

PHYSICIAN-ASSISTED SUICIDE AND EUTHANASIA: SAFEGUARDING AGAINST THE “SLIPPERY SLOPE” – THE NETHERLANDS VERSUS THE UNITED STATES

I. INTRODUCTION

O for a draught of vintage! that hath been
Cool'd a long age in the deep-delved earth,
Tasting of Flora and the country green,
Dance, and Provencal song, and sunburnt mirth!
O for a beaker full of the warm South,
Full of the true, the blushful Hippocrene,
With beaded bubbles winking at the brim,
And purple-stained mouth;
That I might drink, and leave the world unseen,
And with thee fade away into the forest dim:
John Keats, “Ode to a Nightingale”¹

Physician-assisted suicide (PAS) and euthanasia are highly controversial topics, and the proposed legalization of both has fueled a highly emotional debate. Those who adamantly oppose the legalization of PAS and euthanasia provide a very grim “slippery slope argument” that predicts the mass extermination of vulnerable groups of people.² In comparison, those who avidly support the legalization of PAS and euthanasia promote the right to die in a humane and dignified manner, free from terrible pain and suffering.³ Two countries providing fuel to this debate are the Netherlands and the United States. The Netherlands has increasingly permitted PAS and euthanasia through the common law system for the past twenty years,⁴ and on April 1, 2002, the Termination of Life on Request and Assisted Suicide Act (TLRSA)

1. JOHN KEATS, ODE TO A NIGHTINGALE 286, *reprinted in* THE OXFORD AUTHORS (Elizabeth Cook ed., 1990).

2. See Marcia Angell, *Euthanasia in the Netherlands – Good News or Bad?*, 335(22) NEW ENG. J. MED. 1676 (1996).

3. Margaret P. Battin, *Is a Physician Ever Obligated to Help a Patient Die?*, in REGULATING HOW WE DIE 23 (Linda L. Emanuel ed., 1998). “The principle of mercy, or avoidance of suffering, underwrites the right of a dying person to an easy death, to whatever extent possible, and clearly supports physician-assisted suicide in many cases.” *Id.*

4. See Angell, *supra* note 2, at 1676. If PAS and euthanasia are legalized, a country will slide down the “slippery slope” toward involuntary euthanasia “performed on the very old, the very young, the disabled, and those who [are] financially costly or otherwise burdensome.” *Id.*

formally established the legalization of PAS and euthanasia.⁵ In the United States, the state of Oregon legalized PAS in 1994 under the Death With Dignity Act (DWDA).⁶ Are these two countries the trailblazers of the ultimate right to control the manner of one's own death or are they swimming in the murky waters of selective termination?

This Note provides an in-depth analysis of the historical background of PAS and euthanasia in the Netherlands and the United States. The analysis supplies the framework necessary to support the conclusion that the cultural differences between the two countries have resulted in different levels of determining which patients are eligible for assistance in death: Oregon's DWDA drawing an objective line and the Netherlands' TLRASA drawing a subjective line. Part II introduces two different concepts of PAS and euthanasia and the two opposing arguments surrounding the debate over legalization of PAS and euthanasia. Part III focuses on the historical evolution of the legalization of PAS in Oregon and provides a detailed description of the DWDA. Part IV examines the Netherlands' case law over the last twenty years that led to the legalization of PAS and euthanasia and a critical evaluation of the TLRASA. Part V compares the DWDA and the TLRASA and the cultural differences between the United States and the Netherlands. Part VI supplies the conclusion that the cultural differences between the two countries support the theory that the Netherlands' utilization of a subjective line to determine who is qualified to request assistance in death is equally protective against abuse as Oregon's objective line.

II. THE DEBATE OVER THE LEGALIZATION OF PAS AND EUTHANASIA

A. *Euthanasia and PAS Defined*

Before delving into the debate whether euthanasia and PAS should be legalized, the definitions of both terms are necessary. Euthanasia and PAS are two separate concepts defined by actions taken by both physician and patient.⁷ The terms are distinguished by whether the physician actively participates at the time of the patient's death or whether the patient plays a physical role in the act of his or her death.⁸

5. Termination of Life on Request and Assisted Suicide (Review Procedures) Act §§ 1-24, available at Ministry of Foreign Affairs-The Netherlands, <http://www.minbuza.nl/english/Content.asp?Key=416729&Pad=400025,257588,257609> (last visited Feb. 26, 2003) [hereinafter TLRASA].

6. The Oregon Death With Dignity Act, 13 OR. REV. STAT. §§ 127.800-.897 (2000) [hereinafter DWDA].

7. Richard M. Sobel & A. Joseph Layon, *Physician-Assisted Suicide: Compassionate Care or Brave New World?*, 157(15) ARCH. INT. MED. 1638 (1997).

8. Diane E. Meier, *Doctors' Attitudes and Experiences with Physician-Assisted Death: A Review of the Literature*, in PHYSICIAN-ASSISTED DEATH 7-8 (James M. Humber et al. eds., 1994).

Euthanasia is defined as an "act of causing death painlessly, so as to end suffering."⁹ Most laypersons think of euthanasia as "mercy killing" or putting someone out of his or her misery.¹⁰ Euthanasia is classified as voluntary or involuntary.¹¹ Voluntary euthanasia is the lethal injection of medication into the patient's bloodstream by the physician at the patient's request to hasten his or her death.¹² Involuntary euthanasia is the lethal injection of medication by the physician without the patient's explicit request for assistance in death.¹³

PAS is the lethal prescription of medication written by the physician at the patient's request.¹⁴ PAS is considered voluntary because this form of assistance requires the patient to self-administer the lethal dose of medication.¹⁵ Hence, the physician does not have an active role at the time the patient ingests the medication.¹⁶

The concepts of euthanasia and PAS are not new to the modern world.¹⁷ Many ancient societies not only allowed suicide, but encouraged it when one outlived his or her usefulness to society.¹⁸ Furthermore, ancient Romans and

9. WEBSTER'S NEW WORLD DICTIONARY AND THESAURUS 211 (1996). *See also* GERALD DWORKIN ET AL., EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE: FOR AND AGAINST 108 (1998). The word euthanasia originates from the Greek language and is defined as "good death." *Id.*

10. DEREK HUMPHRY, *LAWFUL EXIT: THE LIMITS OF FREEDOM FOR HELP IN DYING* 13 (1993). Mercy killing is defined as "ending another person's life without his or her request in the belief that it is a compassionate act." *Id.*

11. *See Meier, supra* note 8, at 7.

12. Steven Miles M.D. et al., *Considerations of Safeguards Proposed in Laws and Guidelines to Legalize Assisted Suicide*, in *PHYSICIAN-ASSISTED SUICIDE* 208 (Robert F. Weir ed., 1997). *See also Meier, supra* note 8, at 8.

Implicit in the definition of voluntary euthanasia is the recognition that death is in the best interest of the patient requesting assistance, as assessed by the patient, that his or her pain and suffering outweigh the benefit of any additional duration of life, and that the patient is physically incapable of suicide.

Id.

13. *See Meier, supra* note 8, at 7.

14. *See id.* at 8.

15. *See id.*

16. *See Miles et al., supra* note 12, at 208. The physician who supplies the prescription for the lethal dose of medication is viewed as the facilitator. *See id.* The facilitator is the person who provides the opportunity for the other person to commit suicide. *See id.* The patient who requests the prescription and ingests the medication to hasten his or her death is viewed as the principal - the one who committed the ultimate act of suicide. *See id.*

17. A. Alvarez, *The History of Suicide*, in *LAST RIGHTS: ASSISTED SUICIDE AND EUTHANASIA DEBATED* 63-65 (Michael M. Uhlmann ed., 1998).

18. *See generally* Thane Josef Messinger, *A Gentle and Easy Death: From Ancient Greece to Beyond Cruzan*, 71 *DENV. U. L. REV.* 175, 180-84 (1993). The ancient civilization of Ceos promoted a tradition of gathering the elderly together at somewhat of a celebratory feast where all would partake in the consumption of a lethal drink. *See id.* The Ceos civilization viewed the elderly as no longer beneficial to society. *See id.* In ancient Greece, hemlock, a poisonous plant, was available to those persons who gained permission to end his or her life from the Senate. *See id.* Ancient Rome considered terminal illness as good cause for suicide and seemed to differentiate between "lengthening life or death." *Id.* The sentiment of the people seemed to be if one's body was no longer able to function, then why not "free the

Greeks widely believed that "man [was] the master of his own body, with the right to decide his own fate."¹⁹ Is the modern world simply looking backward or creating a precedent of personal autonomy and freedom of choice?

B. Proponents of PAS and Euthanasia

Arguments favoring PAS and euthanasia surround two common themes, personal autonomy and the right to be free from undue suffering at the end of life.²⁰ Proponents contend "that the decision to end one's life is intensely personal and private, harms no one else, and ought not be prohibited by the government or the medical profession."²¹ Advancements in medical technology over the past twenty years have resulted in the ability to keep people alive much longer than in the past.²² Before the modern era of medicine, physicians did not have the scientific technology to prolong a patient's life and dying was accepted as a natural event.²³ Today, "the possibility of being maintained indefinitely on life-support engenders a fear of prolonged suffering and loss of dignity and control during our final days."²⁴ The modern mindset evolved from the hope of prolonging life to analyzing the quality of life that has been retained.²⁵ "Medicalization" of the dying process led to a strong argument in favor of individual control at the end of life and personal autonomy.²⁶ Proponents assert that PAS and euthanasia provide appropriate safeguards against the invasion of medical technology and

struggling soul." *Id.* See also DWORKIN, *supra* note 9, at 94-95.

19. See Messinger, *supra* note 18, at 182.

20. See Battin, *supra* note 3, at 23.

21. Lois Snyder et al., *Physician-Assisted Suicide*, 135(3) ANNALS INTERNAL MED. 209 (2001).

22. HARRY A. SULTZ & KRISTINA M. YOUNG, HEALTH CARE USA: UNDERSTANDING ITS ORGANIZATION AND DELIVERY 166-67 (1997). "The array of medical interventions and diagnostic modalities has increased exponentially in the past [thirty] years, including a vast expansion of pharmaceuticals to treat acute conditions and manage chronic ones." *Id.* See also Charon Pierson, *The Public and Private Problem of Euthanasia: A Comparison of the Netherlands and the United States*, 19(6) GERIATRIC NURS. 309 (1998).

23. See *id.* at 309.

24. *Id.* Factors connected to the "medicalization" of the dying process include: "fee-for-service insurance, . . . entitlement payment systems, [i]ncreased services . . ." *Id.* See also DWORKIN, *supra* note 9, at 84. In the past people may have feared death, but now with the advent of medical science, people often fear the alternative to death; a drawn out, painful affair, attached to numerous machines and away from the comfortable surroundings of home. See *id.*

25. Dr. Nickolas A. Pace, *Law and Ethics at the End of Life: The Practitioner's View, in DEATH, DYING AND THE LAW 9* (Sheila A.M. McLean ed., 1996).

26. See Snyder, *supra* note 21, at 209. End of life suffering includes: pain, nausea, anxiety, depression, loss of bowel and bladder functions, total dependency on others for activities of daily living, feelings of hopelessness, and lack of dignity. See *id.* See also Pierson, *supra* note 22, at 309. See also JOHN GRIFFITHS ET AL., EUTHANASIA & LAW IN THE NETHERLANDS 169 (1998). Those in support of personal autonomy believe that a person is "entitled to define his own conception of human dignity . . ." *Id.*

outliving one's own death.²⁷ Hence, the debate concerning PAS and euthanasia has developed with ferocious speed along with strong opinions for and against the legalization of PAS and euthanasia.²⁸

Proponents of the legalization of PAS and euthanasia suggest that if one has total control of his or her life, one should have the same control over the time, place, and manner of one's death.²⁹ A further contention is that all persons should have the complete right to self-determination; moreover, "[c]hoosing how to die is part of choosing how to live."³⁰ Thus, PAS and euthanasia provide people with the ability to die with dignity and not in a manner that would be considered offensive and self-degrading.³¹

Another argument in support of PAS and euthanasia is the principle of mercy.³² The basis for this principle is that one should not cause pain and suffering, and when possible, act to eliminate such pain.³³ This principle seems to comport naturally with the role of the physician.³⁴ Physicians are in the best position to provide PAS and euthanasia because they can provide the appropriate medication or prescription to the patient; physicians have the expertise to control any possible adverse effects of the medication; physicians can make decisions in an objective manner; and physicians have a duty to abide by professional medical standards.³⁵ Hence, physicians, in their role as caretaker, can prevent patients from undue suffering caused by a protracted dying process by providing a "merciful" death.³⁶

Additionally, some argue that physicians have an obligation to provide all-encompassing end-of-life treatment to their patients, which under certain circumstances involves assistance in death.³⁷ Proponents assert that if this care

27. See Snyder, *supra* note 21, at 209. See also DWORKIN, *supra* note 9, at 84. "The greater the ability of health professionals to prolong lives that would otherwise ebb away, the more necessary it becomes for societies to institute safeguards to allow patients to reject medical interventions that serve only to prolong dying." *Id.*

28. DEREK HUMPHRY & MARY CLEMENT, *FREEDOM TO DIE: PEOPLE, POLITICS, AND THE RIGHT-TO-DIE MOVEMENT* 314 (1998).

29. See GRIFFITHS, *supra* note 26, at 169.

30. See Battin, *supra* note 3, at 23.

31. William J. Winslade Ph.D., J.D., *Physician-Assisted Suicide: Evolving Public Policy*, in *PHYSICIAN-ASSISTED SUICIDE*, *supra* note 12, at 227.

32. See GRIFFITHS, *supra* note 26, at 172. The principle of mercy is compassion at the end of life and prevention of undue suffering. See *id.*

33. See Battin, *supra* note 3, at 23.

34. See *id.*

35. See *id.* at 26. See also DWORKIN, *supra* note 9, at 133.

36. See Battin, *supra* note 3, at 23. "Suicide assisted by a humane physician spares the patient the pain and suffering that may be part of the dying process, and grants the patient a 'mercifully' easy death." *Id.* See also Winslade, *supra* note 31, at 228. Physicians are viewed as "gatekeepers at the borders of life and death." *Id.*

37. Roseamond Rhodes, *Physicians, Assisted-Suicide, and the Right to Live or Die*, in *PHYSICIAN ASSISTED SUICIDE: EXPANDING THE DEBATE* 171 (Margaret P. Battin et al. eds., 1998). The rationale supporting the contention that physicians have an obligation to assist their patients in end-of-life decisions is that "by professional training, doctors should know how to hasten death with minimum discomfort or violence, and . . . because of their access to medical

is not provided, patients may feel a sense of abandonment at the time physicians are most needed.³⁸ Hence, medical science indirectly caused the suffering that terminally³⁹ and chronically ill⁴⁰ patients must endure.⁴¹ Therefore, physicians should not turn their backs on patients requesting relief from pain and suffering “even at the price of shortening life.”⁴² Based on the physician-patient relationship, granting a patient his or her request to die in a peaceful, dignified manner could be viewed as one of the most compassionate acts physicians perform.⁴³ During his testimony to the House of Representatives Committee involving an oversight hearing on PAS, Dr. Timothy E. Quill, an advocate for complete end-of-life care, stated:

All available options to alleviate suffering must be publicized to both physicians and patients, for we have an obligation to be responsive to those who are disintegrating as persons in spite of our best efforts without violating their or our personal values. The method used to help patients at the very end is less important than more fundamental processes of caring, joint decision making [sic], excellent palliative care, and a commitment not to abandon no matter how the process unfolds.⁴⁴

technology and pharmacology . . .” *Id.* at 171.

38. See Snyder, *supra* note 21, at 209.

39. See WEBSTER’S, *supra* note 9, at 633. Terminal is defined as “close to causing death.”

Id.

40. MOSBY’S DICTIONARY: MEDICAL, NURSING, & ALLIED HEALTH 255 (3d ed. 1990).

Chronic disease is defined as “a disease that persists over a long period of time as compared with the course of an acute disease. The symptoms of chronic disease are usually less severe than those of the acute phase of the same disease.” *Id.*

41. L.L. BASTA, LIFE AND DEATH ON YOUR OWN TERMS 52-53 (2001).

42. Howard Brody, *Assisting in Patient Suicides is an Acceptable Practice for Physicians*, in PHYSICIAN-ASSISTED SUICIDE, *supra* note 12, at 138.

