A "Good Death"Defined by Law: Comparing the Legality of Aid-In-Dying around the World

Kristina Ebbott

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A “GOOD DEATH” DEFINED BY LAW: COMPARING THE LEGALITY OF AID-IN-DYING AROUND THE WORLD

Kristina Ebbott†

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Aid-in-dying is a complex issue that incites heated global debate. This issue will become more substantial throughout the next fifty years as the elderly population increases because the elderly are more likely to face decisions regarding end-of-life care. Despite polarized views on this subject, four countries have enacted laws that provide specific regulatory systems that permit a person to seek aid-in-dying from a physician. An additional country permits aid-in-dying, not by statute, but by providing exemptions to prosecution in its penal code. These cases all provide examples of how changes in social acceptance and medical technology affect the way the law treats the concept of human dignity at the end of life. To learn from these examples, we must study them and analyze which regulatory structures work best and why.

Part I of this article introduces the reader to the various terms used in discussions regarding this topic. Part II gives the historical background of euthanasia practices around the world and the movements that have sought to legalize different forms of euthanasia. Part III examines the five countries that have legalized...
aid-in-dying and the different regulatory systems those countries have employed in an attempt to provide patients with choices while avoiding abuses. Finally, in Part IV, I provide an assessment of the changing cultural climate that has contributed to the legalization of aid-in-dying in certain countries and whether it is preferable to enact laws that explicitly permit certain forms of aid-in-dying. Part IV also sets forth the author’s perception of the most functional attributes of each law.

I. DEFINING THE TERMS: WHAT IS ALL THIS TALK ABOUT EUTHANASIA, PHYSICIAN-ASSISTED SUICIDE, AND AID-IN-DYING?

To understand the way that assisted-suicide laws function and how they are formed, it is imperative to distinguish the societal definitions of euthanasia and assisted suicide from the legal definitions of these actions. Webster’s Desk Dictionary defines “euthanasia” as a Greek word for “easy death” or “mercy killing.” “Mercy killing” has a more elaborate definition, which is “the act or practice of killing or permitting the death of hopelessly sick or injured persons or animals with as little pain as possible for reasons of mercy.”

The legal definition of “euthanasia” is “[t]he act or practice of killing or bringing about the death of a person who suffers from an incurable disease or condition, esp. a painful one, for reasons of mercy. . . . sometimes regarded by the law as second-degree murder, manslaughter, or criminally negligent homicide.” It seems that the common definition of “euthanasia” is more sympathetic than the legal definition, especially considering that the law sometimes permits a charge of murder or manslaughter to accompany the act. Black’s Law Dictionary also distinguishes between different forms of euthanasia. For instance, “active euthanasia” is defined as “euthanasia performed by a facilitator (usually a physician) who not only provides the means of death but

7. See infra Part III.
8. See infra Part IV.
10. Id. at 339.
11. BLACK’S LAW DICTIONARY 634 (9th ed. 1999).
12. Id.
13. Id.
also carries out the final death-causing act.” This was the type of euthanasia performed by Dr. Kevorkian when he injected some of his patients with lethal drugs.\(^\text{14}\)

It is also interesting to note the difference between the definitions of “nonvoluntary euthanasia” and “voluntary euthanasia.” “Nonvoluntary euthanasia” is “[e]uthanasia of an incompetent, and therefore nonconsenting, person,” whereas “voluntary euthanasia” is defined as euthanasia “performed with the terminally ill person’s consent.”\(^\text{16}\) Here, competence and consent are what distinguish nonvoluntary from voluntary forms of euthanasia. As will be discussed in Part III, this difference is reflected in Oregon’s Death with Dignity Act, in which measures are in place to ensure that a patient is both mentally competent to elect to request a prescription for lethal medication and that the choice she is making is voluntary in the sense that the patient is not coerced by others to choose death.\(^\text{17}\)

Finally, “passive euthanasia” is defined as “[t]he act of allowing a terminally ill person to die by either withholding or withdrawing life-sustaining support such as a respirator or feeding tube.”\(^\text{18}\) This type of euthanasia was the center of controversy in Quinlan and Schiavo, in which guardians sought to withdraw treatment.\(^\text{19}\)

\(^{14}\) Id.

\(^{15}\) See Kevorkian Case: Judge Agrees to Drop Assisted Suicide Charge, CNN.com (Dec. 31, 2007), http://edition.cnn.com/2007/US/law/12/17/court.archive.kevorkian3/index.html (reporting that “Youk [Kevorkian’s patient] initially thought he was going to inject himself with lethal doses of drugs by operating an apparatus. But unlike his previous cases, Kevorkian administered the fatal ‘death potion’ to Youk himself.”).

\(^{16}\) BLACK’S LAW DICTIONARY, supra note 11, at 634.

\(^{17}\) See The Oregon Death With Dignity Act, Or. Rev. Stat. Ann. § 127.820 (West 2003) (requiring that a consulting physician confirm in writing that “the patient is capable, is acting voluntarily and has made an informed decision”). “Capable” is defined as “in the opinion of a court or in the opinion of the patient’s attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient’s manner of communicating if those persons are available.” See id. § 127.800.

\(^{18}\) BLACK’S LAW DICTIONARY, supra note 11, at 634.

\(^{19}\) See In re Quinlan, 355 A.2d 647, 671–72 (N.J. 1976) (holding that the respirator from a patient in a persistent vegetative state could be removed provided that the patient’s guardian, family, attending physicians, and hospital ethics committee concurred that there was no reasonable possibility of the patient “ever emerging from her present comatose condition to a cognitive, sapient state . . .”); see also In re Guardianship of Schiavo, 932 So. 2d 264, 267 (Fla. Dist. Ct. App. 2005) (holding that a guardian’s compliance with a probate court order to remove a feeding tube was not an abuse and could not be challenged as such).
So, how do these terms relate to physician-assisted suicide or aid-in-dying? First, physician-assisted suicide is “aid-in-dying.” For the purposes of this article, the term “aid-in-dying” is used, when appropriate, as it is currently the most adopted term. Aid-in-dying is perhaps best defined as a semi-passive form of voluntary euthanasia. It is the practice of a physician prescribing lethal medication to a competent person who voluntarily requests the prescription. Voluntary euthanasia is not quite “passive” in terms of allowing someone to die by withdrawing life-sustaining treatment, but it also cannot be defined as “active” because the physician does not administer the drugs herself. The physician is active in writing the prescription, but it is up to the patient to fill the prescription and administer the medication. Most of the basic components of the way in which this process operates are similar throughout different regulatory systems that permit aid-in-dying.

II. HISTORICAL CONTEXT

The word “euthanasia” is derived from a Greek term meaning “good death.” It is this link that prompted a historical discussion of euthanasia to commence during the periods of classical Greek and Roman antiquity. In both Greece and Rome, physician-assisted suicide and individual suicides were a common and tolerated practice. This common view of suicide and euthanasia is primarily attributed to the societal belief at the time that not all human life had inherent value. Some Roman and Greek philosophers connected this concept to the ideas of autonomy and individual

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21. See, e.g., OR. REV. STAT. ANN. § 127.800(11); WASH. REV. CODE § 70.245.010(11) (2009).
22. See BLACK’S LAW DICTIONARY 575 (7th ed. 1999).
23. See, e.g., § 127.800(11); § 70.245.
24. See infra Part III.
25. MERRIAM-WEBSTER’S DESK DICTIONARY, supra note 9, at 188.
26. IAN DOWBIGGIN, A CONCISE HISTORY OF EUTHANASIA: LIFE, DEATH, GOD, AND MEDICINE 8 (Donald T. Critchlow ed., 2005) [hereinafter CONCISE HISTORY OF EUTHANASIA]. In fact, many of the revered thinkers of the time, such as Plato, viewed suicide as a noble and heroic choice if it avoided the agony of a long, terminal illness. Id.
27. Id.
This is thought to be more out of necessity due to severely limited resources than due to any philosophical ideas about individual rights.\textsuperscript{32}

Much of this historical tolerance changed, however, with the rise of Christianity.\textsuperscript{33} The Christian religion emerged in the first century AD, bringing with it different values about death and dying.\textsuperscript{34} Christians were taught that suicide was a form of self-murder, condemning it because it was against “God’s law.”\textsuperscript{35} Other organized religions around the world had similar views on suicide and euthanasia, with some exceptions for religious martyrs.\textsuperscript{36}

This condemnation of euthanasia carried through the medieval period.\textsuperscript{37} It was at this time that the first hospitals were established, thereby creating a different and more formal role for physicians than existed in ancient Rome and Greece.\textsuperscript{38}

