APPLICABILITY OF INTERNATIONAL SCHEMES OF LEGAL SAFEGUARDS IN PHYSICIAN ASSISTED SUICIDE TO FUTURE UNITED STATES POLICY

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I. INTRODUCTION

During a 2006 hearing on the consequences of potential legalization of physician assisted suicide, the daughter of an Oregon woman who had been diagnosed with terminal lung cancer, was in near constant pain toward the end of her life.[1] After describing her mother's final moments, surrounded by loved ones, listening to music, and

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1 *The Consequences of Legalized Assisted Suicide and Euthanasia: Hearing Before the Subcomm. on the Constitution, Civil Rights and Property Rights of the S. Comm. on the Judiciary*, 109th Cong. 8–10 (2006) (statement of Julie S. McMurchie).

reciting poetry, she stated that her family was "given a gift."[2] She said that:

> The inevitability of my Mother's death from her disease was not in question. Her choice to hasten that inevitability was a reflection of her values and emblematic of the personal freedom our country prizes. Her choice was not about making that choice for other's [sic], as in euthanasia, nor was it about compromising the rights of people with disabilities. Her choice in no way demeaned or sought to critique the choices that others with different values make every day . . . Oregon's law is about preserving those choices for everyone.[3]

Oregon was the first state in the nation to legalize physician assisted suicide with the passage of its Death with Dignity Act in 1997.[4] That law has now been used as a framework for eight other states in enacting their own laws; however, their journeys toward legalization were not simple.[5]

Can the United States ever reach a consensus on how to handle requests by terminally ill patients to end their lives by physician-prescribed medication? Differing approaches by states seem to bode poorly for any nation-wide policy scheme. Concerns regarding legal implications in the event of a mistake or misunderstanding cause legislators to pause, and further, concerns over regulation and reporting plague lawmakers who struggle to articulate a possible system that allows for the necessary regulation required in order to support such legislation while still providing for personal choice.

Other countries' frameworks addressing the issue, however, could provide guidance for states that wish to implement these kinds of laws. One country in particular—Switzerland—where assisted suicide is technically illegal, has created, through a nonprofit mechanism, an industry that has come to be called "suicide tourism."[6]

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2 *Id.*

3 *Id.*

4 *Oregon's Death with Dignity Act*, OREGON.GOV, https://www.oregon.gov/oha/ph/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/index.aspx (last visited September 3, 2019).

5 States that have legalized assisted suicide are: California, Oregon, Vermont, New Jersey, Colorado, Hawaii, Montana, the District of Columbia, and Washington.

6 Penny Sarchet, *Tourism to Switzerland for Assisted Suicide is Growing, Often for Nonfatal Diseases*, WASH. POST (Sept. 22, 2014), https://www.washingtonpost.com/national/health-science/tourism-to-switzerland-for-assisted-suicide-is-

For the purposes of this note, the phrases "physician-assisted suicide," "assisted suicide," "assisted dying," and other terms will be used interchangeably, along with the acronym "PAS." A footnote in a California appellate opinion regarding the state's End of Life Option Act noted that even the terminology regarding the issue is "highly politicized," with proponents preferring terms such as "aid in dying" or "death with dignity," and opponents tending to use "assisted suicide" or "euthanasia."[7] The Court concluded there did "not seem to be any wholly neutral term."[8] This lack of a neutral term to describe the issue is indicative of the complicated ethical problems facing jurisdictions that embark upon the process of legalization, and the interchangeable uses of varying terms in this note should not be construed to signify a particular view on the topic.

Legal euthanasia is a related, but separate topic from assisted suicide. It will also be considered in this note only where applicable for comparative purposes, and when discussing Colombian laws. Legal euthanasia, or the bringing about the death of a person who is terminally ill, is often referred to as "mercy killing."[9] The essential difference between euthanasia and physician assisted suicide is that in euthanasia, the doctor administers the lethal medication, rather than writing a prescription that is then executed by the patient herself, which is the case in a physician assisted suicide.[10]

This note will consider approaches taken by U.S. jurisdictions and foreign nations towards creating a legal regime regarding physician assisted suicide and, will argue that a combination of existing safeguards used by various U.S. jurisdictions and those used by countries, such as Colombia and Switzerland, may be the most rational path forward for more hesitant U.S. jurisdictions.

The legality of physician-assisted suicide has been at issue for more than two decades. The United States Supreme Court in 1997 decided that state-specific bans did not violate the Due Process Clause of the Fourteenth Amendment of the Constitution.[11] Questions of

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growing-often-for-nonfatal-diseases/2014/09/22/3b9de644-2a14-11e4-958c-268a320a60ce_story.html.

7 People ex rel. Becerra v. Superior Court, 29 Cal. App. 5th 486, 489 (2018).

8 *Id.*

9 *Euthanasia*, *Legal Information Institute*, CORNELL L. SCH., https://www.law.cornell.edu/wex/euthanasia (last visited October 2020).

10 Yvette Brazier, ed. Timothy J. Legg, PhD, CRNP, *What are Euthanasia and Assisted Suicide?*, MEDICAL NEWS TODAY (Dec. 17, 2018), https://www.medicalnewstoday.com/articles/182951#euthanasia-and-assisted-suicide-.

11 *See* Washington v. Glucksberg, 571 U.S. 702 (1997).

legality do not just exist in the United States. In Australia, physician assisted suicide remains illegal in every state, but one—Victoria—and as of August 20, 2019, only one patient in the country has utilized the law to end her life.[12] While a 2016 study indicated that where physician-assisted suicide is legal there is little indication of abuse of the practice, and moreover, it is rare in the United States for doctors to prescribe life-ending measures, even where they are legally permitted.[13]

There can be no discussion of physician-assisted death without touching upon ethical and moral considerations. As discussed below, these considerations are accounted for by lawmakers, advocates, and opponents alike during the decision-making process. Should states seeking legalization put much weight into these concerns?