43. Timothy E. Quill et al., *The Debate Over Physician-Assisted Suicide: Empirical Data and Convergent Views*, 128(7) ANNALS OF INTERNAL MED. 552 (1998). Although the author, Dr. Quill, asserts that all physicians are obligated to providing supportive end-of-life care, he does not agree that physicians are obligated to provide PAS if it is against their moral and fundamental values. See *id.* Dr. Quill suggests that if legalized PAS is an option for the patient and after much discussion of alternatives, the patient is still adamant in his or her desire for PAS and his or her physician does not morally agree, then the physician should refer the patient to a physician with views more similar to that of the patient. See *id.*

44. *House of Representatives Committee on the Judiciary Subcommittee on the Constitution Oversight Hearing on “Assisted Suicide in the United States,” Testimony by Timothy E. Quill, M.D.*, (Apr. 29, 1996), available at <http://www.house.gov/judiciary/2168.htm> (last visited Nov. 15, 2002). Dr. Quill is a proponent of PAS but not euthanasia. See *id.* The position that Dr. Quill takes is PAS should be used as a last resort measure. See *id.* Dr. Quill stated in his testimony to the House of Representatives that “[a]ssisted suicide should never be an alternative to good palliative care.” *Id.* Nonetheless, if palliative care no longer relieves the patient’s suffering and all other alternatives have been explored, then PAS should be a legal option. See *id.*

Caring for patients over a long period of time and allowing them to live in a manner of their choosing should naturally lead to caring for patients in their time of death.⁴⁵ Thus, physicians supplying end-of-life care to their patients should be allowed to relieve their patients' suffering with all viable options, including PAS and euthanasia if so indicated.⁴⁶

The distinction between "killing" and "letting die" is another component in the debate regarding whether PAS and euthanasia should be legalized.⁴⁷ The Acts and Omissions Doctrine⁴⁸ frames the distinction between "killing" and "letting die."⁴⁹ The Doctrine sets forth that "failure to perform an act, with certain foreseen bad consequences of that failure, is morally less bad than to perform a different act which has identically foreseeable bad consequences."⁵⁰

Proponents of PAS and euthanasia assert that "killing" and "letting die" are morally equivalent.⁵¹ However, opponents of euthanasia and PAS disagree.⁵² For example, many opponents view the act of withdrawing fluids and nutrition or turning off a respirator as "letting die."⁵³ On the other hand, PAS and euthanasia are considered "killing" because the physician writes the lethal prescription or injects the patient with a lethal dose of medication.⁵⁴

Proponents of PAS and euthanasia view the two cases as equivalent because, in both situations, the physician acts, and the patient's death.⁵⁵ Moreover, when nutrition and fluids or oxygen are withdrawn, the patient

45. See Rhodes, *supra* note 37, at 163, 171. Proponents additionally argue that if patients know their physician will not allow them to needlessly suffer, the trust between patient and physician will be strengthened. See *id.* Trust between patients and their physicians normally develops from a continuum of supportive and appropriate care provided by the physician over a period of years. See *id.* Patients who have placed a high amount of trust in their physicians in the past usually have an expectation that their physician will continue to provide the same supportive care in the future. See *id.* Furthermore, with PAS and euthanasia as an option, patients may be more willing to attempt additional therapeutic measures based on the knowledge that if the measures do not better their situation or even worsen their suffering, there are still means available to alleviate their suffering. See *id.*

46. See *id.* at 163.

47. Bernard Gert et al., *An Alternative to Physician-Assisted Suicide: A Conceptual and Moral Analysis*, in *PHYSICIAN ASSISTED SUICIDE: EXPANDING THE DEBATE*, *supra* note 37, at 186. Another argument involving "killing" and "letting die" involves the psychological aspect of the physician. See *id.* Many propose that it is psychologically easier to "omit rather than to act." *Id.* See also Tom L. Beauchamp, *The Autonomy Turn in Physician-Assisted Suicide*, 913 ANNALS OF N.Y. ACAD. OF SCI. 111 (2000).

48. See GRIFFITHS, *supra* note 26, at 158.

49. See also Beauchamp, *supra* note 47, at 111. "[K]illing is causal action that brings about another's death, whereas letting die is the intentional avoidance of causal intervention so that disease, system failure, or injury causes death." *Id.*

50. See GRIFFITHS, *supra* note 26, at 158 (quoting Glover 1977:92).

51. F. M. KAMM, *MORTALITY*, VOL. II 18 (1996).

52. See Beauchamp, *supra* note 47, at 111.

53. See *id.* at 115. "Letting die" is the termination of life-saving medical technology because it is futile or because the patient has refused such treatment. See *id.*

54. See GRIFFITHS, *supra* note 26, at 159.

55. See *id.*

normally dies as the result of starvation and dehydration or lack of oxygen, not the underlying disease.⁵⁶ Thus, the logical conclusion seems to be that allowing a patient to suffer from starvation or lack of oxygen is inhumane when compared to a “merciful” death provided by PAS or euthanasia.⁵⁷

C. Opponents of PAS and Euthanasia

The principal argument against PAS and euthanasia is the “slippery slope” argument.⁵⁸ Opponents contend that the legalization of PAS and euthanasia will lead to cataclysmic events resulting in the arbitrary termination of vulnerable groups of people.⁵⁹ Some argue, “[R]estrictions initially built into legislation will eventually be revised or ignored, ever increasing the possibilities for unjustified killing.”⁶⁰ Thus, the legalization of PAS and euthanasia would promote discrimination against the mentally ill, the elderly, and the disabled.⁶¹

Additionally, the legalization of PAS and euthanasia will lead to society, and more importantly, physicians becoming calloused toward the termination of life.⁶² The Health Council of the Netherlands⁶³ postulated that:

56. Cf. Beauchamp, *supra* note 47, at 115. Another distinction between the two concepts surrounds the causation of death. *See id.* Opponents assert that when fluids and nutrition are withdrawn, the patient dies from the underlying disease. *See id.* Yet, when the patient ingests or is injected with a lethal dose of medication, his or her death was caused by the action of the physician and not the underlying pathology. *See id.*; *see also* GRIFFITHS, *supra* note 26, at 159. “Letting die” is allowing nature to take its course. *See id.*

57. *See* GRIFFITHS, *supra* note 26, at 159.

58. John Keown, *Euthanasia in the Netherlands: Sliding Down the Slippery Slope?*, in *EUTHANASIA EXAMINED: ETHICAL, CLINICAL, AND LEGAL PERSPECTIVES* 262 (John Keown ed., 1995). The basic “slippery slope” argument in regard to the legalization of PAS and euthanasia is: If voluntary PAS and euthanasia are legalized, society will become desensitized to both forms of assisted death, which will gradually lead to the involuntary termination of vulnerable groups that are viewed as no longer useful to society. *See id.*

59. *See* DWORKIN, *supra* note 9, at 43. *See also* Herbert Hendin, *The Dutch Experience; Euthanasia*, 17 *ISSUES L. & MED.* 223 (2002). *See also* Herbert Hendin, *Physician-Assisted Suicide and Euthanasia in the Netherlands: Lessons From the Dutch*, 277(21) *JAMA* 1720 (1997).

60. *But cf.* Beauchamp, *supra* note 47, at 111. Beauchamp suggests that although the “slippery slope” argument contains valid social concerns, the argument does not set forth valid reasons to “deny vulnerable or non-vulnerable parties” assistance in death. *Id.* Moreover, Beauchamp proposes that the opponents’ argument is somewhat paternalistic in the fact that it essentially suggests that these vulnerable groups are not capable of making a valid decision concerning PAS. *See id.*

61. *See* DWORKIN, *supra* note 9, at 43. Because these vulnerable groups suffer from distinct hardships, they would not be adequately protected if the legalization of PAS and euthanasia permeates throughout society. *See id.* *See also* Hendin, *supra* note 59, at 223.

62. *See* Hendin, *supra* note 59, at 223.

63. Mission Statement of the Health Council of the Netherlands, *available at* <http://www.gr.nl/missie.php> (last visited Nov. 22, 2002). The Health Council of the Netherlands is an advisory board that informs the Ministers and Parliament of issues encompassing all areas of public health. *See id.*

A danger lurks in the possibility that the freedom to engage in euthanasia will lead to a certain routine and habituation, which raises the danger that required standards of care will not always be adhered to in making judgments whether or not euthanasia or assistance with suicide is in fact indicated.⁶⁴

Persons inflicted with the mental illness of depression are considered vulnerable to the legalization of PAS and euthanasia.⁶⁵ Terminally ill patients who request PAS or euthanasia are likely suffering from depression.⁶⁶ If depression is not correctly diagnosed and treated by physicians during an evaluation in regard to a request for PAS and euthanasia, many patients may be assisted in death prematurely.⁶⁷ Opponents contend that depression is difficult to diagnose especially in cases of terminally ill patients.⁶⁸ Furthermore, many physicians do not perform a correct assessment of the patient's mental condition or refer the patient for psychiatric evaluation.⁶⁹ Thus, without proper treatment, depressed patients are more likely to request and receive assistance in death.⁷⁰

The elderly and disabled are also considered groups that would be vulnerable to the abuses of legalized PAS and euthanasia.⁷¹ One argument is that these two groups are more likely to be pressured into requesting PAS or

64. See GRIFFITHS, *supra* note 26, at 178 (quoting Gezondheidsraad 1982:72).

65. WESLEY J. SMITH, *FORCED EXIT: THE SLIPPERY SLOPE FROM ASSISTED SUICIDE TO LEGALIZED MURDER* 124 (1997).

66. See Mark E. Chopko, *Responsible Public Policy at the End of Life*, 75 U. DET. MERCY L. REV. 557, 580 (1998). In most studies of persons who commit suicide, ninety-five percent have a mental illness at the time of death. *See id.*

67. *See id.*

68. See Quill, *supra* note 43, at 552. The difficulty in diagnosing depression in the terminally ill patient is due to the overlapping symptoms of depression and a terminal illness. *See id.* Those symptoms include: "fatigue, sleep disturbance, poor concentration, loss of interest in normal affairs, weight loss, and preoccupation with death." *Id.* Additionally, if a patient is diagnosed with depression based on suicidal thoughts, then every person requesting assistance in death would be considered depressed. *See id.*

69. See DWORKIN, *supra* note 9, at 48. *See also* GRIFFITHS ET AL., *supra* note 26, at 223. A survey of psychiatrists in the Netherlands reported that only three percent of patients requesting PAS or euthanasia were referred for psychiatric consultation. *See id.*

70. See DWORKIN, *supra* note 9, at 48. A survey by New York State Task Force on Life and the Law provided information that "most doctors 'are not trained to diagnose depression, especially in complex cases such as patients who are terminally ill'." *Id.* Moreover, even if a patient is diagnosed with depression, the survey showed that those patients often went untreated. *See id.* Terminally ill patients who receive appropriate treatment for depression and pain will no longer desire assistance in death. *See id.*

71. Mark C. Siegel, Note, *Lethal Pity: The Oregon Death With Dignity Act, Its Implications for the Disabled, and the Struggle for Equality in an Able-Bodied World*, 16 LAW & INEQ. 259, 261 (1998).

euthanasia because of financial burdens and “social devaluation.”⁷² A second argument is that the legalization of PAS and euthanasia has nothing to do with a fundamental right or liberty but serves as a vehicle for “bigotry against disabled people that sends the loud message that disabled people’s lives are worthless.”⁷³ Moreover, if PAS and euthanasia are only offered to the terminally ill or the severely disabled and not offered to all competent adults, society will only further devalue these vulnerable groups.⁷⁴

Many elderly and disabled people are not gainfully employed and are dependent on others for financial assistance.⁷⁵ The lack of financial support decreases the choices available to the elderly and disabled, and persons in this circumstance may tend to more readily accept the option of death.⁷⁶ Moreover, the elderly and disabled may feel as if they are an emotional and financial burden to their families, and the legalization of PAS and euthanasia may lead them to end their lives prematurely.⁷⁷ Thus, the option of PAS and euthanasia “may create a generally pressured climate where patients feel the need to justify their decisions to go on living.”⁷⁸

In addition to financial burdens placing the disabled and elderly at a higher risk for being pressured into requesting assistance with death, the attitude that the young and healthy are more valuable than the elderly and disabled also places these two groups in danger of coercion.⁷⁹ A society that is outwardly uncertain and apprehensive in regard to its disabled citizens and how those citizens conform to its culture only compounds and strengthens the disabled citizens’ feelings of worthlessness.⁸⁰ This “sense of despair” coupled with the lack of financial stability might lead elderly and disabled persons to request PAS and euthanasia more often than would persons who have high

72. See Kristi L. Kirschner M.D. et al., *Physician-Assisted Death in Context of Disability in PHYSICIAN-ASSISTED SUICIDE*, *supra* note 12, at 164.

73. See SMITH, *supra* note 65, at 181. Opponents suggest that if disabled persons choose PAS or euthanasia, they only did so out of despair over their treatment by society. *See id.* Furthermore, declaring that PAS and euthanasia are options that promote personal autonomy is oxymoronic in the case of the disabled. *See id.* Opponents assert that disabled persons have been denied every other fundamental choice in their lives such as: the right to employment; they have been made to live separately from the rest of society; they have not been able to pursue certain educational aspirations; and their romantic and sexual expressions have been prohibited. *See id.*

74. Felicia Ackerman, *Assisted Suicide, Terminal Illness, Severe Disability, and the Double Standard*, in *PHYSICIAN ASSISTED SUICIDE: EXPANDING THE DEBATE*, *supra* note 37, at 151.

75. *See id.*

76. *See id.*

77. *See id.*

78. *Id.*

79. See SMITH, *supra* note 65, at 39.

80. *See id.*

societal value and adequate financial resources.⁸¹ Thus, the lives of the elderly and disabled would be terminated at a much higher rate than others.⁸²

Opponents predict that the legalization of PAS and euthanasia will lead to the atrocities that occurred in Nazi Germany.⁸³ Karl Brandt, the officer in charge of the "Nazi killing program," testified during his trial that: "The underlying motive was the desire to help individuals who could not help themselves and were thus prolonging their lives of torment."⁸⁴ Opponents acknowledge that an extreme distance distinguishes the ideology of Nazi Germany and the modern views regarding PAS and euthanasia, but they warn, "Lessons from the past can only be ignored at our peril."⁸⁵

In addition to the "slippery slope" argument, opponents contend that the legalization of PAS and euthanasia will destroy the patient-physician relationship.⁸⁶ The main thrust of the argument is that legalization would "undermine the patient-physician relationship and the trust necessary to sustain it [and] alter the medical profession's role in society."⁸⁷ This lack of trust could result in people not seeking medical treatment when ill and a society that fears physicians and hospitals.⁸⁸

Historically, the role of the physician in society has been the healer of the sick.⁸⁹ Opponents posture that PAS and euthanasia do not comport with

81. *See id.*

82. *See id.*

83. Ja Emerson Vermaat, "Euthanasia" in the Third Reich: Lessons for Today?, 18 ISSUES IN L. & MED. 93 (2002). *See also* Siegel, *supra* note 71, at 263-64. When Adolf Hitler became the leader of Germany in the 1930s between 100,000 to 200,000 disabled persons were arbitrarily terminated. *See id.* at 264. Hitler possessed an immense hatred for "inferior human beings." *Id.* This hatred led to the sterilization of 375,000 disabled persons between 1933 and 1939. *See id.* The Disabled included: "physically disabled, mentally ill or challenged, deaf, blind, alcoholic or who otherwise did not meet Hitler's specifications of a healthy Aryan." *Id.* Hitler gave his approval to an order called Aktion T-4; a program that called for the systematic killing of the disabled. *See id.* The "qualified" patients were removed from the hospital and taken to a separate facility. *See Siegel, supra* note 71, at 263-64. Once at the facility they would be taken as a group into the "shower room" and the door would be locked. *See id.* The physician would then push a button that released carbon monoxide into the room killing the patients. *See id.*

84. *See* Vermaat, *supra* note 83, at 93. *See also* Wikipedia Encyclopedia Website, available at http://www.wikipedia.org/wiki/Karl_Brandt (last visited Nov. 22, 2002). Karl Brandt was Adolf Hitler's personal physician and was assigned to administer the Nazis' T-4 Euthanasia Program, otherwise known as the "killing program." *See id.* Brandt participated in many different experiments on humans and was instrumental in the euthanasia of thousands of mentally and physically handicapped. *See id.* After World War II, Brandt was tried and convicted for these crimes. *See id.* Brandt was sentenced to death by hanging. *See id.*

85. *See* Vermaat, *supra* note 83, at 93.