Although the status of the physician had changed, the practice of medicine was not advancing quickly.\textsuperscript{39} Because medieval hospitals were founded as religious institutions, there was a strong Christian influence on medical practices.\textsuperscript{40} Another reason that
religious influence presided over medieval medicine was that physicians could not do much medically to alleviate their dying patients’ ailments.\textsuperscript{41} The medieval physician would often play the role of spiritual advisor at the deathbed, having exhausted the limited medical possibilities for curing the patient.\textsuperscript{42}

Ideas about euthanasia changed somewhat in the eighteenth century.\textsuperscript{43} The concept of euthanasia was debated more and regained acceptance in writings by contemporary thinkers.\textsuperscript{44} The expansion of the newspaper press also aided in a more widespread discussion and gained sympathy for suicide and euthanasia.\textsuperscript{45} The increasing spread of information through the press made suicides common knowledge, and, thus, more commonplace and less shocking and taboo in society.\textsuperscript{46} Because people were able to read about the stories behind the suicides, each incident of suicide seemed more or less justifiable.\textsuperscript{47} With justifiable reasons behind suicides, the people committing suicide were more commonly viewed as victims rather than criminals.\textsuperscript{48}

This trend continued through the century’s Enlightenment era, with interest in science peaking and people beginning to question religious theories regarding life and death.\textsuperscript{49} As during the Greek and Roman eras, many scholars of the time saw suicide as a question of individual liberty and personal autonomy.\textsuperscript{50} These ideas had an effect on the law: the result of prominent thinkers questioning the cruelty and purpose of the laws prohibiting suicide

\textsuperscript{41} \textit{Id.} at 19.

\textsuperscript{42} \textit{Id.} The Christian version of the “good death” was strikingly different from the ancient Greek and Roman understanding of the term. \textit{Id.} at 17–18.

The good death would involve the administration of the sacraments and provide the opportunity for the sick person to atone for any wrongdoings committed in life. Those in pain, distress, and despair were meant to be comforted in all physical and moral ways, but suffering was also viewed as punishment for past sins and a means of emulating the passion of the Savior himself. \textit{Id.} at 18.

\textsuperscript{43} \textit{Id.} at 27.

\textsuperscript{44} \textit{Id.}

\textsuperscript{45} \textit{Id.} at 28.

\textsuperscript{46} \textit{Id.} at 29.

\textsuperscript{47} \textit{Id.}

\textsuperscript{48} \textit{Id.} “The effect was less approval of suicide than acceptance of it as a fact of human existence and, for some, a belief that religious definitions of suicide were oversimplistic.” \textit{Id.}

\textsuperscript{49} \textit{Id.} at 30.

\textsuperscript{50} \textit{Id.} at 31 (citing Voltaire, Montesquieu, and Hume as scholars who emphasized this belief).
was that judges were increasingly softening their decisions regarding the reasons behind suicides.\textsuperscript{51} These judges would often rule that a person who had committed suicide was not guilty by reason of insanity.\textsuperscript{52}

The Victorian era of the nineteenth century proved to be a step backward for the social acceptance of euthanasia and suicide. The Christian Evangelical movement, which strictly opposed any form of suicide, was rapidly on the rise in Europe and America.\textsuperscript{53} The preachers associated with this movement taught that strict moral reformation of society was needed and that “Christ’s coming was at hand.”\textsuperscript{54} This era experienced a reversion to the medieval model of a “good death.”\textsuperscript{55} Ministers taught that suffering at death was a sign of God’s grace.\textsuperscript{56} This belief coincided with the Evangelical emphasis on sin, judgment, the torments of hell, and the worship of a “suffering Jesus.”\textsuperscript{57}

Medicine in the nineteenth century was still not particularly advanced in terms of curing diseases.\textsuperscript{58} Although the medical profession was becoming more sophisticated, doctors could not do much for dying patients except counsel them and administer opiates to ease pain.\textsuperscript{59} The theory at the time was that there came a point when the physician should cease attempts to cure the patient, but that death should not be hastened because it can be more comfortable with palliative care.\textsuperscript{60} At this time, a few doctors were publicly admitting that they had performed euthanasia on patients when asked.\textsuperscript{61} Despite this willingness by some physicians to speak approvingly of euthanasia, it remained a concept that the medical

\textsuperscript{51}. Id. at 32. Italian criminologist Cesare Beccaria was extremely critical of the laws proscribing suicide, reasoning that “punishing the suicide’s body by dragging it though the streets or driving a stake through the cadaver’s heart was as ridiculous as whipping a statue. Similarly, confiscating the property of the deceased was merely punishing the innocent.” Id. at 33.

\textsuperscript{52}. Id. at 32 (suggesting that “[t]his pattern in legal judgments reflected the mounting tendency to ascribe voluntary death to natural causes rather than the influence of Satan.”). This idea reflects the Enlightenment emphasis on science and skepticism of religious theories.

\textsuperscript{53}. Id. at 39.

\textsuperscript{54}. Id.

\textsuperscript{55}. Id.

\textsuperscript{56}. Id. at 39–40.

\textsuperscript{57}. Id. at 40–41.

\textsuperscript{58}. Id. at 42–43.

\textsuperscript{59}. Id. at 42.

\textsuperscript{60}. Id. at 44–45.

\textsuperscript{61}. Id. at 51.
profession as a whole condemned. 62

Social views on euthanasia changed drastically when Charles Darwin published *On the Origin of Species* in 1859. 63 The scientific theory of evolution established by Darwin’s work changed the public’s understanding of the human species. 64 Those who were persuaded by this line of thought viewed human life as being no more valuable than any other natural form of life. 65 All human life was no longer “sacred” in light of the scientific concepts that humans evolved from lesser life forms and that the success of the species was due to natural selection in which only the fittest beings in the species survived to pass on their genetic legacy. 66

Evidence of natural selection grew into a social concern over “degeneracy”—the fear that the poor, uneducated, and feeble members of society (who had substantially higher birthrates than the wealthy and more educated classes) would eventually take over as the majority class. 67 This theory spawned the idea of eugenics, which developed in the 1860s. 68 Supporters of euthanasia argued that euthanizing feeble members of society was merely doing what nature would have done through natural selection, in the absence of social programs for the downtrodden. 69

Another broad trend sweeping the Western World during the nineteenth century was secularization, wherein many educated

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62. *Id.* Specifically, the official stance of the medical profession was that euthanasia “could only be regarded as the practice of murder.” *Id.* (citation omitted). There was a tendency to distinguish between active and passive euthanasia, as the *Boston Medical and Surgical Journal* (later the *New England Journal of Medicine*) endorsed the “voluntary refusal to use heroic, extreme methods to keep dying patients alive simply to prolong their lives.” *Id.* Yet the institution found that “[t]here was a world of difference between letting nature take its course and actually shortening patients’ lives through medical intervention.” *Id.* Here, the *Boston Medical and Surgical Journal* was already entertaining a “right-to-die” in terms of a patient’s right to refuse life-prolonging treatment. *See id.*

63. *Id.* at 52.

64. *Id.*

65. *Id.* at 53.

66. *Id.*

67. *Id.* This concern was shared by Darwin as well, who “worried about how modern medicine, hospitals, asylums, and other charitable institutions affected evolution. Because they essentially protected society’s unfit from the blind ruthlessness of natural selection, they enabled the weak and improvident to survive and reproduce their own kind.” *Id.*

68. *Id.* at 54 (defining eugenics as “efforts to improve the biological quality of future generations”).

69. *Id.* As crass as this may sound, at the time this was seen as a kinder way to carry out nature’s work. *Id.* Instead of allowing the more “unfit” human beings to suffer on the street, that suffering would be cut short through euthanasia. *Id.*
people adopted the idea “that individual freedom of thought trumped obedience to church dogma.” Secularization caused many people to depart from the traditional Christian view of a “good death” and to perceive death as a medical event instead.

In the early twentieth century, social perceptions of euthanasia in the United States were reflected in case law and legislation. In 1902 and 1908, for instance, the Texas Court of Criminal Appeals overturned two murder convictions for assisted suicides. Nevertheless, by 1973, assisted suicide was outlawed by the Texas legislature. Early attempts to legalize euthanasia included bills introduced in Ohio and Iowa in 1906; both were defeated.

In 1915, Illinois witnessed a famous incident involving passive euthanasia. The doctor in the “Baby Bollinger” case refused to perform a life-saving operation on a deformed baby. The parents had agreed to forego the surgery. Nevertheless, the state still attempted, but ultimately failed, to prosecute the doctor for his refusal to intervene under a criminal negligence theory.

