_Proposition_106, [https://perma.cc/EK2E-MZHG] (last visited June 20, 2018); see also Boyle, supra note 55 (stating that this law will help people end their lives “with a measure of grace,” while allowing organizations who oppose this measure to opt out of participating).
decision to healthcare providers, have a terminal illness with six
months to live, be evaluated and deemed mentally competent by at
least two physicians, and voluntarily express his or her wishes to
receive the medication.90 The Act does not allow patients suffering
from dementia or Alzheimer’s disease to be eligible,91 emphasizing
the cognitive and independent decision-making requirement of the
act.92

Colorado has yet to publish a report detailing the first year of its
End of Life Options Act, but the first patient to utilize the law was
Kathy Myers on April 16, 2017, a patient who had been diagnosed
with terminal Chronic Obstructive Pulmonary Disease.93 Kathy’s
husband was very thankful for Colorado’s Act and the doctors who
participated: “[t]he doctors stepped out of their comfort zone, and
I thank them very much.”94 Kathy’s experience illustrates that
medical aid in dying practices give comfort and peace of mind to not
only the patient, but the patient’s family and loved ones as well.

6. Hawaii

Hawaii became the most recent state to pass death with dignity
legislation when its governor signed the Our Choice, Our Care Act
into law on April 5, 2018.95 The Act is modeled after Oregon’s Act,
and includes “strict eligibility criteria and safeguards that ensure a
safe, compassionate and patient-centered end-of-life practice.”96 The
safeguards require the patient to take the medication on his or her
own, the evaluation of two physicians, an information session about
all end-of-life care options, a confirmation of the patient’s mental
health by a mental health professional, two separate medication

90. See COLO. REV. STAT. ANN. §§ 25-48-101 to -123 (West, Westlaw through
91. Id. § 25-48-108.
92. See Boyle, supra note 55.
93. See Erin Powell, Colorado Woman Ends Her Life Under Physician-Assisted Suicide
94. Id. Kathy was on hospice care for the last eight months of her life. Id. A
week before her predicted date of death, Kathy drank a mixture of prescribed
medication while sitting in her hospital bed surrounded by family and medical staff.
Id. Kathy was dead within about two minutes of drinking the mixture, and according
to her husband, Kathy’s death was “very quick . . . very gentle.” Id.
requests made at least twenty days apart, and the observation of a written request by two witnesses.\(^\text{97}\) While the Act will not go into effect until January 1, 2019, Governor David Ige explained he was honored to sign the bill to allow terminally ill and mentally competent patients to "make their own end-of-life choices with dignity, grace and peace."\(^\text{98}\)

7. *The District of Columbia*

Washington D.C.'s Death with Dignity Act became effective in February 2017.\(^\text{99}\) The Act has many of the same requirements of other medical aid in dying laws in that a patient must be terminally ill with a prognosis of six months to live, reside in the District of Columbia, and be at least eighteen years old.\(^\text{100}\) Also, "the patient cannot be suffering from impaired judgment as a result of depression or a psychiatric or psychological condition and must be capable of making the decision, expressing an intent to take a medication that will cause death, and must be physically capable of taking the medication."\(^\text{101}\) Uniquely, the Act requires physicians to complete an "education module prior to registering and prescribing medication for an eligible patient."\(^\text{102}\) There are also patient and pharmacy education modules which provide information about medical aid in dying and the responsibilities of the respective parties.\(^\text{103}\)

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97. *Id.*

98. *Id.*


101. D.C. Death with Dignity Program: Frequently Asked Questions, supra note 100; see also D.C. CODE § 7-661.04(b).


8. Montana

Montana is currently the only state that permits medical aid in dying through common law ruling. In 2007, Robert Baxter—a patient diagnosed with terminal lymphocytic leukemia—and a group of physicians brought an action challenging the constitutionality of Montana’s homicide statutes as applied to physicians who provide aid in dying to terminally ill, mentally competent patients. The district court ruled in Baxter’s favor, holding that a patient may use the assistance of a physician to obtain a lethal dose of medication. The Montana Supreme Court affirmed the district court’s decision, reasoning that as long as a patient’s consent is properly given in making the request for life-ending medication, a physician cannot be prosecuted under Montana’s homicide statute.

The decision was not unanimous. Justice Rice dissented, stating Montana’s prohibition against homicide protects and preserves human life, which is the ultimate recognition of human dignity and a “foundation for modern society, as it has been for millennia past.” While Montana has yet to enact any policies allowing or prohibiting medical aid in dying, the Montana Supreme Court’s decision demonstrates that state courts are willing to allow doctors

104. Death with Dignity Around the U.S., supra note 30.
105. Complaint at 1–3, Baxter v. State, No. DV2007-787 (Mont. Dist. Oct. 17, 2007). Chemotherapy was becoming increasingly ineffective for Baxter, and he was suffering from debilitating symptoms including infections, chronic fatigue and weakness, anemia, nausea, massively swollen glands, significant digestive problems, and immense pain and discomfort. Id. at 4.
106. Baxter v. State, 224 P.3d 1211, 1214 (Mont. 2009). The district court also held that “the patient’s right to die with dignity includes protection of the patient’s physician from the prosecution under the State’s homicide statutes.” Id.
107. Id. at 1217 (“[A] physician who aids a terminally ill patient in dying is not directly involved in the final decision or the final act . . . [t]he patient’s subsequent private decision whether to take the medicine does not breach public peace or endanger others.”).
108. Id. at 1233 (Rice, J. dissenting). Justice Hegel, sitting in place of Chief Justice McGrath, also joined in the dissenting opinion of Justice Rice. Id. at 1240.
to provide medical aid in dying assuming certain criteria are met, even in light of their state’s homicide statute.\textsuperscript{110}

\section*{D. States That Prohibit Medical Aid in Dying}

The vast majority of states—altogether, 43 states—prohibit medical aid in dying.\textsuperscript{111} Lawmakers in 21 states rejected related bills in 2015, and 11 more states blocked similar bills in 2016.\textsuperscript{112} Yet, of the states prohibiting medical aid in dying, 30 of them were considering death with dignity or similar acts in the 2017 legislative session.\textsuperscript{113} Despite being largely rejected in the 2015–2016 legislative sessions, the fact that legislation continues to be proposed illustrates that states are considering some form of medical aid in dying. It is likely that more states will join the eight jurisdictions that already allow medical aid in dying in the near future.\textsuperscript{114}

Critics of medical aid in dying laws often argue that terminally ill patients who are poor, uneducated, uninsured, or fearful of the financial consequences of their illness will be exploited and unwillingly forced to participate in medical aid in dying.\textsuperscript{115} But studies like those done by Dr. Arthur Chin and reports from the Oregon Public Health Division indicate that these concerns are

\footnotesize{\textsuperscript{110} Baxter, 224 P.3d at 1214. Some of the criteria described by the Montana Supreme Court were that the patient had to suffer from a terminal illness and be able to give proper consent when requesting the life-ending medication. \textsuperscript{Id.} at 1215.}

