PROTECTING THE RIGHT TO LIVE: INTERNATIONAL COMPARISON OF PHYSICIAN-ASSISTED SUICIDE SYSTEMS

> Creating a new 'right' . . . will endanger society and send a false signal that a less than 'perfect' life is not worth living.[1]

The "right to die" movement is not bounded by sovereign borders normally thought to define the unique culture of a people.[2] The impact of improved medical technology on the quality of life has precipitated an international quest for patient autonomy in health care decision-making. The right to die movement promotes a continuum of choice in patient autonomy that extends from palliative care[3] and withdrawal of treatment[4] to physician-assisted suicide.[5] This desire to provide the full continuum of choice has fueled an international movement to recognize the greatest level of patient

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1. *Bernadin's Plea Against Assisted Suicide*, USA TODAY, Nov. 14, 1996, at 3A. Cardinal Joseph Bernadin, near death at the time, wrote a letter to the Supreme Court, urging the Court not to recognize a right to physician assisted-suicide in two cases pending before the Court. *Id.*

2. A search on the world wide web produces information from national and international societies who support the "right to die" movement. *See generally Welcome to the Scottish Voluntary Euthanasia Society* (visited Jan. 5, 1997) <http://www.netlink.co.uk/users/vess/vess.html> (advocating the right of every human to choose his or her own death and the manner of death and to have the option of legalized voluntary euthanasia available); *Voluntary Euthanasia Society of Victoria* (visited Jan. 5, 1997) <http:///www.vicnet.net.au/~vse/v1a.htm#legal> (describing the role of the society in Victoria, Australia, as one of the thirty member societies of the World Federation Right to Die Societies, in providing information to the public and in lobbying the legislature for legal reform that would allow medically assisted suicide to be provided to requesting, competent, and incurably ill adults); *The Hemlock Society USA* (visited Jan. 5, 1997) <http://www.irsociety.com/hemlock.htm> (describing the Hemlock Society's belief in the right of terminally ill people to "self-determination for all end-of-life decisions," including physician-assisted suicide).

3. JAMES M. HOEFLER, DEATHRIGHT: CULTURE, MEDICINE, POLITICS, AND THE RIGHT TO DIE 136-37 (1994). Palliative care provides terminal care focusing on the individuality of the dying person, as opposed to the nature, development, or progression of the person's illness. Care is normally provided in the comfort of home and with the support of family and friends. The treatment philosophy emphasizes "caring rather than curing[;]" medical support focuses on symptom management and pain relief. *Id.*

4. The principle of patient self-determination to refuse medical treatment was acknowledged in the United States as early as 1914 when Judge Cardozo explicitly ruled that medical procedures require patient consent. ROBERT M. VEATCH, DEATH, DYING, AND THE BIOLOGICAL REVOLUTION: OUR LAST QUEST FOR RESPONSIBILITY 91 (1989). However, there is no consensus that a physician or guardian has the right to refuse medical treatment for an incompetent patient who lacks legal capacity to refuse treatment. The role of surrogate decision-making is less clear, due in part to the different types of incompetent patients and surrogate decision-makers. *Id.* at 107.

5. *See* sources cited *supra* note 2.

autonomy - the right to make an affirmative decision to terminate one's own life.

The right to die, however, should not demean the coexisting right to choose life. Given the option of physician-assisted suicide, few people would choose the right to die over the right to live.[6] Many competing interests challenge the right to die.[7] However, protecting the right to live while granting the right to die is the greatest challenge in developing a system that permits physician-assisted suicide. Right to die proponents fear a difficult death; right to life proponents fear the inability to choose life in the face of death. Although history has yet to prove definitively that both fears can be balanced to provide autonomy and protection of rights for each group, the right to die movement continues to realize victories in the international legal arena.[8]

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6. As the first country to legalize euthanasia, the Netherlands experienced a 1990 physician-assisted death rate of less than one percent of the population. *See* Richard Fenigsen, *Physician-Assisted Death in the Netherlands: Impact on Long-Term Care*, 11 ISSUES L. & MED. 283, 284-85 (1995). In 1990, the Netherlands, a country of 15 million people, experienced as many as 11,800 reported cases of medical assistance to end a patient's life. The total of 11,800 includes reported cases defined as "physician-assisted suicide," "active euthanasia," and "morphine overdose intended to terminate life." *See also* Julia Belian, Comment, *Deference to Doctors in Dutch Euthanasia Law*, 10 EMORY INT'L L. REV. 255, 288 (1996) (Dr. Fenigsen "has remained an outspoken critic of Dutch euthanasia practices" following his resignation from the Royal Dutch Medical Society after the Society's release of euthanasia guidelines for the prosecution and punishment of doctors who assist in euthanasia.). In contrast, Australian legislators believe that their system of a narrower scope will substantially limit the number of patients who die with the assistance of a physician. *See* 2 THE RIGHT OF THE INDIVIDUAL OR THE COMMON GOOD: REPORT OF THE INQUIRY BY THE SELECT COMMITTEE ON EUTHANASIA, TRANSCRIPTS OF ORAL EVIDENCE, LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY GOVERNMENT (July 1995) (visited Sept. 17, 1996) <http://www.nt.gov.au/lant/rotti/vol2.shtml> [hereinafter COMMITTEE REPORT, VOLUME 2]. Committee Report statements by Ms. Cracknell indicate that "[t]he extent of utilisation of the Act . . . would be very, very low . . . . [W]e are looking at 6 to a dozen [people per year and] . . . at those people who comply with the conditions of the Act . . . and have reached that point where palliative care is no longer adequate to them." *Id.*

7. *See* Catherine L. Bjorck, *Physician-Assisted Suicide: Whose Life Is It Anyway?*, 47 SMU L. REV. 371 (1994) (discussing questions of ethics and law); ERICH H. LOEWY, TEXTBOOK OF HEALTHCARE ETHICS 185-87 (1996) (discussing questions of health care ethics); Kenneth L. Vaux, *The Theologic Ethics of Euthanasia*, 19 HASTINGS CENTER REP. 19 (Special Supp., Jan.-Feb. 1989) (discussing questions of religion and ethics as they relate to euthanasia); Thomas J. Marzen, *"Out, Out Brief Candle": Constitutionally Prescribed Suicide for the Terminally Ill*, 21 HASTINGS CONST. L.Q. 799 (1994) (discussing questions of the constitutionality of assisted suicide).

8. *See infra* Introduction.

INTRODUCTION

The international right to die movement recently celebrated two victories. On July 1, 1996, the Northern Territory of Australia enacted the Rights of the Terminally Ill Act (Act),[9] marking the world's first legislation legalizing physician-assisted suicide.[10] Although a permanent injunction has prevented Ballot Measure 16, an instance of legislation by referendum, from being enacted,[11] Oregon voters narrowly approved in November 1994 what would have been the world's first legislation to decriminalize physician-assisted suicide.[12] Prior to passage of the Oregon referendum and the Northern Territory legislation, the Netherlands had been the only country to create a defense for euthanasia.[13] The Dutch Supreme Court has recognized that a physician who terminates life at the express wish of a patient may, under certain conditions, invoke the criminal defense of *force majeure*.[14]

This note compares the three systems that have been approved.[15] The development of each system provides the best background to date for comparing the scope, criteria, and enforcement protocols of systems that permit voluntary euthanasia.[16] Part I compares the Dutch judicial system

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9. RIGHTS OF TERMINALLY ILL ACT (Austl.) (visited Jan. 5, 1997) <http://www.nt.gov.au/lant/rotti/>.

10. *Euthanasia Law Upheld*, ROCHESTER SENTINEL (IND.), July 24, 1996, at 4.

11. Lee v. Oregon, 891 F. Supp. 1429 (D. Or. 1995). The court held that the Act violated the Equal Protection Clause of the Fourteenth Amendment of the Constitution of the United States. All defendants were permanently enjoined from recognizing the Act. *Id.* at 1437.

12. Edward R. Grant & Paul B. Linton, *Relief or Reproach?: Euthanasia Rights in the Wake of Measure 16*, 74 OR. L. REV. 449, 449 (1995).

13. BARRY R. FURROW ET AL., HEALTH LAW § 17-70 (1995).

14. Office of Health & Env't, Royal Neth. Embassy, Washington, D.C., *The Termination of Life by a Doctor in the Netherlands* (1995) [hereinafter *Termination of Life*] (on file with the *Indiana International & Comparative Law Review*). *Force majeure* is a form of duress which "constitutes generally recognised grounds for immunity from criminal liability." Article 40 of the Dutch Criminal Code generally states that "[a]ny person who was compelled by *force majeure* to commit an offence shall not be criminally liable." Duress associated with euthanasia, assisted suicide, or the termination of life without a request applies when a physician is faced with a conflict of duty; the conflict is between a duty to preserve life and a duty to relieve unbearable suffering when the patient has no prospect for improvement. To successfully raise a defense of *force majeure* that allows an immunity from prosecution, the physician must fulfill specified criteria. *Id.*

15. The term "system" is used to denote the purpose, scope, criteria, and enforcement criteria of a policy that permits voluntary euthanasia. Note that all systems are not currently in force. *See supra* text accompanying notes 9-14.

16. Each system uses different terminology for an act commonly discussed in the United States as physician-assisted suicide. Although some of the definitional and reporting differences are discussed in Parts I and II, the term "euthanasia" will be consistently used to refer to the act permitted and defined by the system being discussed.

with the Australian legislative system. The discussion focuses on the differences of the systems, including criteria to limit usage and minimize abuse, as well as on the intent of Northern Territory legislators to distinguish the Australian system from the Dutch system. Upon its enactment in 1996, the Rights of the Terminally Ill Act reflected this intent by including more detail and express safeguards to protect the system's limited purpose than appeared in the Dutch system which has developed through nonstatutory case precedent since 1973.

Part II addresses the distinctive criteria of the American referendum system. The discussion focuses on criteria unique to the Oregon Ballot Measure 16 referendum, as well as on the inherent weaknesses in the application and interpretation of this type of statute. Although Oregon's Ballot Measure 16 incorporated criteria not found in either the Dutch or Australian system, the legislation lacked protective criteria found only in the Australian system. Additionally, the interpretive difficulties resulting from referendum legislation's lack of legislative history weaken Oregon's protective criteria. Because the improved criteria of the Australian system were not incorporated cumulatively into the American criteria improvements, the American system lacks the maximum available statutory safeguards to protect the right to live.