86. *See id.* *See also* Snyder, *supra* note 21, at 212. *See also* Gaylin et al., *Doctors Must Not Kill*, 259 JAMA 2140, 2141 (1988).

87. *See* Snyder, *supra* note 21, at 209.

88. *See id.*

89. *See id.* at 212. "The profession's most consistent ethical traditions have always emphasized healing and comfort and have demurred at the idea that a physician should intentionally bring about the death of any patient." *Id.*

this traditional role and cite the Hippocratic Oath (Oath)⁹⁰ in support of this contention. The Oath states in relevant part,

I will follow that system of regimen which, accord my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will neither give a deadly medicine to anybody if asked for it, nor will I make a suggestion to this effect.⁹¹

If physicians are obligated by law to provide their patients with a lethal prescription or injection upon request, physicians will no longer be viewed as healers but those who take life.⁹² Moreover, if PAS and euthanasia are legalized and physicians are obligated to assist in death, the consequence will be that physicians become the principal decision-makers regarding who will receive this treatment.⁹³ This contention is grounded in the theory that the determination of pain and suffering can never be truly objective.⁹⁴ Thus, the floodgates will open and euthanasia will be provided to those who have not made their desires known because the physicians will subjectively decide who is unbearably suffering.⁹⁵ This result is not compatible with the trusting relationship between patients and their physicians.

Those who are against the legalization of PAS and euthanasia propose that the goal should be for physicians to use their medical knowledge to alleviate the pain and suffering with the use of palliative care, not to intentionally kill patients with a lethal prescription or injection of medication.⁹⁶ In her testimony to the Judiciary Subcommittee on the Constitution, Dr. Kathleen Foley,⁹⁷ an opponent of legalizing PAS and euthanasia, stated that:

[Physicians] must focus [their] efforts and attention on improving the care of the dying. The currently proposed laws

90. Ludwig Edelstein, *The Hippocratic Oath: Text, Translation, and Interpretation*, in CROSS-CULTURAL PERSPECTIVES IN MEDICAL ETHICS 3-9, (Robert M. Veatch ed., 2nd ed. 2000). The Hippocratic Oath was written by Hippocrates, an ancient Greek physician, during the 400's B.C. [hereinafter Oath]. *See id.* The Oath reflects the high standards that govern the actions of physicians. *See id.* Furthermore, the Oath requires physicians, in their role as healer, to aid those who are sick and not cause any harm. *See id.*

91. *Id.*

92. *See* Gaylin, *supra* note 86, at 2141.

93. HERBERT HENDIN, *SEDUCED BY DEATH* 164 (1997).

94. *See id.*

95. *See id.*

96. *See* Snyder, *supra* note 21, at 209.

97. Testimony Judiciary Subcommittee on the Constitution "Medical Issues Related to Physician Assisted Suicide" Kathleen M. Foley, M.D., (Apr. 29, 1996), available at <http://www.house.gov/judiciary/2167.htm> (last visited Nov. 22, 2002). Dr. Foley is the Chief of Pain Service at Memorial Sloan-Kettering Cancer Center, and Professor of Neurology, Neuroscience, and Clinical Pharmacology at Cornell University. *See id.*

only provide for protection of physicians. They do little to advance the care of patients at the end of life. They provide a false sense of autonomy. Real autonomy at the end of life can only be realized when a full range of treatment is available and affordable and patients understand all their options Control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount Palliative care—affirms life, and regards dying as a normal process; neither hastens nor postpones death; provides relief from pain and other distressing symptoms; integrates the psychological and spiritual aspects of patient care; offers a support system to help patients live as actively as possible until death; offers a support system to help the family cope during the patient's illness and their own bereavement.⁹⁸

III. HISTORICAL BACKGROUND OF PAS IN THE UNITED STATES

A. *Physician-Assisted Suicide in the United States*

Although euthanasia continues to be prohibited in the United States, steps toward legalizing PAS have emerged in the past fifteen years.⁹⁹ Currently, Oregon is the only state that formally legalized PAS.¹⁰⁰ PAS is statutorily illegal in thirty-six states and the District of Columbia.¹⁰¹ In ten states, PAS is illegal under state common law.¹⁰² Three states do not have statutory or common law prohibiting PAS.¹⁰³

Shortly before Oregon's DWDA was passed and in the years succeeding, other states have also attempted to pass laws allowing PAS and euthanasia.¹⁰⁴

98. *Id.*

99. SUSAN M. BEHUNIAK & ARTHUR G. SVENSON, *PHYSICIAN-ASSISTED SUICIDE: THE ANATOMY OF A CONSTITUTIONAL LAW ISSUE* 14 (2003).

100. *See id.* at 28.

101. *Assisted Suicide Laws By State – July 1998*, USA TODAY, July 6, 1998, available at <http://euthanasia.com/stlaws.html>. (last visited Nov. 22, 2002). The thirty-six states that statutorily prohibit PAS are: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Virginia, Washington, and Wisconsin. *See id.* The District of Columbia also statutorily prohibits PAS. *See id.*

102. *See id.* The ten states that prohibit PAS under common law include: Alabama, Idaho, Maryland, Massachusetts, Michigan, Nevada, Ohio, South Carolina, Vermont, and West Virginia. *See id.*

103. *See id.* The three states that do not have statutory laws or common laws prohibiting PAS are: North Carolina, Utah, and Wyoming. *See Assisted Suicide Laws By State, supra* note 101.

104. *See SMITH, supra* note 65, at 213.

In 1988, California attempted to legalize euthanasia for terminally ill patients, but the bill lacked the amount of signatures required to qualify initiative for the ballot.¹⁰⁵ In 1991, Washington proposed a similar bill, called initiative 119, that would allow euthanasia for terminally ill patients.¹⁰⁶ However, the bill was rejected.¹⁰⁷ In 1992, California once again tried to legalize euthanasia for the terminally ill with the introduction of Proposition 161.¹⁰⁸ Proposition 161 was voted down by referendum fifty-four percent to forty-six percent.¹⁰⁹ In 1994, Michigan attempted to legalize euthanasia for the terminally ill and disabled.¹¹⁰ This bill was never voted on due to lack of sufficient signatures.¹¹¹

Oregon legalized PAS in 1994 when it approved the DWDA.¹¹² Although the law was passed in 1994, it did not become effective until October 27, 1997, because of numerous legal proceedings that resulted in an injunction against the DWDA.¹¹³ In an effort to repeal the statute because of doubts surrounding sufficient safeguards within the DWDA, the Oregon Legislature introduced Measure 51 in November of 1997.¹¹⁴ Oregon voters confirmed their desire to legalize PAS by defeating the Measure by a margin of sixty percent to forty percent.¹¹⁵

105. *See id.*

106. *See id.*

107. *See id.*

108. *See id.*

109. *See id.*

110. *See SMITH, supra* note 65, at 213.

111. *See id.*

112. *See DWDA, 13 OR. REV. STAT. §§ 127.800-.897. See also Joseph Cordaro, Note, Who Defers to Whom? The Attorney General Targets Oregon's Death With Dignity Act, 70 FORDHAM L. REV. 2477, 2484 (2002). Measure 16 was passed by referendum with a fifty-one to forty-nine percent vote. See id. See also Cheryl K. Smith, Safeguards for Physician-Assisted Suicide: The Oregon Death with Dignity Act in DEATH DYING AND THE LAW, supra* note 25, at 71. Definition of referendum: when a state's legislature has approved a bill and then allows the people of the state to vote on whether or not to approve the bill. *See id.* The bill does not become effective until after voter approval is obtained. *See id.*

113. *Lee v. Oregon, 107 F.3d 1382, 1386 (9th Cir. 1997). One day before the DWDA was to become effective District Judge, Michael Hogan, temporarily enjoined the implementation of the Act. See id. In 1995, Judge Hogan held that the Act violated the Equal Protection Clause of the United States Constitution and granted a permanent injunction against the implementation of the Act. See id. On appeal, the Ninth Circuit Court of Appeals concluded that the plaintiffs lacked standing to bring suit against Oregon and vacated the District Court's judgment. See id. The United States Supreme Court denied certiorari of the case. See id.*

114. *See BEHUNIAK & SVENSON, supra* note 99, at 152. The arguments of the Oregon Legislature to repeal the Death with Dignity Act included: the use of oral medication may not be effective in bringing about a quick and painless death; Measure 16 does not include any specific requirement for psychological counseling or family notification; strong enforcement requirements are not in place to compel physicians to report assisted suicide to the state Health Division; Measure 16 does not include a definition for residency, which could lead to a flood of people into Oregon who wish to utilize the PAS law. *See id.*

115. *See Cordaro, supra* note 112, at 2484. *See also Beauchamp supra* note 47, at 111.

B. The Constitutional Battle Surrounding PAS

A turning point in the right to die movement in the United States occurred after the Supreme Court's decision in *Cruzan v. Director*,¹¹⁶ which set forth that patients have a constitutionally protected right to refuse food and hydration.¹¹⁷ The *Cruzan* decision and Oregon's legalization of PAS caused quite a stir among many states, resulting in the promulgation of laws specifically prohibiting PAS.¹¹⁸ The specific ban on PAS in Washington and New York led to proponents of PAS in both states filing lawsuits based on Constitutional grounds.¹¹⁹

In 1997, the United States Supreme Court handed down two decisions in *Vacco v. Quill*¹²⁰ and *Washington v. Glucksberg*¹²¹ regarding constitutional issues surrounding the PAS debate.¹²² In both cases, a group of terminally ill patients and several physicians sued the states of Washington and New York on the ground that the states' laws prohibiting PAS were unconstitutional and abridged their fundamental liberty right to PAS.¹²³ The Court unanimously concluded in both cases that a terminally ill patient does not have a constitutionally protected right to PAS.¹²⁴

In *Glucksberg*, the plaintiffs asserted that Washington's law violated the Due Process Clause of the Fourteenth Amendment of the United States

116. *Cruzan v. Dir., Mo. Dep't Health*, 497 U.S. 261 (1990).

117. *See Cruzan*, 497 U.S. at 261. This case involved a thirty-two year old woman, Nancy Cruzan, who was in a persistent vegetative state after suffering injuries in a car accident. *See id.* The lack of oxygen to Cruzan's brain after the accident was the cause of her permanent brain damage. *See id.* A person in a permanent vegetative state does show some motor reflexes but has no cognitive function. *See id.* After the accident, Cruzan was able to breathe independently because her brain stem was intact. *See id.* However, because Cruzan could not orally ingest food or water, a feeding tube was surgically placed in her stomach. *See id.* Cruzan's parents wanted the feeding tube removed in order to hasten their daughter's death based on the grounds that she would not have wanted to live in such a state. *See id.* The hospital refused to comply with the parents' request. *See Cruzan*, 497 U.S. at 261. The Cruzans then sought judicial consent to remove the feeding tube. *See id.* The United States Supreme Court concluded that the Fourteenth Amendment of the United States Constitution provides a competent adult with a fundamental right to refuse lifesaving nutrition and hydration. *See id.* The Court also concluded that Missouri was allowed to require a clear and convincing standard of proof regarding a person's wishes prior to being incompetent. *See id.* The Missouri Supreme Court had previously held that Nancy Cruzan did not meet this evidentiary standard and the feeding tube was not removed. *See id.* However, the Cruzans later presented additional evidence to a Missouri Superior Court. *See Cruzan*, 497 U.S. at 261.. The court found in favor of the Cruzans, and Nancy Cruzan's feeding tube was removed. *See id.* A few weeks after the removal of the feeding tube, Nancy Cruzan died. *See id.*

118. *See BEHUNIAK & SVENSON*, *supra* note 99, at 57.

119. *Id.*

120. *Vacco v. Quill*, 521 U.S. 793 (1997).

121. *Washington v. Glucksberg*, 521 U.S. 702 (1997).

122. *See Vacco*, 521 U.S. at 793; *see also Glucksberg*, 521 U.S. at 702. *See also Chopko*, *supra* note 66, at 569.

123. *See Vacco*, 521 U.S. at 793; *see also Glucksberg*, 521 U.S. at 702.

124. *See Vacco*, 521 U.S. at 796; *see also Glucksberg*, 521 U.S. at 705.

Constitution.¹²⁵ The plaintiffs argued that the Due Process Clause “extends to a personal choice by a mentally competent, terminally ill adult to commit physician-assisted suicide.”¹²⁶

The United States Supreme Court held that Washington’s law prohibiting PAS did not violate the Due Process Clause.¹²⁷ The Court noted that the practice of assisted suicide has been illegal under common law for over 700 years and is still illegal in the vast majority of the states.¹²⁸ Although the Court recognized that many of the fundamental rights protected by the Due Process Clause are grounded in personal autonomy, it concluded that the Due Process Clause could not be extended to all such personal decisions.¹²⁹ Furthermore, the Court found that the Washington statute was rationally related to the State’s interest in: “1) preserving life; 2) preventing suicide; 3) avoiding the involvement of third parties and use of arbitrary, unfair, or undue influence; 4) protecting family members and loved ones; 5) protecting the integrity of the medical profession and; 6) avoiding future movement toward euthanasia and other abuses.”¹³⁰

Although the Court held that terminally ill patients do not have a fundamental right to PAS, the door to PAS was not completely closed. The Court noted that the United States is a democratic society and the debate over PAS should continue throughout the states.¹³¹ Thus, each individual state must make the determination of whether to legalize PAS.¹³²

125. See *Glucksberg*, 521 U.S. at 708.

126. *Id.* at 708. The Ninth Circuit Court of Appeals affirmed the district court’s decision holding that Washington’s law was unconstitutional because it placed “an undue burden on the exercise of that constitutionally protected liberty interest.” *Id.* at 709.

127. See *id.* at 709, 720-21. In deciding the case, the Supreme Court used the two-pronged substantive analysis test, which includes: 1) whether the right in question is “deeply rooted in this Nation’s history and tradition;” 2) whether the plaintiff has provided a “careful description” of the right in question. *Id.* at 720-21.

128. See *id.* at 710-19. The laws prohibiting suicide have never included exceptions regarding terminally ill persons, and in the past few years, states have again evaluated the prohibition of assisted suicide and reaffirmed its illegality. See *Glucksberg*, 521 U.S. at 716. The Court also noted the Federal Assisted Suicide Funding Restriction Act of 1997 in support of its holding. See *id.* at 718. The Federal Assisted Suicide Funding Restriction Act prohibits the spending of federal funds in support of PAS. See *id.*

129. See *id.* at 722, 727. The plaintiffs asserted the following descriptions of interests: “a right to determine the time and manner of one’s death . . . the right to die . . . a liberty to choose how to die . . . a right to control of one’s final days, the right to choose a humane . . . dignified death . . . and the liberty to shape death.” *Id.* at 722. Rights protected under the Due Process Clause that are concerned with personal autonomy include: right to procreate; right to marry; and abortion. See *id.* at 726.

130. See *Glucksberg*, 521 U.S. at 728. The court also considered the possible abuses of legalization such as: the discriminatory termination of the disabled, terminally ill, and elderly; the fear of sliding down “the slippery slope” toward voluntary and involuntary euthanasia. See *id.* at 733.