70. Id. at 57–58.
71. Id. at 58. “Increasingly, people perceived death to be a medical event that could be alleviated by ether, chloroform, or morphine. To some, that included administering overdoses to terminally ill patients.” Id. at 58.
72. Id. at 72.
73. Id.
74. Id.
75. Id.
76. Id. at 73.
77. Id. An interesting fact to note about this case is that the doctor who refused to operate, Dr. Haiselden, had adopted two girls and raised them with the help of his mother. Id. A strong source of Dr. Haiselden’s support of euthanasia for the handicapped at birth was “his bitter hatred of institutionalization,” including institutions for orphand children. Id. He even published a “muckraking exposé” of the deplorable conditions for the mentally handicapped in an Illinois institution. Id.; see also Baby Dies; Physician Upheld, CHI. DAILY TRIB., Nov. 18, 1915 [hereinafter Baby Dies; Physician Upheld].
78. See Baby Dies; Physician Upheld.
79. See Martin S. Pernick, The Black Stork: Eugenics and the Death of “Defective” Babies in American Medicine and Motion Pictures Since 1915, 7–8 (1996). Although the case underwent several official investigations by the hospital and local authorities, Dr. Haiselden was never sanctioned for refusing to save the baby’s life. See id. A panel of doctors criticized Dr. Haiselden’s actions but ultimately found that “he was ‘fully within his rights in refusing to perform any operation which his conscience will not sanction.’” Id. at 7. Additionally, although the Illinois Attorney General demanded an indictment, the state’s attorney refused to file charges, reasoning that “the Bollingers had the right to withhold their consent and that parental consent would have been required to operate.” Id. at 7–8.
The pre-World War I years found American and European societies experiencing a massive growth of asylums for the mentally and physically handicapped and an increasing number of patients in them.\textsuperscript{80} By the 1930s, the number of asylums and patients created even more intense feelings that the dependent handicapped population was a burden on society, especially when society was in the middle of the Great Depression and in the aftermath of a devastating war.\textsuperscript{81} In addition, the physicians treating the mentally ill grew increasingly frustrated because the patients seemed nearly impossible to treat.\textsuperscript{82}

This increasing support for euthanasia fueled the founding of the first two pro-euthanasia organizations.\textsuperscript{83} The first was the Voluntary Euthanasia Legalization Society (VELS), founded in Great Britain in 1935.\textsuperscript{84} Three years later, the Euthanasia Society of America (ESA) was established in the United States.\textsuperscript{85} Both organizations took the official stance of supporting only voluntary euthanasia, although some of the individual members supported additional involuntary forms of euthanasia.\textsuperscript{86}

The VELS introduced a bill in 1936 “that would make it legal for terminally ill adults to request medical aid-in-dying.”\textsuperscript{87} As the organization expected, the bill was defeated.\textsuperscript{88} In 1939, the ESA drafted a bill for introduction in the New York legislature, similarly targeting voluntary euthanasia only for terminally ill adults, but the organization could not find any legislators willing to introduce it.\textsuperscript{89}

\textsuperscript{80.} CONCISE HISTORY OF EUTHANASIA, supra note 26, at 65. Additionally, Europe and the United States were experiencing diverging views on religion. \textit{Id.} at 75. While Europe saw a substantial decrease in organized religion, religion became more pervasive in the United States with the revival of Evangelism and the initiation of the Fundamentalist movement. \textit{Id.} at 75–76. This is believed to have resulted mostly from the Europeans’ proximity to the horrors of the World War I front, which caused many Europeans to question whether there was a God. \textit{Id.} at 77. This contributed to changing views on euthanasia and the value of human life as “[i]t was difficult for clerics to maintain that life was sacred when it was spent so cheaply by politicians and generals.” \textit{Id.} at 77.

\textsuperscript{81.} \textit{Id.} at 79–80.
\textsuperscript{82.} \textit{Id.}
\textsuperscript{83.} \textit{Id.} at 80.
\textsuperscript{84.} \textit{Id.}
\textsuperscript{85.} \textit{Id.} at 82.
\textsuperscript{86.} \textit{Id.} at 81, 84.

\textsuperscript{87.} \textit{Id.} at 81. This concept is not unlike the laws that exist today. See, \textit{e.g.}, \textit{infra} Part III (legislation in Oregon, Washington, the Netherlands, Belgium, and Luxembourg has made it legal for terminally ill adults to request aid-in-dying).

\textsuperscript{88.} CONCISE HISTORY OF EUTHANASIA, supra note 26, at 81.
\textsuperscript{89.} \textit{Id.} at 84.
Other attempts were made to introduce similar legislation in 1937 in Nebraska and Ohio, but these failed as well.  

Nevertheless, public opinion polls taken in the United States from 1937 and 1939 showed that forty-five percent of those polled supported euthanasia for deformed or mentally handicapped infants, while thirty-seven percent of the public supported voluntary euthanasia for terminally ill adults. Although unsuccessful in the legislature, the euthanasia movement in the 1930s received a considerable amount of public support and publicity. In 1939, Time magazine reported that mercy killings were occurring at a rate of one per week. Additionally, courts showed a willingness to acquit people convicted of murder in especially compelling mercy-killing cases.

The public support enjoyed by euthanasia advocates in the 1930s soon faded as the Nazi atrocities involving eugenics were exposed during World War II. This was especially true in the United States, where the American Medical Association maintained its conservative position in matters of bioethics. Also, the Catholic Church was on the rise, becoming omnipresent in politics and popular culture. A public opinion poll taken in 1950 showed a ten percent drop in support for physician-assisted suicide as compared to a poll taken in 1939.

The focus of debate shifted away from euthanasia and toward a “right to die” in the 1960s when “[i]mportant technological innovations in the medical treatment of the terminally ill were beginning to spark a mounting debate over the issue of unnecessary and unwanted treatment.” Included in this debate were the “doctrine of double effect” and the concept of “situational ethics.” One advocate found links between the ability to control

90. Id. at 85.
91. Id. at 89.
92. Id. at 86.
93. Id.
94. Id. at 87.
95. Id. at 91.
96. See id. at 99.
97. Id. at 100.
98. Id. at 98.
99. Id. at 91.
100. Id. at 105 (explaining under the “double effect” doctrine there is no commission of sin if an earlier death resulted from a doctor administering narcotics to alleviate patient pain, so long as the patient consented to the use of drugs; and under “situational ethics” there were no absolute moral standards to
death and the struggle over women’s reproductive rights. Yet there was still a powerful voice coming from the oppositional mainstays of the Catholic Church and the American Medical Association.

Euthanasia advocacy groups, now supporting a “right to die,” gained optimism as the twentieth century decades rolled past. Concern over population control grew in the 1960s. The realization that the world’s resources could not sustain an infinite number of people once more changed the way that people thought about the value of life. High birthrates in many countries, coupled with the increased ability of medicine to keep people alive for longer, meant that “the traditional idea that each individual life was sacred appeared outdated when the populations of countries such as India and China were nudging close to the billion mark.”

At the same time, the Catholic Church permitted “withhold[ing] unwanted, unnecessary treatment as long as it was clearly the patient’s wish.” This hint of acceptance now became the focus of the euthanasia movement, which saw the right to withhold treatment as an important stepping-stone toward winning a right to medical assistance in dying. The rights of patients and medical costs became popular topics of discussion within the medical profession, and society as a whole became more comfortable talking about death and the dying process. Important legal battles ensued over the next few decades following the 1960s. In 1976, the New Jersey Supreme Court ruled that Karen Ann Quinlan had a right to privacy that encompassed the right to terminate medical treatment. Ms. Quinlan had been in a coma for three months when her parents asked the hospital to guide medical treatment and what was right or wrong depended upon the circumstances facing each patient.

101. Id. at 106.
102. See id. at 107.
103. Id. at 111.
104. See id. at 115.
105. See id.
106. Id.
107. Id. at 116.
108. Id.
109. See id. at 120.
110. Id. at 121.
disconnect her from the respirator that was keeping her alive. The hospital refused, and the respirator continued to support her. Finally, the court ruled that she had a legal “right to die,” and ordered the hospital to comply with her parents’ request. Quinlan was highly publicized, and it “helped to crystallize the evolving sentiment in favor of a personal right to control the time, place, and manner of one’s death.”

Throughout the 1980s and 1990s, organizations supporting assisted suicide grew stronger. In 1980, the Hemlock Society was founded in the United States. This organization departed from the focus of most other euthanasia groups at the time by advocating for the legalization of mercy killing in addition to voluntary euthanasia.

The AIDS epidemic was also influential in the increased push to support euthanasia. AIDS patients found themselves suffering “prolonged pain, disfigurement, and loss of dignity,” which led many to seek euthanasia as an alternative. Highly advanced medical technology permitted people with incurable diseases to stay alive for longer periods of time. This is still the case today, and because terminal illnesses like AIDS are treatable but not curable, advanced medicine has the potential to prolong patients’ suffering.