\footnotesize{\textsuperscript{111} Death with Dignity Around the U.S., supra note 30. These states include Alaska, Alabama, Arizona, Arkansas, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming. \textsuperscript{Id.}}

\footnotesize{\textsuperscript{112} Frederick J. White III, Lessons from Recent Polls on Physician-Assisted Suicide, 17 NAT’L CATH. BIOETHICS Q. 247, 247–57 (2017).}

\footnotesize{\textsuperscript{113} \textsuperscript{Id.}}

\footnotesize{\textsuperscript{114} \textsuperscript{Id.} at 1215.}

\footnotesize{\textsuperscript{115} C.f. Toward the Tipping Point: Death with Dignity in 2018, DEATH WITH DIGNITY, https://www.deathwithdignity.org/news/2018/01/death-with-dignity-in-2018/ [https://perma.cc/95Q2-KBEK] (last visited June 20, 2018) (“Across the country, generations, and party lines, we see a profound shift in how our culture views assisted death. Where citizens like you lead, legislators will follow. State by state, day by day, we are approaching the tipping point.”).}

\footnotesize{\textsuperscript{115} S.W. Tolle, Care of the Dying: Clinical and Financial lessons from the Oregon Experience, 128 ANNALS INTERNAL MED. 566, 568 (1998) (“[P]hysician-assisted suicide remains essentially a coercive choice for persons without insurance coverage for hospice or comfort measures.”).}
misplaced.\textsuperscript{116} Other opponents argue if patients really do want to die, instead of participating in medical aid in dying, they could refuse treatment and die a “natural way” from their disease.\textsuperscript{117} But a patient’s choice to die “naturally” from his or her disease does not truly give a patient choice or control. The patient still has to deal with immense pain, loss of autonomy, and prolonged suffering.

E. An Examination of Physicians’ Opinions

As part of the death with dignity discussion, it is important to examine the opinions of physicians regarding medical aid in dying. After all, physicians are the individuals who give patients access to potentially life-ending medication. The nation’s largest physician group, the American Medical Association (AMA), has publicly opposed medical aid in dying acts.\textsuperscript{118} The AMA suggests that allowing medical aid in dying would fundamentally contradict the role of the physician as a healer and would pose additional societal risks.\textsuperscript{119} Dr. Daniel Mirda, an oncologist, argues that from a physician’s point of view, it is difficult to prescribe life-ending medication because so much effort is dedicated to helping patients cope with their illness.\textsuperscript{120} Dr. Mirda believes that prescribing such medication is equivalent to saying, “I don’t have a chance of helping you.”\textsuperscript{121} Another physician argues that legalizing medical aid in dying would send a negative
message to patients that their lives are no longer worth living and adversely affect the trust between physicians and patients.  

Other opponents of the medical aid in dying movement argue that the focus should not be on medical aid in dying, but on improving end-of-life care. Dr. Ira Byock, one of the leading opponents of the right-to-die movement, believes that the public is not talking about improving quality of life for terminally ill patients, and “instead of fixing the problem, we’re simply legalizing assisted suicide.” Opponents argue that this mindset could lead to the over-prescription of life-ending medication. Similarly, the Internal Association for Hospice and Palliative Care stated that no country or state should even consider the legalization of medical aid in dying or euthanasia until universal access to palliative care and appropriate medications are available for every patient. Critics also rely on the “slippery slope” argument—that medical aid in dying would eventually allow patients suffering from mental disorders to receive life-ending measures. In support of this argument, Dr. Byock notes that in the Netherlands, where medical aid in dying is permitted, more than forty people have sought and received medical aid in dying for depression and other mental health conditions.

122. John R. Peteet, A Doctor’s View on Assisted Suicide, NewBoston Post (Nov. 11, 2015, 6:13 PM), http://newbostonpost.com/2015/11/11/a-doctors-view-on-assisted-suicide/ [https://perma.cc/E78G-Y89R] (stating that legalizing medical aid in dying will make patients “less likely to trust that their doctors will be there for them when they need them most,” and as a society we will no longer be able to “offer hope that suffering has dignity and can be made more bearable”).

123. Josh Sanburn, The Last Choice, TIME 48, 51 (Sept. 28, 2015) (“The palliative-care industry is four times bigger than it was in 2000.”).

124. Id. Dr. Byock also equates medical aid in dying to “approaching fire safety not by enforcing building codes and mandating safety education but by building diving boards to nowhere on the top floors.” See Bever, supra note 1 (citing a Catholic seminarian who calls a decision to use medical aid in dying “anything but brave” and insisting “suffering is not worthless, and our lives are not our own to take”).


126. Liliana De Lima et al., International Association for Hospice and Palliative Care Position Statement: Euthanasia and Physician-Assisted Suicide, 20 J. PALLIATIVE MED. 8, 12 (2017). The IAHPF describes “palliative care” as an approach to care that “improves the quality of life of patients and their families facing the problem associated with life-threatening illness . . . .” Id. at 10.


128. Id. Dr. Byock also believes that the medical aid in dying situation has since
Despite the AMA’s opposition, physicians who support medical aid in dying explain that assisting a terminally ill patient’s choice to die has evolved from an initially shocking concept into a practice centered around the patient’s right to choose. A 2014 survey of practicing physicians revealed that 54% of respondents believed medical aid in dying should be allowed. A similar survey of physicians in Colorado revealed that a majority of physicians (56%) supported medical aid in dying before the state’s law was passed. And, while palliative care may be beneficial for some patients, there are many shortcomings including a lack of funding, resources, and training of palliative care staff. Palliative care may also be ineffective and unhelpful for patients who have lost their will to live, their autonomy, or their dignity. The argument that physicians will become over-prescriptive is also without merit. The facts show that

“gone off the rails.” Sanburn, supra note 123, at 51.

129. Id. at 50 (quoting Dr. Tanya Spirtos: “Thirty years ago I would’ve said physicians never should’ve been involved in this,” but “we couldn’t just stand behind a blanket opposition statement we came up with in 1987.”).


132. See Theo A. Boer, Euthanasia, Ethics, and Theology: A Dutch Perspective, 6 J. LUCIAN BLAGA UNIV. SIBIU 197, 204 (2014) (explaining the myriad of problems in nursing homes include “shortage of staff, insufficient hygiene, lack of privacy, and a socially undertrained staff,” and make patients suffering a terminal illness apprehensive to utilize a nursing home for end-of-life care); Samuel H. Lipuma, Continuous Sedation Until Death as Physician-Assisted Suicide/Euthanasia: A Conceptual Analysis, 38 J. MED. & PHIL., 190 (2013) (stating palliative care often involves the patient being heavily sedated until death, which causes decreased functioning in the brain similar to those medications prescribed through medical aid in dying cases).

the overwhelming majority of physicians in Washington and Oregon do not prescribe life-ending medications on an annual basis.\textsuperscript{134} Indeed, less than 1\% of licensed physicians prescribed life-ending medications over the last year.\textsuperscript{135}

Dr. Peteet’s argument—that medical aid in dying will result in patients feeling like doctors have “given up” on them—is also misplaced.\textsuperscript{136} Even if medical aid in dying becomes legalized nationwide, patients will not be forced to participate or exercise their right to medical aid in dying.\textsuperscript{137} Instead, medical aid in dying would give terminally ill patients who meet specific criteria the choice to end their life on their own terms.\textsuperscript{138} The argument can also be made that medical aid in dying does not conflict with doctors’ oath to “do no harm,” but instead fulfills that duty.\textsuperscript{139} Forcing a patient to suffer from a terminal illness instead of prescribing the patient’s desired life-ending medication arguably causes more harm. For people like Brittany Maynard, mentioned in the introduction, there would have been significantly more harm—in the form of debilitating seizures and stroke-like symptoms.