In Section II, this note will survey existing United States laws, both judicial and statutory, on assisted suicide at the federal and state levels. Section III will focus on three countries that have either legalized assisted suicide or approached the issues associated with it in creative ways. This note will discuss Switzerland, which uses a non-profit approach rather than a centralized legislative or judicial approach to assisted suicide. It will then analyze Colombia, which has implemented requirements for panels of experts to sign off on patient requests. Finally, it will compare the common struggles in legalization between Australia and the United States. This note will also apply varying foreign approaches to these laws with respect to their potential efficacy to achieve legalization in the United States. Section IV will touch on ethical considerations typically discussed when laws are proposed in this field. Section V will make policy recommendations.

II. ASSISTED DYING IN THE UNITED STATES

A. Federal Law—A Rejection of a Constitutional "Right to Die"

In the United States, there is no federal law governing physician-assisted suicide.[14] The Supreme Court, however, has considered the constitutionality of the issue on multiple occasions. Additionally,

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12 *Assisted Dying: Australian Cancer Patient First To Use New Law*, BBC (Aug. 5, 2019), https://www.bbc.com/news/world-australia-49230903.

13 Ezekiel J. Emanuel, Bregje D. Onwuteaka-Philipsen, John W. Urwin, Joachim Cohen, *Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe*, JAMA (2016).

14 *See generally* Larry I. Palmer, *The Legal and Political Future of Physician-Assisted Suicide*, JAMA (May 7, 2003), https://jamanetwork.com/journals/jama/fullarticle/196488.

Congress, has held various hearings over the last several decades regarding the issue.[15] Despite these hearings, there has never been a consistent conclusion reached regarding the imminent future of the topic, at least in the federal context.

The first case in which the concept of, what would become known as, the "right to die" came seven years prior to the Court's eventual consideration of physician assisted suicide, and was a major component of why those decisions were made.[16] In *Cruzan v. Dir., Mo. Dep't of Health*, parents sued on behalf of their daughter, who had been left in a vegetative state resulting from a car accident, requesting a court order directing the removal of their daughter's feeding tube.[17] The Court affirmed the state court's refusal to direct such an order, holding that the Constitution did not forbid the state from requiring evidence of the incompetent patient's wishes regarding the withdrawal of life sustaining care to be clear and convincing.[18] Though in that case the Court "strongly suggested" that the Due Process Clause "protects the traditional right to refuse unwanted lifesaving medical treatment," and that Cruzan's incompetence at the time of the requested refusal led the court to its ultimate conclusion.[19] Put another way, the fact that Nancy Cruzan had no say in her treatment or lack thereof was the central issue in the case that led to its ultimate result. Based on this interpretation, it almost seems as though a door was left open for those who did have a say in their treatment, to ultimately choose whether to resort to a certain treatment to die. However, as discussed below, the Court did not agree and relied heavily on its decision in *Cruzan* with regard to later cases on the subject.[20]

In 1997, the Court heard two major cases that directly considered the constitutionality of the issue.[21] In *Washington v. Glucksberg*, petitioners were physicians who occasionally treated "terminally ill, suffering patients" and who would have assisted some of these patients in ending their lives if not for Washington's assisted suicide ban.[22] At

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15 *See, e.g., The Consequences of Legalized Assisted Suicide and Euthanasia: Hearing before the Subcomm. on the Const., C.R. and Prop. Rts. of the Senate Comm. on the Judiciary*, 109th Cong. (2006).

16 Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261 (1990); *Assisted suicide: The Recent "Physician Assisted Suicide" Cases*, THE BRIDGE, https://cyber.harvard.edu/bridge/Philosophy/asuicide1.htm (last visited Sept. 4, 2019).

17 *Cruzan*, 497 U.S. at 265.

18 *Id.* at 269-70.

19 *Glucksberg,* 571 U.S. at 720 (quoting *Cruzan*).

20 *Id.*

21 *Id.*; *Vacco*, *infra* note 33.

22 *Id.* at 702 (1997).

the time, Washington state law provided that a "person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide," a felony punishable by up to five years imprisonment and a $10,000 fine.[23] Washington also had in effect the "Natural Death Act," which, was enacted in 1979 and provided that the "withholding or withdrawal of life-sustaining treatment at a patient's direction shall not, for any purpose, constitute a suicide."[24]

The court held that the statute, which made it a felony for any person to knowingly cause or aid a suicide, was not a violation of the Fourteenth Amendment of the United States Constitution.[25] While the court did not address the question of whether aiding a suicide itself was constitutional, it allowed the states the opportunity to do so.[26]

The Court in *Glucksberg* noted that, due to advances in modern medicine, Americans had become "increasingly likely to die in institutions, from chronic illnesses," and that due to this increase, states began reexamining their laws banning assisted suicide.[27] Despite this, at the time of *Glucksberg*, most states had already chosen to reaffirm these prohibitions.[28] Oregon, however, was the one state that rejected this approach by 1997, and in 1994 rather enacted, through ballot initiative, the "Death with Dignity Act" legalizing physician assisted suicide for "competent, terminally ill adults."[29]

In Chief Justice Rehnquist's majority opinion, he asserted that to rule in favor of the respondents would be to "reverse centuries of legal doctrine and practice, and strike down the considered policy choice of almost every state."[30] Rehnquist suggested that respondent's characterization of the issue—whether there was a right to choose how to die and control the final days of one's life—was not actually the issue under consideration; circumventing that question, Rehnquist rather posed that the question at issue as whether the "'liberty' specially protected by the Due Process Clause includes a right to commit suicide which itself includes a right to assistance in doing so."[31] The Court acknowledged that, while the decision at issue in *Glucksberg*, namely, to commit suicide with the assistance of another, may be "just as

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23 *Id.* at 707-08; WASH. REV. CODE 9A.36.060(1) (1994).
24 WASH. REV. CODE § 70.122.070(1).
25 *Glucksberg*, 521 U.S. at 705 (1997).
26 *Id.*
27 *Id.*
28 *Id.*
29 *Id.*; For the impetus behind the change in Oregon's law, *see infra* Section II(b).
30 *Glucksberg*, 521 U.S. at 705.
31 *Id.* at 722-723.

personal and profound as the decision to refuse unwanted medical treatment"—which had been recognized in *Cruzan*, discussed below—that decision "has never enjoyed similar legal protection."[32] He also distinguished the "open door," discussed above, from *Cruzan* by noting that the "right assumed in *Cruzan* . . . was not simply deduced from abstract concepts of personal autonomy," further noting that since, at common law, forced medication is classifiable as the tort of battery, and Cruzan's inability to consent was the factor that disallowed a decision for her family in that case.[33]