113. Concise History of Euthanasia, supra note 26, at 122.
114. Id.
115. Id.; see also In re Quinlan, 355 A.2d at 671 (holding that if responsible attending physicians conclude there is no possibility of Ms. Quinlan emerging from the comatose state, the life support should be discontinued upon a consultation with the hospital’s Ethics Committee).
116. Concise History of Euthanasia, supra note 26, at 122 (noting that, regardless of Quinlan, public opinion in support of euthanasia had increased since the 1950s). In support of this proposition, the author cites Gallup polls that asked “[whether] voluntary euthanasia should be permitted by law if the patient is incurably ill.” Id. The poll results showed that fifty-three percent answered yes in 1973, sixty percent in 1977, sixty-five percent in 1985, and sixty-nine percent in 1990. Id. Nevertheless, it should be recognized that survey findings do not necessarily demonstrate a tendency to support legalization. Id. at 122–23.
117. Id. at 129.
118. Id. This group disbanded in part due to highly controversial actions taken by some of the members. Id. at 130. These actions involved members of the organization assisting suicides of people whose “full ability to consent was questionable.” Id.
119. Id. at 134.
120. See Miller, Long-Term Care, End-of-Life Issues, supra note 2, at 2.
121. See id. (citing a report from the Centers for Disease Control and Prevention, which found that “the medical advances of the past century have shifted the leading cause of death from infectious disease to chronic disease,
Whether socially accepted or taboo, suicide and euthanasia have always been practiced.\textsuperscript{122} It is not the existence of the act that has changed throughout history, but the social, moral, and legal acceptability of it.\textsuperscript{123} History reveals a picture of a societal tug-of-war over the issue of euthanasia.\textsuperscript{124} This unsteady environment has affected the ability of many countries to pass legislation on the subject.\textsuperscript{125} Since the late nineteenth century, there has been an increasing societal interpretation of euthanasia as “actual mercy killing or medically assisted suicide,” as opposed to involuntary forms of euthanasia.\textsuperscript{126} This shifting social understanding may have contributed to the laws on aid-in-dying that have recently been enacted.

III. COUNTRIES THAT HAVE LEGALIZED ASSISTED SUICIDE

A. The Netherlands

1. Legislative Background

Although euthanasia in the Netherlands had been illegal since the late nineteenth century, the act of euthanasia continued to be openly practiced throughout the country.\textsuperscript{127} Doctors were sometimes charged with assisting suicides, but were not often found guilty.\textsuperscript{128} Those who were convicted typically received light penalties compared to the twelve-year statutory maximum resulting in longer life spans.”).

122. See Concise History of Euthanasia, supra note 26, at 8–9 (discussing euthanasia and suicide as common practices in ancient Greece and early imperial Rome).
123. See id. at 5. “[T]he history of euthanasia has been largely conditioned by evolving opinions about what constitutes a good death, which in turn has depended on shifting value systems governing such things as sin, suffering, resignation, judgment, penance, and redemption.” Id.
124. See id. at 153 (concluding that “the global struggle over how society defines a right to die is far from over.”).
125. See id. at 145–52 (comparing and contrasting the difficulties of passing euthanasia bills in Great Britain, the United States, Canada, Australia, and the Netherlands).
126. Id. at 49.
127. See id. at 128. “Almost overnight, the Dutch adopted the idea that as long as people are going to use drugs, visit bordellos, and conceive babies out of wedlock, the government should regulate these behaviors rather than condemn them. The same thinking applied to euthanasia.” Id.; see also Jennifer M. Scherer & Rita J. Simon, Euthanasia and the Right to Die: A Comparative View 54 (1999) (stating that euthanasia and assisted suicide are regularly practiced).
128. See Scherer & Simon, supra note 127, at 55.
sentence. In 1981, guidelines for non-criminal aid-in-dying were established by the Rotterdam criminal court. Three years later, the Royal Dutch Medical Association (KNMG) proposed similar guidelines. These were termed the “rules of carefulness,” by which the practice of euthanasia could be justified.

In 1991, the attorney general of the Dutch Supreme Court released a study on the practice of euthanasia and other end-of-life medical decisions in the Netherlands, commonly known as the “Remmelink Report.” By 1993, “the Dutch Parliament agreed to endorse euthanasia under certain conditions” but refused to grant physicians immunity from prosecution in all cases. Due to the high rate of unreported cases of euthanasia (presumably out of fear of prosecution), the KNMG and Ministry of Justice joined in creating a notification procedure for deaths resulting from

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130. *See Scherer & Simon, supra* note 127, at 56. The guidelines stated that the patient must be suffering from unbearable pain; the patient must be conscious; the desire to die must be enduring; the decision to die must be given freely and voluntarily; the patient must have been given alternatives to euthanasia and time to consider the alternatives; no reasonable solution to the problem must exist; the death of the patient cannot inflict unnecessary suffering on others; more than one person must be involved in the euthanasia decision; the patient must have a clear understanding of his condition; and extreme care must be taken in actually making the final euthanasia decision.

131. *See id.* at 57. These rules suggested that euthanasia not be prosecuted . . . (1) if the mentally competent patient made freely and knowingly and repeatedly documented requests for euthanasia, (2) if the patient experienced untreatable, unrelievable pain (the illness did not have to be terminal), and (3) if the physician in charge of the patient consulted at least one other physician, who agreed that euthanasia was the only solution.


133. *Id.* at 57–58.

134. *See id.* at 60 (stating that “no legal right to euthanasia existed, and physicians could be prosecuted if the guidelines were not followed.”).
This procedure required that physicians “inform the medical examiner (or coroner) of the circumstances of the death instead of declaring a natural death,” which was incorporated into the Burial Act of 1994. However, this position was “ambiguous” as euthanasia [would] remain a crime even if it [was] carried out by a doctor who complied with all the restrictions . . . . But at the same time, the modification of the Burial Act implied that a doctor [would] not be prosecuted if he or she carefully committed that crime.

A series of court rulings at the time resulted in a situation where euthanasia and assisted suicide remained offenses subject to the defense of necessity. The 1984 guidelines set by the KNMG were revised in 1995. These guidelines constituted the foundation for the 2002 law legalizing assisted suicide.

135. See id. at 57.
136. Id.
137. Gevers, supra note 129, at 332.
138. See Neil M. Gorsuch, The Future of Assisted Suicide and Euthanasia 104 (Robert P. George ed., 2006) (citing Schoonheim, in which the Dutch Supreme Court announced this defense to the legal ban on assisted suicide. Nederlandse jurisprudentie 1985, no. 106, translated in John Griffiths, Alex Boed & Helen Weyers, Euthanasia & Law in the Netherlands 322–28 (Amsterdam U. Press, 1998)). “The court defended the doctor’s conduct . . . because of the perceived ‘necessity’ resulting from a conflict of duties or force majeure (overmacht) confronting the doctor, explaining that the killing was justified by the doctor’s judgment about the quality of his patient’s life . . . .” Id. (emphasis in original).
139. See Scherer & Simon, supra note 127, at 60. The changes in the guidelines were that assisted suicide is preferable to euthanasia . . . [,] consulting physicians who provide their opinions should not be connected to either the patient or the physician . . . [, and] if the attending physician is opposed to euthanasia and assisted suicide, he or she has the obligation to locate another physician who is willing to perform euthanasia or assisted suicide.
2. The Termination of Life on Request and Assisted Suicide Act

On April 1, 2002, the Termination of Life on Request and Assisted Suicide Act became effective in the Netherlands.\textsuperscript{141} The Act’s definition of assisted suicide is: “intentionally assisting in a suicide of another person or procuring for that other person the means [to commit suicide] . . . .”\textsuperscript{142} Under the Act, assisted suicide is permitted when a physician meets the requirements of “due care.”\textsuperscript{143} The physician must:

1. hold[] the conviction that the request by the patient was voluntary and well-considered,
2. hold[] the conviction that the patient’s suffering was lasting and unbearable,
3. . . . inform[] the patient about the situation he [is] in and about his prospects,
4. . . . and the patient [held] the conviction that there was no other reasonable solution for the situation he was in,
5. . . . consult[] at least one other, independent physician who has seen the patient and has given his written opinion on the requirements of due care, referred to in parts 1–4, and,
6. ha[ve] terminated a life or assisted in a suicide with due care.\textsuperscript{144}