Part III discusses a concern prevalent in all three countries, namely, the need to ensure that euthanasia is available as a choice on a continuum of patient autonomy. Although both the Netherlands and Australia have national health care systems providing full access to health care, the United States does not offer full opportunity for health care to all citizens. Furthermore, although the option of euthanasia is available to all criteria-qualified citizens, the option of palliative care is not fully accessible to all citizens in each of these three countries. Euthanasia is not available as a true choice if a patient cannot first be assured access to health care and palliative care.

Even though statutory criteria can limit a system's scope, safeguard the system's purpose, and improve the balance of the right to die with the right to live, a system has yet to emerge that proportionately balances the risk of abuse of either right. If a country is to err in balancing life and death, it is best to err on the side of life.

I. COMPARISON OF A JUDICIAL AND LEGISLATIVE SYSTEM: THE NETHERLANDS AND AUSTRALIA

A. *The Comparative Definition of Euthanasia*

Definition is a basic issue in any discussion of euthanasia.[17] The Greek roots of "euthanasia" mean "good death."[18] Although vague, "good death" continues to be closest to a conclusive definition.[19] Testimony at public committee meetings held prior to passage of the Rights of the Terminally Ill Act reflected a concern for the definition; the expressed concern was to distinguish the meaning of the Australian legislative term from that perceived to be commonly used in the Netherlands.[20] The perceived distinction is between the physician's stated intent as opposed to the physician's motive.[21] A physician's intent rests with an agreement on the purpose and scope of a system that permits euthanasia. The defined scope of a system should effectively convey the system's purpose.[22] If the purpose of a system is to limit the option of euthanasia to a small category of patients, narrowing the scope of a system's permitted assistance effects such a purpose.

Australian legislators chose to define euthanasia as the right of a patient to request his or her physician to assist in terminating life when, "[i]n the course of a terminal illness, [he or she] is experiencing pain, suffering and/or distress to an extent unacceptable [to him or her]."[23] The definition

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17. *But see* GEORGE P. SMITH, II, FINAL CHOICES: AUTONOMY IN HEALTH CARE DECISIONS 92 (1989) (illustrating that blurred definitions have minimized the importance of terminology debates).

18. CARLOS F. GOMEZ, M.D., REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS 22 (1991). "Euthanasia" represents a "compound of two Greek words . . . *eu* meaning 'well' or 'good,' and *thanatos* meaning 'death.'" *Id.*

19. *Id.* (discussing the interchangeability of words used in the Netherlands).

20. COMMITTEE REPORT, VOLUME 2, *supra* note 6 (statement of Dr. John Fleming, Director of Southern Cross Bioethics Institute).

21. *Id.* Dr. Fleming defined "intention" as "an act which brings about a result" and distinguished between acts which look similar but which actually differ because of a difference in intent. In contrast, in the context of a doctor who administers euthanasia, his or her "motivation" would be to relieve suffering. *Id.*

22. 1 THE RIGHT OF THE INDIVIDUAL OR THE COMMON GOOD: REPORT OF THE INQUIRY BY THE SELECT COMMITTEE ON EUTHANASIA, LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY GOVERNMENT § 2 (May 1995) (visited Jan. 5, 1997) <http://www.nla.gov.au/nt/rotti/vol1a.html#preface> [hereinafter COMMITTEE REPORT, VOLUME 1]. The full range of definitions, including the express distinctions between "active and passive" and "voluntary and involuntary" euthanasia, were not included in the final Rights of Terminally Ill Act. The Select Committee on Euthanasia in its report to the Northern Territory legislator addressed the concern for consistency in terminology. The Committee's report defined the terminology accepted by the Committee. *See* RIGHTS OF TERMINALLY ILL ACT, § 3 (Austl.) (visited Jan. 5, 1997) <http:// www.nt.gov.au/lant/rotti/>.

23. RIGHTS OF TERMINALLY ILL ACT, § 4 (Austl.) (visited Jan. 5, 1997) <http://www.nt.gov.au/lant/rotti/>.

encompasses a full range of assistance: a physician may "assist" by prescribing, preparing, giving, or administering the medication to the patient.[24]

In contrast, the Dutch acknowledge a full range of assistance within different narrow categories of assistance: "the termination of life at the request of the patient (euthanasia); assisted suicide: the doctor supplies a drug which the patient administers himself or herself; and the termination of life without a request from the patient [manslaughter or murder]."[25] Under Dutch law, a physician who has terminated a patient's life at the patient's request may plead the defense of *force majeure*.[26] Motive is important in the wide range of permitted assistance that a physician can provide because the motive determines the enforcement of the criminal law, including prosecution.[27] Therefore, even though the Australian and Dutch systems define euthanasia differently, both recognize a full range of physician assistance.

In developing the Australian system, the Australian legislators also criticized the Netherlands' timing in developing its system. The Dutch Supreme Court recognized the physician defense of *force majeure* for euthanasia in 1984 even though the Dutch had been actively involved in euthanasia since the early 1970's.[28] Furthermore, three Dutch attempts to enact euthanasia legislation have failed and few physicians have been prosecuted under the current judicial criteria.[29] Dutch legislation in 1994 established a reporting requirement but did not change the criminal status of euthanasia.[30] The Australian Committee referred to the Dutch enforcement system as "[t]he abnormal position which the Supreme Court decision created."[31] Thus, the Australian legislature was concerned with implementing a system that permitted physicians to assist their patients in suicide with defined criteria, enforcement, and reporting standards to minimize abuse.[32]

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24. These terms comprise Australia's definition of "assist." *Id.* § 3.

25. *Termination of Life*, *supra* note 14.

26. *See supra* note 14 and accompanying text.

27. *See supra* note 14 and accompanying text.

28. COMMITTEE REPORT, VOLUME I, *supra* note 22, § 4.1.

29. *Id.* Bills introduced in 1986, 1987, and 1993 failed to pass. Thus, euthanasia remains technically illegal by statute. There have been only two prosecutions, with the most recent in 1995 for the death of an infant. *Id. But see Termination of Life*, *supra* note 14 (Since the November 1990 establishment of a voluntary notification procedure, a total of 26 cases have been prosecuted in the years 1991 through 1994. The voluntary notification procedure became a statutory requirement effective June 1, 1994.).

30. COMMITTEE REPORT, VOLUME I, *supra* note 22, § 4.1.

31. *Id.*

32. GOMEZ, *supra* note 18, at 25-39 (discussing the chronological events of Dutch case history).

A similar concern with the timing of judicial and legislative interaction has been discussed in the Netherlands.[33] Dutch tradition is that the legislature "*makes the law*" by promulgating general rules and that the judiciary merely "*find[s] the law*" by applying legislative rules to specific disputes.[34] However, a shift in law-making responsibility from the legislature to the judiciary has resulted in issues, such as euthanasia, being submitted to the courts prior to any legislative action; the courts thus have recently rendered many decisions that form the only legal statement in a given field of law.[35]

The Australian legislation represents an extreme contrast in timing and manner of development. The Rights of the Terminally Ill Bill of 1995 was introduced into the Legislative Assembly of the Northern Territory on February 22, 1995.[36] Although debate on the bill was adjourned until May, the Assembly established by resolution a Select Committee on Euthanasia to receive and examine evidence and report to the Assembly by May 16, 1995.[37] The Committee called witnesses, advertised for written and oral submissions, distributed information about the Bill, and held two weeks of hearings.[38] The Legislative Assembly passed the Rights of the Terminally Ill Bill on May 25, 1995; an amendment, the Rights of the Terminally Ill Amendment Act of 1996, passed on February 20, 1996.[39] The amended Act was enacted on July 1, 1996.[40]

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33. Jimmy M. Polak & Maurice V. Polak, *Faux Pas Ou Pas De Deux? Recent Developments in the Relationship Between the Legislature and the Judiciary in the Netherlands*, 33 NETH. INT'L L. REV. 371 (1986). The Board of Editors of Netherlands International Law Review asked the authors to write an article addressing developments in the relationship between the Dutch legislature and judiciary. The interest was inspired by a few cases "in which the Supreme Court of the Netherlands (*Hoge Raad*) seemed to act as an 'assistant-legislator' rather than as a '*bouche de la loi*' [*mouth of the law*]. The four cases involved "transsexuals and the civil registry," "pension rights and divorce," "euthanasia," and "family plot: parents and children" (concerning the personal and property relationships between parents and children). *Id.* at 384-404.

34. *Id.* at 372.

35. *Id.* at 384. The authors noted that "[t]he attempts undertaken by the legislature to bring about clarification and legal certainty in this field have affected Dutch society . . . for a number of years, and will certainly continue to do so in the near future." *Id.* at 394. Interestingly, the "near future" referred to in 1986 has extended into current times. *See supra* note 29 and accompanying text.

36. COMMITTEE REPORT, VOLUME 1, *supra* note 22, § 1.1.

37. *Id.* §§ 1.3-1.4. A total of 104 people appeared before the Committee, and 1126 written submissions were received; all but four submissions were from Australia. (Two submissions each were from the United Kingdom and the United States.). *Id.* § 3.10.

38. *Id.* § 1.3.

39. RIGHTS OF THE TERMINALLY ILL AMENDMENT ACT 1996 (Austl.) (visited Jan. 5, 1997) <http://www.nt.gov.au/lant/rotti/amend.shtml>.

40. *Id.*

Unlike the Dutch system that today represents a system developed primarily from twenty-three years of case precedent, the Australian system includes specific statutory criteria that developed over a year of inquiry, debate, and amendment. The development of the Australian system permitted the system's current well-defined scope, the first level of safeguard for the right to live, to be defined and enforceable from the day of enactment.

B. *The Comparative Regulation of Euthanasia*

1. *Assessment Criteria*

Assessment criteria, which define the scope of the system, narrow the circumstances where an individual may elect euthanasia as an option. Effectively conveyed criteria further establish a second level of safeguard for the system's scope. Thus, both a limited scope and well-defined criteria create obstacles to unintended use that would represent an abuse of the intended purpose of the system. For purposes of comparative analysis, assessment criteria are generally grouped into categories representing system goals: medical condition, medical consultation, voluntary request, and quality of decision.