The same year as *Glucksberg*, the Court decided *Vacco v. Quill*, holding that a similar New York State provision banning assisted suicide did not violate the Fourteenth Amendment.[34] In that case, three practicing New York physicians claimed that the state's ban on assisted suicide, a statutory crime, prevented them from prescribing lethal medication to "'mentally competent, terminally ill patients' who [were] suffering great pain and desire[d] a doctor's help in taking their own lives," though it would be "'consistent with the standards of their medical practices'" to do so.[35] The physicians alleged that there was essentially no difference between the prescription of lethal medication and the refusal of lifesaving treatment, which was permitted by the state.[36] Citing the then newly-decided case *Glucksberg*, the Court found that the statutes at issue did not violate the Equal Protection Clause of the Fourteenth Amendment since any citizen, "regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; *no one* is permitted to assist a suicide."[37] The Court disagreed with the Respondents, finding that there was no distinguishable difference between refusal of lifesaving care and assisted death; instead, the majority stated that the distinction between the two practices was "widely recognized and endorsed in the medical profession and in our legal traditions."[38] This distinction, as described by the Court, appeared to turn on acting versus declining to do so, or otherwise, something being given to a patient to hasten death versus something being taken away from a patient for the same result.[39] The added "action," so to speak, taken by physicians in assisted suicide

32 *Id.* at 725.
33 *Id.*
34 Vacco v. Quill, 521 U.S. 793, 797 (1997).
35 *Id.*
36 *Id.* at 798.
37 *Id.* at 800.
38 *Id.*
39 *Id.*

cases, was the necessary factor needed for the Court to come to the conclusion that the Constitution did not guarantee a right to die in this manner.[40]

The Court is not the sole branch of the federal government that has considered the implications of national laws regarding a "right to die." A year after both houses of Congress controversially intervened in the widely publicized case of Terri Schiavo, the Senate Committee on the Judiciary Subcommittee on the Constitution, Civil Rights, and Property Rights held a hearing on "The Consequences of Legalized Assisted Suicide and Euthanasia."[41] Then-Senator Russ Feingold testified about the importance of leaving decisions surrounding end of life care to patients and families, criticizing Congress's decision to interfere in the Schiavo case.[42]

In 2017, Republican Representative Brad Wenstrup introduced H.Con.Res.80, "Expressing the sense of the Congress that assisted suicide (sometimes referred to as death with dignity, end-of-life options, aid-in-dying, or similar phrases) puts everyone, including those most vulnerable, at risk of deadly harm and undermines the integrity of the health care system."[43] Citing elderly persons who are "subject to emotional or financial pressure to end their lives," the resolution emphasized the government's "legitimate interest in prohibiting assisted suicide," which "rationally relate[s] to 'protecting the vulnerable from coercion.'"[44] The resolution denounced the self-reporting schemes employed by states with legal schemes along with the 'astounding lack of transparency in the practice of assisted suicide' such that state officials "admittedly have no method of knowing if it is being practiced within the bounds of State laws."[45] The resolution concluded with:

> [i]t is the sense of the Congress that the Federal Government should ensure that every person facing the end of their life has access to the best quality and comprehensive medical

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40 *Vacco*, 521 U.S. at 797.

41 Carl Hulse & David D. Kirkpatrick, *Congress Passes and Bush Signs Legislation on Schiavo Case,* N.Y. TIMES (Mar. 21, 2005), https://www.nytimes.com/2005/03/21/politics/congress-passes-and-bush-signs-legislation-on-schiavo-case.html (explaining the circumstances surrounding Congressional legislation to move the case to federal court).

42 *The Consequences of Legalized Assisted Suicide and Euthanasia: Hearing Before Sen. Subcomm. On the Constitution, Civil Rights and Property Rights*, 109th Cong. 2006 (statement of Senator Russ Feingold).

43 H.R. Con. Res. 80, 115th Cong. (2017).

44 *Id.*

45 *Id.*

> care, including palliative, in-home, or hospice care, tailored to their needs and that the Federal Government should not adopt or endorse policies or practices that support, encourage, or facilitate suicide or assisted suicide, whether by physicians or others.[46]

No action has been taken on the resolution since it was introduced and referred to the House Subcommittee on Health in September 2017.[47]

The federal government did indicate its disapproval for assisted suicide in 1997, when the Assisted Suicide Funding Restriction Act became public law.[48] The law provided that, due to "recent legal developments," presumably the decisions in *Glucksberg* and *Vacco*, it "may become lawful in areas of the United States to furnish services in support of such activities."[49] In that effort, the Act provided that federal funds could not be used to pay for any items or services for the purpose of assisting "suicide, euthanasia, or mercy killing of any individual."[50]

Thus, court precedent along with Congress's subsequent legislative repudiation of federal funding for programs related to assisted dying have meant that the enactment of death with dignity laws or the affirmation of bans on such laws have been left up to the individual states.[51] Following the decisions in *Glucksburg* and *Vacco*, Harvard Medical School Professor Ezekiel Emanuel, who opposed legalization, stated that the "prospects for the [further] legalization of physician-assisted suicide are zero as a practical matter. [Legalization of PAS] is not going to happen in the federal courts after these decisions."[52] To date, Emanuel has been correct with respect to federal efforts. The states, however, are another matter entirely.

B. Selected Existing U.S. State Law

As of October 2019, assisted suicide has been legal in eight states: California, Oregon, Washington, Vermont, New Jersey, Montana,

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46 *Id.*

47 *Id.*

48 Assisted Suicide Funding Restriction Act of 1997, 42 U.S.C. § 14401 (1997).

49 *Id.*

50 *Id.*

51 Roberto Suro, *States to Become Forum for Fight Over Assisted Suicide*, WASH. POST (June 27, 1997), http://www.washingtonpost.com/wp-srv/national/longterm/supcourt/stories/062797c.htm.