These standards do not require a patient to be terminally ill or suffer any physical pain.\textsuperscript{145} Also absent are a “specified waiting period after the request for euthanasia before it may be performed” and any “requirement that the patient place his or her wishes in writing.”\textsuperscript{146} Assisted suicide may be requested by minors aged sixteen to eighteen.\textsuperscript{147} They may request assisted suicide on their own as long as they are “deemed to have a reasonable understanding of [their] interests.”\textsuperscript{148} A parent or guardian must

\textsuperscript{142}. Id.
\textsuperscript{143}. Id.
\textsuperscript{144}. GORSUCH, supra note 138, at 106.
\textsuperscript{145}. Id.
\textsuperscript{146}. Id.
\textsuperscript{147}. Id. (adding that minors aged twelve to sixteen may also request assisted suicide, but must have parental consent).
\textsuperscript{148}. Termination of Life on Request and Assisted Suicide Act, supra note 141.
be involved in the decision-making process, but the minor may make his own decision independent of his parents’ wishes.\textsuperscript{149}

The watchdog presiding over physicians assisting patients with suicides consists of five “Regional Evaluation Commissions,” which assess whether a case of euthanasia or assisted suicide complies with the statute’s criteria regarding due care.\textsuperscript{150} A case only comes before the public prosecutor if the commission determines that the physician did not exercise due care, although the public prosecutor has the authority to run an independent investigation, if necessary.\textsuperscript{151} These commissions also publish annual reports, which are available to the public.\textsuperscript{152}

\textbf{B. Belgium}

\textit{1. The Belgian Act on Euthanasia}

The Belgian Act on Euthanasia was also adopted in 2002.\textsuperscript{153} The Act defines euthanasia as “intentionally terminating life by someone other than the person concerned, at the latter’s request.”\textsuperscript{154} This law is similar to the one in the Netherlands. The Belgian law permits physicians to assist in the suicide of a patient whose suffering can be physical or mental.\textsuperscript{155} After committing an act of euthanasia, a physician must submit a report to the Federal Control and Evaluation Commission.\textsuperscript{156} This commission will

\begin{footnotesize}
\begin{enumerate}
\item[GORSUCH, supra note 138, at 106 (citing Termination of Life on Request and Assisted Suicide Act, supra note 141).]
\item[\textit{Id.}]
\item[\textit{Id.}]
\item[\textit{Belgian Act, supra note 153, at 182.}]
\item[\textit{Id.}]
\item[\textit{Id. at 185. The registration form that the doctor is required to complete must be submitted to the commission within four working days of the patient’s death. \textit{Id.} The commission consists of sixteen members, eight of which are medical doctors with at least four of those persons being professors at a Belgian university. \textit{Id.} Four members are either law professors at a Belgian university or practicing attorneys. \textit{Id.} The final four members are selected from groups that}]
\end{enumerate}
\end{footnotesize}
review the circumstances of the physician’s acts in assisting with the patient’s suicide.\textsuperscript{157} If the commission is satisfied that the physician complied with the statutory guidelines, then no further action will be taken.\textsuperscript{158} If, however, the commission finds that the statute was breached by the physician, the case will be referred to the public prosecutor in the jurisdiction in which the euthanasia was performed.\textsuperscript{159}

2. \textit{Comparison with the Netherlands}

This law differs slightly from the Netherlands Act in several ways. First, for euthanasia to be legal, the patient must be an adult or an emancipated minor.\textsuperscript{160} Other minors are not allowed to choose physician-assisted suicide, even if they have the consent of their parents.\textsuperscript{161} The requirements of competency and voluntariness are still in place, but Belgium requires that the patient’s request be repeated to ensure that it is voluntary.\textsuperscript{162} In addition, the patient’s condition must be “medically futile”; that is, it cannot be alleviated by any existing medical treatments.\textsuperscript{163} Similar to the Netherlands Act, the physician must hold a personal belief that there is no reasonable alternative for the patient to exercise, and the physician must ensure that the patient is fully informed of her condition and the options available.\textsuperscript{164} Yet, in contrast with the Netherlands, the Belgian Act requires the physician to have several conversations with the patient that are spread out over a reasonable period of time.\textsuperscript{165}

handle issues regarding terminally ill patients. \textit{Id.} Like the Netherlands commission, the Belgian commission is charged with distributing reports for the benefit of the legislature. \textit{Id.} at 186. These reports are to be submitted every two years (whereas they are submitted on an annual basis in the Netherlands). \textit{Id.}

\textsuperscript{157} \textit{Id.} at 186. The commission particularly evaluates the second part of the registration form, which includes, among other information, details about the patient’s condition, the voluntariness of the requested euthanasia, and the persons with whom the physician consulted with regarding the patient’s request. \textit{Id.}

\textsuperscript{158} \textit{Id.}

\textsuperscript{159} \textit{Id.}

\textsuperscript{160} \textit{Id.} at 182.

\textsuperscript{161} \textit{Id.}

\textsuperscript{162} \textit{Id.} at 186.

\textsuperscript{163} \textit{Id.} at 182, 184.

\textsuperscript{164} \textit{Id.}

\textsuperscript{165} \textit{Id.} at 182.
Additional requirements are imposed when the physician believes that the patient is not expected to die in the near future.\textsuperscript{166} In that case, a second physician must be consulted.\textsuperscript{167} That physician must be a psychiatrist or specialist in the field of the patient’s disorder.\textsuperscript{168} There is also a one-month waiting period between the patient’s request and the act of euthanasia.\textsuperscript{169} All patient requests must be in writing.\textsuperscript{170}

The Belgian statute also distinguishes cases in which a patient is no longer able to express her will.\textsuperscript{171} These circumstances require an advance directive that instructs the physician to perform euthanasia.\textsuperscript{172} Euthanasia is permitted under an advance directive if the physician can verify that the patient suffers from an incurable disorder, the patient is no longer conscious, and the condition is irreversible.\textsuperscript{173} Other physicians and hospital staff must be consulted in this circumstance, as well.\textsuperscript{174}

3. Effects of the Belgian Act

Reports indicate that the overall rate of “euthanasia” in Belgium has increased since the law’s enactment.\textsuperscript{175} It is thought that the overall increase is due to much higher numbers of deaths, which result from palliative care measures taken in hospitals.\textsuperscript{176} These include continuous deep sedation and the increased use of strong painkillers, such as morphine, which can inadvertently hasten death (known as the “doctrine of double effect”).\textsuperscript{177}

\textsuperscript{166} Id. at 183.
\textsuperscript{167} Id.
\textsuperscript{168} Id.
\textsuperscript{169} Id.
\textsuperscript{170} Id.
\textsuperscript{171} Id. at 183–84.
\textsuperscript{172} Id.
\textsuperscript{173} Id.
\textsuperscript{174} Id.
\textsuperscript{175} Gene Emery, \textit{Belgium has Significant Hike in Euthanasia After Law}, \textit{Reuters} (Sept. 9, 2009), http://www.reuters.com/article/healthNews/idUSTRE5886AN20090909. The percentage increased from 1.1 percent in 1998 to 1.9 percent in 2007. \textit{Id.}
\textsuperscript{176} See id.
C. Luxembourg

Luxembourg approved its euthanasia law in 2008, completing the legalization of aid-in-dying among the Benelux countries.\textsuperscript{178} The law is similar to the legislation in Belgium and the Netherlands, where “euthanasia would be allowed for the terminally ill and those with incurable diseases or conditions, only when they asked to die repeatedly and with the consent of two doctors and a panel of experts.”\textsuperscript{179} There have been few reports discussing the effectiveness of the law. Although the law passed by a fairly narrow margin in Parliament,\textsuperscript{180} the Luxembourg Parliament had a significant enough majority in favor of the law to pass a constitutional amendment to override the Grand Duke’s expected veto of the bill.\textsuperscript{181} After the Grand Duke’s refusal to sign the law, Parliament decided to proceed without the consent of the monarchical ruler of the country.\textsuperscript{182} Thus, the legalization of euthanasia in Luxembourg not only changed the options available to terminally ill patients, it also initiated a structural change in Luxembourg’s government as a whole.

D. The United States

The United States has been gradually progressing toward granting its citizens a right to die, including the ability to receive aid-in-dying.\textsuperscript{183} The United States is different from other countries


\textsuperscript{179} Id.

\textsuperscript{180} Id. (the law passed by a 30-to-26 vote margin).

\textsuperscript{181} Vanessa Mock, Luxembourg Monarch Muzzled over Euthanasia, INDEP. (Dec. 11, 2008), http://www.independent.co.uk/news/world/europe/luxembourg-monarch-muzzled-over-euthanasia-1062382.html (noting that while the “hereditary monarch’s powers are largely nominal . . . , no new legislation can come into force without royal assent,” and that the amendment limits Luxembourg’s monarchs to “announcing decisions of parliament.”).