An inherent distinction between the Dutch and Australian criteria is the manner in which the two sets of criteria have developed.[41] Australian Northern Territory legislators were expressly concerned with developing a distinction in the development, establishment, and application of criteria because they wanted to minimize potential abuse of the system's scope.[42] Their legislative efforts succeeded in establishing a system of specific criteria for a euthanasia system which responded to the swell of public opinion favoring voluntary euthanasia.[43]

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41. *See* discussion *supra* Part I.A.

42. *See* EXTRACTS FROM THE PARLIAMENTARY RECORD OF THE DEBATES OF THE LEGISLATIVE ASSEMBLY ON THE RIGHTS OF THE TERMINALLY ILL BILL, Legislative Assembly of the Northern Territory, May 24 - 25 A.M. (visited Jan. 5, 1997) <http://www.nt.gov.au/lant/rotti/euthanas.shtml> [hereinafter PARLIAMENTARY RECORD OF LEGISLATIVE DEBATES (This was discussed in a debate between Mr. Hatton and Mr. Stirling. Mr. Hatton asked the question: "Is it better to let the common law evolve before you pass a statute or is it better to pass a statute in advance of the common law?" Mr. Stirling replied that legislation will already be broadened beyond its original scope through pressure to amend legislation to include groups excluded by the criteria and through the natural functioning of the legal system: "Safeguards are lowered in practice and the process of desensitisation to the practice of euthanasia will mean that the net will grow ever wider.").

43. Of the 1126 submissions reported in the Inquiry by the Select Committee on Euthanasia, 72% of the submissions favored euthanasia or the right of an individual choice, though only 23% of the submissions were received from Northern Territory residents. Of the

a. *Medical Condition*

The Dutch neither expressly[44] nor in application view terminal illness as a requisite medical condition for permitting euthanasia.[45] The required medical condition is defined as "unacceptable and hopeless suffering."[46] The stipulated test is an assessment of whether the attending physician can reasonably conclude "that the patient was suffering unbearably."[47] However, the basic criterion for qualification, the level of suffering, has been acknowledged as difficult to apply.[48]

A second level of assessment requires the physician to determine the patient's suffering is "without prospect of improvement."[49] The objective test for hopelessness of suffering requires that "[p]rofessional medical judgment must have established beyond doubt that the patient's situation is beyond improvement, which is the case when there is no realistic therapeutic perspective."[50] However, if a review of the physician's assistance determines that a patient made a free choice, the physician can invoke a presumption that the standard for level of suffering likewise was met. The Court attempts to narrow assistance to "extremely strict conditions" by

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255 submissions from territory residents, only 48% (122) favored euthanasia. COMMITTEE REPORT, VOLUME 1, *supra* note 22, § 3.10.

44. Robert J.M. Dillmann & Johan Legemaate, *Euthanasia in the Netherlands: The State of the Legal Debate*, 1 EUR. J. HEALTH L. 81, 83-84 (1994).

45. Office of Health & Env't, Royal Neth. Embassy, Washington, D.C., Memo from the Ministerie van Justitie, Directie Voorlichting, *Consequences of Supreme Council Decree for Prosecution Policy in Relation to Euthanasia and Assisted Suicide* [hereinafter *Consequences of Prosecution Policy*] (on file with the *Indiana International & Comparative Law Review*). "In principle[,] the cause of the suffering and the circumstance of the terminal phase are deemed irrelevant. According to both ministers [i.e., the Ministers of Justice and Public Health], the basic consideration must be the unbearable suffering of the patient concerned without any prospect of improvement." *Id.* *See also* GOMEZ, *supra* note 18, at 39. This concept was reinforced in a 1986 court decision that dismissed charges against a physician who had assisted in the death of a patient who was not terminally ill.

46. Dillmann & Legemaate, *supra* note 44, at 84. The requirement was defined by the General Board of the Royal Dutch Medical Association (RMDA) in 1984 and has "been confirmed in court decisions." *Id.*

47. *Consequences of Prosecution Policy*, *supra* note 45.

48. *Id.*

49. *Termination of Life*, *supra* note 14. *See also Consequences of Prosecution Policy*, *supra* note 45.

50. *Consequences of Prosecution Policy*, *supra* note 45. A perspective is defined as realistic if "a. current medical practice considers a prospect of improvement to exist[,] provided [that] adequate treatment is administered, b. this can be achieved within a reasonable term[,] and c. a reasonable balance is deemed to exist between the expected results and the burden placed on the patient while undergoing treatment." *Id.*

requiring that there is "no possibility of any form of treatment whatsoever being effective."[51]

The Dutch Supreme Court has further recognized psychological suffering as a permissible condition for physician assistance.[52] A physician must determine that the patient's request has been carefully considered and was made "when the patient was fully mentally competent" and that "no further treatment could be effective."[53] However, the Supreme Court has also acknowledged that with a case of psychological suffering, unlike physical suffering, it is almost impossible to objectively establish whether there is an opportunity for improvement.[54]

In an attempt to ensure an objective evaluation, the Dutch prosecution policy instructs the physician to take greater care in assessing whether the psychological suffering is unbearable.[55] In addition, as the suffering becomes proportionately more psychological, greater care in assessment must be taken.[56] One measure of the physician's level of care in assessment is the length of time taken in making the decision.[57]

The Australian intent to implement specific measurable criteria is distinguished by a focus on the narrower medical condition of terminal illness. A patient who is terminally ill must be experiencing "severe pain or suffering."[58] Although a terminal illness is defined as "an illness that will, in the normal course and without application of extraordinary measures, result in the death of the patient,"[59] the legislators did not define a terminal condition by a specific period of limited life expectancy.[60] Legislative

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51. *Termination of Life*, *supra* note 14. If a psychiatric patient does not desire further treatment, a physician cannot provide assistance and receive immunity under the defense of *force majeure*. *Id.*

52. *Id.* A 1994 Dutch Supreme Court case did not permit the physician to invoke the defense of *force majeure* and found the physician guilty of assisting the patient to commit suicide. However, the Court did not impose a penalty. *Id.* Although the court did not permit that physician to invoke the defense, the court did establish a standard that if met would permit a physician to raise the defense. *See infra* text accompanying notes 52-56.

53. *Termination of Life*, *supra* note 14..

54. *Id.*

55. *Id.*

56. *Consequences of Prosecution Policy*, *supra* note 45.

57. *Id.*

58. RIGHTS OF TERMINALLY ILL ACT, § 7(1)(d) (Austl.) (visited Jan. 5, 1997) <http://www.nt.gov.au/lant/rotti/>.

59. *Id.* § 7(1)(b)(i).

60. PARLIAMENTARY RECORD OF LEGISLATIVE DEBATES, *supra* note 42 (The debate relays a discussion between Dr. Lim, Mr. Bell, and Mrs. Braham. Dr. Lim was concerned that deletion of a 12-month life expectancy requirement in the definition of terminal illness would permit a greater range of patients to qualify, including those with an illness that would likely not result in death for 20 years. Mr. Bell was opposed to a terminal illness definition that did not include a 12-month life expectancy and argued that 12 of the 25 members who voted against the bill at the second-reading stage presumably also found the definition

concern echoed a concern common in bioethic discussions: a physician cannot guarantee a diagnosis of limited life expectancy nor the length of life remaining.[61] However, by excluding a time frame for life expectancy, the legislators have widened the scope of the system and increased potential abuse of the right to live.

Is the system intended more for use in a particular phase of terminal illness: at the time of diagnosis when the length of life expectancy is the greatest or in the final stages of illness when the length of life expectancy is the least?[62] While the patient's medical condition is described as terminal, the patient is required to be experiencing unacceptable "pain, suffering and/or distress."[63] If the legislators intended to create a primary threshold at the patient's level of discomfort, it is questionable why they were not more concerned with expressing an intent that the euthanasia option only be available into the extension of an illness. At the time of diagnosis, there is less known about the diagnosis, progression and effects of illness, as well as the ability to provide comfort measures. By omitting a time frame for life expectancy, the Australian legislators have enlarged the scope of the system, foregone an opportunity to provide a more objective expression of the intended scope, and created vagueness in the intended application.

b. *Medical Consultation*

There is little detail in the Dutch system relative to a consultation requirement. Simply stated, the attending physician must consult with "at least one other physician with an independent viewpoint who must have read the medical records and seen the patient."[64] The general purpose for consultation is to verify that the request is genuine and appropriate.[65] While the Dutch courts have not discussed the requirement of secondary medical

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unacceptable. Mrs. Braham recommended the insertion of the terminal illness definition without a 12-month life expectancy requirement, so that the legislation was consistent with existing statutory language.).

61. *Id.* (relaying debate between Mr. Perron and Mr. Stirling).

62. Legislators could not agree at what stage in a terminal illness the system was intended as an option. Statement of a 12-month time frame for life expectancy was deleted in final amendments to the Rights of Terminally Ill Act. *Id.*

63. RIGHTS OF TERMINALLY ILL ACT, § 7(1)(d) (Austl.) (visited Jan. 5, 1997) <http://www.nt.gov.au/lant/rotti/>.

64. *Termination of Life*, *supra* note 14. *See also* Dillmann & Legemaate, *supra* note 44, at 84 (stating that of the five cumulative requirements for physician assistance, one is "e. consultation of another physician").

65. Maurice A.M. de Wachter, *Euthanasia in the Netherlands*, 22 HASTINGS CENTER REP. 23, 23 (Mar.-Apr. 1992).

consultations,[66] more emphasis is placed on the patient and physician together reaching the decision that the patient's circumstances qualify for euthanasia.[67]

In contrast, the Australian system includes more consultation requirements and a higher level of specificity in the consultation criteria. The attending physician's assessment must include a consultation with "[t]wo other persons, neither of whom is a relative of or employee of, or a member of the same medical practice as, the first medical practitioner or with each other."[68] Furthermore, one physician must be "experienced in the treatment of a terminal illness from which the patient is suffering;" one physician must be a qualified psychiatrist.[69] This safeguard prevents a physician from making an arrangement with either another physician in his or her own practice or a relative of another physician in his or her own practice and ensures that a physician with specialized knowledge and experience is involved in a patient's physical and psychological assessment.[70]

In addition to requirements ensuring the professional competency of the attending and consulting physicians,[71] the Australian legislators also outlined the level of consultation among the practitioners.[72] The qualified psychiatrist must examine the patient and determine "that the patient is not suffering

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66. *See generally* GOMEZ, *supra* note 18, at 25-39 (discussing court cases, holdings, and implications on the formal limits of Dutch euthanasia).