52 *Id.*

Colorado, Hawaii, and the District of Columbia.[53] Of those states, only Montana's legal scheme for physician assisted suicide derives from a court decision, *Baxter v. State*, which held that under state law, a "terminally ill patient's consent to physician aid in dying constitutes a statutory defense to a charge of homicide against the aiding physician" when no other consent exceptions apply.[54] Additionally, the court noted that nothing in state legal precedent nor state statutes, indicated that physician aid in dying was "against public policy," and used the Montana Rights of the Terminally Ill Act to demonstrate the state legislature's "respect for a patient's autonomous right to decide if and how he will receive medical treatment at the end of his life."[55] The court did not make a determination as to whether a state's constitutional right to physician assisted suicide existed.[56] Some have referred to the effect of the case as nothing but a loophole that allows the practice to continue, creating a criminal defense rather than a affirmative right.[57] To that end, opponents introduced a bill in early 2019 that would have made it illegal for doctors to help patients end their lives, effectively overruling the 2009 court decision.[58] The bill died in the legislative process, four months after it was introduced.[59] Other states that have legalized PAS, have done so statutorily.

Oregon was the first state to legalize assisted suicide, passing its "Death with Dignity" law in 1997.[60] The law puts several restrictions on its use, including the following, among other, requirements: patients must be residents of Oregon; the patient must also be eighteen years or older, capable of making and communicating his or her own healthcare decisions, and diagnosed with a terminal illness that, according to a physician, will lead to death within six months.[61] In addition, physicians must meet specific criteria for participation, and

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53 Death with Dignity Acts, DEATH WITH DIGNITY, https://www.deathwithdignity.org/learn/death-with-dignity-acts/ (last accessed Feb. 7, 2021).

54 Baxter v. State, 354 Mont. 234, 251 (2009).

55 *Id.* at 250, 251.

56 Mont. Court: State Law Doesn't Prevent Assisted Suicide, ASSOCIATED PRESS (Dec. 31, 2009), https://www.spokesman.com/stories/2009/dec/31/montana-high-court-state-allows-assisted-suicide/.

57 Jacob Fuhrer, *Bill Aims to Ban Physician-Assisted Suicide in Montana*, KPAX (Jan. 29. 2019), https://www.kpax.com/news/montana-legislature/2019/01/29/bill-aims-to-ban-physician-assisted-suicide-in-montana/.

58 *Id.*

59 H.B. 284, 66th Leg. Reg. Sess. (Mont. 2019).

60 *Oregon's Death with Dignity Act*, OREGON.GOV, https://www.oregon.gov/oha/ph/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/index.aspx (last visited Sept. 3, 2019).

61 Or. Rev. Stat. §§ 127.800–127.890 (1997).

patients must comply with regulations in order to receive a prescription for lethal medication. [62] The Death with Dignity Act contains no specific oversight or regulation that is distinct from the that afforded to other forms of medical care.[63] Notably, Oregon does not specify how long a resident must have lived in the state.[64]

Studies published in medical journals by the organizations including the National Institutes of Health can provide some background as to the effect of the changed law,[65] but the impetus for the change was largely the result of strategic campaigns and the eventual ballot measure.[66] An increase in "dissatisfaction with the medical profession," along with a growing "national 'right to die' movement," both helped lead to the legalization of assisted suicide in Oregon.[67] Patient concerns regarding doctors' tendencies to "lose sight of the patient as a person," combined with their struggle for autonomy in their own care, caused deference toward the medical profession to drop.[68] This focus on autonomy allowed the right to die movement to grow.[69] Previously a crime, suicide had been decriminalized nationwide by the mid 1970s, and during that time states began to recognize that the withholding or withdrawing of life-sustaining treatment did not amount to suicide.[70] In 1976, the Supreme Court of New Jersey became the first to consider a "right-to-die" case.[71] There, the court, through an analysis of the subject's right to privacy, concluded the same—that the father of a young woman, in a persistent vegetative state, could remove the respirator causing to the woman's death.[72] This first court case on the matter spurred the formation of organizations asserting the right to die and the publication of more widespread

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62 *Id.*

63 *Oregon's Death with Dignity Act*, *supra* note 60.

64 *Id.*

65 *See generally* Linda Ganzini, M.D., M.P.H., Elizabeth R. Goy, PhD, & Steven K. Dobscha, M.D., *Why Oregon Patients Request Assisted Death: Family Members' Views*, 23(2) J. GEN. INTERN. MED. (2008); *see also* Arthur E. Chin, M.D., Katrina Hedberg, M.D., M.P.H., Grant K. Higginson, M.D., M.P.H., & David W. Fleming, M.D., *Legalized Physician-Assisted Suicide in Oregon – The First Year's Experience*, N. ENGL. J. MED. (1999).

66 Taylor E. Purvis, *Debating Death: Religion, Politics, and the Oregon Death with Dignity Act*, YALE J. BIOL. MED (2012) [hereinafter *Debating Death*].

67 *Id.*

68 *Id.*

69 *Id.*

70 *Id.*

71 *Id.*

72 *Id.*; *see generally In Re Quinlan*, 70 N.J. 10 (1976).

literature on the subject.[73] Oregon's culture, as well, "fostered a unique environment for the eventual success of [assisted suicide] legalization," in that it tends to be more progressive than the United States as a whole and its residents have generally taken positions against government interference in health care.[74] Prior to legalization, nearly sixty percent of Oregon citizens supported legalizing assisted suicide.[75] This national and state landscape, combined with a robust legalization campaign, led to the eventual legalization of PAS in Oregon.

The safeguards built into Oregon's law are stringent: first, euthanasia is strictly prohibited, meaning the patient must administer the life ending medication his or herself; the physician's role is primarily in prescribing the medication.[76] In order to request a prescription for lethal medication, the patient must, as noted above, be an adult resident of Oregon who is capable of making and communicating health care decisions and has been diagnosed with a terminal illness that will lead to his or her death within six months.[77] If a patient meets those requirements, that patient is deemed eligible to request lethal medication from a physician licensed to practice in Oregon—however, more steps must be fulfilled in order to receive the prescription.[78] Notably, the patient must make two *oral* requests to his or her physician that are separated by at least fifteen days.[79] Additionally, the patient must make an additional written request to his or her physician, which must be signed in the presence of two witnesses.[80] Along with a consulting physician, the prescribing physician must both confirm the diagnosis and prognosis of the patient and determine whether the patient is capable of making and communicating medical decisions.[81] If either physician suspects impairment of judgment by a mental disorder, the patient must have a psychological examination.[82] Additionally, the physician must counsel the patient regarding other alternatives,

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73 *Debating Death*, *supra* note 66.