\textsuperscript{182} Id. (reporting how the “unprecedented crisis” has worried Luxembourg’s citizens).

in that the individual states, not the country as a whole, assume the right to decide whether or not to legalize aid-in-dying.\textsuperscript{184}

1. Oregon

a. Legislative History

Oregon was the first state to legalize aid-in-dying with its Death with Dignity Act.\textsuperscript{185} The Act was initially approved by Ballot Measure 16 in the 1994 general election.\textsuperscript{186} It was later challenged in 1997 by Ballot Measure 51, which was referred by the state legislature and which sought to repeal the Act.\textsuperscript{187} This ballot measure was defeated by a sixty percent vote.\textsuperscript{188} The Act was challenged a second time by the administration of President George W. Bush, but was ultimately upheld by the United States Supreme Court in 2006.\textsuperscript{189}

\textsuperscript{184}. See Vacco v. Quill, 521 U.S. 793, 808–09 (1997) (stating that it would be constitutional for New York, as a state, to draw a legislative distinction regarding assisted suicide and the right to withdraw life support). This opinion refused to recognize a guarantee to physician-assisted suicide under the Constitution’s Equal Protection clause, but did not hold that physician-assisted suicide was unconstitutional. Id. at 799–800; Scherer & Simon, supra note 127, at 40. Rather, the Court left the decision for the states to approve through ballot measures or legislation. Id. at 40.

\textsuperscript{185}. See The Oregon Death With Dignity Act, OR. REV. STAT. ANN. §§ 127.800-95 (1999).

\textsuperscript{186}. Lori Long, OR. LEGISLATIVE POLICY & RESEARCH OFFICE, BASICS ON . . . BALLOT MEASURE 51, 1 (1997), available at http://www.leg.state.or.us/comm/comm srv s/51final.pdf (noting that Ballot Measure 16 was approved by a two percent margin). A day before the Act went into effect, the United States District Court of Oregon issued a temporary restraining order against the Act and later issued a permanent injunction. Lee v. Oregon, 891 F. Supp. 1429 (D. Or. 1995). This was ultimately reversed on appeal and lifted. Lee v. Oregon, 107 F.3d 1382 (9th Cir. 1997), cert. denied, 522 U.S. 927 (1997).

\textsuperscript{187}. Long, supra note 186, at 1.

\textsuperscript{188}. OR. SECRETARY OF STATE OFFICIAL RESULTS, STATE MEASURE NO. 51, NOV. 4, 1997, http://www.sos.state.or.us/elections/nov497/other.info/m51abst.htm (noting that Measure 51 was defeated 666,275 to 445,830).

\textsuperscript{189}. See Gonzales v. Oregon, 546 U.S. 243 (2006) (granting State of Oregon an injunction that prevented the application of the U.S. Attorney General’s interpretive rule, which indicated that physicians operating under the state Death with Dignity Act were violating the federal Controlled Substances Act).
b. Oregon’s Death with Dignity Act

Under the Death with Dignity Act, a patient must be “qualified” under the statute to request and receive death-with-dignity. To request assistance under the Act, the patient must be an adult (18 years or older), “capable” of making and communicating health care decisions as defined by the statute, a resident of Oregon, and diagnosed as terminal. The patient’s wish to die must be made voluntarily and the resulting request for life-ending medication must be written. Following a fifteen-day waiting period, the qualified patient must reiterate her wish to die, at which point the attending physician can write the prescription.

Akin to the Benelux laws, the attending physician under the Oregon statute must satisfy a number of requirements to assist the patient. First, the physician must verify that the patient is “qualified,” according to the terms stated above. Second, the physician must inform the patient of a list of factors that are important in making the decision to request lethal medication. These factors include the patient’s medical diagnosis and prognosis and any feasible alternatives to the treatment permitted under the Act. Third, the physician must refer the patient to a consulting physician to confirm the diagnosis and determine the patient’s capacity and voluntariness. The physician must also comply with recording requirements set out in the statute.

Physicians under Oregon’s act have requirements that depart from those of the Benelux nations. The physician is required to recommend that the patient notify her next of kin and counsel the patient about the importance of having another person present when the patient takes the medication prescribed. The patient...
must also be informed that she has an opportunity to rescind the request at any time and be offered that opportunity again at the end of the fifteen-day waiting period. There must also be verification, immediately prior to writing the prescription, that the patient’s decision is informed.

2. Washington

Washington was next to follow suit in the United States by approving Ballot Initiative 1000 in the 2008 general election. This ballot initiative was modeled on the Oregon measure, and both statutes have the same provisions. Washington’s Death with Dignity Act is primarily enforced by the State Department of Health, which collects the data reported by physicians operating under it. The Department of Health is also in charge of providing statistical reports annually.

3. Aftermath

Relatively few people have utilized the Death with Dignity Act in Oregon, but the number is gradually increasing.

unable to notify next of kin shall not have his or her request denied for that reason.

200. Id. § 127.815(h); see supra note 194 and accompanying text.

201. Id. §§ 127.815(i), .830. The statute does not describe the details of this second verification. Thus, it is unclear as to whether the physician is required to repeat all of the subjects listed under section 127.815(c), see supra text accompanying note 196, or whether the physician merely has to confirm that the patient remembers the initial conversation regarding those factors and understands the consequences of his actions.


203. See supra note 186 and accompanying text.


206. See WASH. REV. CODE ANN. § 70.245.150(3) (West Supp. 2010).

207. See Jackson Pickett, Can Legalization Improve End-of-Life Care? An Empirical Analysis of the Results of the Legalization of Euthanasia and Physician-Assisted Suicide in the Netherlands and Oregon, 16 ELDER L.J. 333, 360 (2009) (discussing the legalization of physician-assisted suicide and its effect on physicians' behavior and
Studies show that 401 people have received prescriptions under the law from enactment through 2008. In Washington, six prescriptions were dispensed by May of 2009, but there has only been one report of death from drugs prescribed under the Act. The Washington number can be expected to increase, as there is little data at this time due to the law’s relatively new enactment.

4. Montana

A recent decision issued by the Montana Supreme Court recognized a patient’s right to aid-in-dying by determining that doctors are immune from prosecution for assisting in a patient’s request to die under Montana state law. The case originated in district court, where the plaintiff challenged “the constitutionality of the application of Montana homicide statutes to physicians who provide aid in dying . . . .” Plaintiff Robert Baxter won his case against the state when the Montana District Court issued an opinion in 2008 affirming his right to choose aid-in-dying.

On appeal, the Supreme Court of Montana addressed the issue of whether the district court erred in its decision that “competent, terminally ill patients have a constitutional right to die with dignity, which protects physicians who provide aid in dying from prosecution under the homicide statutes.” The court

211. Baxter v. Montana, 224 P.3d 1211, 1214 (Mont. 2009). The complaint specifically lists the state constitutional rights of the terminally ill that are allegedly violated when a physician is prosecuted for aid-in-dying. Those rights are: the right of privacy; the right of individual dignity; the right to due process of law; the right to equal protection of the laws; and the right to seek safety, health, and happiness in all lawful ways. Complaint at 7, Baxter v. Montana, No. ADV-2007-787, (Mont. 1st Dist. Ct. Dec. 5, 2008), 2008 WL 6627324 available at http://www.compassionandchoices.org/documents/Baxter%20complaint.pdf. The complaint states that physicians’ “own fundamental rights of individual privacy and due process of law” are violated as well. Id.
212. See Baxter, 2008 WL 6627324. The plaintiffs include Mr. Baxter, four physicians, and Compassion & Choices. Id.
213. Baxter, 224 P.3d at 1213–14. Mr. Baxter passed away as a result of lymphocytic leukemia just hours after the district court judge issued her decision. Compassion & Choices, Montana Death With Dignity,
declined to rule on the constitutional claims, stating that “this Court is guided by the judicial principle that we should decline to rule on the constitutionality of a legislative act if we are able to decide the case without reaching constitutional questions.” However, the court did analyze the Montana Rights of the Terminally Ill Act, which “confers on terminally ill patients a right to have their end-of-life wishes followed, even if it requires direct participation by a physician through withdrawing or withholding treatment.” The court ultimately found that “[t]he Terminally Ill Act explicitly shields physicians from criminal, civil, or professional liability for the act of withdrawing or withholding life-sustaining treatment from a terminally ill patient who requests it.” The court additionally noted that “failure to give effect to a terminally ill patient’s life-ending declaration is a crime” under the Terminally Ill Act.