67. *Id.* at 39 (discussing the last reviewed decision cited as *The Hague, 1986*).

68. RIGHTS OF TERMINALLY ILL ACT, § 7(1)(c) (Austl.) (visited Jan. 5, 1997) <http://www.nt.gov.au/lant/rotti/>.

69. *Id.* § 7(1)(c)(i)(ii).

70. PARLIAMENTARY RECORD OF LEGISLATIVE DEBATES, *supra* note 42 (reflecting the discussion by Mr. Ede).

71. RIGHTS OF TERMINALLY ILL ACT, § 3 (Austl.) (visited Jan. 5, 1997) <http://www.nt.gov.au/lant/rotti/>. All physicians must be "entitled to practice as a medical practitioner (however described) in a State or Territory of the Commonwealth for a continuous period of not less than 5 years and who is resident in, and entitled under the Medical Act to practise medicine in, the Territory." A qualified psychiatrist must be:

> (a) person entitled under a law of a State or Territory of the Commonwealth to practise as a specialist in the medical specialty of psychiatry;
> (b) a specialist whose qualifications are recognised by the Royal Australian and New Zealand College of Psychiatrists as entitling the person to fellowship of that College;
> (c) a person employed by the Commonwealth or a State or Territory of the Commonwealth, or an Agency or authority of the Commonwealth or a State or Territory, as a specialist or consultant in the medical specialty of psychiatry.

Id. See also PARLIAMENTARY RECORD OF LEGISLATIVE DEBATES, *supra* note 42 (reflecting discussion of Dr. Lim). Although legislators debated inclusion of a 10-year requirement instead of the five-year requirement, the intent was to ensure that an assisting physician has adequate clinical experience. *Id.*

72. RIGHTS OF TERMINALLY ILL ACT, § 7(1)(c) (Austl.) (visited Jan. 5, 1997) <http://www.nt.gov.au/lant/rotti/>.

from a treatable clinical depression."[73] The second consulting physician must examine the patient and concur with the original opinion regarding the existence and seriousness of the illness, the likelihood of the patient's death as a result of the illness, and the prognosis.[74] The consultation requirement provides greater assurance that a medical assessment is made on a valid long-term physical and psychological prognosis.[75] Thus, while both the Dutch and Australian systems include a medical consultation requirement, the Australian system better protects the neutrality and effectiveness of the physical and psychological assessment that qualifies a patient for life-terminating assistance.

c. *Voluntary Request*

Several concerns generally relate to an accurate assessment of the voluntariness of the patient's request: the physician's knowledge of the patient, the manner in which the patient makes the request, and the durable nature of the consent. The Dutch courts have generally emphasized the importance of the attending physician's relationship with the patient.[76] "The attending physician must know the patient well enough to assess whether the request is indeed voluntary . . . ."[77] However, problems can arise when an assisting physician does not know the patient well because the patient is a referral from another physician who, due to religious or moral reasons, has declined to provide assistance.[78]

The manner in which the patient makes the request for assistance is further evidence of the voluntariness of the decision. The Dutch courts require that the patient's request to his or her physician be made persistently[79] and very emphatically[80] and be "durable."[81] A 1973 court

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73. *Id.* § 7(1)(c)(iv).

74. *Id.* § 7(1)(c)(iii).

75. *See* PARLIAMENTARY RECORD OF LEGISLATIVE DEBATES, *supra* note 42 (reflecting discussion of Mr. Ede).

76. *See supra* note 67 and accompanying text.

77. *Termination of Life*, *supra* note 14.

78. *See* GOMEZ, *supra* note 18, at 43. The acknowledgment that an assisting physician may not meet the emphasized importance of knowing the patient well is the only discussion of the court's general preference. No specific standards or requirements have been expressed. A physician that declines to provide a requesting patient with euthanasia assistance due to religious or moral concerns (not strictly medical reasons) is "bound to refer the patient to another physician who feels no such scruples." *Id.* The Royal Dutch Society for the Promotion of Medicine (KNMG) guidelines require that if a physician excuses himself or herself from assisting a patient, the physician "cannot be further involved in the decisionmaking process because there can be no question of an objective participation in the decision for euthanasia." *Id.* at 42-43.

79. *Termination of Life*, *supra* note 14. *See also* de Wachter, *supra* note 65, at 24 (listing the requirements for "voluntariness" to include that "[t]he patient's request must be

decision further held it to be a "generally established and acceptable medical practice" to provide euthanasia assistance when "[t]he patient has indicated in writing . . . that he desires to terminate his life."[82] However, no later court has discussed a requirement of writing, nor included the writing requirement in its list of criteria for permitting the *force majeure* defense.[83] The requirement of a written request also is not listed in the guidelines for the attending physician's mandatory report to the municipal pathologist.[84]

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persistent.").

80. Office of Health & Env't, Royal Neth. Embassy, Washington, D.C., Memo from the Ministerie van Justitie, Directie Voorlichting, *Compulsory Euthanasia Notification Procedure Comes into Force on 1 June* [hereinafter *Compulsory Notification Procedure Press Release*] (Press Release dated May 11, 1994) (on file with the *Indiana International & Comparative Law Review*).

81. Dillmann & Legemaate, *supra* note 44, at 84. A list of requirements published in 1984 by the General Board of the Royal Dutch Medical Association and confirmed in court decisions lists five cumulative requirements; one requirement is a "voluntary and durable request." *Id.*

82. GOMEZ, *supra* note 18, at 30. The 1973 *Leeuwarden* court reviewed the first case of a physician charged for providing assistance. The physician was charged with killing her 78-year-old mother who had been a resident in a nursing home for two months. The physician asserted she injected her mother with 200 milligrams of morphine with an intent to end her mother's life in response to her mother's request for assistance. Although the court found criminal fault with the physician because her intent was to kill her mother rather than alleviate pain, the court did not pass the statutory sentence and instead suspended a one-year prison sentence on the condition that the physician not be found guilty of another punishable act within the one-year period. In its opinion, the court recognized that a patient's life may not be continued when the following four conditions, in the medical opinion of the physician, are present:

> A. When it concerns a patient who is incurable because of illness or accident—which may or may not coupled with shorter or longer periods of improvement or decline—or who must be regarded as incurably ill from a medical standpoint.
>
> B. Subjectively, his physical or spiritual suffering is unbearable and serious to the patient.
>
> C. The patient has indicated in writing, it could even be beforehand, that he desires to terminate his life, in any case that he wants to be delivered from his suffering. . . .
>
> E. Action is taken by the doctor, that is, the attending physician or medical specialist or in consultation with that physician.

Id. at 28-31. The court found this assessment to be "generally established and acceptable medical practice." *Id.* at 30. Note should be made that the court did not accept a fifth condition that the dying phase has begun for the patient or is indicated. *Id.*

83. *See generally* GOMEZ, *supra* note 18, at 25-39 (discussing court cases, holdings, and implications of the formal limits on Dutch euthanasia).

84. Office of Health & Env't, Royal Neth. Embassy, Washington, D.C., Fax from the the Ministerie van Justitie, Directie Voorlichting, *Guidelines for the Attending Physician in Reporting Euthanasia to the Municipal Pathologist* [hereinafter *Reporting Guidelines*] (Fax dated Feb. 15, 1996) (on file with the *Indiana International & Comparative Law Review*). The guidelines only ask if there was a living will and request that a copy of any existing living will

Thus, while the Dutch criteria require that a patient's consent be emphatic, persistent, and durable, neither case precedent nor statutory reporting guidelines provide specific objective requirements to minimize potential abuse of voluntary consent.

Unlike the Dutch requirement, the Australian system does not address the type of relationship required by the attending physician. The legislators viewed the decision to assist as less of a one-on-one decision and more of a decision representing a range of medical expertise.[85] Section 6 of the Act imposes a penalty to protect the patient from a variety of potentially interested third parties: from a family member acting as the primary caregiver to a party possessing a financial interest in the premature death of the patient.[86] This provision represents a legislative concern with protecting the patient from the influence of third parties and from conditions extraneous to the patient's self-determination.

Additionally, the Australian system provides a physician with a series of specific and objective requirements to ensure a voluntary and durable request. The series of expressions of consent and required timing of conduct include: express request by patient to end his or her life;[87] signature of the patient, or of the person acting on his or her behalf, on a certificate of request a minimum of seven days following the initial request;[88] and lapse of a minimum of forty-eight hours from the signing of the certificate to the act of assistance.[89] In addition, a physician providing assistance must not have had any indication prior to the act of assistance that the patient no longer wished to end his or her life.[90] If an indication is made, the physician is required to, as soon as possible, "destroy the certificate of request and note . . . that fact on the patient's medical record."[91]

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be forwarded to the municipal pathologist. *See generally Compulsory Notification Procedure Press Release*, *supra* note 80 (presenting text of section 10(1) of the Act on the Disposal of the Dead). The Act on the Disposal of the Dead established a statutorily-mandated requirement to report acts of assistance to the Public Prosecutor. The press release indicates an additional question of why there was not a living will. However, there is not further clarification in the press release that indicates a change of criteria requires that a patient's voluntary consent be expressed in writing. *Id.*

85. *See supra* Part I. B.1.b.

86. RIGHTS OF TERMINALLY ILL ACT, § 6(1) (Austl.) (visited Jan. 5, 1997) <http://www.nt.gov.au/lant/rotti/>. The Act imposes a penalty upon a person improperly influencing a physician "to assist or refuse to assist" a patient who has requested assistance. *Id.* The assessed penalty for such an action is $10,000. No penalty is assessed to a person who accepts an inducement; however the person does not possess a "legal right to receive or retain the reward." *Id.* § 6(2).

87. *Id.* § 7(1)(f).

88. *Id.* § 7(1)(i).

89. *Id.* § 7(1)(n).

90. *Id.* § 7(1)(o).

91. *Id.* § 10(2).

Therefore, the series of three steps requires an Australian patient to request assistance a minimum of three times during passage of a minimum of nine days from the initial request to the act terminating life. The legislators also included a requirement of two "cooling off" periods over a passage of nine days so that the patient has time to consider the decision and to discuss the decision with his or her family.[92] The specific criteria provide an objective measure to assure that the patient has expressed a durable request for assistance.