74 *Id.*

75 *Id.*

76 *Death with Dignity Act Requirements*, OREGON.GOV, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/requirements.pdf (last visited Nov. 4, 2019) [hereinafter, OR DWD Requirements].

77 *Id.*

78 *Id.*

79 *Id.*

80 *Id.*

81 *Id.*

82 OR DWD Requirements, *supra* note 76.

including palliative care, and the physician *must request*, but not require, that the patient notify his or her next-of-kin of the request being made.[83] Following the law's 1997 enactment, the legislature added an additional requirement that pharmacists be informed of the intended use of the medication. Compliance with the law requires physician self-reporting to the Oregon Health Authority, though that is not required if the patients begin the process but opt not to receive the prescription.[84]

The most important safeguard for physicians who adhere to the requirements of the law is the protection from criminal prosecution. Additionally, the "choice of [the use of the Death Without Dignity Act] cannot affect the status of a patient's health or life insurance policies."[85]

After its initial passage, Oregon's law received widespread national attention after a California woman, Brittany Maynard, was forced to move to Oregon to end her life with medication after her condition became "unbearable."[86] Two years after Maynard used Oregon's law, California's End of Life Option Act took effect in 2016.[87] After a court challenge, the law was briefly suspended in 2018, when a judge deemed it unconstitutional.[88] The law was reinstated in June 2018.[89] Under California's legal scheme, a licensed medical doctor in California may prescribe lethal medication to a California resident who is at least eighteen years old and deemed terminally ill (i.e., with no more than six months to live), and mentally competent by two physicians.[90] There are several regulations governing the process of obtaining a prescription, and most are designed to ensure the mental

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83 *Id.*

84 *Id.*

85 *Id.*

86 Daniel E. Slotnik, *Brittany Maynard, 'Death with Dignity' Ally, Dies at 29*, N.Y. TIMES (Nov. 4, 2014), https://www.nytimes.com/2014/11/04/us/brittany-maynard-death-with-dignity-ally-dies-at-29.html.

87 CAL. HEALTH & SAFETY CODE § 443 (Deering 2015).

88 Soumya Karlamangla, *Califorina's physician-assisted suicide law is overturned – for now*, L.A. TIMES (May 25, 2018), https://www.latimes.com/health/la-me-ln-end-of-life-option-act-20180525-htmlstory.html.

89 Esmeralda Bermudez, *California Appeals Court Reinstates Law Allowing Terminally Ill Patients To End Their Lives,* L.A. TIMES (June 15, 2018), https://www.latimes.com/local/california/la-me-ln-suicide-law-20180615-story.html.

90 Soumya Karlamangla, *Q&A: How California's Aid-In-Dying Law Will Work*, L.A. TIMES (May 12, 2016), https://www.latimes.com/local/lanow/la-me-ln-end-of-life-option-act-qa-20160511-story.html.

competency and degree of illness of the patient.[91] While the law does not require insurance companies to cover the medication, California's statewide health plan for low-income residents, Medi-Cal, does cover the treatment.[92] Notably, insurance companies, including Medi-Cal, are prohibited from informing patients that this treatment is covered.[93]

California is not the only state that has faced an uphill battle in legalizing a Death with Dignity Law; Washington, D.C.'s own highly-contested version of the law was enacted in 2017.[94] It has many of the same features as those of other states: patients must be D.C. residents, and a doctor must determine that they have less than six months to live.[95] As of August 2019, four residents obtained prescriptions for lethal medication, and two have used that medication to end their lives.[96] In 2016, the House of Representatives, which, along with the Senate, governs the local affairs of the District of Columbia, passed an appropriations bill with a rider that would have repealed the Death with Dignity Act for the District.[97] After significant opposition from PAS advocates, the rider was kept out of the final bill.[98] The following year, after a concurrent resolution failed to gain traction, Representative Brad Wenstrup noted he was "hopeful that [Congress] will be able to [repeal the D.C. law] in [FY 2019's] legislation."[99]

New Jersey's "Aid in Dying for the Terminally Ill Act" was enacted in August 2019.[100] The law allows "mentally capable, terminally ill adults ages 18 and older, with six months or less to live, to be able to request a doctor's prescription" for life-ending medication.[101] The request for life-ending medication must be made twice orally and once in writing, with the oral requests separated by fifteen days, and the

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91 *Id.*

92 *Id.*

93 *Id.*

94 Kate Ryan, *2 Die Under DC Law That Allows Terminally Ill to End Their Own Lives*, WTOP (Aug. 2, 2019), https://wtop.com/dc/2019/08/2-die-under-dc-law-that-allows-terminally-ill-to-end-their-own-lives/.

95 *Id.*

96 *Id.*

97 *Group Warns D.C. Death with Dignity Act Opponents Not to Try to Repeal Law Again*, COMPASSION & CHOICES (May 2, 2018), https://compassionandchoices.org/news/group-warns-d-c-death-dignity-act-opponents-not-try-repeal-law/.

98 *Id.*

99 *Id.*

100 Katelyn Newman, *New Jersey Enacts Medical Aid-in-Dying Law*, U.S. NEWS & WORLD REPORT (Aug. 1, 2019), https://www.usnews.com/news/best-states/articles/2019-08-01/medical-aid-in-dying-law-goes-into-effect-in-new-jersey.