Overall, the court found that aid-in-dying is not against public policy, according to Montana Supreme Court precedent and Montana statutes. The court found that public policy is not violated when a physician assists in a patient’s death because it is “the patient—not the physician—who commits the final death-causing act by self-administering a lethal dose of medicine.” Montana is facing a situation in which its supreme court has authorized terminally ill patients’ access to aid-in-dying by holding that physicians are not criminally or civilly liable for complying with a competent, terminally ill patient’s request for lethal medication under current state law. Nevertheless, the court did not approach the subject of whether aid-in-dying is a constitutional right under the Montana Constitution. By restricting its holding to the judicial realm, the court has chosen to leave the future of the state’s aid-in-dying laws up to the legislative process.


214. Baxter, 224 P.3d at 1214.
215. Id. at 1218 (citing MONT. CODE ANN. § 50-9-103 (2009)).
216. Id. at 1219 (citing MONT. CODE ANN. § 50-9-204 (2009)).
217. Id.
218. Id. at 1222.
219. Id.
220. Id. at 1219.
221. Id. at 224 P.3d 1211. If the court had ruled aid-in-dying to be a constitutional right, it would have been the first to do so in the nation. See Johnson, supra note 210.
5. Connecticut

On June 1, 2010, Judge Julia L. Aurigemma of the Connecticut Superior Court granted a motion to dismiss an action brought by two Connecticut physicians who were seeking declaratory and injunctive relief to allow them to perform aid-in-dying. The physicians were specifically seeking protection from prosecution under a Connecticut statute that criminalizes the act of intentionally causing or aiding another person to commit suicide. The plaintiff-physicians had experience treating “terminally-ill, mentally-competent patients who have requested, or discussed the possibility of, aid in dying,” and were seeking to legally assist those patients because, in their professional judgment, “aid in dying would be a medically and ethically appropriate option for those patients who request it.” The court found that the case was barred by the sovereign immunity doctrine and that it was a non-justiciable claim. As in Montana, the Connecticut court determined that the legality of aid-in-dying is best left to the legislature and not the court.

E. Switzerland

Switzerland is an outlier among the countries where aid-in-dying has been legalized. Officially, there is no statute explicitly legalizing any form of aid-in-dying, but Switzerland is important to this issue because it has permitted both physician-assisted suicide and assisted suicide since 1937. Instead of explicit legalization, the limitations of assisted suicide are described in the country’s Penal Code.

223. Id. (citing CONN. GEN. STAT. § 53(a)-56 (2009)).
224. Blick, 2010 WL 2817256, at *1. The opinion describes certain terminal patients, like those treated by the plaintiffs, as facing the limited choices of “prolonged and unrelied anguish on the one hand, or unconsciousness [due to terminal sedation] and total loss of control and personal dignity on the other.” Id.
225. Id. at *15.
226. Id.
227. SChERER & SIMON, supra note 127, at 69.
Article 115 of the Swiss Penal Code states that assisted suicide is not a criminal offense if “there is no personal motive for or gain through the assistance.” Article 114 of the Penal Code prohibits killing on request.

1. Swiss Academy of Medical Sciences Guidelines

The Swiss Academy of Medical Sciences has formulated its own guidelines for physicians based on the Penal Code. These guidelines rely on Article 16 of the Penal Code to define a patient with the ability to make decisions. Article 16 requires that the patient be able to “understand information regarding the decision” he is making, be capable of evaluating the situation and the consequences of possible alternatives, and be able to “express his own choice.” These requirements encompass the core values of competence and voluntary choice that all of the countries discussed thus far have incorporated in their legislation. The guidelines also state that a physician’s assistance in a patient’s wish to commit suicide is allowed when the patient is “in the final phase of life, when the situation becomes intolerable for the patient.”

Physicians are given a checklist of conditions that must be present before they can assist a patient in dying. The patient’s condition must be terminal and alternative possibilities must be discussed. The patient must be competent to make the decision, must have put sufficient thought into the decision, must be making the decision voluntarily, and must repeat his wish to end his life. All of these conditions must be reviewed by a third person, who is

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229. Scherer & Simon, supra note 127, at 70 (elaborating that an assisted suicide must be performed solely for humane reasons, without personal gain); see also Care of Patients in the End of Life: Medical-Ethical Guidelines of the SAMS, Swiss Academy of Medical Sciences, 1, 6 (2004) [hereinafter SWISS ACADEMY], available at http://www.samw.ch/dms/en/Ethics/Guidelines/Currently-valid-guidelines/e_RL_Lebensende.pdf.

230. SWISS ACADEMY, supra note 229 at 6.

231. Id.

232. Id. at 7.

233. Id.

234. See note 143 (Netherlands); notes 162, 164 (Belgium); notes 181–82 (Luxembourg); notes 193–96 (Oregon); note 207 (Washington) and accompanying text.

235. SWISS ACADEMY, supra note 229, at 6.

236. Id.

237. Id.

238. Id.
not required to be a doctor. Finally, the patient must act on his own to end his life. This means that a physician is not able to administer drugs through a syringe or an I.V., but must give medication to the patient to take on his own.

2. Suicide Tourism and Suicide Clinics

Lay people are permitted to practice aid-in-dying in Switzerland. It is also the only country that permits non-residents to seek euthanasia within its jurisdiction. Switzerland is distinguished by its so-called “suicide clinics,” which accept patients from all over the world. This leads to the issue of “suicide tourism,” which has recently been of great concern to some lawmakers.

EXIT Switzerland is a major group organizing aid-in-dying through Swiss clinics. The organization requires a patient to be competent, terminally ill, and over the age of 18. Once a patient applies to a clinic, she is evaluated by an EXIT physician. When there is doubt, a team consisting of a lawyer, a psychiatrist, and a second physician evaluate the patient. The process of assisting in the patient’s death requires that a member of the EXIT team and a witness remain with the patient throughout the procedure. The team first administers relaxants and then barbiturates to the patient until she passes away.

239. Id.
240. Id.
241. See id.
242. Assisted Suicide in the World, supra note 140.
243. Id.
245. Id. (reporting that the Swiss Federal Council is proposing legislation that would limit the practice of assisted suicide or ban it altogether due to the borderline law-infringing actions taken by groups that run suicide clinics).
248. Id.
249. Id.
250. Id.
251. Id.
The absence of a specific law regulating aid-in-dying in Switzerland has created a significant amount of controversy. 

A lack of strict reporting requirements puts into question the competency of those receiving assistance. Also, the seemingly wide-open doors of suicide clinics have led to high publicity and questionable practices.

A recent article reported that the Swiss Parliament is currently considering two proposals from the Federal Council to remedy the regulatory deficiency. The first proposal aims to “ensure that the person committing suicide is doing it of [his] own free will, and that the person assisting [him] is not driven by personal gain.”

It would limit the availability of assisted suicide to patients with a terminal illness (whereas the current situation allows assistance “for those suffering from a chronic or mental illness”). Many of the other requirements of the first proposal are similar to what is in place in existing legislation in other parts of the world. The Council prefers the first proposal being considered by Parliament over the second, as the second option would completely ban organized assisted suicide.

Overall, both options seek to restrict “organized” assisted suicide, not assisted suicide altogether.

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252. See Swiss Plan, supra note 244.
253. See id. (stating that if either legislative proposal is adopted “people . . . who have a mental illness could no longer legally take advantage of assisted suicide.”).
254. Reports from 1997 estimated that there were about 100–120 patients dying at the clinics each year. See FOX ET AL., supra note 247. Recent reports state, “At least 117 Britons have traveled abroad for an assisted suicide since 2002, at an average of two a month . . . .” Swiss Plan, supra note 244.
255. See Swiss Plan, supra note 244.
256. Id.
257. Id.
258. See, e.g., id. Provisions of the prospective plan that are similar to already-existing laws include requirements that the patient give “proper consideration” of options before proceeding; that the patient provide certificates from two doctors affirming mental capacity and diagnosing the patient with a terminal illness; and that “[t]hose assisting with suicide” discuss alternatives to suicide with patients. Id.
259. Id.
260. See Swiss Plan, supra note 244.
IV. CONCLUSION

A. Cultural Climate

Perhaps the temporal distance that society now has from the practices of eugenics and genocide associated with the Nazi atrocities of World War II has opened a pathway for today’s society to accept euthanasia as a legitimate legal option. People may now be able to separate a system that allows for voluntary assisted suicide from government-mandated eugenics. There is evidence that modern society can tolerate limited and workable passive and voluntary euthanasia (such as the right to refuse treatment and aid-in-dying). Permitting euthanasia with such a limited scope can detract from fears of sliding down a “slippery slope” into the realm of involuntary euthanasia. As is demonstrated in some of the regulatory systems explored in this article, a carefully crafted law can accomplish this goal.