131. See *id.* at 735.

132. See *id.* at 789.

In *Vacco*, the plaintiffs brought suit against the state of New York based on the Equal Protection Clause of the Fourteenth Amendment of the United States Constitution.¹³³ The plaintiffs asserted that if New York allows a competent patient to refuse life-sustaining treatment, then a competent patient should also have the right to request PAS because there is no basic difference between the two situations.¹³⁴ The Supreme Court held that New York's ban on PAS did not violate the Equal Protection Clause and was "rationally related to a state interest."¹³⁵

The Court's analysis drew a bright line between the causation and intent of PAS and the refusal of life-sustaining treatment.¹³⁶ The Court set forth that in the case of refusal or withdrawal of life-sustaining treatment, the patient dies from the underlying disease, whereas in the case of PAS, the patient dies from the lethal prescription of medication.¹³⁷ Moreover, the Court concluded that the physician's intent is different in the two circumstances.¹³⁸ In the refusal or withdrawal of life-sustaining treatment, the physician is only complying with his patient's desire to stop treatment and this may or may not result in the patient's death.¹³⁹ In the case of PAS, where the physician prescribes the lethal dose of medication, the physician intends the termination of the patient's life.¹⁴⁰

C. Oregon's Death With Dignity Act

Although the United States Supreme Court ruled that there is no constitutional right to assisted suicide, this does not ban the individual states

133. See *Vacco*, 521 U.S. at 793.

134. *Id.* at 798-99. The Second Circuit Court of Appeals accepted this argument when it held that New York's ban on PAS resulted in the unequal treatment of competent patients and furthermore, the unequal treatment was not "rationally related to any legitimate state interest." *Id.*

135. *Id.* at 797, 808-09. The court listed the same state interests as in the *Glucksberg* case: "prohibiting intentional killing and preserving life; preventing suicide; maintaining physicians' role as their patients' healers; protecting vulnerable people from indifference, prejudice, and psychological and financial pressure to end their lives; and avoiding the possible slide toward euthanasia . . ." *Id.* Although the Court found no violation of the Constitution in regard to the statutes prohibiting PAS, Justice O'Connor's concurring opinion held that the democratic process will lead the States to "strike the proper balance between the interests of terminally ill, mentally competent individuals who would seek to end their suffering and the State's interests in protecting those who might seek to end life mistakenly or under pressure." *Id.* This opinion seems to give the debate over the legalization of PAS back to the States (likely quoting *Glucksberg*). See *Vacco*, 521 U.S. at 808-09.

136. *Id.* at 800-01. The Court reasoned that "the distinction between assisting suicide and withdrawing life-sustaining treatment, a distinction widely recognized and endorsed in the medical profession and in our legal traditions, is both important and logical; it is certainly rational." *Id.* See also *Chopko*, *supra* note 66, at 575.

137. See *Vacco*, 521 U.S. at 801.

138. See *id.*

139. See *id.*

140. See *id.* at 802.

from promulgating their own laws regarding PAS.¹⁴¹ Currently, the only state that has passed a law legalizing PAS is Oregon.¹⁴² Oregon's DWDA allows a person who meets specific criteria to obtain a lethal prescription of medication from a physician for the purpose of ending his or her life in a humane and dignified manner.¹⁴³ In order to qualify for such a prescription: 1) the person must be a "capable" adult;¹⁴⁴ 2) the person must be a resident of Oregon;¹⁴⁵ 3) the person must be suffering from a terminal disease and;¹⁴⁶ 4) the request for PAS must be voluntary.¹⁴⁷

To aid in the prevention of abuse,¹⁴⁸ several safeguards were included in the DWDA.¹⁴⁹ First, a physician must diagnose the patient with a terminal disease, and further determine if the patient is competent and has voluntarily

141. See Justice O'Connor, *The Supreme Court Decides the 'Glucksberg' and 'Quill' cases*, in *LAST RIGHTS: ASSISTED SUICIDE AND EUTHANASIA DEBATED*, *supra* note 17, at 614.

142. See SMITH, *supra* note 65, at 116.

143. DWDA, 13 OR. REV. STAT. §§ 127.800-.897 (2001).

144. See *id.* ch. 127.800 § 1.01(1) - (6). Capable adult is defined by the Act as a person who is eighteen years of age or older and has the ability to make health care decisions and communicate these decisions to his or her health care provider. See *id.*

145. See *id.* ch. 127.860 § 3.10. Determinations of residency include: Oregon driver license, voter registration card, ownership or lease of property, or tax return. See *id.* All factors must be inclusive to the state of Oregon. See *id.*

146. See *id.* ch. 127.800 § 1.01(12). Terminal disease is defined by the Act as an "incurable and irreversible" disease diagnosed by a physician that will result in death within six months. See DWDA, 13 OR. REV. STAT. 127.800 § 1.01(12).

147. See *id.* ch. 127.810 § 2.02. To aid in the determination of whether a request is voluntary, the patient must sign a formal written request with two witnesses who can verify that the patient is "capable" and is making the request without any coercion. See *id.* Moreover, to provide assurances of no undue pressure, one of the witnesses is prohibited from being: a relative by blood, marriage, or adoption; someone who would benefit financially from the patient's death, such as a beneficiary of the patient's will or; a person who owns or operates a health care facility where the patient resides or receives medical treatment. See *id.* Additionally, the physician who primarily cares for the patient and treats his or her disease is never allowed to be a witness to the written request. See *id.* To further safeguard the voluntary nature of the patient's request, the Act provides that anyone who coerces the patient to request PAS is subject to criminal liability. See *id.* ch. 127.890 § 4.02.

148. Susan R. Martyn & Henry J. Bourguignon, *Now is the Moment to Reflect: Two Years of Experience with Oregon's Physician-Assisted Suicide Law*, 8 ELDER L.J. 1, 3 (2000). Safeguards to the Oregon Death With Dignity Act include: 1) undue coercion used to influence a patient to request PAS; 2) inadequate protection of those persons with mental illness or who are incompetent; 3) the physician, not the patient will make the decision about assisted suicide. See *id.*

149. See Steven Miles M.D. et al., *Considerations of Safeguards Proposed in Laws and Guidelines to Legalize Assisted Suicide*, in *PHYSICIAN-ASSISTED SUICIDE*, *supra* note 12, at 212. Safeguards to the DWDA include some limits on a patient's autonomy. See *id.* The rationale behind the safeguards is to protect vulnerable patients who might be coerced into requesting PAS. See *id.* The three main safeguards in place are: 1) the request for PAS must be carefully considered and not made under circumstances suggesting undue influence of others; 2) the patient must be able to participate in his or her own death; 3) the patient must be able to provide sound reasoning for requesting PAS. See *id.* See also *DEATH DYING AND THE LAW*, *supra* note 25, at 74-80.

requested PAS.¹⁵⁰ Second, the physician must inform the patient of: the diagnosis; all alternative treatment available;¹⁵¹ the risks and adverse effects of the medication prescribed;¹⁵² the end result of ingesting the prescribed medication; and¹⁵³ that he or she can revoke the request for PAS at anytime.¹⁵⁴ Third, the treating physician must refer the patient to another physician for a confirmation of the terminal illness, a determination of patient competency, and affirmation of the voluntary nature of the request.¹⁵⁵ In addition to referring the patient to another physician, the treating physician must also refer the patient for psychological counseling if physician determines that the patient is depressed or experiencing any "psychiatric or psychological disorder."¹⁵⁶ Furthermore, the treating physician must also suggest that the patient inform his or her family of the decision,¹⁵⁷ have someone present when he or she takes the medication, and ingest the medication in a private location.¹⁵⁸

In addition to providing the above safeguards, the DWDA also contains an additional layer of protection against abuse by requiring that a prescription for a lethal dose of medication can only be written if certain time periods are complied with and the patient requests PAS on at least three occasions.¹⁵⁹ A physician must wait fifteen days after the patient's initial oral request for PAS and two days after the patient's written request before writing the prescription.¹⁶⁰ Moreover, at the time the patient makes his or her second oral request for PAS, the physician must offer the patient the chance to revoke the request.¹⁶¹ Also, before the physician writes the prescription he or she must

150. See DWDA, 13 OR. REV. STAT. 127.815 § 3.01(1)(a).

151. See *id.* ch. 127.815 § 3.01(1)(c)(E). Alternative treatment consists of but is not limited to "comfort care, hospice care and pain control." *Id.*

152. See *id.* ch. 127.815 § 3.01(1)(c).

153. See *id.* ch. 127.815 § 3.01(1)(c)(C)-(D); see also *id.* ch. 127.820 § 3.02. The physician providing the second opinion must confirm the referring physician's diagnosis in writing. See DWDA, 13 OR. REV. STAT. 127.820 § 3.02.

154. See *id.* ch. 127.815 § 3.01(1)(h); see also *id.* ch. 127.845 § 3.07. The statute also provides that the patient may revoke the request in "any manner without regard to his or her mental state." *Id.* This seems to imply an additional safeguard of allowing the patient to rescind the request even though he or she may be incompetent at the time of revocation as compared to the requirement of competency when requesting PAS. See *id.*

155. See *id.* ch. 127.815 § 3.01(1)(d).

156. See DWDA, 13 OR. REV. STAT. 127.815 § 3.01(1)(e); see also *id.* ch. 127.825 § 3.03. The statute sets forth that no patient requesting PAS shall be prescribed a lethal dose of medication until it is determined that the patient "is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment. . . ." *Id.*

157. See *id.* ch. 127.815 § 3.01(1)(f); see also *id.* ch. 127.835 § 3.05. As long as the patient has met the other criteria of the statute, his or her request for PAS will not be denied if the family is not notified. See *id.*

158. See DWDA, 13 OR. REV. STAT. 127.815 § 3.01(1)(g).

159. See *id.* ch. 127.840 § 3.06. The patient must make two oral requests within fifteen days of one another and a formal written request for PAS. See *id.*

160. See *id.* ch. 127.850 § 3.08.

161. See *id.* ch. 127.840 § 3.06.

confirm that the patient is making a voluntary, informed decision.¹⁶² Additionally, the physician who prescribes the lethal dose of medication must document all of the above requirements in the patient's medical record.¹⁶³ Upon dispensing the medication, the physician is required to file this information with the Oregon Department of Human Services.¹⁶⁴ Finally, to ensure against any possibility of sliding down the "slippery slope," the DWDA specifically prohibits euthanasia¹⁶⁵ and imposes criminal liability on anyone who fabricates a request for PAS or destroys a revocation of the request with the purpose of causing the patient's demise.¹⁶⁶

D. The Survival of Oregon's Death With Dignity Act

The strongest challenger of the DWDA is the Attorney General of the United States, John Ashcroft.¹⁶⁷ On November 6, 2001, Ashcroft issued a

162. *See id.* ch. 127.815 § 3.01(1)(i). *See also* DWDA, 13 OR. REV. STAT. 127.800 § 1.01(7)(a)-(e). Informed decision is defined as a decision by a patient "based on an appreciation of the relevant facts" provided that the treating physician has discussed specific information with the patient: the medical diagnosis, prognosis, possible adverse effects of the prescribed medication, the outcome of ingesting the medication, and all "feasible" alternatives to PAS. *Id.* *See also* Cheryl K. Smith, *Safeguards for Physician-Assisted Suicide: The Oregon Death with Dignity Act*, in *DEATH DYING AND THE LAW*, *supra* note 25, at 76. The informed decision is comparable to an informed consent. *See id.* An informed consent is required before a physician performs surgery or other invasive procedure on a patient. *See id.* Before performing the procedure, the physician is required to disclose to his or her patient the nature of the procedure, all alternatives, and all risks involved. *See id.* The informed decision requirement of the DWDA is more stringent than an informed consent because it explicitly requires a physician to inform the patient of all other options to PAS. *See id.* The drafters of the DWDA required this more stringent requirement based on the grounds that the decision to end one's life is considerably more significant than the decision to undergo an invasive medical procedure. *See id.*

163. *See* DWDA, 13 OR. REV. STAT. 127.855 § 3.09(1)-(7).

164. *See id.* ch. 127.865 § 3.11.

165. *See id.* ch. 127.880 § 3.14. The Act sets forth that "[n]othing [in the statute] shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia." *Id.*

166. *See id.* ch. 127.890 § 4.02(1). A person involved in this type of illegal conduct will be guilty of a Class A felony. *See id.* Additionally, a person who coerces a patient into requesting PAS will be guilty of a Class A felony. *See* DWDA, 13 OR. REV. STAT. 127.890 § 4.02(1).

167. Robert Steinbrook, *Physician-Assisted Suicide in Oregon – An Uncertain Future*, 346(6) *NEW ENG. J. MED.* 460 (2002). Ashcroft is a conservative Republican and has been a staunch opponent of PAS. *See id.* In addition to the Attorney General's challenge to Oregon's Death With Dignity Act, Congress has made two attempts to invalidate the Act. *See id.* The Lethal Drug Abuse Prevention Act of 1998 would have given the Drug Enforcement Agency the authority to revoke any physician's registration to prescribe a controlled substance for the purpose of PAS. *See id.* This bill never received a vote by the House of Representatives and died with the end of the 1998 Congressional Session. *See id.* The Pain Relief Promotion Act of 1999 would have made PAS a federal crime with a prison term of up to twenty years. *See id.* The bill was passed by the House of Representatives but never received a vote in the Senate; thus, the bill was terminated at the end of the 106th Congress. *See* Steinbrook, *supra* note 167,

ruling, otherwise known as the “Ashcroft Directive,”¹⁶⁸ which concluded that Oregon’s DWDA was in violation of the federal Controlled Substances Act (CSA)¹⁶⁹ and physicians were prohibited from prescribing any medication for the purpose of PAS.¹⁷⁰ Ashcroft based his ruling on the theory that prescribing a lethal dose of medication for the purpose of PAS was not a “legitimate medical purpose.”¹⁷¹ The effect of this ruling on Oregon physicians who prescribed a lethal dose of medication for their patients would be revocation of their prescription license, possible criminal prosecution, and jail term.¹⁷² As a result, Oregon filed a lawsuit to enjoin Ashcroft from any attempted enforcement of the ruling.¹⁷³ The United States District Court for the District of Oregon issued a temporary restraining order on November 8, 2001.¹⁷⁴

On April 17, 2002, the District Court held that the prescription of a lethal dose of medication for the purpose of PAS does not violate the CSA.¹⁷⁵ Furthermore, the Court concluded that Ashcroft’s ruling did not hold any weight and was not deserving of any judicial deference.¹⁷⁶ Along with this holding, the Court issued a permanent injunction against the “Ashcroft

at 460. *See also* Cordaro, *supra* note 112, at 2485.

168. *See* BEHUNIAK & SVENSON, *supra* note 99, at 198-99. Based on the Controlled Substances Act, Ashcroft issued a decision that narcotics and other controlled substances may not be dispensed to assist in suicide. *See id.* If a physician prescribed a controlled substance for the purpose of assisted suicide, his or her license to prescribe medication would be suspended. *See id.* Ashcroft further expounded that the ruling was applicable regardless of whether the State statutorily allowed PAS. *See id.* Proponents of the legalization of PAS vehemently objected Ashcroft’s ruling on the ground that the CSA was never intended to regulate medical practice; the CSA was promulgated to enforce laws against illegal drug abuse and drug trafficking. *See id.*

169. *See id.* at 170.

170. *See* Steinbrook, *supra* note 167, at 460. *See also* Michael C. Dorf, *Ashcroft v. Oregon: Telling the States What to do in Cases of Physician-assisted Suicide*, available at <http://writ.news.findlaw.com/dorf/20011114.html> (last visited Nov. 22, 2002). The federal Controlled Substances Act (CSA) is a 1970 law aimed at the prevention of drug abuse and illegal-drug trafficking. *See id.* The ruling by Ashcroft essentially reversed the previous ruling of the former Attorney General, Janet Reno. *See id.* Reno had previously ruled that the intention of the CSA was not to remove the states as the main regulators of medical practice. *See id.*

171. *See* Cordaro, *supra* note 112, at 2479.

172. *See* Dorf, *supra* note 170.