Statistics also reveal that it is inaccurate to suggest that medical aid in dying takes advantage of patients with mental illness. To even request a prescription for lethal medicine, a patient must first be “capable” of making that request.\textsuperscript{140} In Oregon, for example, “capable” is defined as “the ability to make and communicate health care decisions to health care providers,” as determined by the patient’s attending physician or consulting psychiatrist or

\textsuperscript{134} Ezekiel J. Emanuel et al., \textit{Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe}, 316 J. AM. MED. ASS’N 79, 81 (2016); see also Loggers, \textit{supra} note 63, at 1420 (discussing Washington’s death with dignity law which institutes random audits of medical checklists and physician charts to ensure the law is being complied with. Loggers states her review has found Washington physicians in “100\% compliance with the completion of mandated forms and processes”).

\textsuperscript{135} Emanuel et al., \textit{supra} note 134.

\textsuperscript{136} See Peteet, \textit{supra} note 122.

\textsuperscript{137} Larson, \textit{supra} note 125, at 10–11 (advocating for common-sense legal safeguards to prevent abuses of palliative care).

\textsuperscript{138} Beaird, \textit{supra} note 133 (“The right to die is the inherent right of the patient . . . . If a patient in physical, mental or emotional turmoil wishes to end his or her suffering, they should have a safe, controlled and effective means of doing so.”).

\textsuperscript{139} Sanburn, \textit{supra} note 123, at 52.

\textsuperscript{140} \textit{E.g.}, OR. REV. STAT. ANN. § 127.805 (West 2017); see also Warraich, \textit{supra} note 119.
psychologist. This is in contrast to patients who may end their lives by withdrawing medical treatment “even if they have major depression or are suicidal.”

F. The American Push for Medical Aid in Dying

In a country where 22,134 deaths were attributed to pharmaceutical drugs in 2010—namely, opioids prescribed to treat severe illness—it is no wonder why the majority of the American public supports terminally ill patients having the choice to end their life on their own terms instead of relying on prescribed pharmaceuticals to manage their illness. While medical aid in dying is largely prohibited in the United States, recent surveys indicate this may not be the case for long. Gallup conducted a nationwide, seven-year long survey from 2008 to 2015 examining the public’s opinion of medical aid in dying. The survey revealed that in 2008, 68% of adult respondents supported a law permitting medical aid in dying. Support for a medical aid in dying law slightly wavered for a few years after, but ultimately increased to 70% in 2015.

Gallup’s study also revealed that the majority of respondents believe physicians should be allowed to assist a patient in ending his

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141. OR. REV. STAT. ANN. § 127.800(3).
142. See Warraich, supra note 119 (“Unlike assisted suicide, which requires patients to be screened for depression, patients can ask for treatment withdrawal even if they have major depression or are suicidal. Furthermore, withdrawal decisions are usually made for patients who are so sick that they frequently have no voice in the matter.”).
143. Christopher M. Jones & Karin A. Mack, Pharmaceutical Overdose Deaths, United States, 2010, 309 J. AM. MED. ASS’N 657, 658 (2013). The authors reviewed data consisting of death records and coroners’ reports from the National Center for Health Statistics. Id. at 657.
145. JEFF JONES & TED DAVISON, GALLUP POLL SOCIAL SERIES: VALUES AND BELIEFS 2 (2015), http://www.gallup.com/file/poll/183440/Doctor_Assisted_Suicide_150527%20%20%20%20%20.pdf [https://perma.cc/RRC8-PX39]. The question asked to survey participants was: “When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient’s life by some painless means if the patient and his or her family request it?” Id.
146. Id.
or her life if the patient requests it.\footnote{147} Another survey, conducted by Rutgers University, examined the opinions held by New Jersey residents regarding medical aid in dying.\footnote{148} The poll found that 63% of New Jerseyans surveyed supported medical aid in dying and the legislation proposed in the New Jersey Congress.\footnote{149}

A third survey, conducted on a nationwide basis by LifeWay Research, revealed that 67% of Americans surveyed believe it is morally acceptable for terminally ill patients to seek a physician’s help in ending their life.\footnote{149} The survey found differences in belief between cohorts of different religious faiths, but the majority of respondents still held the belief that medical aid in dying is morally acceptable.\footnote{151}

Recall the story of twenty-nine-year-old Brittany Maynard.\footnote{152} Maynard’s struggle with terminal cancer and her decision to utilize medical aid in dying has the potential to impact a younger, motivated generation.\footnote{153} This is concerning to opponents of medical aid in dying, as Maynard’s story speaks to a “new audience, and [the

\footnote{147} Id. at 3. The question asked to survey participants was, “When a person has a disease that cannot be cured and is living in severe pain, do you think doctors should or should not be allowed by law to assist the patient to commit suicide if the patient requests it?” In 2008, 62% of respondents answered this question with “should.” Id. Thereafter, support amongst respondents decreased for a few years, but ultimately increased to 68% in 2015. Id.


\footnote{149} Contrary to belief, respondents’ religious denomination did not have much of an effect on the results, as more than six in ten Catholics and Christians supported the measure. Id. The survey found a more noticeable divide among political affiliation, as just over half of conservative respondents opposed the bill and think thought ending life is morally wrong. Id. at 4. Also of note is that while 63% of respondents supported the bill, 89% felt that it is morally acceptable for a patient with a terminal illness to end his or her life. Id. at 2.


\footnote{151} Id.

\footnote{152} Bever, supra note 1.

opponents] know that the younger generation of America has shifted attitudes about gay marriage and the use of marijuana, and maybe they are going to have that same impact in pushing [medical aid in dying] forward.  

Surveys assessing American opinions about medical aid in dying indicate it may not remain prohibited for long. Those beliefs, coupled with the potential acceptance of medical aid in dying by younger generations, illustrate that patients may soon be afforded the opportunity to die with dignity, on their own terms.

III. MEDICAL AID IN DYING IN MINNESOTA

As previously discussed, Minnesota is one of the many states that does not allow medical aid in dying. But, this may not be the case much longer. Past and current legislation, as well as shifting opinions of the Minnesota public, suggest a possible change in Minnesota legislative policy in the future.