101 *Id.*

written request witnessed by at least two people.[102] At least one witness to the written request must meet the following criteria: he/she must not be related to the patient; must not be entitled to the patient's estate; must not be in a leadership role in a health care facility where the patient receives care; and must not be the patient's doctor.[103] The patient must be a New Jersey resident. Medication must be given directly to the patient by either the prescribing doctor or a pharmacist.[104] While a legal challenge to the law was filed shortly after its enactment, resulting in a short-lived temporary restraining order, as of August 27, 2019, a state Appellate Court lifted the order on the act and later the same day, the New Jersey Supreme Court denied an application for review of the order vacating the restraining order.[105]

Washington State's Death with Dignity Act was enacted in March 2009, allowing terminally ill Washington residents with less than six months to live to obtain lethal doses of medication from physicians.[106] Safeguards include physician reporting requirements; mandatory pharmacist reporting; allowances for health care facilities, pharmacists, and physicians to opt out of participation; and standards for any medication dispensed under the act that ultimately was not self-administered.[107] The conservative media outlet *National Review* decried Washington State's efforts to decrease barriers to access for assisted suicide (including a shortened waiting period) as a "slippery slope," an argument against legalization that has become common amongst opposition.[108]

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102 *Id.*

103 *Id.*

104 Medical Board Summary, *Medical Aid in Dying for the Terminally Ill Act*, NJ CONSUMER AFFAIRS, https://www.njconsumeraffairs.gov/bme/Documents/BME-Medical-Aid-in-Dying-for-the-Terminally-Ill-Act-Summary.pdf (last visited Jan. 9, 2019).

105 *New Jersey*, DEATH WITH DIGNITY, https://www.deathwithdignity.org/states/new-jersey/ (last visited Sept. 4, 2019); Order on Application, *Glassman v. Grewal*, No. 083382 (N.J. 2019), https://njcourts.gov/host/appellate/supremeorder.pdf?c=b3.

106 *Death with Dignity Act*, WASH. STATE DEPARTMENT OF HEALTH, https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct (last visited Sept. 4, 2019).

107 *Frequently Asked Questions About Death with Dignity*, WASH. STATE DEP'T OF HEALTH, https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/FrequentlyAskedQuestions (last visited Sept. 4, 2019).

108 Wesley J. Smith, *When Assisted Suicide 'Protections' Become 'Barriers'*, NATIONAL REVIEW (Jan. 29, 2020), https://www.nationalreview.com/corner/when-assisted-suicide-protections-become-barriers/.

Colorado's assisted suicide scheme was legalized by ballot initiative in November 2016.[109] The measure was modeled on Oregon's law, which was passed twenty-two years prior.[110] Opponents of the measure, however, criticized a lack of safeguards, including the fact that the law did not require a doctor present at time of death, did not prevent "doctor shopping," and did not "prevent an heir from plotting the death of a relative to gain inheritance."[111] A unique aspect of Colorado's law is the addition of criminal penalties for "tampering with a person's request for medical aid-in-dying medication or knowingly coercing a person with a terminal illness to request the medication."[112]

Hawaii, similarly, legalized physician assisted suicide in April 2018.[113] Safeguards include requiring multiple healthcare providers to confirm the patient's prognosis and diagnosis, along with their ability to make decisions; a counselor must also assess whether the patient may be suffering from mental conditions that could interfere with their decision-making, including depression.[114] Hawaii's requirements also include a final attestation signed by the patient following his or her initial three requests, further establishing criminal penalties for tampering with requests for prescriptions and coercion, as does Colorado.[115]

Vermont voted to legalize physician assisted suicide through its Patient Choice and Control at End of Life Act in 2013.[116] The bill was based on a "pared-down" version of the Oregon statute, but opponents feared it was less restrictive in its guidelines for doctors. [117] No government agency was given oversight of the Act, and the State government noted that any "[a]lleged abuses under the law would be

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109 Jennifer Brown, *Colorado Passes Medical Aid in Dying, Joining Five Other States*, DENVER POST (Nov. 8, 2016), https://www.denverpost.com/2016/11/08/colorado-aid-in-dying-proposition-106-election-results/.

110 *Id.*

111 *Id.*

112 *Medical Aid in Dying*, COLORADO DEP'T OF PUB. HEALTH & ENV'T, https://www.colorado.gov/pacific/cdphe/medical-aid-dying (last visited Feb. 6, 2020).

113 Sophia Yan, *Medically Assisted Suicide Becomes Legal in Hawaii*, ASSOCIATED PRESS (Apr. 5, 2018), https://www.apnews.com/91a066e44af64b538eaa7472bf6a9cb2.

114 *Id.*

115 HAW. REV. STAT § 327E-12 (2019).

116 Terri Hallenbeck, *Vermont End-Of-Life-Bill Heads To Governor*, USA TODAY (May 14, 2013), https://www.usatoday.com/story/news/politics/2013/05/14/vermont-physician-assisted-death-bill/2157333/.

117 *Id.*

investigated by the relevant licensing board, the State's Attorney's Office, and/or the Vermont Attorney General's Office."[118] Notably, the Act specifically "prohibits a life insurance company from denying benefits to individuals who act in accordance with" the Act.[119]

As recently as January 2020, Virginia has introduced a bill to legalize assisted suicide, sparking a traditional confrontation of opponents and supporters, but nonetheless keeping the debate alive in the country.[120] Virginia's House Bill 1649 would allow an "adult diagnosed with a terminal condition to request and an attending health care provider to prescribe a self-administered controlled substance for the purpose of ending the patient's life in a humane and dignified manner."[121]

III. ASSISTED DYING GLOBALLY—SELECTED APPROACHES

Assisted suicide is legal, or effectively so, in several countries around the world. One of the most recent countries to legalize assisted dying, though in a limited fashion, was Australia, where the state of Victoria enacted the Voluntary Assisted Dying Act 2017 in June 2019.[122] While Australia's law contains many of the same provisions and safeguards as many of the laws in United States jurisdictions legalizing assisted suicide, other countries seemingly can take a far different approach. This section will investigate those varied approaches.

A. Switzerland—Non-Profit Workarounds

Switzerland's legal schema surrounding assisted suicide is unique.[123] Though both voluntary euthanasia and assisted suicide are technically illegal under the country's criminal law, assisted suicide is

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118 *Act 39 Frequently Asked Questions*, VERMONT DEPARTMENT OF HEALTH, https://www.healthvermont.gov/sites/default/files/documents/pdf/Act39_faq.pdf (last visited Feb. 6, 2019).

119 *Id.*

120 Andrew Ringle, *Bill to Allow Physician-assisted Suicide Introduced in Va.*, ABC 13 NEWS (Jan. 31, 2020), https://wset.com/news/at-the-capitol/bill-to-allow-physician-assisted-suicide-introduced-in-va.

121 Health Care; Decision Making; End of Life, Penalties, H.B. 1649, VIRGINIA LEGISLATIVE INFORMATION SYSTEM (proposed Jan. 16, 2020).