173. *Oregon v. Ashcroft*, 192 F.Supp.2d 1077, 1079 (Dist. of Or. 2002). The suit was based on the ground that the ruling of Ashcroft was an encroachment of the federal government “into the sovereign interests” of the state. *Id.*

174. *Id.*

175. *Id.* at 1093. *See also* BEHUNIAK & SVENSON, *supra* note 99, at 203. The Court decided the case based on statutory interpretation of the CSA and concluded that the CSA does not prohibit the dispensing of controlled substances by a physician in acquiescence with a prudent state statute. *See id.*

176. *Ashcroft*, 192 F.Supp.2d at 1079.

Directive.”¹⁷⁷ Presently, the case is on appeal to the United States Court of Appeals for the Ninth Circuit.¹⁷⁸

In addition to the federal government's attack on Oregon's DWDA, a class action lawsuit, *Lee v. Oregon*,¹⁷⁹ was filed by a group of terminally ill patients and their physicians against Oregon to enjoin the enforcement of the DWDA.¹⁸⁰ In *Lee*, the plaintiffs asserted that the DWDA violated their equal protection and due process rights under the Fourteenth Amendment of the United States Constitution, their freedom of religion and association rights under the First Amendment, and their legal rights contained within the Americans with Disabilities Act.¹⁸¹ The Ninth Circuit Court of Appeals held that the plaintiffs lacked standing to initiate the lawsuit and, moreover, the lawsuit was not ripe for decision.¹⁸² Hence, the case was dismissed and the DWDA became effective on October 27, 1997, giving Oregon's citizens the option of PAS.¹⁸³

E. Oregon Statistical Information

Every year Oregon publishes a statistical report containing numerical data regarding the patients who have requested PAS and have taken the lethal prescriptions to hasten their death.¹⁸⁴ Since the DWDA's enactment in 1997, 129 patients have died from ingesting a lethal dose of medication prescribed

177. *Id.*

178. See BEHUNIAK & SVENSON, *supra* note 99, at 203.

179. See *Lee*, 107 F.3d. at 1382-92.

180. *Id.* The district court held that the DWDA did violate the equal protection clause of the Fourteenth Amendment and ordered a permanent injunction against the enforcement of the Act. *See id.* The district court based its ruling on the ground that the DWDA did not provide sufficient safeguards to depressed patients who might be more apt to request PAS. *See id.* Thus, resulting in an unequal protection for those who are mentally ill as compared to those who are not. *See id.* In support of its decision, the district court pointed to the lack of requirement to refer a patient requesting PAS to a mental health specialist under the DWDA. *See id.* The Court also mentioned the problem of the somewhat arbitrary nature of determining the longevity of a terminal disease; the exact timetable of when a disease will progress to the stage of death can only be definitely determined by hindsight. *See Lee*, 107 F.3d. at 1382-92. Moreover, the Court was concerned with the fact that the DWDA did not include a provision for an oversight committee to review these decisions to grant requests. *See id.* *See also* HENDIN, *supra* note 93, at 170.

181. *Lee*, 107 F.3d at 1386.

182. *See id.* at 1391-92. The Court reasoned that the DWDA did not force the physicians to grant a patient's request with any threat of criminal punishment. *See id.* Therefore, the plaintiffs had not suffered any injury that could be remedied by the law. *See id.*

183. *See id.* at 1392.

184. *Fifth Annual Report on Oregon's Death with Dignity Act*, available at arresult.cfm (last visited Apr. 8, 2003) [hereinafter Oregon Report]. *See also* William McCall, Oregon Assisted Suicides More Than Double, available at http://story.news.yahoo.com/news?tmpl=story2&acid=541&u=/ap/20030305/ap_on_he_me/a (last visited Mar. 17, 2003). In 2002, thirty-eight terminally-ill patients in Oregon ended their lives by ingesting a lethal dose of medication. *See id.* This was double the number of patients that ended their lives by PAS in 1998. *See id.*

by a physician.¹⁸⁵ Approximately one out of six requests for PAS has been granted since the enactment of the DWDA, and approximately one out of ten requests has resulted in the hastening of death.¹⁸⁶

Persons most likely to request PAS are divorced females who have a college education.¹⁸⁷ The majority of terminally ill patients who received a prescription for a lethal dose of medication were suffering from cancer.¹⁸⁸ Patients did not list pain as the main reason for requesting PAS.¹⁸⁹ In 2002, the principal motives for requesting PAS were: loss of autonomy (eighty-four percent); the lack of ability to participate in enjoyable activities (eighty-four percent); and losing control of certain bodily functions (forty-seven percent).¹⁹⁰ Only one patient who succumbed to death as the result of PAS in 2002 did have health insurance and ninety-two percent of patients were receiving treatment from a hospice program.¹⁹¹ The majority of the physicians, who acceded to the request for PAS, were oncology specialists.¹⁹²

F. The Culture and Attitude Toward PAS and Euthanasia in the United States

The majority of the American public endorses the legalization of PAS.¹⁹³ Surveys reveal that up to sixty percent of American physicians endorse

185. See Oregon Report, *supra* note 184.

186. *Nine in 10,000 Oregonians Die by Assisted Suicide; Vulnerable Groups not Overrepresented*, 57(10) AM. J. HEALTH-SYS. PHARM. 932 (2000). After receiving palliative care, some patients, who had been given the lethal prescription, elected not to ingest the lethal dose of medication. See *id.*

187. See Oregon's *Death with Dignity Act*, available at <http://www.ohd.hr.state.or.us/chs/pas/ar-tbl-1.htm> (last visited Nov. 16, 2002). The numerical data is: sixty-two percent female; thirty-eight percent had their college degrees compared to fourteen percent who did not; thirty-three percent were divorced compared to fourteen percent who were not. See *id.*

188. See Oregon Report, *supra* note 184. Other diseases included: amyotrophic lateral sclerosis, chronic lower respiratory disease, AIDS, congestive heart failure, multi-system organ failure, scleroderma, Shy-Drager syndrome, and interstitial pulmonary disease with fibrosis. See *id.*

189. See *id.*

190. See *id.*

191. See Oregon Report, *supra* note 184. The remaining twenty-four percent of the patients that were not involved with hospice were offered hospice care and had refused. See *id.*

192. See *id.* The 2002 survey's numerical breakdown is: internal medicine (twenty-nine percent), oncologists (forty-five percent), family practitioners (twenty-four percent, and other (five percent). See *id.*

193. See Quill, *supra* note 43, at 552. Surveys over the past fifteen years show that two-thirds to three-fourths of the American public support assistance in death by physicians. See *id.* Moreover, the surveys provide evidence that Americans do not view PAS and voluntary euthanasia as morally distinct. See *id.* Quill suggests that these surveys may not be the accurate view of the public based on an inadequate understanding of the availability of hospice care and the right to refuse treatment. See *id.* See also Ezekiel J. Emanuel, *Euthanasia and Physician-Assisted Suicide: A Review of the Empirical Data From the United States*, 162(2) ARCH. OF INT. MED. 142-52. Those who oppose PAS and euthanasia tend to be Catholic faith or have a strong religious faith. See *id.*

PAS.¹⁹⁴ Although the majority of physicians approve PAS, only half of the physicians surveyed would personally provide PAS to their patients.¹⁹⁵ Surveys indicate that most physicians are much less likely to support the legalization of euthanasia as compared to PAS.¹⁹⁶ Unlike physicians, the American public does not distinguish between PAS and euthanasia.¹⁹⁷ Furthermore, the preeminent medical association of the United States, the American Medical Association (AMA), strongly opposes the legalization of PAS or euthanasia.¹⁹⁸

A factor contributing to the resistance against the widespread legalization of PAS in the United States is the deterioration of the physician-patient relationship.¹⁹⁹ Before the industrial boom and the advent of modern technology, physicians were considered friends of the family; however, in modern American, this close relationship is no longer viable.²⁰⁰ Today, "physicians tend to be strangers whom we are suspicious of rather than friends we can trust."²⁰¹ This new attitude has resulted in patients questioning the care provided by physicians as evidenced by a tremendous increase in medical malpractice lawsuits filed in the United States.²⁰²

The movement away from family practice physicians to specialists is another reason for the deterioration of the physician-patient relationship.²⁰³ In the past, patients spent more time with one physician who treated the entire person.²⁰⁴ Today, many physicians specialize in a particular field of medicine

194. See Quill, *supra* note 43, at 552.

195. See *id.*

196. See *id.*

197. See Emanuel, *supra* note 193, at 145.

198. See AMA Official Website, *Euthanasia Policy* E-2.21 and *Physician-Assisted Suicide Policy* E-2.211, available at http://www.ama-assn.org/apps/pf_online/?f_n=browse&doc=policyfiles/CEJA/E... (last visited Nov. 25, 2002). The AMA is the predominant medical association in the United States. See *id.* "The involvement of physicians in euthanasia heightens the significance of its ethical prohibition." *Id.* The AMA recommends aggressive palliative care for end-of-life treatment. See *id.* "Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks." *Id.* See also HENDIN, *supra* note 93, at 149.

199. JAMES M. HOEFLER, *DEATHRIGHT: CULTURE, MEDICINE, POLITICS, AND THE RIGHT TO DIE* 76 (1994).

200. See *id.* Due to advances in industry and science, the interpersonal relationship between patient and physician declined steadily in the last century. See *id.* Instead of visiting patients in their homes, patients were required to travel to the physician's office. See *id.* This increased the volume of patients a physician could see per day; thus, increasing his or her salary. See *id.* Furthermore, with the advent of medical technology more patients were being treated at hospitals where the latest equipment could be used to diagnose disease. See *id.*

201. See HOEFLER, *supra* note 199, at 71.

202. See *id.* at 63.

203. See *id.* at 77.

204. See *id.*

resulting in patients seeing a variety of physicians for each medical ailment.²⁰⁵ The following is a description of this new trend:

Patients and specialists tend to be strangers almost by definition since patients only go to a specialist when first encountering a particular sort of disorder and stop going when the problem has been addressed. As a result, specialization cannot help but diminish and discount the interpersonal involvement between patient and physician.²⁰⁶

The decrease in physicians' personal involvement in the patient-physician relationship has led to decreased communication regarding a patient's health decisions over the duration of his or her life.²⁰⁷ Thus, poor communication between patient and physician, especially in regard to end-of-life care, may result in patients not receiving adequate measures of comfort during the dying process.²⁰⁸

In addition to the advances in industry and science, the major changes in health insurance in the past twenty years have led to insurance companies

205. *See id.* *See also* SULTZ & YOUNG, *supra* note 22, at 168. Seventy percent of the physicians in the United States are specialists. *See id.* Because of the high number of specialists, many Americans equate specialty medical treatment with higher quality of care. *See id.* In certain cases, this notion may be true. *See id.* However, in cases where a specialist is not needed, the cost of health care can be unnecessarily increased by the utilization of high-priced diagnostic tests. *See id.*

206. *See* HOEFLER, *supra* note 199, at 77.

207. *See id.*

208. *See* HENDIN, *supra* note 93, at 152-53. The American culture is preoccupied with economic growth, strength, and maintaining the vigor and attractiveness of youth. *See id.* This ideal leads people to disregard the thought of growing old, let alone contemplating one's own death. *See id.* This preoccupation is related to the modern day lack of connection with family and the egocentric nature of the modern American society. *See id.* Americans are now more likely to die in an institutional hospital setting rather than in the comfort of their homes surrounded by family members. *See id.* Thus, the United States has become an individualistic society that has moved away from the sense of connectedness to family and community. *See id.* A consequence of this loss of connectedness to family and community is that Americans have fewer emotional relationships. *See* HENDIN, *supra* note 93, at 152-53. Hence, the fear of death is strong in an individualistic society. *See id.* Therefore, when death occurs in one of these relationships, it is felt deeply and intensely. *See id.* *See also* Linda L. Emanuel, *A Question of Balance*, in *REGULATING HOW WE DIE*, *supra* note 3, at 247. *See also* HOEFLER, *supra* note 199, at 10. Before the twentieth century, "death was an accepted part of the life cycle that spanned the birth-death continuum." *Id.* at 11. The reasons given for this acceptance were that the culture was more farm-based and many households consisted of several different generations. *See id.* The sick were taken care of in the home by family members and died in the home surrounded by loved ones. *See id.* Along with the industrial revolution came employment outside of the family home and the relocation away from families to obtain these industrial jobs. *See id.* The author described the dying process by stating that "what has generally been an accepted phase of life for two millennia in most parts of the world has been transformed in the late-twentieth-century United States into a lonely, disconcerting, and disconnected process to be avoided at all costs." *Id.* at 27.

instructing physicians how to operate their practices and placing limits on monetary reimbursement for treatment.²⁰⁹ To compensate for the decreased amount of remuneration received from insurance companies, physicians have increased their patient volume, thus, lessening the amount of time spent with each patient.²¹⁰ Furthermore, private insurance companies that govern the United States health care system have led to a consumer approach to medical treatment where patients "shop around" for physicians who accept their insurance.²¹¹ Due to physician "shopping," most Americans have contact with several physicians throughout their lifespan and do not receive the comprehensive care needed to facilitate a good life and a good death.

The modern approach to medical care in the United States has resulted in many citizens not being able to afford health insurance.²¹² As of 2001, approximately forty million Americans were not covered by health insurance.²¹³ Lack of insurance leads to less availability of necessary medical treatment to those patients who likely need it the most, such as terminally ill patients not receiving sufficient care at the end of life.²¹⁴ Hence, the

209. See SULTZ & YOUNG, *supra* note 22, at 188-95. Reform concerning how health care is financed and delivered has changed dramatically in the last century. See *id.* In the early 1900s Americans paid health related expenses out-of-pocket. See *id.* During the New Deal era the financing of health care moved rapidly away from this source of payment to government programs and private insurers. See *id.* In the 1960s the federal government became heavily involved in the financing of health care by the promulgation of Medicare and Medicaid insurance regulation for the poor and aged. See *id.* By the 1970s, fee-for-service financing of health care was the predominant model. See *id.* Fee-for-service paid for each medical service provided by the physician or hospital, thus, promoting the overuse of services that may not have been essential for treatment. See *id.* at 190. Along with fee-for-service financing, the explosion in medical technology in the 1970s added to the rising costs of health care. See SULTZ & YOUNG, *supra* note 22, at 190. Furthermore, American workers utilized the health care system unabashedly with no regard to cost containment. See *id.* Beginning in the mid 1970s, the U.S. health system started to move rapidly toward the model of managed care in an attempt to restrict the out-of-control costs of health care. See *id.* Under the managed care model of health care finance, "providers are paid in advance a preset amount for all the services their insured population is projected to need in a given time period." *Id.* If the physician exceeds the amount allotted for services, he or she suffers a financial loss. See *id.*

210. See HOEFLER, *supra* note 199, at 226.

211. See *id.*

212. See *id.*

213. See SULTZ & YOUNG, *supra* note 22, at 22-23. Before managed care, many physicians would accept patients without insurance or unable to pay for services. See *id.* at 22-25. The physicians could provide care for these patients because they could spread the cost of treatment to their insured patients by increasing the amount of fees charged to the insurance companies. See *id.* Currently, many physicians refuse to provide care to these patients, because the physicians are no longer compensated for their services. See *id.*; see also Quill, *supra* note 43, at 552; see also Susan M. Wolf, *Facing Assisted Suicide and Euthanasia in Children and Adolescents*, in REGULATING HOW WE DIE, *supra* note 3, at 108. The United States is the only developed country that does not provide all citizens with health care coverage. See *id.*

214. See Quill, *supra* note 43, at 552. Limited access to "preventive care, emergency care, hospitalization, long-term care, and hospice" provides sub-optimal treatment to patients. *Id.* Persons who are not covered by insurance include the indigent, disabled, and the elderly. See *id.* Many times these are the exact groups who require greater medical attention based on other

diminished levels of patient-physician communication and progressive changes in health care delivery in the United States has resulted in many Americans not receiving adequate care during the dying process.