A. Legislation in Minnesota

1. Prior Legislation

The Minnesota legislature first considered a medical aid in dying bill during the 2015–2016 session. The bill, entitled Compassionate Care, was authored and sponsored by Senators Eaton, Pappas, Dibble, Marty, and Goodwin. In order to obtain a lethal prescription, the bill required the patient be a competent adult, a resident of Minnesota, have a terminal illness, and request medical aid in dying by submitting two written requests.

154. Id. Caplan also states that Maynard’s legacy “may change the politics” in the medical aid in dying debate. Id.


156. See S.F. 1880, 2015 Leg., 89th Sess. (Minn. 2015).

157. Id.

158. Id. (defining “adult” as a person over 18 years of age; “aid in dying” as the “medical practice of a physician prescribing medication to a qualified patient who is terminally ill, which medication on a qualified patient may self-administer to bring about the patient’s own death;” “competent” as the understanding that the patient has the “capability to understand and acknowledge the nature and consequences of health care decisions;” and “terminal illness” as “the final stage of an incurable and irreversible medical condition that an attending physician anticipates . . . will produce a patient’s death within six months”).

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154. Id. Caplan also states that Maynard’s legacy “may change the politics” in the medical aid in dying debate. Id.


156. See S.F. 1880, 2015 Leg., 89th Sess. (Minn. 2015).

157. Id.

158. Id. (defining “adult” as a person over 18 years of age; “aid in dying” as the “medical practice of a physician prescribing medication to a qualified patient who is terminally ill, which medication on a qualified patient may self-administer to bring about the patient’s own death;” “competent” as the understanding that the patient has the “capability to understand and acknowledge the nature and consequences of health care decisions;” and “terminal illness” as “the final stage of an incurable and irreversible medical condition that an attending physician anticipates . . . will produce a patient’s death within six months”).
must submit. Further, it described the physician’s and patient’s process for self-administering the prescribed medication, which the patient would be free to do whenever he or she wished.

In 2015, the bill received a discussion-only hearing, with no legislative action taken until early 2016. The bill was then heard in the Health, Human Services, and Housing Committee in the Senate, but was pulled by Senator Eaton before a vote could take place due to insufficient support.

The lack of support was likely a result of an absence of important safeguards, which was subsequently addressed in the 2017 bill. For example, Dr. Annette Hanson, a practicing physician in Minneapolis, believes the bill was insufficient for a number of reasons: (1) it did not carry a requirement for a prescribing physician to have any expertise, training, or experience in recognizing mental disorders in a patient; (2) it did not require a prescribing physician to assess a patient’s capacity for high-stakes medical decisions; and (3) it did not require a physician to evaluate a patient’s capacity to understand all plausible care options, which could lead to more vulnerable groups of people being targeted by the bill. The lack of procedural safeguards in this bill, while largely modeled after the Oregon and Washington Acts, likely resulted in its removal.

Dr. Hanson raises some seemingly valid concerns. But, as Professor Thaddeus Pope, Director of the Mitchell Hamline Health Law Institute, explains, there is no need for those concerns. Citing statistics from Oregon, Professor Pope explains that most of the thirty-two people who died under the Oregon Death with Dignity Act in 2016 were white, had a college degree, and were insured—not
groups likely to be advantage of.¹⁶⁷ According to Professor Pope, Oregon’s Act is “not being foisted on minorities or on the vulnerable.”¹⁶⁸

2. Current Legislation

Senators Eaton, Klein, Marty, Dibble, and Latz again introduced a medical aid in dying bill during Minnesota’s 90th Legislative Session.¹⁶⁹ The 2017 bill contains many of the same provisions and language as the 2015 bill, but adds a key requirement in subdivision 20.¹⁷⁰ Subdivision 20 requires physicians to report to the Commissioner of Health that they prescribed medication to a qualified patient.¹⁷¹ The bill was introduced and read in February of 2017, and was then referred to the Health and Human Services Finance and Policy Committee. Currently, the bill’s status is pending within the committee.¹⁷²

B. The Minnesota Public’s Opinion

The public’s opinion on whether medical aid in dying should be allowed in Minnesota is crucial to the success of any proposed legislation. Researchers at Greenberg Quinlan Rosner undertook a study in 2016 to gauge Minnesota’s public opinion regarding medical aid in dying.¹⁷³ The study surveyed 509 Minnesota residents who would likely participate in the 2016 general election from August 29, 2016, to September 1, 2016.¹⁷⁴ The survey results showed that 73% of respondents supported medical aid in dying.¹⁷⁵

¹⁶⁷. Id.
¹⁶⁸. Id. Professor Pope also stated, “Instead, it’s [the Death with Dignity Act] overwhelmingly used by educated, insured, white cancer patients.” Id.
¹⁷⁰. Id.; see also H.F. 1885, 2017 Leg., 90th Sess. (Minn. 2017).
¹⁷¹. Minn. S.F. 1572.
¹⁷². Id.
¹⁷⁴. Id. at 1 n.1. The survey was two questions, with the first question reading, in relevant part: “People would have to meet certain criteria, including being a Minnesota resident, having a terminal illness with less than six months to live, be age 18 or over, and be mentally capable. Do you support or oppose this legislation that would authorize medical aid in dying?” Id. at 1 fig.1.
¹⁷⁵. Id. at 1.
Surprisingly, the results did not significantly differ between respondents with different demographic factors including gender, age, or geographic location in Minnesota. The largest demographic difference between respondents was found in political party affiliation. For example, 87% of respondents who indicated affiliation with the Democratic party supported legislation authorizing medical aid in dying, while 76% of respondents who indicated affiliation with an independent party supported such legislation. By contrast, only 53% of respondents who indicated affiliation with the Republican party supported the legislation.

IV. THE PRACTICE OF MEDICAL AID IN DYING INTERNATIONALLY

A. The Netherlands, Belgium, Luxembourg, Switzerland, Colombia, and Canada

Internationally medical aid in dying can be legally practiced in the Netherlands, Belgium, Luxembourg, Switzerland, Colombia, and Canada. The Netherlands was the first country in the world to legalize both euthanasia and medical aid in dying. The Netherlands has six criteria a patient must meet to be considered a candidate for medical aid in dying:

1. The request is informed and voluntary;
2. The suffering experienced by the patient is unbearable;
3. There is no prospect of improvement in the patient’s medical condition;
4. There are no acceptable alternatives to the patient’s medical condition;
5. A second physician has been consulted; and

176. Id.
177. Id. at 2.
178. Id.
179. Id.
180. Id. Also worth noting is that 71% of Minnesota Catholics in this study supported medical aid in dying despite opposition from the Catholic Church and affiliated organizations, and 70% of respondents who have cared for a terminally ill individual supported legislation authorizing medical aid in dying. Id.
181. See Emanuel et al., supra note 134, at 81. Interestingly, Quebec permitted medical aid in dying two years before Canada permitted it nationally. Id. at 80.
182. Boer, supra note 132, at 197. Despite the Netherlands passing a law permitting medical aid in dying in 2002, the process took about twenty years, as the first legislation was introduced in the mid-1980s. Id.
The medication prescribed meets state-of-the-art medical standards.\textsuperscript{183}