While the Australian legislature sought to provide safeguards for a voluntary durable request free from third-party interests, the legislature also sought to ensure assistance when the patient met the statutory criteria. The system permits a patient who is unable to sign the required certificate of request to request a third party to sign the certificate on his or her behalf.[93] The requirement limits the use of a substitute signature to the occasion when a patient cannot personally sign the certificate but can request a third-party signature.[94] The risk of third-party abuse is further limited by a requirement that the third-party must not be one of the physicians involved "or a person likely to receive a financial benefit directly or indirectly as a result of the death of the patient."[95] A third-party who signs for the patient automatically forfeits any benefit, financial or otherwise, that the person would ordinarily obtain upon the death of the patient.[96] Thus, the Australian system provides specific, objective steps to assure opportunity for assistance through a durable request.

While the Northern Territory legislature sought to provide safeguards for a voluntary durable request, the legislature fell short of providing the maximum level of safeguard. The legislature did not expressly adopt a

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92. PARLIAMENTARY RECORD OF LEGISLATIVE DEBATES, *supra* note 42 (reflecting debate among Mr. Perron, Mr. Hatton, Mr. Ede, Mr. Manzie, Mr. Stirling, and Mr. Bailey). The required passage of time is also intended to encourage patients to request assistance earlier than may be requested without a waiting period. Prior to a compromise among the legislators, including discussion of the timing requirements included in Oregon's Ballot Measure 16, the act had included a minimum passage of 14 days. *Id.* Mr. Bailey argued the point that a shortened time frame was less an issue because the required decline in medical condition had already heightened the threshold for permitted assistance. He referred to the need for a patient to "reach the stage where the pain and suffering is no longer bearable and palliative care is no longer working." *Id.* He compared the substitution as one that increased the "slope" of decline in medical condition required to qualify for assistance. He argued that once the patient reached that sharp slope, there need not be an extended waiting period. *Id.* (Note that this argument is only upheld when the threshold for the slope is well-defined, measurable, and protected from abuse.).

93. RIGHTS OF TERMINALLY ILL ACT, § 7(1)(I) (Austl.) (visited Jan. 5, 1997) <http://www.nt.gov.au/lant/rotti/>.

94. *Id.*

95. *Id.* § 9(1).

96. *Id.* § 9(2).

policy requiring that a patient's completed series of requests be invalid if he or she is not competent to express at the time of assistance any change in his or her mind.[97] Omission of the policy was based on the security that other safeguards had been included to ensure patient self-determination free of abuse.[98] The additional safeguard was believed to potentially hinder patient self-determination when the patient's health deterioration from the time of initial request to the time of act prevented him or her from expressing a last assurance of consent at the time of assistance.[99] However, the omission of the requirement, regardless of the numerous other safeguards, presents a true opportunity for abuse of the patient's voluntary request for assistance.[100]

d. *Quality Decision*

Two considerations generally relate to the quality of a patient's decision: the patient's competency to make a decision and knowledge of the alternatives. While the Dutch require that the patient's request be carefully considered, there is no express requirement addressing a patient's competency in making a decision.[101] There is little case law, and there are no medical professional guidelines addressing the issue of competency.[102] Similar to the Australian omission of a requirement of contemporaneous consent,[103] euthanasia can be performed on an incompetent patient if the patient provided written consent prior to loss of competency.[104] Evidence of

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97. PARLIAMENTARY RECORD OF LEGISLATIVE DEBATES, *supra* note 42 (reflecting debate between Mr. Lim and Mr. Perron). Mr. Lim argued that once the patient is no longer able to communicate [and has met all requirements of consent], the doctor must assume that the prior request remains the patient's current request. He raised the issue that the patient may express that he or she would no longer request assistance if he or she had the ability to communicate. The issue is raised that the legislation permits a physician to provide assistance to a patient, absent the patient's ability to communicate at the time of assistance. *Id.*

98. *Id.*

99. *Id.*

100. *See supra* note 97 and accompanying text.

101. *Termination of Life*, *supra* note 14. *See also* Dillmann & Legemaate, *supra* note 44, at 84 (A list of requirements published in 1984 by the General Board of the Royal Dutch Medical Association and confirmed in court decisions lists five cumulative requirements; none of the requirements addresses competency of the patient.).

102. *Termination of Life*, *supra* note 14. *See also* de Wachter, *supra* note 65, at 24. The Dutch refer to mental competency as the ability to request termination of life. This definition does not, however, explain the wide range of incompetent patients who have received euthanasia assistance: severely defective newborn babies, persons who are irreversibly comatose, and patients who are severely mentally handicapped.

103. *See supra* notes 97-99 and accompanying text.

104. *See* de Wachter, *supra* note 65, at 24.

the validity of a request is greater when the request has been written or re-signed within the five years preceding the act of euthanasia."[105]

While prior written consent is generally required in order to provide assistance to an incompetent patient, a similar requirement is not extended to severely handicapped newborn infants who survive the withdrawal of treatment.[106] "At least three of the eight [Dutch] centers of neonatology surveyed . . . in 1989 permitted[,] . . . in exceptional cases, . . . actively terminating the life of a severely handicapped infant as soon as it is born when its defects are so extreme that bringing about a speedy death seems the most merciful treatment."[107] Thus, the lack of a Dutch general competency requirement results in an increase in the type and number of patients who qualify for euthanasia; evidence of this result is that patients who have never expressed a request and who can no longer revoke a prior written request can receive life-terminating assistance from a physician. This movement erodes the basic requirement that a patient voluntarily request assistance to terminate his or her life.

Dutch assessment criteria do require that "the doctor and the patient must have considered and discussed alternatives to euthanasia."[108] The requirement was indirectly addressed in 1984 when the Dutch Supreme Court overturned a lower court decision "because the latter had decided the matter from too limited a perspective."[109] In its criticism of the lower court's decision, the Court questioned if there had been other ways to alleviate the patient's suffering.[110] In remanding this case, the Court instructed that there be an overall consideration whether the act of euthanasia was justified.[111] The court held that a condition of "psychic suffering" or "potential disfigurement of personality" created an acceptable standard for requesting

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105. *Id.*

106. *Id.*

107. *Termination of Life*, *supra* note 14. In this circumstance, the defense of *force majeure* permits a physician's immunity only in exceptional circumstances. Criminal proceedings have been instituted in two cases when the lives of "barely viable newborn babies were terminated after a doctor had ascertained that from a medical point of view there was no point in continuing treatment." *Id.* Although in one case the court permitted a defense of *force majeure*, the Minister of Justice continues to desire that the instructions to prosecute will prompt "case law from which criteria can be derived to apply to similar cases." *Id.*

108. *Termination of Life*, *supra* note 14. *See also* GOMEZ, *supra* note 18, at 30-32 (discussing that a 1981 district court added this requirement to the original four requirements outlined by a 1973 court). *See also* Dillmann & Legemaate, *supra* note 44, at 84 (The "full information" requirement was included in guidelines published in 1984 by the General Board of the Royal Dutch Medical Association and have been upheld in court decisions.).

109. GOMEZ, *supra* note 18, at 36.

110. *Id.*

111. *Id.* at 38-39. However, the court dismissed charges filed against the physician who had assisted his patient in terminating his life; the patient was not terminally ill nor in acute physical pain. *Id.*

euthanasia.[112] Because the court requires that the physician discuss the full range of options with the patient, the court's decision would suggest that the range of alternatives required for discussion would also include psychiatric assistance. However, this requirement neither appears in criteria[113] nor is held to be required by the court.[114] Thus, while the Dutch courts require that a physician discuss and consider alternatives with the patient, no decision has expressly identified the range of alternatives which must be discussed.

In contrast, the Australian system expressly establishes two requirements of competency: a patient minimum age of eighteen years[115] and physician satisfaction that the patient is of sound mind.[116] The legislators intended that the sound mind requirement be interpreted in coordination with the requirement of a qualified psychiatrist's exam[117] and confirmation "that the patient is not suffering from a treatable clinical depression."[118] A patient who is suffering from or being treated for a treatable clinical depression is considered incompetent and unable to qualify for physician assistance in terminating his or her life until the condition has been successfully treated.[119]

Similarly, the Australian system expressly requires that a physician provide a patient with a minimum identified range of medical treatment options. "[P]alliative care, counselling[,] . . . psychiatric support and extraordinary measures" available to sustain the patient's life, must be discussed with the patient.[120] Information on availability of palliative care must be provided by a practitioner who possesses "special qualifications in the field of palliative care."[121] To ensure an informed decision, the Act requires that the patient, prior to making a final request,[122] be informed of the nature of his or her illness and its likely course.[123]

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112. *Id.*

113. Dillmann & Legemaate, *supra* note 44, at 84.

114. GOMEZ, *supra* note 18, at 36-39.

115. RIGHTS OF TERMINALLY ILL ACT, § 7(1)(a) (Austl.) (visited Jan. 5, 1997) <http://www.nt.gov.au/lant/rotti/>.

116. *Id.* § 7(1)(h).

117. *See* PARLIAMENTARY RECORD OF LEGISLATIVE DEBATES, *supra* note 42 (reflecting debate between Mr. Hatton, Mr. Bailey, Mr. Burke, and Mr. Ede).

118. RIGHTS OF TERMINALLY ILL ACT, § 7(1)(c)(iv) (Austl.) (visited Jan. 5, 1997) <http://www.nt.gov.au/lant/rotti/>.

119. *See* PARLIAMENTARY RECORD OF LEGISLATIVE DEBATES, *supra* note 42 (reflecting debate between Mr. Hatton, Mr. Bailey, Mr. Burke, and Mr. Ede).

120. RIGHTS OF TERMINALLY ILL ACT, § 7(1)(e) (Austl.) (visited Jan. 5, 1997) <http://www.nt.gov.au/lant/rotti/>.

121. *Id.* § 7(3). The Act requires that if the physician who has received a request for assistance does not have "special qualifications in the field of palliative care," the practitioner must involve the required consulting practitioner (not the required consulting psychiatrist) or any other physician who has the required special qualifications. *Id.*

122. *Id.* § 7(1)(f).

123. "'Illness' includes injury or degeneration of mental or physical faculties . . . ." *Id.* § 3.