IV. HISTORY OF PHYSICIAN-ASSISTED SUICIDE AND EUTHANASIA IN THE NETHERLANDS

A. *The Last Twenty Years of Case Law*

Until the Netherlands' TLRASA became effective on April 1, 2002, case law legalized PAS and euthanasia.²¹⁵ Before the TLRASA was enacted, euthanasia and PAS were illegal under the Dutch Criminal Code (Code).²¹⁶ Although illegal, three theories were employed to legitimize assisted suicide and euthanasia against the legal implications of criminal liability under the Code.²¹⁷ First, a defendant could contend that he or she was "compelled by an overpowering force to put the welfare of his patient above the law," otherwise known as *force majeure* or *overmacht*.²¹⁸ Second, a defendant could assert that the Code simply does not apply to physicians.²¹⁹ Third, an argument could be made that the defendant's behavior may have violated the letter of the law but not the purpose of the law, otherwise known as the doctrine of "absence of substantial violation of the law."²²⁰

One of the first cases dealing with euthanasia in the Netherlands, *Postma*,²²¹ was decided in 1973.²²² In *Postma*, a physician injected her mother

socioeconomic factors. *See id.*

215. Ezekiel J. Emanuel, *Euthanasia: Where the Netherlands Leads Will the World Follow?*, 322(7299) BRIT. MED. J. 1376, 1377 (2001).

216. THE AMERICAN SERIES OF FOREIGN PENAL CODES, THE DUTCH PENAL CODE 200 (Louise Rayar & Stafford Wadsworth trans., 1997) [hereinafter DUTCH PENAL CODE]. *See also* INTRODUCTION TO DUTCH LAW FOR FOREIGN LAWYERS 313 (Jeroen Chorus et al. eds., 1993). The Dutch employ a national penal code that has its roots in the French Code Penal. *See id.*

217. *See* DUTCH PENAL CODE, *supra* note 216, at 200; *see also* GRIFFITHS, *supra* note 26, at 308 (quoting Articles 293 and 294 of the Dutch Penal Code). "A person who takes the life of another person at that other person's express and earnest request is liable to a term of imprisonment of not more than twelve years . . ." *Id.* "A person who intentionally incites another to commit suicide, assists in the suicide of another, or procures for that other person the means to commit suicide, is liable to a term of imprisonment of not more than three years . . ." *Id.* The Code did provide a defense of justification or necessity. *See id.* at 307. "A person who commits an offense as a result of a force he could not be expected to resist . . . is not criminally liable." *Id.*

218. *See* HENDIN, *supra* note 93, at 47. *See also* GRIFFITHS, *supra* note 26, at 99.

219. *See* GRIFFITHS, *supra* note 26, at 61. This defense is called the "medical exception" argument. *Id.*

220. *Id.*

221. *Postma*, Netherlandse Jurisprudentie 1973, no. 183: 558, *cited in* GRIFFITHS, *supra* note 26, at 51-53.

222. *See id.* The physician's mother was a seventy-eight year old widow who was residing in a nursing home after suffering a stroke that resulted in left-sided paralysis. *See id.* On many occasions, the physician's mother requested her daughter's assistance in death. *See id.* The

with an overdose of morphine²²³ for the purpose of assisting her mother in death.²²⁴ Although the District Court in Leeuwarden found the physician guilty of killing on request, it adopted conditions as to when it is permissible for a physician to provide a patient with an amount of pain medication that could possibly result in the hastening of his or her death. The permissible conditions adopted were: when a patient is suffering from an incurable illness;²²⁵ when the patient is inflicted with unbearable mental or physical suffering;²²⁶ when the patient has made a written request for termination of his or her life; and when the treating physician is the person who complies with the request.²²⁷ In addition to this decision, the Royal Dutch Medical Association (KNMG)²²⁸ announced in the same year that, "euthanasia should remain prohibited under Article 293,²²⁹ but that combating pain and discontinuing futile treatment could be justified, even if the patient dies as the result of the act or omission."²³⁰

In 1981, the Rotterdam District Court decided the *Wertheim* case.²³¹ *Wertheim* set forth that physicians must comply with certain criteria in order for assisted suicide to be justifiable under Article 294²³² of the Code.²³³

Medical Inspector testified at court of the acceptable conditions under which a physician could provide a dose of pain medication that could possibly hasten the patient's death. *See id.* The District Court accepted all of the conditions except the requirement that the patient be in the "dying phase" of his or her illness. *See Postma*, 1973, no. 183: 558, cited in GRIFFITHS, *supra* note 26, at 51-53. Because the physician gave the injection of morphine with the purpose of immediately terminating her mother's life instead of for palliative care, the Court found the physician guilty of killing on request. *See id.* The physician was given a sentence of one week in jail and one year probation. *See id.* *See also* Jocelyn Downie, *The Contested Lessons of Euthanasia in the Netherlands*, 8 HEALTH L. J. 119, 120-22 (2000).

223. DAVIS'S DRUG GUIDE FOR NURSES 797 (3rd ed. 1993). Morphine is a narcotic analgesic that causes respiratory depression when an overdose is given. *See id.*

224. *See Postma*, 1973, no. 183: 558, cited in GRIFFITHS, *supra* note 26, at 51-53.

225. *See id.*

226. *See id.*

227. *See id.*

228. *See* GRIFFITHS, *supra* note 26, at 5. The KNMG is the predominant medical association of physicians in the Netherlands. *See id.*

229. *See* DUTCH PENAL CODE, *supra* note 217, 200; *see also* GRIFFITHS, *supra* note 26, at 308 (quoting the Dutch Penal Code).

230. *Physician-assisted Suicide and Euthanasia in the Netherlands: A Report to the House Judiciary Subcommittee on the Constitution*, 14 ISSUES IN LAW & MED. 301 (1998).

231. *Wertheim*, Netherlands Jurisprudentie 1982, no. 63: 223, cited in GRIFFITHS, *supra* note 26, at 58-60.

232. *See* DUTCH PENAL CODE, *supra* note 217, at 200; *see also* GRIFFITHS, *supra* note 26, at 308 (quoting the Dutch Penal Code).

233. *See Wertheim*, 1982, no. 63: 223, cited in GRIFFITHS, *supra* note 26, at 58-60. The woman assisted with suicide was sixty-seven years old, suffering from numerous physical and mental inflections, and had previously made several statements concerning her desire for death. *See id.* The woman had requested assistance from her physician; however, he refused and referred her to the activist. *See id.* After meeting with the woman on more than one occasion, the activist agreed to assist her in death. *See id.* The District Court concluded that the activist did not comply with the criteria it set forth to provide assistance with suicide and found her in violation of Article 294 of the Code. *See id.* The activist received a six-month jail term and one

Wertheim involved a voluntary-euthanasia activist who assisted a woman with suicide after the woman's physician had refused to do so.²³⁴ The activist's defense was duress caused by the woman's persistent yearning for death.²³⁵ Although the activist was found guilty, the District Court adopted standards for justifiable assisted suicide in regard to Article 294 of the Code, which included:

[T]he physical or mental suffering of the person was such that he experiences it as unbearable; this suffering as well as the desire to die were enduring; the decision to die was made voluntarily; the person was well informed about his situation and the available alternatives, was capable of weighing the relevant considerations, and had actually done so; there were no alternative means to improve the situation; the person's death did not cause others any unnecessary suffering.²³⁶

The Court further concluded that justifiable assisted suicide requires: 1) the decision to provide assistance must be made by more than one person;²³⁷ 2) the decision-making process must involve a physician, and he or she must decide the manner which is employed to bring about death;²³⁸ 3) "the decision to give assistance and the assistance itself must exhibit the utmost care."²³⁹

In 1984, another important euthanasia case, *Schoonheim*, was decided.²⁴⁰ In *Schoonheim*, a physician administered a lethal injection to a ninety-five year old woman to terminate her life.²⁴¹ The Netherlands Supreme Court concluded

year probation. *See id.*

234. *See Wertheim*, 1982, no. 63: 223, cited in GRIFFITHS, *supra* note 26, at 58-60.

235. *See id.*

236. *See GRIFFITHS, supra* note 26, at 59.

237. *See Wertheim*, 1982, no. 63: 223, cited in GRIFFITHS, *supra* note 26, at 58-60.

238. *See id.*

239. *See id.* The patient is provided "Utmost care" if he or she is in the terminal phase of his or her illness and the physician discusses the patient's treatment with another physician or, if the patient is not in the terminal phase, he or she is referred to a mental health clinician. *See id.* *See also* Downie, *supra* note 222, at 122.

240. *Schoonheim*, *Nederlandse Jurisprudentie* 1985, no. 106, cited in GRIFFITHS, *supra* note 26, at 62-65. This was the first case of euthanasia to come before the Supreme Court of the Netherlands. *See id.* In this case, the ninety-five year old woman was mentally competent, but had many physical afflictions that had left her bedridden and decreased her vision, speech, and hearing. *See id.* Furthermore, the woman had made repeated statements to her physician in regard to her suffering and had asked the physician to perform euthanasia on numerous occasions. *See id.* In the short period before her death, the woman's health declined rapidly, and she once again asked for help in terminating her life. *See id.* After the physician had consulted with his assistant and the woman's family members, he acceded to the request for euthanasia. *See id.* The physician then reported himself to the police. *See Schoonheim*, 1985, no. 106, cited in GRIFFITHS, *supra* note 26, at 62-65. *See also* Downie, *supra* note 222, at 123-24.

241. *See Schoonheim*, 1985, no. 106, cited in GRIFFITHS, *supra* note 26, at 62-65. *See also* Downie, *supra* note 222, at 123-24.

that the lower court did not sufficiently consider the *overmacht* defense²⁴² for necessity and referred the case back to another appellate court.²⁴³ The Appellate Court then determined that the physician's defense of necessity was appropriate.²⁴⁴ Thus, the physician was acquitted of the crime of euthanasia.²⁴⁵ Moreover, the decision of the Court firmly established the defense of justification or necessity.²⁴⁶

Soon after the *Schoonheim* case was decided, the KNMG published its official position on euthanasia.²⁴⁷ The KNMG's position closely coincided with the decisions of the courts.²⁴⁸ The KNMG set forth guidelines for physicians performing euthanasia or PAS that included: 1) the request must be voluntary; 2) the patient must carefully consider such a request; 3) the desire for death must be firm; 4) the patient has "unacceptable suffering;" and 5) the physician has discussed the request with another physician who affirms the planned euthanasia.²⁴⁹

Admiraal was the first case to confirm that a physician may not be held criminally liable for performing euthanasia as long as he or she complies with the KNMG's guidelines.²⁵⁰ In *Admiraal*, the physician, after complying with

242. See *Schoonheim*, 1985, no. 106, cited in GRIFFITHS, *supra* note 26, at 62-65.

243. See *id.* The Court did reject the "no substantial violation of the law" theory; however, the Court wanted the necessity theory of *overmacht* analyzed more thoroughly. *Id.* The Supreme Court's reasoning in its decision included an analysis of the patient's "unbearable suffering," lack of dignity, the ability to die with dignity, and the consideration of alternatives to euthanasia. See *id.*

244. See *id.*

245. See *id.*

246. Pols, *Nederlandse Jurisprudentie* 1987, no. 607, cited in GRIFFITHS, *supra* note 26, at 63-64. This case involved a psychiatrist who assisted a friend with suicide at the friend's request. See *id.* The Supreme Court rejected the psychiatrist's defense of "medical exception" and held that the necessity defense to euthanasia was not intended as a sole exception applicable to physicians. See *id.* However, the Court, as it did in the *Schoonheim* case, disagreed with the lower court's refusal to allow the defense of *overmacht* in regard to necessity and referred the case back to another court of appeals for further analysis. See *id.* The Court of Appeals rejected the defense of necessity based on the grounds that the psychiatrist did not consult with any other physician before performing euthanasia, and moreover, the relationship with the woman extended beyond that of doctor-patient. See *id.*

247. See Keown, *supra* note 58, at 261. The official opinion regarding permissible euthanasia was published in 1984. See *id.*

248. See *id.*

249. See Pieter Admiraal, *Voluntary Euthanasia: The Dutch Way*, in DEATH, DYING AND THE LAW, *supra* note 25, at 114.

250. Admiraal, *Nederlandse Jurisprudentie* 1985, no. 709, cited in GRIFFITHS, *supra* note 26, at 66-67. The patient, who the physician assisted in death, resided in a nursing home and totally depended on others for her care. See *id.* She had asked the physician at the nursing home for his assistance with euthanasia but he refused. See *id.* After the patient was referred to Admiraal, she informed him on more than one occasion of her suffering. See *id.* Admiraal discussed the plan for euthanasia with his colleagues before complying with the request. See *id.* During the trial, the prosecution argued that Admiraal failed to meet the guideline of consulting another physician because he did not contact a neurologist having the special expertise in the area of multiple sclerosis. See *id.* The District Court disagreed and held that by consulting his colleagues, Admiraal had met the consultation requirement. See *Admiraal*,

the KNMG's criteria, provided euthanasia to a woman suffering from multiple sclerosis.²⁵¹ Because the physician followed the KNMG's guidelines, he was acquitted.²⁵² This decision was further strengthened when the Minister of Justice informed the KNMG that physicians who acted in accordance with the "Requirements of Careful Practice" would not be criminally prosecuted for the crime of euthanasia.²⁵³

Another case that implemented the KNMG's guidelines was *Chabot*.²⁵⁴ In *Chabot*, a psychiatrist supplied PAS to a patient inflicted only with psychological ailments.²⁵⁵ Once again, the Netherlands Supreme Court confirmed that assisted suicide and euthanasia could be justified by proving *overmacht*.²⁵⁶ In addition, the Court verified that a patient with only mental suffering might receive assistance in death by euthanasia or PAS if the KNMG's standards were followed.²⁵⁷ Nonetheless, the physician was convicted of assisted suicide because he failed to have the patient independently examined by another physician.²⁵⁸ Thus, the Court drew a line between physical and mental suffering by suggesting that if a person is only inflicted with mental agony, then a mere discussion with another colleague is not enough to satisfy the KNMG's guidelines.²⁵⁹

In 1995 and 1996, two similar cases, *Prins*²⁶⁰ and *Kadijk*,²⁶¹ were presented to the Dutch courts regarding the assistance in death of two newborn infants, both inflicted with severe anomalies.²⁶² Due to the infants' suffering

1985, no. 709, cited in GRIFFITHS, *supra* note 26, at 66-67.

251. *See id.*

252. *See id.*

253. *See Admiraal*, 1985, no. 709, cited in GRIFFITHS, *supra* note 26, at 66-67. *See also Downie, supra* note 222, at 124.

254. *Chabot*, Nederlandse Jurisprudentie 1994, no. 656, cited in GRIFFITHS, *supra* note 26, at 80-82. *See also Downie, supra* note 222, at 125-26.

255. *See Chabot*, 1994, no. 656, cited in GRIFFITHS, *supra* note 26, at 80-82. The woman provided euthanasia was fifty years old and had gone through repeated traumatic events regarding the loss of family members and divorce. *See id.* She had previously sought psychiatric treatment without results and had once before attempted suicide. *See id.* The woman's official diagnosis was "an adjustment disorder" and depression. *See id.* After several meetings with this woman and numerous consultations with colleagues, Dr. Chabot found that her suffering was intense, enduring over a long period of time, "unbearable" to her, and she had no hope for recovery. *See id.* *See also Downie, supra* note 222, at 125-26.

256. *See Chabot*, 1994, no. 656, cited in GRIFFITHS, *supra* note 26, at 80-82.

257. *See id.*

258. *See id.* Although the physician was convicted, he did not receive any punishment. *See id.*

259. *See Chabot*, 1994, no. 656, cited in GRIFFITHS, *supra* note 26, at 80-82. *See also Downie, supra* note 222, at 126.

260. *Prins*, Nederlandse Jurisprudentie 1995, no. 602, cited in GRIFFITHS, *supra* note 26, at 83-84. *See also Downie, supra* note 222, at 126.

261. *Kadijk*, Tijdschrift voor Gezondheidsrecht 1996, no. 35, cited in GRIFFITHS, *supra* note 26, at 83-84. *See also Downie, supra* note 222, at 126-27.