Assuming all six criteria are met, the patient’s request then goes to one of five Regional Review Committees, composed of lawyers, doctors, and an ethicist.\textsuperscript{184} The process is then carried out by the patient’s primary care physician when the doctor and patient both agree that the patient is ready.\textsuperscript{185} These six criteria present a stringent standard for granting medical aid in dying. For example, in the Netherlands in 1995, over 34,000 patients requested medical aid in dying or euthanasia.\textsuperscript{186} Of those applicants, only 793 (about 2.3\%) were determined to meet all six criteria and granted the access to medical aid in dying.\textsuperscript{187} Interestingly, the number of medical aid in dying deaths in the Netherlands has decreased over the last twenty years, comprising only 1.8\% of all deaths in the Netherlands in 2013.\textsuperscript{188}

Opponents of medical aid in dying argue that this criteria is too lenient for a matter as serious and permanent as death, and the requests have a potential to be rubber stamped in the interest of efficiency.\textsuperscript{189} Yet a study by Dr. Marianne Snijdewind reveals

\begin{itemize}
  \item \textsuperscript{183} Id.
  \item \textsuperscript{184} Id. at 197–98. When the Regional Review Committee approves a patient’s request, the decision in final. Id. at 198. The Review Committee may still approve a request that does not meet all six criteria on a case-by-case basis. Id.
  \item \textsuperscript{185} Id. at 203–04. The patient may choose to carry out the process immediately after approval, or wait a period of time. See id. at 200.
  \item \textsuperscript{186} Paul J. van der Maas et al., Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995, 335 NEW ENGL. J. MED. 1699, 1701 (1996). The study revealed that 53\% of physicians in the Netherlands have, at some point in their medical career, performed euthanasia or provided medical aid in dying. Id.
  \item \textsuperscript{187} Id. The most common form of medical aid in dying was the prescription of opioids in large doses, which the patient would self-administer when ready and would cause death within minutes. Id.
  \item \textsuperscript{188} Nicole M. Steck et al., Euthanasia and Assisted Suicide in Selected European Countries and US States: Systematic Literature Review, 51 J. MED. CARE 938, 942 (2013). This literature review found medical aid in dying made up only 0.2\% of all deaths in the United States in 2012. Id. at 942.
  \item \textsuperscript{189} See Angela Chen, Assisted Suicide is Now Legal in Colorado, VERGE (Nov. 8, 2016, 10:53 PM), https://www.theverge.com/2016/11/8/13520908/assisted-suicide-colorado-death-dignity-right-die-election-2016 [https://perma.cc/F7W9-ZQSF] (“There are also concerns that legalizing assisted suicide would lead to a ‘slippery slope’ situation where people become too quick to use the option, or the guidelines for who can request assisted suicide become more and more lax.”).
\end{itemize}
otherwise. The study examined the 645 requests for medical aid in dying made by patients in the Netherlands in 2012 and found that only 162 (25.1%) of the requests were granted as meeting all of the requisite criteria. This study demonstrates that patients applying for medical aid in dying are not merely “rubber stamped” and given a prescription, but still have to meet the approval criteria and have their request granted by the Review Committee.

Belgium has many of the same requirements for patients seeking medical aid in dying, including submitting an oral and written request, consulting with at least two physicians, and passing a mental health/competency screening. Like the Netherlands, Belgium’s medical aid in dying rate makes up a very small majority of the total deaths, constituting 4.6% of total Belgian deaths in 2013.

Colombia permits active euthanasia as well as medical aid in dying. Adult patients suffering from a terminal illness who request aid in dying are assessed by a treating physician who determines if the patient is a candidate for euthanasia or aid in dying. The physician then examines the patient’s competency and ability to express his or her will to die, and then the request is sent to an Interdisciplinary Scientific Committee that reviews the case.


191. See Snijdewind et al., supra note 190, at 1635. The study also examined the type of illness that requesting patients suffered from. Id. at 1636. Patients with a somatic condition or with cognitive decline had the greatest approval rate, while patients with a psychological condition had the lowest approval rate. Id.


193. See Chambaere, supra note 192, at 1180 (revealing that palliative care had been involved in some extent in 73.7% of these cases).


196. Id. at 327.
Members of the Committee must be independent and have no personal or professional relationship with both the treating physician and the patient. As of 2016, only one case of euthanasia has been reported in Colombia. The case involved 79-year-old Ovidio Gonzáles, a man suffering from a rare terminal facial cancer that caused “intense chronic pain.”

Medical aid in dying in Switzerland is not clearly regulated, “and there are no specific laws that determine under what conditions a person can request assistance.” Rather, Switzerland allows medical aid in dying as long as there are no “self-seeking” motives involved. Assisted dying organizations such as Dignitas and Exit operate within Switzerland to provide assisted death services. In 2015, the Exit organization was involved in 782 cases—over half of medically aided deaths in Switzerland that year.

Similarly, the medical aid in dying law in Canada does not lay out certain criteria. Instead, physicians are permitted to assist in a patient’s suicide if the patient has given clear consent and faces enduring and intolerable suffering from “a grievous and irremediable medical condition.” Canada’s federal government has provided a “consistent framework across Canada” for medical aid in dying, but largely leaves specific policies related to the implementation and reporting to the individual provinces. Health Canada, the country’s federal health agency, reported that from June 17, 2016 to June 30, 2017, there were 1,382 medically assisted deaths in participating jurisdictions.

197. Id.
198. Mariana Parreiras Reis de Castro et al., Euthanasia and Assisted Suicide in Western Countries: A Systematic Review, 24 REVISTA BIOÉTICA 355, 357 (2016).
199. Id. at 358.
200. Id. at 360.
201. Id. at 360.
205. Id.
206. Id. at 6.
207. Id. at 6.
B. International Attitudes on Medical Aid in Dying

In order to determine whether support for medical aid in dying is strictly confined to only a few countries, it is worth briefly examining the attitudes of citizens in countries that prohibit medical aid in dying. In New Zealand, a country currently prohibiting medical aid in dying, 81% of citizens reported that they believe aid in dying should be legalized in their country.\textsuperscript{208} In Germany, a survey found that two-thirds of respondents would support a law that would enable active medical aid in dying for terminal patients.\textsuperscript{209} In response, the German government announced plans to tighten its stance on medical aid in dying and banned certain right-to-die organizations from operating in Germany.\textsuperscript{210} In Australia, a survey of varying religious faiths indicated a wide range of support for the legalization of medical aid in dying laws,\textsuperscript{211} and polls suggest that 70-75% of Australians support some form of medical aid in dying legislation.\textsuperscript{212}