B. Should Aid-in-Dying be Regulated by Law?

Regulation via laws that permit some limited forms of aid-in-dying seems to be the better option when considering the situation that the United Kingdom is currently facing. There, prosecutors tend to look the other way in many cases where it appears that euthanasia was voluntary, yet the Director of Public Prosecutions cannot assure anyone that he will not be prosecuted. Instead of drawing a line to designate what is legally permissible and what is impermissible, the country leaves its citizens in the dark. The terminally ill who want the option of aid-in-dying not only have to suffer through the pain and anguish of their disease, but also the anxiety of wondering whether their loved ones will be prosecuted for helping to end their suffering at their direction.

For physician assisted aid-in-dying, it is argued that legalization allows physicians to practice publicly, thus encouraging an open

261. See supra Part III (discussing the legalization of assisted suicide).
262. See, e.g., SWISS ACADEMY, supra note 229, at 6 (discussing competency and voluntariness).
264. See id. (noting that there are factors to guide decisions but “no guarantees against prosecution.”).
265. See id.
exchange of information with colleagues and patients. Laws also create accountability in people’s actions and provide checks to ensure that practices are performed within the legal parameters. If there is an opportunity to clarify the nature of the law and how it operates, that opportunity should be taken.

C. Well-Functioning Components of Current Aid-in-Dying Laws

Throughout the regulatory provisions established to limit the scope of euthanasia practices, several recurring themes can be identified. First, all of the laws insist that the aid-in-dying be voluntary. Second, they mandate that the person receiving aid-in-dying be mentally competent to make a decision to die and that the decision be informed. Finally, these laws express a preference that a second opinion be sought from an independent medical professional.

Among the Benelux countries, Belgium’s statute seems to provide the most specific guidelines without being overly complex or restrictive. It allows patients to have greater options at end-of-life stages, but has stronger measures in place to ensure that a patient is competent, fully informed, and making a voluntary

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266. See Charles Baron et al., Statute: A Model State Act to Authorize and Regulate Physician-Assisted Suicide, 33 HARV. J. ON LEGIS. 1, 8–9 (1996) (stating that the legal prohibition of aid-in-dying forces physicians to “be compelled by fear of prosecution to [provide assistance in suicide] in secret, without the opportunity to discuss the case fully and freely with colleagues or other professionals.” Whereas, when aid-in-dying is legalized, “physicians have access to a variety of professional consultations, often including review by ethics committees or consultants, in connection with other profoundly serious medical-ethical decisions.”).

267. Id. at 9 (noting that accountability helps to ensure that a patient is competent and fully informed).

268. In Switzerland, where aid-in-dying is openly practiced and the limitations are few, ambiguity also reigns. The state prosecutor in Zurich even argues for legalization, stating that “there should be tighter controls, regulating the quality of the help offered … [a]nd more transparency when it comes to individual cases, to finances and to the organisation itself.” Roger Boyes, Murky Truth Behind Swiss Suicide ‘Clinic’ Dignitas, TIMES ONLINE (Oct. 25, 2008), http://www.timesonline.co.uk/tol/life_and_style/health/article5006805.ece. Whether liberally accepted or strictly prohibited, people are calling for definition to be put to this prevalent practice. See TRIGGLE, supra note 263.


270. Id.; see, e.g., Assisted Suicide in the World, supra note 140.


272. Id.

273. See Belgian Act, supra note 153.

274. Id.; supra notes 155–76 and accompanying text.
Belgium’s statute covers more ground than other legislation in that it prescribes different measures for different end-of-life scenarios and specifies the requisite condition of the patient. It also insists on greater competency of the patient by limiting aid-in-dying to adults. The likelihood that a patient will be making a voluntary and informed decision is also strengthened by the requirements that there be repeated requests by the patient to the doctor, that several consultations between the doctor and patient take place, and that the physician inform the patient of her condition and all of the alternatives available.

One of the foregoing requirements—that a terminally ill patient have “several” conversations with her physician—is vulnerable to abuse: Doctors who oppose aid-in-dying might insist on having a more than sufficient number of conversations, and, thus, indirectly impose a waiting period on patients who do not have much time left. Although this abuse may not be frequent, it would be better to clear up the vague interpretation surrounding the word “reasonable” by suggesting an appropriate end to the conversations. This could be measured in time or content, as some statutes already require specific temporal waiting periods and others provide a list of topics to be covered prior to assisting in a death.

The Oregon and Washington Acts also have admirable

275. Id.; supra notes 160–65.
276. See supra notes 163, 171–73 (The Act distinguishes between a patient that is terminal, one who is terminal but death is not imminent, and a patient who is unconscious.).
277. See supra notes 160–61 and accompanying text.
278. See supra note 165 and accompanying text.
279. Physicians and hospitals are allowed to refuse to provide aid-in-dying. Although doctors are not required by any statute to assist patients in their decision to die, there is a possibility that a physician could act upon his moral beliefs by postponing the process to limit the patient’s ability to continue to seek aid-in-dying. I surmise that this circumstance is not highly likely because physicians are subject to strict professional guidelines and would be more apt to simply refer the patient elsewhere if they choose to opt out of acting under the permissive legal provisions for aid-in-dying. Whether or not physicians are willing to refer their patients elsewhere, some physicians practicing in jurisdictions that permit aid-in-dying have chosen not to participate in a patient’s decision to exercise her rights under the law. See Physicians for Compassionate Care Education Foundation Home Page, http://www.pcccf.org/index.htm (last visited Oct. 29, 2010) (an organization of physicians founded as a response to the passing of Oregon’s Death With Dignity Act that outwardly opposes “doctor assisted suicide”).
280. See, e.g., supra notes 169, 194 and accompanying text.
281. See supra note 185 and accompanying text.
safeguards. The residency requirement (included in all countries except Switzerland) eliminates the problems that arise from “suicide tourism.” The requirement that requests be written increases the assurance of competency and the intent of the patient. The laundry list of subjects that physicians are required to review with their patients further ensures an informed patient. A referral to a second doctor helps to reinforce the attending physician’s judgment regarding the appropriateness of the assistance. The written opinion of the consulting physician provides a second source of records for future evaluation. Doctors are appropriately designated as the select group that may assist in a patient’s request because they have the expertise to ensure that the process goes smoothly and painlessly.

Evidence provided in studies that attempt to evaluate aid-in-dying legalization does not provide a clear depiction of whether one law is performing more successfully than another. One factor that makes the comparison difficult is the cultural variations between each country. While some studies report that euthanasia (including legalized physician-assisted suicide and non-voluntary euthanasia) has increased in Belgium since Parliament passed its statute, other reports indicate that the Netherlands has experienced a decrease in aid-in-dying, and that it is seldom exercised in Oregon. Another statistical problem is the lack of data acquired prior to each law’s enactment, which limits the opportunity for a comprehensive before-and-after examination. Finally, there is not enough data compiled from recently enacted laws to permit much analysis on how they are performing.

282. See supra note 204 and accompanying text.
283. See supra note 242 and accompanying text.
284. See supra note 245 and accompanying text.
286. See Penney Lewis, The Empirical Slippery Slope from Voluntary to Non-Voluntary Euthanasia, 35 J.L. MED. & ETHICS 197, 205 (2007) (commenting that “cultural factors may significantly influence baseline rates [in statistical studies], thus further decreasing the possibility of drawing inferences from evidence in one jurisdiction as to what will happen in another”).
287. See supra Parts III.A.2, III.B.3, III.D.1.b.
288. Naturally, more data is available for the Netherlands, Belgium, and Oregon, since their laws have existed for a longer period of time. Washington and Luxembourg do not have much data, as their acts were enacted in 2008, and Switzerland does not provide much opportunity for statistical comparison due to
There is still much to learn about how these new laws are operating in their respective cultures. Nevertheless, it appears that certain statutory provisions are worth maintaining. These legal safeguards are linked to important core values that can be found running throughout the recently enacted aid-in-dying laws. Those values include the legal competence of patients to seek aid-in-dying and the voluntary and informed nature of their decision to die. A majority of the laws restrict the practice of assisting in death to a medical professional who has the expertise to ensure that the process goes smoothly. This factor, along with review processes that are in place, guard against abuses that might otherwise be inflicted upon the class of persons whom the laws are designed to serve. Each of the five regulatory systems studied in this paper has a strong foundation. Only time can tell whether they will stand as they are or evolve into something new.

289. See, e.g., supra notes 274–78 and accompanying text; see also supra notes, 283–85 and accompanying text.
290. See supra notes 275, 281–85 and accompanying text.
291. See supra notes 144, 162, 164, 179, 192–97, 204, 238 and accompanying text.
292. See, e.g., supra note 285 and accompanying text.