122 *Euthanasia and Assisted Dying*, QUEENSLAND UNIVERSITY OF TECHNOLOGY, https://end-of-life.qut.edu.au/euthanasia (last visited Sept. 4, 2019).

123 *Medically Assisted Suicide in Switzerland*, MY DEATH MY DECISION UK, https://www.mydeath-mydecision.org.uk/info/options/assisted-suicide-switzerland/ (last visited Sept. 5, 2019).

practiced regularly.[124] In Switzerland, assisted suicide is only considered a criminal offense if it is undertaken for "selfish motives"; otherwise, it is not technically prohibited.[125] It is also worth noting that it is "irrelevant whether or not the person has a terminal illness," and "friends and relatives can provide assistance for people to die, not just doctors."[126] This has made Switzerland a "destination" of sorts for those residing in other countries who wish to end their lives with medical intervention.[127] This option is costly and not without its own risks and drawbacks, principal among which is the potential for criminal investigation.[128]

A non-profit group called DIGNITAS provides assisted suicide to members, though it requires their wishes be verified by doctors.[129] DIGNITAS, which exists in Switzerland and Germany, was founded in 1998 with the "objective of ensuring a life and a death with dignity for its members and of allowing other people to benefit from these values."[130] One of DIGNITAS's primary services is "accompanied suicide," or, as it describes the service on its website: "In case of an illness which will lead inevitably to death, unendurable pain or an unendurable disability, DIGNITAS can arrange, on reasoned request and

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124 *Id.*

125 *Id.*

126 *Id.*

127 *Medically Assisted Suicide in Switzerland*, MY DEATH MY DECISION UK, https://www.mydeath-mydecision.org.uk/info/options/assisted-suicide-switzerland/ (last visited Sept. 5, 2019).

128 *Id. See also Court Rulings*, DIGNITAS, http://www.DIGNITAS.ch/index.php?option=com_content&view=article&id=56&Itemid=90&lang=en (last visited Sept. 5, 2019); *Swiss Doctor Avoids Prison in Assisted Suicide Case*, SWISS INFO (July 9, 2019), https://www.swissinfo.ch/eng/mental-illness_swiss-doctor-avoids-prison-in-assisted-suicide-case/45086114; AFP, *Swiss Doc Convicted for Helping Fit Woman Commit Suicide*, THE GUARDIAN (May 1, 2020), https://guardian.ng/news/swiss-doc-convicted-for-helping-fit-woman-commit-suicide/ (explaining that Exit VP was convicted for allowing a healthy woman, along with her dying husband, to use the company's services).

129 George Harrison, *Right to Die? What Is DIGNITAS, Why Do People Go There to End Their Lives and Where Is the Assisted Dying Clinic in Switzerland?*, THE SUN (May 30, 2018), https://www.thesun.co.uk/news/4245459/DIGNITAS-assisted-dying-clinic-switzerland/.

130 DIGNITAS, http://www.DIGNITAS.ch/index.php?option=com_content&view=article&id=4&Itemid=44&lang=en (last accessed Nov. 1, 2019); *but see* Michael Cook, *Head of DIGNITAS Charged with Profiting from Assisted Suicide*, BIOEDGE (May 26, 2018), https://www.bioedge.org/bioethics/head-of-dignitas-charged-with-profiting-from-assisted-suicide/12708 (discussing accusation that DIGNITAS' founder, Ludwig Minelli, had profited off of DIGNITAS's work after charging certain clients higher prices for PAS services).

medical proof, for its members the possibility of an accompanied suicide."[131] From its founding to 2014,[132] over 1,700 people have turned to DIGNITAS to end their lives.[133] With the philosophy that the choice to end one's life is a human right, DIGNITAS does not limit its services to those who reside in Switzerland.[134]

The self-imposed safeguards of DIGNITAS mirror the safeguards built into the laws of other countries, including medical documentation and examination, counseling, official methods of request, and submission of that request to a medical doctor.[135]

Switzerland's position as a known destination for those seeking assisted suicide while still expressly prohibiting the act is unique. Article 114 of the Swiss Criminal Code, titled "homicide at the request of the victim," provides that "[a]ny person who for commendable motives, and in particular out of compassion for the victim, causes the death of a person at that person's own genuine and insistent request is liable to a custodial sentence not exceeding three years or to a monetary penalty."[136] This provision is generally considered to be regarding euthanasia rather than assisted suicide, an important distinction for the functioning of the law in Switzerland.[137] A 1997 government examination of the possibility of decriminalizing euthanasia which included legal experts, those in the medical field, and ethicists recommended, despite a proposal to the contrary, that euthanasia remain illegal.[138] This penalty is markedly less than that for the offense of "[i]nciting and assisting suicide," which distinguishes the motive for inciting or assisting suicide as "selfish" on the part of the assistor; the penalty for that crime is a "custodial sentence not exceeding five years."[139] It appears from the language of these statutes that assisting suicide is only

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131 DIGNITAS, *supra* note 128.

132 *Id.*

133 *How Dignitas Works: On What Philosophical Principles Are The Activities of This Organization Based?* DIGNITAS (May, 2014) http://www.DIGNITAS.ch/images/stories/pdf/so-funktioniert-DIGNITAS-e.pdf.

134 *Id.*

135 *Id.*

136 SCHWEIZERISCHES STRAFGESETZBUCH [STGB], CODE PÉNAL SUISSE [CP], CODICE PENALE SVIZZERO [CP] [CRIMINAL CODE] JAN. 1, 1990, art. 114, (Switz).

137 Samia A. Hurst & Alex Mauron, *Assisted Suicide and Euthanasia in Switzerland: Allowing a Role for Non-Physicians*, BMJ (Feb. 1, 2003), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1125125/ [*hereinafter* Hurst].