262. *See MOSBY'S DICTIONARY, supra* note 40, at 69. The definition of anomaly is a "deviation from what is regarded as normal; a congenital malformation, such as the absence of a limb or the presence of an extra finger." *Id.*

and no chance of survival, the parents requested euthanasia from the physicians.²⁶³ Thus, in both cases, the physicians performed euthanasia on patients who had not specifically requested it.²⁶⁴ Both District Courts accepted the defense of necessity and both physicians were acquitted.²⁶⁵ The *Prins* court based its decision on the grounds that certain guidelines are to be met in such a situation.²⁶⁶ The guidelines include:

[T]he baby's suffering had been unbearable and hopeless, and there had not been another medically responsible way to alleviate it; both the decision-making leading to the termination of life and the way in which it was carried out had satisfied the 'requirements of careful practice;' the doctor's behavior had been consistent with scientifically sound medical judgment and the norms of medical ethics; termination of life had taken place at the express and repeated request of the parents as legal representatives of the newborn baby.²⁶⁷

Thus, based on these two cases, the door opened in the Netherlands for the occurrence of involuntary euthanasia.²⁶⁸

B. Termination of Life on Request and Assisted Suicide (Review Procedures) Act

The above cases and guidelines shaped the history of the Netherlands' legalization of PAS and euthanasia.²⁶⁹ The case law outlined the defense of justification for physicians who elected to provide euthanasia or assisted suicide but did not set forth that patients have a right to PAS and euthanasia.²⁷⁰ This changed in April 2002, when the Netherlands' TLRASA became

263. See *Kadijk*, 1996, no. 35 and *Prins*, 1995, no. 602, cited in GRIFFITHS, *supra* note 26, at 83-84. See also Downie, *supra* note 222, at 126. In both cases, the physicians complied with the requests after consultation with other colleagues. See *id.*

264. See *Kadijk*, 1996, no. 35 and *Prins*, 1995, no. 602, cited in GRIFFITHS, *supra* note 26, at 83-84. See also Downie, *supra* note 222, at 126.

265. See *Kadijk*, 1996, no. 35 and *Prins*, 1995, no. 602, cited in GRIFFITHS, *supra* note 26, at 83-84. See also Downie, *supra* note 222, at 126.

266. See *Kadijk*, 1996, no. 35 and *Prins*, 1995, no. 602, cited in GRIFFITHS, *supra* note 26, at 83-84.

267. See GRIFFITHS, *supra* note 26, at 83.

268. See *id.*

269. See *id.*

270. See *id.* at 107. Because the Netherlands case law created a justification for physicians to perform euthanasia, "the patient, even when his [or her] case [met] all of the legal requirements, [had] no 'right' to euthanasia." *Id.*

effective.²⁷¹ The TLRASA codified the Netherlands case law and the KNMG's guidelines, in effect giving Dutch citizens the right to request PAS and euthanasia.

The TLRASA allows a physician to assist a patient, who has attained the age of twelve years and is "deemed capable of making a reasonable appraisal of his own interests,"²⁷² with suicide or perform euthanasia provided that he or she follow certain guidelines referred to as "due care criteria."²⁷³ To comply with the criteria, the physician must be satisfied that: 1) the patient's suffering is "unbearable, and . . . there [is] no prospect of improvement;"²⁷⁴ 2) the patient's request was made voluntarily after careful consideration and,²⁷⁵ 3) based on the patient's situation, no "reasonable alternative" is available.²⁷⁶ In addition to the above criteria, the physician must inform the patient "about his situation and his prospects"²⁷⁷ and refer the patient to another physician who is required to write an opinion based on the above criteria.²⁷⁸

After a physician provides a patient with PAS or euthanasia, he or she is required to complete a comprehensive report regarding compliance with the "due care criteria" and notify the municipal pathologist.²⁷⁹ The report is then forwarded to a regional review committee for an assessment of whether the physician followed the "due care criteria."²⁸⁰ If the committee concludes that the physician did not follow the criteria, they notify the Board of Procurators General of the Public Prosecution Service for the purposes of a criminal investigation.²⁸¹ If a physician does not meet the "due care criteria" as set

271. See TLRASA § 1-24, available at Ministry of Foreign Affairs-The Netherlands, <http://www.minbuza.nl/english/Content.asp?Key=416729&Pad=400025,257588,257609> (last visited Nov. 1, 2002).

272. *Id.* § 2(2)-(4). The Act sets forth: 1) if the patient requesting PAS or euthanasia is between the ages of twelve and sixteen, his or her parents or guardian must *agree* to the termination of life; 2) if the patient is between the ages of sixteen and eighteen, his or her parents or guardian must be *consulted*. See *id.* Moreover, if the patient is sixteen or older and "no longer capable of expressing his [or her] will," PAS or euthanasia can be provided if before reaching this "state," he or she was "capable of making a reasonable appraisal of his [or her] own interest" and had made a written request for such termination of his [or her] life. *Id.*

273. See *id.* § 2(1)(a)-(f). See also The Netherlands Penal Code Art. 293(2), available at <http://www.minbuza.nl/english/Content.asp?Key=416729&Pad=400025,257588,257609> (last visited Nov. 22, 2002). The Code sets forth that PAS or euthanasia is not an offense if the physician follows the "due care criteria" and files a report with the municipal pathologist. See *id.*

274. See TLRASA § 2(1)(b).

275. See *id.* § 2(1)(a).

276. See *id.* § 2(1)(d).

277. *Id.* § 2(1)(c).

278. See *id.* § 2(1)(e).

279. See *id.* § 7(2).

280. See TLRASA § 3(1); see also *id.* § 8(1). Along with the report, the committee may ask the physician to provide additional information either orally or in writing to aid in the assessment of the physician's conduct. See *id.* See also *id.* § 8(2).

281. See *id.* § 9(2)(a).

forth in the TLNASA, he or she can be held criminally liable and imprisoned for up to twelve years.²⁸²

C. Netherlands Statistical Information

The government of the Netherlands supported two national surveys performed in 1990 and 1995, concerning PAS and euthanasia.²⁸³ In 1990, 1.8% or 2300 of all deaths in the Netherlands were the result of euthanasia and 0.3% or 400 deaths were the result of PAS.²⁸⁴ In 1995, 2.4% or 3200 of all deaths were caused by euthanasia and 0.3% or 400 deaths were caused by PAS.²⁸⁵ Probable reasons for the increase in the number of euthanasia cases from 1990 to 1995 were the rising number of elderly, higher average age at death, the advance of medical technology, and a higher number of cancer cases resulting in death.²⁸⁶ Additionally, the number of accepted euthanasia and PAS requests increased from thirty percent in 1990 to thirty-seven percent in 1995.²⁸⁷ The authors of the studies attributed the increase in requests for PAS and euthanasia to the evolving societal climate of young persons who were more likely to request PAS or euthanasia.²⁸⁸

Like the Oregon survey, pain was not the first indicator of a request for PAS or euthanasia.²⁸⁹ In 1990, the predominant reasons for requesting PAS or euthanasia were loss of dignity (fifty-seven percent), pain (forty-six percent), "unworthy dying" (forty-six percent), the desire not to be dependent on others (thirty-three percent), and "tiredness of life" (twenty-three percent).²⁹⁰ Cancer was the most likely underlying disease of the patients requesting PAS or euthanasia.²⁹¹ Moreover, more women than men received PAS or euthanasia.²⁹²

282. See The Netherlands Penal Code art. 293(1).

283. See GRIFFITHS, *supra* note 26, at 207. The two surveys include: Van der Maas, Van Delden & Pijnenborg 1992 and Van der Wal & Van der Maas 1996. See *id.* See also Angell, *supra* note 2, at 1676. A commission was appointed in 1990 by the Dutch Government to determine the statistical information related to the practices of PAS and euthanasia. See *id.* Professor Jan Remmelink, the attorney general of the Dutch Supreme Court, was chosen to supervise the study. See *id.*

284. See GRIFFITHS, *supra* note 26, at 210.

285. See *id.*

286. See *id.* at 211.

287. See *id.*

288. See *id.*

289. Paul J. Van der Maas et al., *Euthanasia and Other Medical Decisions Concerning the End of Life*, 338 LANCET 669, 672 (1991).

290. See *id.*

291. See GRIFFITHS, *supra* note 26, at 224. In the 1995 survey, eighty percent of patients who received PAS or euthanasia were suffering from cancer. See *id.*

292. See *id.* at 223. In the 1995 survey fifty-five percent of those who received PAS or euthanasia were women. See *id.*

Furthermore, both studies collected data on the number of deaths caused by euthanasia without the patients' request.²⁹³ The data revealed that in 1990, 0.8% or 1000 deaths in the Netherlands were the result of euthanasia without the patients request, and in 1995, 0.7% or 900 deaths occurred by euthanasia absent patient request.²⁹⁴ The authors of the 1990 study analyzed the circumstances surrounding involuntary euthanasia.²⁹⁵ In most of the cases, the physician had previously discussed euthanasia with the patient and the patient had stated his or her desire for such treatment if suffering became unacceptable.²⁹⁶ The majority of the patients were near death and experiencing an extreme amount of suffering.²⁹⁷ Moreover, the physician consulted the patient's family before performing euthanasia.²⁹⁸

D. The Culture and Attitude Toward PAS and Euthanasia in the Netherlands

Historically, the Dutch have been known for their liberal views and tolerance.²⁹⁹ In the 1960s, the social revolution made its impact on the Dutch culture.³⁰⁰ Secularism became the dominant power in society.³⁰¹ No longer did most of the population look to the Dutch Reformed Church and the Roman Catholic Church for guidance.³⁰² The Dutch embraced the idea of personal

293. See SMITH, *supra* note 65, at 100-01. Opponents suggest that physicians provide euthanasia to patients that have not explicitly asked for assistance in death because they feel comfortable in a legal system that allows them to "kill." See *id.*; but *c.f.*, GRIFFITHS, *supra* note 26, at 226-27. Proponents contend that physicians provide euthanasia to patients without their explicit request based on a long-standing relationship with that person. See *id.* This relationship allows the physician to understand what assistance the patient would desire. See *id.*

294. See GRIFFITHS, *supra* note 26, at 210.

295. See Van der Maas, *supra* note 289, at 672.

296. See *id.* The patient then usually experienced deterioration in health due to the underlying illness and was no longer able to communicate with the physician. See *id.*; see also GRIFFITHS, *supra* note 26, at 225.

297. See Van der Maas, *supra* note 289, at 672. See also GRIFFITHS, *supra* note 26, at 225.

298. See Van der Maas, *supra* note 289, at 672.

299. See Hendin, *supra* note 59, at 223. In the sixteenth and seventeenth centuries, the Dutch battled to secure their religious freedom. See *id.* The Netherlands provided a home for "Jews, Catholics, and free thinkers." *Id.* During this same time period, the Dutch became a major force of the seafaring trade. See *id.* Thus, acceptance of several cultures and customs was required for the country to excel in the world of maritime trading. See *id.* Today, diversity in the Netherlands is manifested by the existence of fifty different religions and twenty-five different political parties existing within its boundaries. See *id.*

300. See Hendin, *supra* note 59, at 223.

301. See *id.* The Dutch are known for their liberal attitudes toward prostitution, drug use, and pornography. See *id.*

302. See HENDIN, *supra* note 93, at 137. The Dutch Reformed Church and the Catholic Church were both the result of Dutch Calvinism. See *id.* The school of thought of Calvinism was that one should live a simple life, be dedicated to work, deny any form of pleasure, and find redemption in suffering. See *id.*

autonomy and pleasure over pain.³⁰³ Thus, this social and cultural climate created a fertile foundation for the topic of euthanasia and PAS to be openly discussed and debated by the general public, physicians, and politicians.³⁰⁴

Since the 1970s, opinion polls in the Netherlands have shown that the majority of Dutch citizens approve euthanasia and PAS.³⁰⁵ Most Dutch religious and political affiliations also support the legalization of euthanasia and PAS.³⁰⁶ Moreover, Dutch physicians have been at the forefront of the legalization movement regarding PAS and euthanasia.³⁰⁷ In support of this contention, the KNMG stated in its report of 1984 that it "considered euthanasia to be a fact of life," and the issue of euthanasia should be regarded as appropriate between physician and patient.³⁰⁸ Furthermore, Dutch physicians and patients prefer euthanasia over PAS, because once the patient and physician determine that assistance in death is appropriate, physicians feel it is their personal responsibility to fulfill the request in an ethical manner that does not permit the possibility of adverse events.³⁰⁹ Additionally, Dutch physicians do not distinguish between euthanasia and PAS, because both acts are intended to result in hastening the patient's death.³¹⁰

303. See Hendin, *supra* note 59, at 223.

304. See generally GRIFFITHS, *supra* note 26, at 50.

305. See *id.* at 199. Both Dutch men and women have an equally positive opinion regarding the legalization of PAS and euthanasia. See *id.* A small gap does exist between the older and younger generations being that the elderly have less favorable opinions toward euthanasia. See *id.*

306. See *id.* The majority of support for euthanasia comes from those without any religious affiliation. See *id.* However, Catholics also show a high support of euthanasia. See GRIFFITHS, *supra* note 26, at 199. The Humanist Society asserted that "the law should allow room for doctors to give support in the dying process in accordance with medical professional standards." See *id.* at 55. The Dutch political party, VVD, supported PAS and euthanasia being allowed as long as the patient made a careful, deliberate request for such assistance. See *id.* at 55.

307. See *id.* at 304. See also Pierson, *supra* note 22, at 309. The predominant medical society in the Netherlands, the KNMG, was highly visible in the movement toward legalizing euthanasia in the Netherlands. See *id.* The judicial system and the KNMG worked closely together to create the guidelines surrounding euthanasia. See *id.* This was evidenced by the many court decisions that adopted the guidelines set forth by the KNMG regarding euthanasia. See *id.*

308. See GRIFFITHS, *supra* note 26, at 65-66.

309. See *id.* at 111. Euthanasia provides a forum where the physician has control of the medication and is present in the case of any untoward side effect, such as vomiting, as compared to PAS where the physician may not be in attendance to correct any unexpected events. See generally *id.* at 113.

310. See Emanuel, *supra* note 193, at 145.

Health insurance is available to nearly all citizens of the Netherlands.³¹¹ Medical costs are considered “normal” or “exceptional.”³¹² “Normal” medical costs include: “[h]ospitalization and medical care by specialists, the services of GPs [general practitioners], paraprofessional services such as physical therapy, speech therapy, midwifery and dental care for the youth”³¹³ “Exceptional” medical costs are equated with long-term care or expensive medical treatment.³¹⁴ Both “normal” and “exceptional” medical costs are covered by a national health insurance plan.³¹⁵ Thus, all Dutch citizens enjoy the benefit of adequate medical treatment without the worry of treatment being too expensive or financially burdensome.³¹⁶

To promote continuity of care, the Dutch health care system registers every citizen with a General Practitioner (Practitioner).³¹⁷ The Practitioner has significant contact with his or her patients because the patient must see the Practitioner before being referred to a specialist or to a hospital.³¹⁸ Moreover, the Practitioner usually provides care to an entire family, and seventeen percent of the visits between patient and physician occur in the patients’ homes.³¹⁹ Studies reveal that in the majority of cases involving euthanasia, a Practitioner was the physician who administered the lethal medication.³²⁰ Moreover, most Dutch citizens die at home in the presence of their Practitioner.³²¹ Hence, the continuity of care in the Netherlands supplies Dutch citizens with the opportunity of developing a long-term relationship with their physician.³²² This long-term relationship promotes good patient-physician

311. See GRIFFITHS, *supra* note 26, at 31-35. All Dutch citizens are provided coverage under this national program. *See id.* For those that are not covered by the public health insurance programs (approximately thirty-five percent of the Dutch population), private health insurance is available under a standard package similar to the public program. *See id.* Dutch citizens pay approximately ten percent of their health-care costs out-of-pocket. *See id.* The government pays another ten percent. *See id.* “The remaining [eighty percent] is covered by insurance premiums, of which [sixty-five percent] are in the context of the public health insurance scheme and [fifteen percent] are for private insurance.” *Id.* at 32.

312. See GRIFFITHS, *supra* note 26, at 31-32. A national health insurance program also covers “normal” medical costs; however, this coverage is only available to those who earn less than a specified amount of income per year, such as elderly patients and persons receiving social security. *See id.*

313. *Id.*

314. *See id.* A national health insurance program covers these “exceptional” medical costs. *See id.* Expensive medical treatment includes: “long-term residential and nursing care for the elderly, comprehensive psychiatric care, home-based care, and comprehensive care for the physically and mentally handicapped.” *Id.* at 31.