The Australian system further requires a patient to seek alternative options prior to permitting a physician to provide life-terminating assistance.[124] The physician cannot assist the patient if, "in his or her opinion and after considering the advice of . . . [a physician specialized in palliative care], there are palliative care options reasonably available to alleviate the patient's pain and suffering to levels acceptable to the patient."[125] If the patient, subsequent to a request for life-terminating assistance, receives palliative care "that brings about the remission of the patient's pain or suffering," the physician cannot act upon the patient's original request for assistance.[126] However, if at some point the palliative care ceases to provide the patient with an acceptable level of alleviation from pain and suffering, the patient can receive life-terminating assistance but must, in order to revitalize the original request, first express a new request to the physician.[127] Thus, the Act has delineated multi-level safeguards in ensuring that a patient requesting life-terminating assistance has knowledge of and is required to try available palliative care options.

A similar delineation of safeguards requires a patient needing psychiatric care to be informed of and receive psychiatric services.[128] A physician cannot provide assistance to a patient who, after a required examination by a qualified psychiatrist, has been diagnosed as suffering from treatable clinical depression.[129] However, the legislators failed to expressly include the comparable requirement that a physician, prior to providing assistance to a patient who has received psychiatric care for clinical depression, receive a renewed request for life-terminating assistance.[130] Since the legislation has been recently enacted, the breadth of interpretation of the legislature's omission upon prosecutorial or judicial review and the potential abuse to the voluntary choice requirement is unknown.

2. *Enforcement-Reporting Procedures*

Assessment criteria protect the purpose and scope of the system while enforcement protocol protect the assessment criteria. Reporting procedures are necessary to an ongoing review of actual acts of assistance, identification of abuses to the system, prosecution of abusive conduct, and identification of changes necessary to protect the system's purpose. Enforcement criteria generally require documentation of assistance provided by a physician,

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124. *Id.* § 8(1).
125. *Id.*
126. *Id.* § 8(2).
127. *Id.*
128. *Id.* §§ 7(1)-7(1)(c)(iv).
129. *Id.*
130. *Id.*

investigation of reported assistance, and prosecution of physicians providing assistance outside the required guidelines.

a. *Dutch Reporting Procedures*

The first Dutch reporting procedure for physician-provided euthanasia assistance was adopted November 1, 1990.[131] The two-step voluntary reporting procedure required the assisting physician to forward a completed questionnaire to the local medical examiner.[132] The medical examiner then reported the assistance to the district attorney who decided if the physician complied with the criteria[133] and if charges should be filed against the physician.[134] Upon the 1991 recommendation of the government-appointed Remmelink Committee, the voluntary reporting procedure became a statutory requirement with the July 1, 1994, enactment of section 10(1) of the Act on the Disposal of the Dead (Disposal Act).[135] The Disposal Act provides a model reporting form of over fifty-five questions that address case history, the request to terminate life, active termination of life without express consent, consultation of other physicians, and termination of life.[136]

b. *Effectiveness of Dutch Reporting Procedures*

The Dutch statutory reporting procedure will increase the amount of information gathered,[137] as well as the number of cases reviewed for abuse.[138] However, the proven uncertainty of the Dutch euthanasia guidelines and review criteria fail to present incentive to report acts of assistance. Unpredictable guidelines increase the uncertainty of a physician's ability to raise the *force majeure* defense. Furthermore, the statutory reporting requirement does not change the manner in which the criteria and their application will evolve.[139] Uncertainty of prosecutorial criteria have further

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131. *Termination of Life*, *supra* note 14 (discussing that the notification procedure was voluntary). *See also* Dillmann & Legemaate, *supra* note 44, at 84.

132. Dillmann & Legemaate, *supra* note 44, at 84.

133. *See supra* Part I.B.1.

134. Dillmann & Legemaate, *supra* note 44, at 84.

135. *Compulsory Notification Procedure Press Release*, *supra* note 84.

136. *Id.*

137. *Id.* In the first year of the voluntary reporting procedure, the number of reports increased. Cases reported for the years 1991, 1992, and 1993 were 591, 1323, and 1318, respectively. *Id.*

138. *Id.*

139. *Consequences of Prosecution Policy*, *supra* note 45. A memorandum from the Ministerie van Justitie has stated that "[t]he prosecution policy is, and *will continue* to be, anchored in Dutch legislation and the jurisprudential interpretation thereof." *Id.* (emphasis added).

increased with the inclusion of information on the reporting form that has not yet been required or discussed by the courts.[140] Several questions arise: Will prior notification be provided when additional prosecutorial elements are added? Will judicial review respond to elements in the same manner as prosecutorial review? Will future courts continue to create new criteria as they find physicians guilty of criminal acts?

A physician does not have a general incentive to report life-terminating assistance. The reporting statute does not stipulate a penalty for providing assistance without prior or subsequent reporting of the assistance.[141] Therefore, if a physician provides assistance that may not meet the criteria and permit raising a defense of *force majeure* when prosecuted for manslaughter or murder, would a physician be compelled by force of a reporting statute to file a report of assistance when that report will automatically trigger review of the potentially indefensible act? In contrast, will a physician be more compelled to chance non-discovery of an act and the result of a review if discovered or report the act which will trigger an automatic review?

The Dutch physician's incentive to report assistance is central to safeguarding the defined limits to permitted euthanasia. Reports of assistance trigger prosecutorial review; prosecution triggers judicial review. Judicial review is mandatory to establish the precedent of guidelines that will provide clearer criteria for physicians, limit assistance to that approved by public policy, and prosecute abuse of the system. The lack of physician incentive to report assistance for review is unsettling.

c. *Australian Reporting Procedures*

In contrast, the Australian system's two-step reporting procedure does not involve completion of a lengthy report; rather, it involves submitting original documentation of assistance and a certificate of death.[142] The physician's report of assistance to the coroner must include: original documentation of two patient requests, medical opinions of the three physicians involved in the assistance, certification of involvement of independent consultants, obedience of the required steps, and prescribed

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140. *See Compulsory Notification Procedure Press Release*, *supra* note 84. The Ministerie van Justitie has indicated that the reporting procedure includes some new elements relating to the Dutch prosecution policy. Examples of items required to report, but not yet required by the courts, include: consultation with the patient's next-of-kin, supplementary considerations that determined the medical decision-making and the time at which action was taken, and notification of the management of the institution where the patient was staying. *Id.*

141. *Id.*

142. RIGHTS OF TERMINALLY ILL ACT, §§ 12-13 (Austl.) (visited Jan. 5, 1997) <http://www.nt.gov.au/lant/rotti/>.

assistance resulting in death.[143] The coroner is required to report annually to the Attorney General on the number of patients who received assistance and may report to the legislature as he or she thinks appropriate.[144] Upon his or her discretion, the coroner may at any time report to the Attorney General on any matter involving the operation of the Act.[145] In response, the Attorney General must, within three sitting days of the legislature after receiving the report, present a copy of the report to the legislature.[146]

d. *Effectiveness of Australian Reporting Procedures*

While the Australian two-step reporting procedure is comparable to the Dutch two-step reporting procedure, the Australian system is distinguished by the physician's incentive to report. Unlike an act of assistance by a Dutch physician, an Australian physician's act of assistance is not presumed to be an illegal criminal act,[147] is not reviewable by the district attorney,[148] and is not punishable as manslaughter or murder.[149] An Australian physician is not "subject to civil or criminal or professional disciplinary action for anything done in good faith and without negligence in compliance with this Act."[150] Thus, absent an inability to meet the tests of "good faith," "without negligence," and in compliance with the Act, an Australian physician can provide assistance to patients without concern of civil, criminal, or professional repercussions.

Lack of experience with this system precludes an opportunity to evaluate the effectiveness of the reporting procedure.[151] However, prior to passage of the Act, the legislature debated the coroner's role in investigation and reporting.[152] A minority of Australian legislators would have required the coroner to review documentation prior to assistance - as an additional

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143. *Id.* §§ 12-14.

144. *Id.* § 14(2).

145. *Id.* § 15.

146. *Id.*

147. *Supra* note 14 and accompanying text.

148. *Supra* note 133 and accompanying text.

149. *Supra* note 23 and accompanying text.

150. RIGHTS OF TERMINALLY ILL ACT, § 20(1) (Austl.) (visited Jan. 5, 1997) <http://www.nt.gov.au/lant/rotti/>.

151. *But see Right-To-Die Cases Stir Profound Ethics Controversy*, MED. & HEALTH, Oct. 21, 1996, *available in* WESTLAW, MEDHLTH. Review of the legislation's ability to protect the permitted scope of euthanasia can soon begin. On September 22, 1996, Bob Dent, an Australian with prostate cancer, became the first person to die under the Northern Territory Rights of the Terminally Ill Act. Mr. Dent's physician was in attendance when he self-administered a lethal injection via a machine connected to a laptop computer.

152. *See* PARLIAMENTARY RECORD OF LEGISLATIVE DEBATES, *supra* note 42 (reflecting debate among Mr. Bailey, Mr. Perron, and Mr. Manzie).

safeguard to abuse.[153] However, a majority of legislators determined the coroner's role to be investigation of death, not investigation of the preliminary circumstances of death.[154] If the coroner reports to the Attorney General only as required annually, the effectiveness of the enforcement protocol will rely heavily on the coroner's investigation. However, the likely effectiveness of the Australian local investigation will overcome the Dutch system's weakness in reliance on a more removed district attorney investigation of the medical examiner's report from the physician.

Vote on the final form of the Act without additional safeguards was proffered on a belief that the variety of safeguards already expressly required in the system were sufficient.[155] In balancing potential safeguards to abuse, the Australian legislators chose to substitute more intensive scrutiny of acts of assistance for an addition of detailed criteria. If the goal of a system is to permit euthanasia with safeguards against abuse, why substitute one deterrence option for another when including both deterrence options will increase the safeguard against abuse? A combination of the two deterrence options—criteria and stringent reporting procedures—would provide enforcement of the system's permitted scope both prior to and after assistance.

II. THE AMERICAN REFERENDUM SYSTEM DISTINGUISHED

A review of the additional safeguards included in the American referendum system as defined by the Oregon Death with Dignity Act, but not found in either the Dutch or Australian system, provides an extension to the list of potential system requirements to safeguard the system's intended scope of assistance.[156] While the American system surpasses some of the statutory protective elements of the Australian system, it does not include all the statutory safeguards of the Australian system. Thus, the American referendum system does not represent a culmination of the statutory safeguards of both systems.[157]

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153. *Id.*

154. *Id.* A coronial test is based upon the coroner's statutory role: a decision for coronial inquiry is based upon a lack of satisfaction with the details of death presented in the required report. The coroner's role further requires providing feedback if the standards should be revised to be further limiting. *Id.*

155. *Id.*

156. A comprehensive comparison of the American referendum system, as defined in Oregon's Death with Dignity Act, with the Dutch and Australian systems is beyond the scope of this note.