With several countries beginning to permit medical aid in dying, it remains to be seen whether this change is a global trend or not. Ruth Horn of Oxford University explains, "there are definitively cultural specific factors that influence the practices and the debates on assisted suicide and euthanasia in a particular country."\textsuperscript{213} It is apparent that many American citizens are in favor of medical aid in dying, but it remains to be seen if, and when, the majority of American legislatures will pass this type of law.

\begin{itemize}
\item \textsuperscript{208} Nicola Rae et al., \textit{New Zealanders' Attitudes Toward Physician-Assisted Dying}, 18 J. PALLIATIVE MED. 259, 263 (2015). This study also revealed that 46% of respondents believed the presence of a mental illness should exclude a patient from being eligible for medical aid in dying. \textit{Id.}
\item \textsuperscript{209} \textit{Euthanasia and Assisted Suicide Laws Around the World}, supra note 201.
\item \textsuperscript{210} \textit{Id.}
\item \textsuperscript{211} See Lara L. Manzione, \textit{Is There a Right to Die?: A Comparative Study of Three Societies (Australia, Netherlands, United States)}, 30 GA. J. INT'L & COMP. L. 443, 448, 448 n.17, 449 (2002).
\item \textsuperscript{213} Burki, \textit{supra} note 204, at 110. Ruth Horn also notes "[t]hese [cultural] differences explain why the debates emerge at different moments, why different arguments are used in each country, and how each country tries to address the problem." \textit{Id.}
\end{itemize}
V. **Final Exit Network**

A. **Description**

Related to the medical aid in dying issue is the work of an organization called Final Exit Network. Final Exit Network is a right-to-die organization that provides individuals experiencing incapacitating physical or mental illness with information on end-of-life care, counseling services, and methods to hasten death. After paying an annual $50 membership fee, a member wanting information about Final Exit Network’s services provides the organization with a personal statement and proof of a medical diagnosis. A case coordinator with Final Exit then contacts the member and conducts a telephone interview to assess the member’s mental capacity and competency. If the case coordinator considers the member to be an ideal candidate for Final Exit services, the coordinator schedules a lengthier evaluation with a first responder. The first responder instructs the member to read a book called *Final Exit*, outlining a method of death via helium asphyxiation, and obtains information about the member’s living situation and familial involvement in the process. Finally, the last step in approval is an examination from Final Exit’s medical director.

Once approved, a member has an exit guide assigned to him or her. The exit guide visits the member in person one month before

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216. Id. at 300.

217. Id.

218. Id. The first responder also obtains information regarding the member’s living situation and determines if the environment is safe for Final Exit to work in. Id.

219. Id. The medical director reviews the medical records provided to Final Exit and determines whether or not the individual has done everything possible to “make life bearable.” Id.

220. Id.; see also Episode Seventeen: Final Exit, CRIMINAL (Mar. 3, 2015), http://thisiscriminal.com/episode-17-final-exit-3-13-2015/ [https://perma.cc/3SBK-5N6W]. This episode featured an interview with Fran Schindler, an exit guide who became involved with Final Exit Network. Id. Fran outlines her experience with the organization and recounts an exit she participated in in Florida. Id. Interestingly, Fran reveals that when she “loses [her]
the scheduled death.\textsuperscript{221} It is important to note that the exit guide does not “\textit{physically assist the member in acquiring the equipment}” for the act.\textsuperscript{222} Once the member has the equipment—a helium tank, hose attachment, and specially-designed hood—the exit guide returns and sits with the member until he or she is ready to begin the procedure.\textsuperscript{223} Again, it is important to note the exit guide does not put the hood on the member, turn on the helium tank, or touch the equipment before or during the procedure, but instead the member must be physically able to carry out this process in his or her own capacity.\textsuperscript{224} After the procedure is finished, the exit guide checks the member’s pulse to verify he or she is dead, removes the equipment from the member’s home, and exits the premises.\textsuperscript{225}

\textbf{B. Criminal Litigation in Minnesota and Georgia}

Final Exit Network has been involved in criminal litigation in both Minnesota and Georgia resulting from alleged claims of assisting in death where a terminally ill patient has chosen to end his or her life.\textsuperscript{226}

\begin{itemize}
\item independence,” she will take her life in a similar fashion as that of Final Exit Network. \textit{Id.} at 20:05.
\item Final Exit Network, Inc., 889 N.W.2d at 300. The exit guide informs the member on where to obtain the materials necessary for the suicide. \textit{Id.}
\item \textit{Id.} (emphasis added).
\item \textit{Id.; see also Episode Seventeen, supra note 220, at 6:25–6:40. The procedure is completed when the individual places the hood over his/her head, which renders the individual unconscious in 5–10 seconds. Death ultimately occurs in 15–20 minutes, when the individual’s brain and brain stem shut down. \textit{Id.}
\item Final Exit Network, Inc., 889 N.W.2d at 300; see also Episode Seventeen, supra note 220, at 12:15–16:00 (discussing how Schindler does not touch any of the equipment until after she determines the member is dead, and at that point, touches the equipment for the first time and disposes of it).
\item Final Exit Network, Inc., 889 N.W.2d at 299–300.
\item \textit{Id.} at 296; Final Exit Network, Inc. v. State, 722 S.E.2d 722 (Ga. 2012). While not discussed in this note, two Final Exit Network volunteers, a volunteer and a physician, were also indicted in Arizona resulting from the alleged assistance in a terminally ill patient’s death; a jury found the two Final Exit Network members not guilty on charges of manslaughter and was hung on their involvement in the patient’s death. See Adam D. Hansen, \textit{Arizona’s Slayer Statute: The Killer of Testator Intent}, 7 \textit{Ariz. Summit L. Rev.} 755, 777 (2014).
\end{itemize}
1. Minnesota

Final Exit Network’s litigation in Minnesota arose from its involvement in the death of D.D.\footnote{\textit{Final Exit Network, Inc.}, 889 N.W.2d at 300.} D.D. suffered from chronic pain from 1996 until her death in May 2007.\footnote{\textit{Id.; see also Docket, State v. Final Exit Network, Inc., No. 19HA-CR-12-1718 (Minn. Dist. Ct., May 16, 2012), \url{http://www.mncourts.gov/Access-Case-Records.aspx} (click “Minnesota District (Trial) Court Case Search”; then click “I Accept the Above Terms and Conditions” hyperlink; then follow “Criminal/Traffic/Petty Case Records” hyperlink; then enter “19HA-CR-12-1718” in the “Case Number” search box; then click search) (showing the disposition of the case at the trial court level as convictions for “Suicide-Aiding,” and “Interference With Dead Body-Concealing Evidence”).} D.D. became a member of Final Exit Network in January 2007, and applied for exit services from the Final Exit Network that same month.\footnote{\textit{Id.}} One month later, D.D. was interviewed by a Final Exit Network first responder and Final Exit Network’s medical director approved D.D. for exit services shortly thereafter.\footnote{\textit{Id.}} In May 2007, Final Exit Network’s medical director and an exit guide flew to Minneapolis and drove to D.D.’s home.\footnote{\textit{Id.}} Upon arrival of the two Final Exit Network representatives, D.D. already had the helium tank and hood in her home to use.\footnote{\textit{Id.}} When ready, D.D. turned the helium tank on, placed the hood over her head, and died.\footnote{\textit{Id.}} Per D.D.’s request, the Final Exit Network representatives removed the supplies and disposed of them in a dumpster in order to avoid any perceived negative stigma of D.D.’s decision.\footnote{\textit{Id.}} D.D.’s husband discovered D.D. on the couch, tucked underneath a blanket, and “peaceful looking” that evening.\footnote{\textit{Id.}} No criminal charges were brought at that time.\footnote{\textit{Id.}}