315. *See id.* at 31-32.

316. *See generally* GRIFFITHS, *supra* note 26, at 31-32.

317. *See id.*

318. *See id.* at 36-37. “The impact of gatekeeping is reflected in the low referral rate: 90% of all complaints are treated by GPs.” *Id.*

319. *See id.* at 31-35.

320. *See id.*

321. *See Pierson, supra* note 22, at 309.

322. *See generally* GRIFFITHS, *supra* note 26, at 36-37.

communication that likely results in discussions regarding end-of-life decisions.³²³

V. COMPARISON OF THE UNITED STATES AND THE NETHERLANDS

A. Oregon's Objective DWDA v. Netherlands Subjective TLRASA

Problems facing both Oregon and the Netherlands in drafting the DWDA and TLRASA, respectively, were how to establish who is eligible for PAS and/or euthanasia and where the determining line should be drawn.³²⁴ Both countries agree that a possibility of the "slippery slope" exists and safeguards must be implemented to protect against selective termination of vulnerable groups of people.³²⁵ The TLRASA and DWDA have some similarities; however, the Netherlands has drawn a subjective line in deciding who should receive PAS and euthanasia, whereas Oregon has drawn an objective line.³²⁶

A major difference between the DWDA and the TLRASA is that the DWDA only allows PAS and strictly prohibits euthanasia,³²⁷ whereas the TLRASA allows both PAS and euthanasia.³²⁸ One reason for this difference may be related to the cultivation of the two statutes.³²⁹ In the United States, patients instigated the movement toward legalized PAS by asserting their "right to die."³³⁰ However, in the Netherlands, the physician's scope of practice, not patients' rights, shaped the laws regarding PAS and euthanasia.³³¹ Additionally, in the Netherlands, the KNMG supported the legalization of PAS and euthanasia and was instrumental in drafting the permissive PAS and

323. *See id.*

324. *See* REGULATING HOW WE DIE, *supra* note 3, at 245.

325. *See id.*

326. *See* TLRASA, ch. 2, § 2(b). The requirement of illness or disease is satisfied if the patient has unbearable suffering and "no prospect for improvement." *Id.*; *see also* DWDA, at ch. 127.800, § 1.01(12). The DWDA requirement is objective because it only allows a physician to provide PAS to a patient who is terminally ill with death likely to result within six months. *See id.* Unlike the Netherlands' TLRASA, this DWDA specification prevents physicians from providing PAS to patients who may be suffering from chronic disease or afflicted with mental illness. *See id.*

327. *See* DWDA, ch. 127.880, § 3.14. "Nothing in ORS 127.800 to 127.897 shall be construed to authorize a physician or any other person to end a patient's life by lethal injection . . ." *Id.*

328. *See* GRIFFITHS, *supra* note 26, at 111.

329. *See id.*

330. *See id.*

331. *See id.* "The issue was legally formulated not so much in terms of what patients have a right to demand as in terms of what doctors are authorized to do." *Id.* Because the KNMG has been instrumental in the movement toward legalization of PAS and euthanasia, public debate in the Netherlands has not been focused on patient rights but on the boundaries of physician judgment. *See id.* at 304. "[T]he Dutch seem comfortable with the idea that doctors can be trusted with the discretion to perform euthanasia . . ." *See* GRIFFITHS, *supra* note 26, at 304.

euthanasia laws, whereas in the United States, the AMA opposes the legalization of PAS and euthanasia.³³² The KNMG and Dutch physicians do not differentiate between PAS and euthanasia; both are viewed as comfort care provisions that allow patients not to suffer during the dying process.³³³ Moreover, Dutch physicians would rather provide euthanasia than PAS because of the possible adverse events that could occur if the patient ingests a lethal dose of medication without supervision.³³⁴ Conversely, many American physicians do differentiate between PAS and euthanasia.³³⁵ Several American physicians consider euthanasia the act of killing because it requires the physician to inject the lethal dose of medication into a patient's bloodstream as compared to PAS, which only involves writing a lethal prescription.³³⁶ The American rationale lends itself to an objective decision as to whom is eligible to receive assistance in death, those patients who are terminally ill and have the physical capability of ingesting the lethal dose of medication.³³⁷ Thus, if a patient receives the lethal prescription, he or she must decide whether to have the prescription filled and is required to make the ultimate decision of whether to consume the medication that will hasten his or her death.³³⁸ Therefore, all of the responsibility in assisting death is not placed with the physician.³³⁹

In addition to allowing both PAS and euthanasia, the TLRASA permits either form of assistance in death to terminally ill or chronically ill patients.³⁴⁰ However, the DWDA requires patients requesting PAS to be terminally ill and likely to die within six months.³⁴¹ This precondition in the DWDA seems very specific when compared to the "unbearable suffering with no hope for recovery" standard of the TLRASA.³⁴² The TLRASA requirement allows a broad interpretation of what the patient and physician deem "unbearable."³⁴³

332. See Pierson, *supra* note 22, at 309. See also AMA Official Website, *supra* note 198 and accompanying text. See also Vacco, 521 U.S. at 793. See also Brief of Amici Curiae American Medical Association et al., available at 1996 WL 656281. The AMA adamantly opposes PAS and euthanasia and has supported opponents of PAS and euthanasia in court cases by co-authoring legal briefs. See *id.* See also HENDIN, *supra* note 93, at 145-46. The "KNMG euthanasia guidelines have been virtually adopted by the courts . . ." *Id.*

333. See GRIFFITHS, *supra* note 26, at 111.

334. See *id.* at 111-13.

335. See *id.*

336. David Orentlicher, *The Alleged Distinction Between Euthanasia And The Withdrawal Of Life-Sustaining Treatment: Conceptually Incoherent And Impossible To Maintain*, 1998 U. ILL. L. REV. 837, 840 (1998).

337. See *id.*

338. See *id.*

339. See *id.*

340. See TLRASA, ch. 2, § 2(1)(b).

341. See DWDA, ch. 127.815, § 3.01(1)(a); see also *id.* ch. 127.800 § 1.01(12).

342. See TLRASA, § 2(1)(b).

343. See Hendin, *supra* note 59, at 223. The Dutch have legalized both PAS and euthanasia on the theory that to only allow PAS would be discriminatory against those who meet all the specific criteria but cannot physically bring about their own death by taking the

Comparatively, the DWDA's objective line does not permit the physician or patient to determine what suffering is "unbearable."³⁴⁴ Thus, the DWDA's requirement of terminal illness seems tangible and less prone to subjective interpretation.

Another difference between the two statutes is that the TLRASA allows patients who are twelve years old and older to request assistance in death³⁴⁵ as compared to the DWDA, which only allows patients eighteen years old and older to request PAS.³⁴⁶ Again, the DWDA omits any subjective thought by only allowing adults to request PAS. Additionally, the TLRASA extends assistance in death to those patients who are "no longer capable of expressing [their] will."³⁴⁷ The DWDA, unlike the TLRASA, only allows competent patients that have the ability to communicate to request PAS.³⁴⁸ Providing euthanasia to an incompetent patient places the physician in a position to subjectively decide what the patient's wishes might have been before he or she became mentally incapacitated.³⁴⁹ By only allowing mentally competent patients to request PAS, a physician is not placed in such a position.³⁵⁰

Both the TLRASA and the DWDA offer safeguards against the possible termination of vulnerable patients.³⁵¹ The safeguards that both laws have in common include: 1) the patient's request must be voluntary; 2) the physician must inform the patient of his or her underlying disease and prognosis; 3) the physician must discuss all other possible alternatives to assisted death; and 4) the physician must refer the patient to another physician for consultation.³⁵² Additionally, both laws contain reporting requirements when PAS or euthanasia is performed and provide criminal punishment for physicians who do not comply with the required safeguards.³⁵³

Although the two laws have similar safeguards and criminal punishments for violation of the requirements, the DWDA is much more particular and

medication prescribed by the physician. *See id.* Furthermore, the Dutch did not want to discriminate against the chronically ill by only offering the option of assisted death to terminally ill patients. *See id.* The rationale behind this reasoning is that it would be unfair not to provide PAS and euthanasia to chronically ill patients because they will likely suffer longer than a terminally ill patient. *See id.*

344. *See* DWDA, ch. 127.800, § 1.01(12).

345. *See* TLRASA, §§ 2(2)-(4). If the patient is between the ages of twelve years old and sixteen years old, the parents must agree to the assistance in death. *See id.*

346. *See* DWDA, ch. 127.800, § 1.01(1).

347. *See* TLRASA, § 2(2). This option is only available to those patients sixteen years old or older. *See id.* Before the patient became incompetent, he or she must have made a written request for euthanasia. *See id.*

348. *See* DWDA, ch. 127.800 § 1.01(3).

349. *See* BASTA, *supra* note 41, at 121-22.

350. *See id.*

351. *See* TLRASA, § 2(1)(a)-(e). *See also* DWDA, ch. 127.815 § 3.01.

352. *See id.*

353. *See* TLRASA, § 21. *See also id.* § 20(B). *See also* DWDA, ch. 127.865 § 3.11; *see also id.* ch. 127.890 § 4.02; *supra* note 166 and accompanying text.

carefully worded as compared to the TLRASA.³⁵⁴ For example, the DWDA lists “comfort care, hospice care and pain control” as possible alternatives to PAS.³⁵⁵ Instead of listing possible options to PAS or euthanasia, the TLRASA stipulates that the physician and patient must conclude that there is “no reasonable alternative in light of the patient’s situation.”³⁵⁶ Based on the wording of this section, the TLRASA is subjective and seems to promote patient-physician collaboration in the decision of assisted death.³⁵⁷ In comparison, the DWDA is more objective because it requires the physician to follow a thorough process without any deviation before providing PAS.³⁵⁸

B. Cultural Explanations

One explanation for the divergence between the objective line of the DWDA and the subjective line of the TLRASA is the physician-patient relationships in both countries.³⁵⁹ In the Netherlands, physicians and patients normally have a long-term relationship³⁶⁰ as compared to the United States, where patients see numerous specialists or are forced to physician “shop” because of insurance requirements.³⁶¹ The long-term patient-physician relationship in the Netherlands results in more opportunities for communication; therefore, Dutch physicians are more likely to understand the needs of their patients more completely than American physicians.³⁶² This understanding coupled with a trusting relationship between patient and physician has likely allowed the Dutch to feel comfortable with a flexible statute that is not overly strict and objective.³⁶³

Additionally, the difference in the availability of health insurance in the Netherlands and the United States explains the objective line of the DWDA

354. See BASTA, *supra* note 41, at 121.

355. See also DWDA, ch. 127.815 § 3.01(1)(c)(E).

356. See TLRASA, ch. 2, § 2(1)(d).

357. See *id.*

358. See DWDA, ch. 127.800-97 §§ 1.01-6.

359. See HOEFLER, *supra* note 199, at 77; *supra* notes 199-208 and accompanying text. See GRIFFITHS, *supra* note 26, at 31-35.

360. See GRIFFITHS, *supra* note 26, at 31-35. The General Practitioner in the Netherlands acts as a gatekeeper. See *id.* Patients must see the Practitioner before being referred to a hospital or a specialist. See *id.* Thus, the referral rate in the Netherlands is quite low. See *id.* Practitioners address Ninety percent of patient complaints of illness. See *id.* See also *supra* notes 317-23 and accompanying text.

361. See GRIFFITHS, *supra* note 26, at 31-35. See also *supra* notes 317-23 and accompanying text.

362. See DWORKIN, *supra* note 9, at 135.

363. See HENDIN, *supra* note 93, at 146. The relationship between Dutch physicians and their patients is facilitated by the fact that most general practitioners reside and practice medicine in the same community as their patient population. See *id.* Furthermore, many Dutch physicians continue to make house calls to their extremely ill and dying patients. See *id.*

and the subjective line of the TLRASA.³⁶⁴ Because many Americans lack insurance, they do not have adequate access to health care³⁶⁵ as compared to the Dutch who enjoy the benefits of national health insurance.³⁶⁶ Private insurance companies mainly concerned with monetary goals provide health coverage to Americans that are insured and have adequate access to medical care.³⁶⁷ Based on the monetary goals, Americans might fear that insurance companies would be more likely to cover the lesser cost of PAS as compared to higher-priced treatments.³⁶⁸ Based on their national health care system, the Dutch do not have this concern.³⁶⁹ Thus, the DWDA's strict requirements and objective line likely dispels Americans' fears of coercion by insurance companies.

VI. CONCLUSION

Opponents of euthanasia and PAS in the Netherlands claim that the TLRASA is too subjective and does not provide sufficient safeguards against the at-will termination of vulnerable groups.³⁷⁰ A logical conclusion would be that the employment of objective standards like those in the DWDA would provide better protection against selective termination. However, based on statistical information, neither the Netherlands nor the United States (Oregon) is sliding down the "slippery slope."³⁷¹ The notion that only an objective line of reasoning would adequately protect against the "slippery slope" may be too paternalistic for the Dutch culture.

The Netherlands has allowed PAS and euthanasia for the last twenty years as compared to the United States where PAS was recently legalized in the state of Oregon in 1994. The Dutch had the benefit of the common law

364. See REGULATING HOW WE DIE, *supra* note 3, at 246-47. See also *supra* notes 209-14 and accompanying text. See also GRIFFITHS, *supra* note 26, at 31-32. National health insurance for all Dutch citizens is the result of "the country's cultural commitment to social equity and solidarity." *Id.*

365. See SULTZ & YOUNG, *supra* note 22, at 22, 42.

366. See DWORKIN, *supra* note 9, at 135. See also Emanuel, *supra* note 208, at 246-47.

Most vulnerable at such times are the many Americans who have no health insurance, let alone a long-standing relationship with a personal physician such as those with whom most Dutch citizens can discuss their fears and problems at length before reaching a choice about whether or not to seek to die.

Id.

367. See generally SULTZ & YOUNG, *supra* note 22, at 172-75.

368. See *id.* See also GRIFFITHS, *supra* note 26, at 304. "The fear often expressed in the American discussion, that . . . the costs of medical care might . . . induce doctors for economic reasons to engage in life-shortening practices . . ." *Id.*

369. See *id.* at 31-35.

370. Interview with David Orentlicher M.D., J.D., Samuel R. Rosen Professor of Law, Indiana University School of Law-Indianapolis, Indianapolis, Ind. (Sept. 27, 2002).

371. See *supra* notes 184-92 and accompanying text; see also *supra* notes 283-98 and accompanying text; see also BASTA, *supra* note 41, at 120.

and full support of its preeminent medical association when they promulgated the TLRASA, whereas Oregon was a pioneer of legalizing PAS in the United States and did not have the cooperation of its dominant medical society. Although the TLRASA seems vulnerable to wide interpretation, many years of corroboration between the Dutch judiciary and the KNMG have resulted in a workable statute that relies heavily on physician judgment and comports well with the liberal views of the Dutch society. Thus, the objective, paternalistic approach utilized in the DWDA may be appropriate for the first PAS law in the United States as compared to the TLRASA that was passed after many years of development within the common law.

Furthermore, the cultural differences between the Netherlands and the United States have led to the opposite lines drawn in determining who is eligible to receive assistance in death.³⁷² The subjective line used in the TLRASA comports with the continuity of care employed by the Dutch health care system in allowing a patient and physician to collaborate freely in regard to end-of-life decisions. Conversely, the objective line drawn by the DWDA logically conforms to the absence of long-standing patient-physician relationships and the paucity of patient-physician communication in the United States. A relationship without trust usually requires specific and definite guidelines before moving forward into untested waters. Although the subjective line employed by the TLRASA and the objective line used by the DWDA in defining who will receive assistance in death are quite divergent in theory, both provide sufficient safeguards and protect against the possibility of sliding down the “slippery slope.”

*Kelly Green, R.N.**

372. See Interview with David Orientlicher M.D., J.D., *supra* note 370.

* J.D., Indiana University School of Law-Indianapolis, 2004 expected.