157. The Oregon Death with Dignity Act, ch. 127, OR. REV. STAT. §§ 127.800-.897 (Supp. II 1996). Examples of some of the elements included in the Rights of the Terminally Ill Act but not included in the Death with Dignity Act include the following requirements: psychiatric consultation for all patients seeking assistance, a second physician consultant to be

A. *Medical Condition*

The Death with Dignity Act (Oregon Act) incorporates two additional factors to limit the purpose of euthanasia and the number of people who generally qualify for assistance: terminal diagnosis with six-month life expectancy and state residency.[158] Since the Oregon Act was enacted as a public referendum ballot measure, there is no act-specific legislative history to assist in defining the residency requirement.[159] However, the residency requirement does limit the group of patients who qualify for assistance.

Furthermore, the Oregon Act defines terminal disease more narrowly than the Australian Act. The Australian Act does not establish a life expectancy time period;[160] in contrast, the Oregon Act limits the scope of assistance to patients who have been diagnosed with a medically confirmed disease that is incurable, irreversible, and will, "within reasonable medical judgment, produce death within six . . . months."[161] While a life expectancy time frame creates a specific, narrow category for permitted assistance, the inherent uncertainty of medical prognosis could create difficulty for physician assessment. However, an application of assessment protocol for terminal illness, already used by palliative care physicians, would assist physicians.[162] The Oregon Act communicates the drafter's intent to deter the option of euthanasia until the last stages of a terminal illness; the Oregon Act effectively narrows the scope of assistance permitted.

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trained in treatment of the patient's terminal illness, a consulting physician to be neither a relative nor employee of or member of the assisting physician's medical practice, and information on palliative care to be provided by a physician with special qualifications in palliative care. *See* RIGHTS OF THE TERMINALLY ILL ACT, (Austl.) (visited Jan. 5, 1997) <http://www.nt.gov.au/lant/rotti/>.

158. The Oregon Death with Dignity Act § 2.01.

159. *Id.* The Oregon Death with Dignity Act, as Ballot Measure 16, "was proposed by initiative petition and was enacted by a vote of 627,980 to 596,018 at the regular general election on November 8, 1994. By proclamation of the Governor dated December 7, 1994, the Act was declared to . . . be in full force and effect." *Id.*

160. *See supra* note 60 and accompanying text. *See also* PARLIAMENTARY RECORD OF LEGISLATIVE DEBATES, *supra* note 42 (reflecting debate among Mr. Perron, Mr. Bell, Dr. Lim, and Mrs. Braham). Australian legislators understood that the omission of a time period widened the scope of the act's application but elected to maintain definitional consistency with other statutes. *Id.*

161. The Oregon Death with Dignity Act § 1.01(12).

162. *See* NATIONAL HOSPICE ORGANIZATION, HOSPICE FACT SHEET (1996) (on file with the *Indiana International & Comparative Law Review*). Hospice care is provided to a patient with a limited life expectancy of six months or less. *Id.*

B. *Voluntary Request*

The Oregon Act incorporates two additional safeguard elements to ensure that the patient's request is voluntary: the requirement of a witness to verify the patient's signature on the written request[163] and an expressly defined requirement of competency.[164] Although both the Australian[165] and Oregon Acts require a written request by the patient, only the Oregon Act requires a witness to the signature in addition to that of the physician.[166] The Oregon Act requires the safeguard of two witnesses to the patient's signature on the written request, one of whom is not "[a] relative of the patient by blood, marriage, or adoption; . . . entitled to . . . the estate of the . . . patient upon death under any will or by operation of law; or . . . [affiliated with a] health care facility where the . . . patient is receiving [care]."[167] This requirement increases the assurance that the patient's request is voluntary and that the patient has not been influenced by third parties.

While the Australian Act requires that a patient requesting assistance be of "sound mind," the Act does not provide a definition for this mental state.[168] In contrast, the Oregon Act requires a patient to be "capable."[169] The Act defines "capable" as having "the ability to . . . 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."[170] Furthermore, the statute provides that a patient's capability is determined by either a court or the physician.[171] Thus, the Oregon Act's statutory definition provides an applicable definition to safeguard the scope of the act, as well as a method to determine a patient's competency when there is a disagreement.

C. *Quality Decisions*

The Oregon Act incorporates three additional safeguards to ensure that a patient's decision is well-informed, fully considered, and durable: counseling of potential risks of medication,[172] passage of a minimum of fifteen days from initial to final request,[173] and an offer made to the patient

163. The Oregon Death with Dignity Act § 2.02(1).
164. *Id.* §§ 2.01, 1.01(6).
165. *See supra* note 89 and accompanying text.
166. The Oregon Death with Dignity Act § 2.02.
167. *Id.* § 2.02(2).
168. *See supra* notes 116-119.
169. The Oregon Death with Dignity Act § 2.01.
170. *Id.* § 1.01(6).
171. *Id.*
172. *Id.* § 1.01(7).
173. *Id.* § 3.08.

at the end of the fifteen-day waiting period of "an opportunity to rescind the request."[174] The Oregon Act requires the physician to inform the patient about the potential risks of taking the prescribed medication.[175] This requirement informs the patient of a concern that arises in euthanasia discussions—when medication does not work as quickly or in the manner desired. Use of the appropriate type and amount of medication to precipitate the type of death anticipated by the patient is not a science, and it can vary with the physician's knowledge of and experience in use of the medication.[176] If a patient elects prescription of medication to terminate life, he or she should be informed of the possible consequences. This notice ensures that the patient has made an informed decision.

The Oregon Act, requiring a minimum passage of fifteen days from the time of the request to assistance in death,[177] represents an increase of the seven-day period required by the Australian Act.[178] The Australian legislators adopted the lesser seven-day period even though some legislators believed that the Oregon Act's longer time period addressed a concern that patients who are suffering from treatable depression will need more time for treatment of and improvement in their mental state.[179] By lengthening the mandatory time period between an initial request and assistance, there is more time for diagnosis of clinical depression and provision of palliative care treatment to ensure a well-considered decision.[180]

In addition to the fifteen-day waiting period, the Oregon Act incorporates a requirement for the physician to solicit an indication of a change in request prior to life-terminating assistance.[181] A similar provision was discussed by the Australian legislatures but not included in the Act.[182] Discussion of the issue focused on the question of competency of the patient at the time of assistance.[183] The provision could be viewed as stating that any act less than a positive indication that the patient has changed his or her mind does not require the physician to discontinue life-terminating assistance.[184] In contrast, the provision could be viewed as requiring that a physician must discontinue assistance absent a positive indication that the patient has not

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174. *Id.* § 3.07.

175. *Id.* § 1.01(7)(c).

176. *See Pain*, MED. & HEALTH, Oct. 21, 1996, *available in* 1996 WL 7993641.

177. The Oregon Death with Dignity Act § 3.08.

178. RIGHTS OF TERMINALLY ILL ACT, § 7(1)(i) (Austl.) (visited Jan. 5, 1997) <http://www.nt.gov.au/lant/rotti/>.

179. *See* PARLIAMENTARY RECORD OF LEGISLATIVE DEBATES, *supra* note 42 (reflecting debate among Mr. Ede, Dr. Lim, Mr. Hatton, and Mr. Bailey).

180. *See supra* note 92. *See also Pain*, *supra* note 176.

181. The Oregon Death with Dignity Act § 3.04.

182. *See supra* notes 97-99 and accompanying text.

183. *Id.*

184. *Id.*

changed his mind.[185] In view of the lack of definitiveness of the provision and a desire to ensure that a patient who has lost competency since the initial request be able to receive assistance, the Australian legislature failed to include this additional safeguard to ensure a durable and voluntary request.[186] Absent any legislative history, the Oregon provision retains the same issues expressed by the Australian legislatures. The ambiguity could be resolved with further clarification. Absent clarification, the requirement of voluntariness is not safeguarded from abuse.

III. AVAILABILITY OF HEALTH CARE ALTERNATIVES

Each of the three systems incorporates the safeguard requirement that a physician prior to providing life-terminating assistance inform the patient of the availability of health care alternatives. Both the Australian and American systems also require that a patient receive psychiatric care, when found necessary, prior to qualification for euthanasia assistance.[187] However, only the Australian system requires that a patient receive palliative care prior to receiving euthanasia assistance when the physician believes "there are palliative care options reasonably available to the patient to alleviate the patient's pain and suffering to levels acceptable to the patient."[188] Although all three systems—Dutch, Australian, and American—express concern that the patient be informed of the availability of health care options and some of the systems require utilization of some alternative health care services, no system coordinates a guarantee that information on availability of other health care alternatives ensures geographic and financial access to health care alternatives.

A. *Access to Health Care*

While the health care systems in the Netherlands, Australia, and United States vary, both the Netherlands and Australia have universal access to health care.[189] In contrast, the United States is one of the few remaining industrialized countries without universal access to health care.[190] Universal

185. *Id.*

186. *Id.*

187. *See e.g., supra* notes 73, 108 and accompanying text; The Oregon Death with Dignity Act, § 3.01(4).

188. RIGHTS OF TERMINALLY ILL ACT, § 8(1) (Austl.) (visited Jan. 5, 1997) <http://www.nt.gov.au/lant/rotti/>.

189. EDWARD M. MENDOZA & BRYN J. HENDERSON, INTERNATIONAL HEALTH CARE: A FRAMEWORK FOR COMPARING NATIONAL HEALTH CARE SYSTEMS 3-6 (1995).

190. *Id.* at 7-8.

coverage does not guarantee immediate access but does guarantee eventual access.[191]

By contrast, the United States can generally guarantee immediate access only for emergency care and only limited access for uninsured routine care when the patient lacks the resources to pay.[192] When access is gained, the uninsured are likely to receive a lower level of health care services.[193] Furthermore, uninsured patients have less access to preventative and nonemergency care that can often eliminate or shorten periods of pain and illness.[194] With increasing financial pressure being placed on hospitals and physicians, access and level of health care service for the uninsured face increasing compromise.[195]

When the scope of a system permitting euthanasia requires that the physician inform the patient of other health care alternatives, of what benefit is the information if access to the other alternatives is not available? In the United States, an estimated thirty-seven million people are uninsured.[196] "Although those greater than 65 years of age and the very poor have access to good coverage, there are increasing numbers of working poor without coverage. Access difficulty is increasing for poor, black, Hispanic, or underinsured citizens."[197]

B. *Access to Palliative Care*

Palliative care, as a health care alternative, is experiencing increased success in alleviating pain and providing comfort to patients with a limited life expectancy diagnosis.[198] A 1986 national hospice study of home-care, hospital-based hospices, and conventional care revealed that a respective ten, four, and eighteen percent of patients experienced persistent pain.[199] In contrast, a 1973 report had indicated that seventy-three percent of patients experienced persistent pain.[200] Although palliative care is improving, there are several barriers to its increasing overall access: fifty countries do not have access to medicinal morphine, few medical schools offer palliative care

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191. *Id.* at 8.