In an unrelated matter, the Georgia Bureau of Investigations (GBI) conducted an investigation into Final Exit Network and seized some of the organization’s materials, including those relating to D.D.’s death.\footnote{\textit{Id.}} The GBI then passed those materials along to the Minnesota Bureau of Criminal Apprehension, which opened an
investigation in early 2010.238 In 2012, a grand jury indicted Final Exit Network for violating a Minnesota statute prohibiting one from “intentionally advis[ing], encourag[ing], or assist[ing] another in taking the other’s own life.”239 After a six-day trial in May 2015, a jury found Final Exit Network guilty of assisting D.D. in taking her life.240

Final Exit Network appealed, claiming that Minnesota Statutes section 609.215, subdivision 1 was facially unconstitutional under the First Amendment, or, in the alternative, that it was unconstitutional under the First Amendment as applied to the facts of Final Exit Network’s case.241 The Minnesota Court of Appeals affirmed the district court’s decision, finding that the section 609.215 was not unconstitutional, and that “the government has a compelling interest in preserving human life and preventing suicide.”242

2. Georgia

The case in Georgia had a very different outcome. Final Exit Network and four individual staff members were indicted by a grand jury in 2010.243 The indictment accused the organization and its staff of violating section 16–5–5(b) of the Georgia Code, which stated that any person “who publicly advertises, offers, or holds himself or herself out as offering that he or she will intentionally and actively assist another person in the commission of suicide and commits any overt act to further that purpose is guilty of a felony.”244 Final Exit Network argued that the statute was unconstitutional on its face because it violated the free speech provisions in both the United States and Georgia constitutions.245

The Georgia Supreme Court sided with Final Exit Network, finding that the Georgia statute violated both the state and federal

238. Id.
239. Id.; see also MINN. STAT. § 609.215, subdiv. 1 (2016).
240. Final Exit Network, Inc., 889 N.W.2d at 302.
241. Id.
242. Id. at 303 (stating further that under section 609.15, assisting another required “targeted speech aimed at a specific individual.”); see also David Bailey, Minnesota Jury Convicts Final Exit Group of Assisting 2007 Suicide, REUTERS (May 14, 2015, 4:28 PM), http://www.reuters.com/article/us-usa-minnesota-finalexit-idUSKBNT2AI20150514 [https://perma.cc/SDT3-DE7V] (describing the circumstances surrounding the conviction).
244. Id. (quoting GA. CODE ANN. § 16–5–5(b) (West 2010)).
245. Id.
constitutions. In its reasoning, the court stated that “[i]t is undisputed that § 16–5–5(b) does not ban assistance in all suicides, conduct which by itself is legal in Georgia. Many assisted suicides are either not prohibited or are expressly exempted from the ambit of OCGA § 16–5–5(b)’s criminal sanctions.”

The court also found that the statute was not narrowly tailored enough to promote the state’s compelling interest in preventing aid in another’s death, indicating the statute’s unconstitutionality. This holding, and the statements by the Georgia Supreme Court, show that Final Exit Network’s activity, while controversial, is not illegal, and its conduct cannot be regulated by unconstitutional state provisions.

The court further reasoned that the statute was “underinclusive,” meaning it did not ban all types of assisted death or all types of offers to assist in the commission of death. Instead, the statute was intended to prevent “Dr. Kevorkianesque” assisters while leaving other, non-Kevorkian-type assisters free to do so without worry of criminal sanction.

C. Analysis of Minnesota and Georgia’s Holdings

In defining “assists,” the Minnesota Court of Appeals used a previous Minnesota case to explain that the term means

246. Id. at 725 (“Accordingly, we conclude OCGA § 16–5–5(b) restricts speech in violation of the free speech clauses of both the United States and Georgia Constitutions.”).

247. Id. at 724. To further support its holding that the statute was unconstitutionally restricting Final Exit Network’s activity, the Georgia Supreme Court also stated, “[n]or does § 16–5–5(b) render illegal all advertisements or offers to assist in a suicide. Individuals who offer to assist in the commission of a suicide in a less than ‘public’ manner are not covered, despite the fact that such communication might have the same consequences as a public offer.” Id.

248. Id.

249. Id. (quoting Brown v. Entm’t Merchs. Ass’n, 564 U.S. 786, 802 (2011)).

250. Dr. Kevorkian was a doctor in Michigan who assisted in the deaths of 130 terminally ill people in the 1990s before he was convicted of second-degree murder and sentenced to 10-to-25 years. Paige Bowers, Final Exit: Compassion or Assisted Suicide? TIME (Mar. 2, 2009), http://content.time.com/time/nation/article/0,8599,1882418,00.html [https://perma.cc/CJ85-9HUT]. Kevorkian was released for good behavior in 2007 after serving eight years. Id.


252. See State v. Melchert-Dinkel, 884 N.W.2d 13, 23 (Minn. 2014). Melchert-Dinkel posed as a young female nurse and gave advice and encouragement on internet message boards on how others should commit suicide. Id. at 16. He was
“proscrib[ing] speech or conduct that provides another person with
what is needed for the person to commit suicide,” or “enabl[ing] the
person to commit suicide.” In its opinion, the Minnesota Court of
Appeals concluded that “the statute burdened no more speech than
necessary to further the state’s compelling interest in preserving
D.D.’s life.” The court also acknowledged that Final Exit’s
communication with D.D., and the organization’s instruction on
how to go about acquiring the equipment and informing D.D. about
the helium-asphyxiation process, met the definition of “assisting,” as
laid out in *Melchert-Dinkel*.  

The Dakota County Attorney, James Backstrom, prosecuted
Final Exit Network in Minnesota. In prosecuting the organization,
Backstrom wanted to make clear that it was not an attack on the
right-to-die movement, but “an effort to bring justice to a
corporation and several of its officers and volunteers who [we] are
alleging advised, encouraged, or assisted [D.D.] in taking her life on
May 30, 2007 in violation of Minnesota law.” Importantly,
Backstrom stated a major factor in deciding to prosecute Final Exit
Network was Minnesota’s lack of a medical aid in dying law, unlike
Oregon. Until Minnesota enacts a law permitting medical aid in

convicted of two counts of aiding in suicide. The Minnesota Supreme Court found
that the statute he was convicted under—Minnesota Statutes section 609.215—
placed an unconstitutional restriction on free speech. *Id.* The court held that while
the part of the statute restricting assisted suicide survived strict scrutiny, the
“advising” and “encouraging” portions of the statute were not narrowly drawn
even to serve the State’s compelling interest in preserving human life, and thus
did not survive strict scrutiny. *Id.* at 23. In its reasoning, the court concluded,
“speech in support of suicide, however distasteful, is an expression of a viewpoint
on a matter of public concern,” and “is therefore entitled to special protection as
the highest rung of the hierarchy First Amendment values.” *Id.* at 24 (internal
quotations omitted).