192. *Id.* at 8-9.

193. Tom Stacy, *The Courts, The Constitution, and a Just Distribution of Health Care*, 3-WTR KAN. J.L. & PUB. POL'Y 77, 79 (1994).

194. *Id.*

195. *Id.*

196. THOMAS S. BODENHEIMER & KEVIN GRUMBACH, UNDERSTANDING HEALTH POLICY: A CLINICAL APPROACH 19 (1995).

197. MENDOZA & HENDERSON, *supra* note 189, at 8.

198. Warren L. Wheeler, *Hospice Philosophy: An Alternative to Assisted Suicide*, 20 OHIO N.U. L. REV. 755, 757 (1994).

199. *Id.*

200. *Id.*

in the curriculum, and physicians fear the legal ramifications of medicating for pain.[201]

Without guaranteed access to medical treatment to alleviate pain, information about palliative care as a health care alternative is of little use to a patient who is enduring a painful illness. The Dutch have established palliative care as a component of their national health care system.[202] A national center coordinates the activity of 135 voluntary organizations that provide care and support to the terminally ill patients in a home setting.[203] Furthermore, hospitals, nursing facilities, and pain control centers provide advanced clinical care to terminally ill patients.[204] Although the Dutch have devoted increased medical training and research resources to palliative care,[205] their health care system has been criticized for having only formally introduced hospice in 1993.[206]

Australian concern about access to palliative care is consistent with general concerns. If access to quality palliative care treatment is available, can all pain be controlled?[207] Access is a concern because there are few physicians with palliative care training.[208] Access to palliative care is further limited in areas outside the major cities of Australia.[209] Even when patients have access to morphine, the full complement of hospice care—psychological, spiritual, and emotional support—is often not available.[210] The Australian legislators discussed the cost effectiveness and necessity of providing palliative care but did not incorporate a guarantee of access to palliative care in the statutory requirements.

Similarly, the American system does not guarantee access to palliative care. Palliative care is not new to the health care continuum in the United States; the National Hospice Organization has advocated the needs of the terminally ill since 1978.[211] "In the 1990s, annual growth in the number of

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201. *Id.* at 757-58.

202. *Termination of Life*, *supra* note 14.

203. *Id.*

204. *Id.* "Four teaching hospitals have been designated as pain control centres . . . . The medical profession draws up treatment protocols on the basis of the latest medical research in the fields of general . . . and anaesthesiological pain relief." *Id.*

205. *Id.*

206. Wheeler, *supra* note 198, at 760. Warren Wheeler, author of the article, spoke to Dr. Peter Admiraal, a trained anesthiologist from Delft, Netherlands, at Dr. Balfour Mount's International Congress on the "Care of the Terminally Ill." Dr. Admiraal conveyed that the first hospice in the Netherlands was opened in 1993. *Id.*

207. *See* COMMITTEE REPORT, VOLUME 1, *supra* note 22, § 3.7.

208. *Id.*

209. *See* PARLIAMENTARY RECORD OF LEGISLATIVE DEBATES, *supra* note 42 (reflecting discussion of Mr. Setter).

210. *Id.*

211. *See* NATIONAL HOSPICE ORGANIZATION, *supra* note 162.

hospice patients nationwide has averaged 13 percent."[212] However, Medicare and Medicaid public assistance programs, available only to select portions of the population, continue to pay for over seventy-five percent of all hospice care provided.[213] Access is further limited when a patient is a member of a minority race,[214] does not have a primary caregiver,[215] or requires "high tech" therapies.[216]

If the overriding purpose of a system of euthanasia is to provide the final alternative on a continuum of patient autonomy, how can a system fulfill its purpose without providing access to other health care alternatives? How can information about alternative services provide comfort and dignity to a patient when those services are not available? Information alone does not permit a patient to effectively choose between enduring a deteriorating, painful, and perhaps slow death and a quick death that at a minimum ensures an end to an unknown future. A system that permits voluntary euthanasia cannot equally guarantee the right to live and the right to die without a guarantee of alternative health care.

IV. CONCLUSION

At the time of this writing, society awaits the outcome of another victory for the international right to die movement. The United States Supreme Court has given physician-assisted suicide a legal spotlight on the national stage by agreeing to review Ninth and Second Circuit Appellate Court decisions that ruled against Washington and New York state bans of assisted-suicide.[217] The Court began to hear arguments in January, 1997;[218]

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212. *Id.*

213. *Id.* "Sources of payment for hospice services are as follows: Medicare, 66.8%; private insurance, 14.6%; Medicaid, 9.1%; indigent (nonreimbursed) care, 6.3%; other, 3.2%." *Id.*

214. *Id.* "Consistent with other health care census statistics, 85% of hospice patients were white; 9% were African American; 3% were Hispanic; and 3% were identified as 'other.'" *Id.*

215. *Id.* "Forty-five percent of hospices admit patients without primary caregivers; another 31% admit patients without caregivers on a case-by-case basis." *Id.*

216. *Id.* "Fifty-one percent of hospices admit individuals requiring 'high-tech' therapies; an additional 42% admit patients needing 'high-tech' services on a case-by-case basis." *Id.*

217. Edward Felsenthal & Paul M. Barrett, *Supreme Court Agrees to Rule on Laws Banning Assisted Suicide*, WALL ST. J., Oct. 2, 1996, at B9 *available in* 1996 WL-WSJ 11800742. The Court will rule on lower court decisions striking down a Washington state law and a New York state ban on assisted suicide. The Court will decide: "Does the Constitution implicitly give people a right to privacy in making decisions about the most personal aspects of their lives, from child-rearing and marriage to contraception and abortion?" *Id. See also American Suicide Foundation Submits Opinion to Supreme Court Opposing Legalization of Assisted Suicide* [hereinafter *American Suicide Foundation*], PR NEWSWIRE, Nov. 12, 1996. "In both cases the courts ruled that there is a constitutional right to suicide for competent

a decision is expected in June.[219] "If the Supreme Court agrees with the federal appellate courts . . . the decision will allow terminally ill citizens throughout the country to hasten death 'without undue interference from the state' . . . ."[220]

"In anticipation of the possibility that the Supreme Court will rule in favor of physician-assisted suicide, several . . . organizations are drafting their own guidelines for the procedure . . . ."[221] These organizations follow the path of other individuals and groups that have formulated protocol.[222] As authors hurriedly work toward the approaching deadline of the Court's decision, they most surely are reviewing what systems are available and asking: What systems have been tried? What concerns still remain?

Over twenty-three years of Dutch experience in permitting voluntary euthanasia can provide history with the lessons from which society seeks to learn. Australian legislators derived comfort in legislating a euthanasia system by safeguarding against the weaknesses of the Dutch judicial system. They responded to a public concern for increased patient autonomy in end-of-life decisions by enacting a system with a more specific set of objective assessment and reporting safeguards than society had yet seen.

As the world prepares for another outcome in the battle between the right to live and the right to die, one must be careful in drawing specific lessons from one experience, culture, and people for application in another setting.[223] Beyond cultural specifics lie similarities in issues inherent to any policy permitting one individual to assist in the death of another.[224] However, a difference in cultural values, as evidenced in the comparison of Dutch and Australian systems, will affect the application of criteria to another culture.

If a state, territory, or country makes a public policy decision to permit a system of voluntary euthanasia—and a right to die—to operate within its

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terminally ill patients and that laws in both states banning assisted suicide are invalid." *Id.*

218. *'The Way We Are,'* WALL ST. J., Jan. 10, 1997 *available in* 1997 WL-WSJ2405269.

219. *American Suicide Foundation, supra* note 217.

220. *Guidelines*, MED. & HEALTH, Oct. 21, 1996, *available in* 1996 WL 7993640.

221. *Id.* Organizations preparing for legalization of assisted-suicide include the Washington State Medical Association and San Francisco Medical Society. *Id.*

222. *See, e.g.*, Charles H. Baron et al, *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 HARV. J. ON LEGIS. 1 (1996) (representing a collaborative effort of attorneys and law school professors); Craig A. Brandt et al., *Model Aid-in-Dying Act*, 75 IOWA L. REV. 125 (1989) (reporting on a collaborative student effort of a year-long seminar); Paul A. Drey & James J. Giszczak, Note, *May I Author My Final Chapter? Assisted Suicide and Guidelines to Prevent Abuse*, 18 J. LEGIS. 331 (1992) (representing a student written work); JACK KEVORKIAN, PRESCRIPTION: MEDICIDE: THE GOODNESS OF PLANNED DEATH (1991) (representing his personal beliefs).

223. Alexander M. Capron, *Euthanasia in the Netherlands: American Observations*, 22 HASTINGS CENTER REP. 30 (Mar.-Apr. 1992).

224. *Id.*

society, they can enact several measures to limit abuse of the system. The measures of development—judicial, legislative, and public referendum—will possess inherent weaknesses specific to the manner of development. However, the society can further limit the scope of the system to narrow the category and type of patients that will qualify. Specific, objective assessment criteria and a reporting and prosecutorial system will limit abuse of the defined scope of the system.

However, a focal point of potential abuse, lack of health care alternatives, will destroy prior safeguards if the society cannot guarantee geographic and financial access to other health care alternatives. This guarantee of health care requires a financial commitment during a time of prevailing concern for health care cost-containment. In a quest for cost efficiency, how high will society rank the need to safeguard the right to live? Will society continue to ensure a right to medical assistance in death before ensuring a right to medical assistance in life?

> The law exists to protect life. When it begins to legitimate the taking of life, . . . one has a right to ask what lies ahead for our life as a society.[225]

Traci R. Little[*]

225. USA TODAY, *supra* note 1, at 3A.

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