2016).

254. *Id.* at 307.

255. *Id.* at 307–08.

256. *Right-to-Die Group Indicted by Minn. Grand Jury*, CBS MINN. (May 14, 2012,
7:27 PM), http://minnesota.cbslocal.com/2012/05/14/right-to-die-group-
indicted-by-minn-grand-jury/ [https://perma.cc/N3TD-J9HX].

257. *Id.*

258. *Id.* (“Until such time as the Minnesota Legislature enacts a law permitting
and defining when and how assisting in a suicide may lawfully occur, I believe that
it is my duty and responsibility to enforce our existing laws by bringing to justice
those responsible for advising, encouraging or assisting individuals in taking their
own lives prematurely and covering up the true nature of what has occurred by
dying, organizations like Final Exit Network and physicians associated with the organization will continue to run the risk of being prosecuted as a result of their actions.

A key distinction between Final Exit’s activity and individuals like Melchert-Dinkel is that Final Exit did not actively seek out people or patients. Patients—on their own accord—came to the organization and requested advice and Final Exit’s services. In D.D.’s case, the organization never solicited or initiated contact.259 The Minnesota Court of Appeals did not acknowledge this, but this is a key difference. An acknowledgment of this distinction with other, more straight-forward medical aid in dying cases may have resulted in a different ruling.

The Georgia court’s opinion opposes the Minnesota court’s reasoning, as Georgia found that its statute restricted free speech. Georgia’s holding has made it apparent that “even in states where a statute criminalizes ‘assisting’ a ‘suicide’, it ought not to be assumed that such a law reaches the conduct of a physician providing aid in dying.”260 Unlike Minnesota, Georgia’s statute was not narrowly tailored enough to meet a compelling state interest, illustrated by the court explaining, “[h]ad the State truly been interested in the preservation of human life . . . it could have imposed a ban on all assisted suicides with no restriction on protected speech whatsoever.”261

Supporters of Final Exit Network argue that the Final Exit Network “option could be one among many that Georgia physicians make available to their terminally ill patients. . . . [A]s with all medical practice, it could likely be governed by best practices as they emerge in the physician community.”262 Other supporters believe that a patient suffering from a terminal illness who decides to end his or her life is making a personal decision, and neither law enforcement nor the state should be involved in permitting or

259. Id.; see also Final Exit Network, Inc., 889 N.W.2d at 299.
260. See, e.g., Kathryn L. Tucker, Aid in Dying: An End of Life-Option Governed by Best Practices, 8 J. HEALTH & BIOMED. 9, 17 n.41 (2012) (explaining that absent a prohibition in aid of dying, Georgia physicians may use Final Exit Network or a similar organization to provide aid to terminally ill patients). Tucker goes on to state, “[a]s with all medical practice, it could likely be governed by best practices as they emerge in the physician community.” Id.
262. Tucker, supra note 260.
prohibiting that choice. While these arguments are intriguing, the state should be involved in crafting the medical aid in dying laws to ensure their safe and uniform practice across the nation. Not having any sort of safeguards, procedures, or checks and balances in place has the potential to lead to further problems down the road.

Critics of Final Exit Network believe that the organization, even if it does not encourage or provide aid in dying, provides “a similar level of assistance while encouraging someone to commit suicide,” and like an individual who provides such support, “could face criminal liability for encouraging and assisting the suicide.” Rita Marker, Executive Director of the Patients’ Rights Council and another critic of the Georgia court’s decision, called Georgia the “wild, wild West for those who are promoting doctor-assisted suicide,” and believed Georgia “open[ed] the floodgates for anyone who wants to do this sort of activity.”

These arguments, however, are without merit. There was no indication in either case that Final Exit Network encouraged the patient to commit the act. Instead, the organization provided information on how a patient could end his or her own life, on his or her own terms, in a painless manner. Importantly, the patient had the choice to die on his or her terms instead of dying from an incurable illness. Marker’s argument that this ruling “opens the floodgates” is drastically overstated. Marker portrays this decision as enabling people everywhere to start acting like Dr. Kevorkian. Final Exit Network is not a Kevorkian-type organization. The organization has procedural safeguards in place, including the screening and evaluation of patients by licensed physicians to ensure patients are a legitimate candidate.


265. Severson, supra note 263.


267. See Final Exit Network, Inc., 889 N.W.2d at 300–01.

268. See Bowers, supra note 250.

269. See FINAL EXIT NETWORK, supra note 214.
VI. CONCLUSION

Brittany Maynard deserved the opportunity to make the choice to live the remainder of her life in excruciating pain or to end her life on her own terms. Oregon’s Death with Dignity Act afforded Maynard that opportunity.\textsuperscript{270} Recall the story of Elizabeth Wallner, a mother diagnosed with a terminal illness, who found comfort and peace of mind in knowing that California permitted her to end her life when she felt comfortable.\textsuperscript{271} This ability to end one’s life is something that other competent, terminally ill patients across the United States should have.

Following the lead of Oregon, Washington, Vermont, California, Colorado, Hawaii, Montana, the District of Columbia, and several countries, the rest of the United States should consider Brittany Maynard’s plight and allow patients to make their own decisions regarding their terminal illnesses. A system of procedural checks, balances, and reviews helps to ensure that the process will not take advantage of vulnerable patients, and that physicians will not become like Dr. Kevorkian.\textsuperscript{272} It is encouraging that reports from state health departments indicate that physicians are not exploiting vulnerable patients.\textsuperscript{273} Like Maynard and Wallner, all competent, terminally ill patients should have the choice to control their life and to die on their own terms.

\textsuperscript{270} See supra Part I.
\textsuperscript{271} See supra Part II.C.4.
\textsuperscript{272} See Boer, supra note 132, at 197 (explaining that a second consulting physician must evaluate the patient before his or her request is approved); Warrach, supra note 119 (noting that patients must receive screening for depression before physicians can grant approval for medical aid in dying).
\textsuperscript{273} See, e.g., Chin et al., supra note 45, at 582; CAL. DEP’T PUB. HEALTH, supra note 83, at 6 (finding that, like Washington, the vast majority of patients in California who requested medical aid in dying were college-educated and had insurance coverage); CTR. FOR HEALTH STATISTICS, supra note 65, at 1 (reporting that 92% of Washington residents making requests for medical aid in dying were insured, 67% “had at least some college education,” and 77% were receiving hospice care before making their request).
Bauer: Dignity in Choice: A Terminally Ill Patient's Right to Choose