138 *Id.*

139 SCHWEIZERISCHES STRAFGESETZBUCH [STGB] [CRIMINAL CODE] Jan. 1, 2007, SR 311, Title I, art. 115 (Switz.).

a crime if the motive is selfish, leaving much room for doctors or organizations, like DIGNITAS, to create their own safeguards and accomplish their goals.[140]

As of 2015, six organizations like DIGNITAS existed in Switzerland: Exit DS, Exit A.D.M.D, Exinternational, SPIRIT, StHD+, and DIGNITAS.[141] Each have different requirements that will meet the conditions they have prescribed for assisted suicide, but only one, Exit DS, requires the lethal medication to be given by the patient's "own hand."[142]

Switzerland's position notably does not require a person seeking assisted suicide be terminally ill—the only factor, statutorily, is an unselfish motive.[143] Though inquiries are opened by police in the case of declared assisted suicide, these have been described as "mostly open and shut cases" since "no crime has been committed in the absence of a selfish motive."[144] Prosecution will occur only where "doubts are raised on the patient's competence to make an autonomous choice… which is rare."[145]

Unique in Switzerland's scheme, apart from aforementioned qualities, is that physicians are not granted a special status in the performance of these services.[146] In 1995, the Swiss Academy of Medical Sciences said it did not classify assisted suicide as a part of a physician's activity, from an ethical perspective; this was paraphrased seven years later by the Swiss Medical Association.[147] University of Geneva Professor Samia Hurst characterized those statements as making assisted suicide "outside the purview of professional oversight" rather than meaning that physicians should not assist suicide; rather, it allows physicians to act under the purview of the law, rather than their professional ethical obligations, putting physicians on an equal field with other altruistic citizens and granting them equal discretion to assist suicide in accordance with Swiss law.[148]

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140 Hurst, *supra* note 137.

141 Saskia Gauthier, Julian Mausbach, Thomas Reisch, & Christine Bartsch, *Suicide Tourism: A Pilot Study on the Swiss Phenomenon*, 41(8) J. MED. ETHICS 611-17 (2015), https://jme.bmj.com/content/41/8/611.

142 *Id.*

143 *Id.*

144 *Id.*

145 *Id.*

146 *Id.*

147 Saskia Gauthier, *supra* note 141.

148 *Id.*

Another common safeguard not present in the Swiss assisted suicide scheme is a residence requirement, leading to its reputation as a destination for those seeking the service.[149] Between 2008 and 2012, 611 "suicide tourists" from thirty-one countries went to Switzerland for assisted suicide.[150]

B. Colombia—Panel-Based Safeguards

Colombia's position on physician assisted suicide is probably the most controversial, primarily due to the country's recent legalization of euthanasia for terminally ill children, an expansion on its 2015 legalization of the practice for adults.[151] Assisted suicide was approved by a Colombian court in the 1990s, but was only given a set of guidelines through the health ministry in 2015.[152] Safeguards include the requirement that physicians receive authorization from a panel made up of a doctor with a specialty in the patient's illness, an attorney, and a mental health professional.[153] The panel only has ten days from the request of the patient to give a definitive answer, and after approval a doctor must be appointed to perform the procedure.[154]

The 1997 Constitutional Court decision removing penalties for euthanasia, indicated that legislators could "regulate this criminal type in an autonomous way, and independently from other modalities of homicide, with the purpose of avoiding excesses or punitive weaknesses."[155] That court held that criminal penalties for mercy killing at

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149 Jacque Wilson, *"Suicide Tourism" to Switzerland Doubled since 2009*, CNN (Aug. 20, 2014), https://www.cnn.com/2014/08/20/health/suicide-tourism-switzerland/index.html.

150 *Id.*

151 Stephanie Nolen, *Colombia takes medically assisted death into the morally murky world of terminally ill children*, GLOBE & MAIL (Mar. 1, 2019), https://www.theglobeandmail.com/world/article-colombia-takes-medically-assisted-death-into-the-morally-murky-world/.

152 *Cancer patient becomes Colombia's first legal euthanasia case*, BBC (July 3, 2015), https://www.bbc.com/news/world-latin-america-33392195.

153 Simeon Tegel, *Colombia just legalized euthanasia. Here's why that's a big deal*, PRI (Apr. 29, 2015), https://www.pri.org/stories/2015-04-29/colombia-just-legalized-euthanasia-heres-why-thats-big-deal.

154 *Listo protocol para regular la euthanasia en Colombia* [*Ready protocol to regulate euthanasia in Colombia*], LA CRÓNICO DEL QUINDIO (Apr. 21, 2015), http://www.cronicadelquindio.com/noticia-completa-titulo-listo_protocolo_para_regular_la_eutanasia_en_colombia-seccion-la_nacin-nota-87321 [translated from Spanish].

155 Corte Constitucional [C.C.] [Constitutional Court], May 20, 1997, sentencia C-239/97, http://www.patientsrightscouncil.org/site/wp-

the request of a patient "breache[d] the right to equity because [they] enact[] discrimination against the person who is seriously ill or under a lot of pain. As such, the State makes the value of human life relative, allowing the existence of diverse citizen categories in Colombia."[156]

While the Colombian Constitution—as with most of the constitutions of the world—states a right to life, the symmetry between penalties for mercy killing and homicide was unsustainable; of importance to the Constitutional Court was the punishment for homicide being in line with the "imputed subject's guilt and behavior; that is why it would be neither reasonable nor proportional that the same sanction were applied to both the responsible for mercy killing and the responsible for simple or aggravated homicide."[157] The Court wrote that those who kill another "on mercy, with the purpose of ending his intense sufferings, acts with a clear altruist sense, and it is that motivation which has impelled the legislator[s]" to create the exception to the rule.[158] Historically, the court went on, "mercy has been . . . considered by the legislator as an attenuation motive of the penalty and thus, in [the Colombian Criminal Statute . . .] it was established that the penalty of homicide could exceptionally be attenuated, exchanged for imprisonment or arrest and even 'grant judicial pardon' when the act was undertaken on the basis of mercy."[159] In the case of mercy killing, the:

> active subject does not kill for disdain towards the other, but because of totally opposed feelings. The active subject considers his victim as a person with equal dignity and rights, but he acknowledges that the person is in a total situation of suffering so that death can be seen as an act of compassion and mercy.[160]

An important consideration made by the Constitutional Court was the "consent of the passive subject."[161] Considering the fact that other crimes, like rape or theft, will have penalties negated in the event that the court finds consent for the action, the court took a similar tack in considering whether this consent should play a role in a discussion of

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content/uploads/2015/05/Colombia_Court_Decision_05_20_1997.pdf [translation provided by Patients' Rights Counsel] [hereinafter, Colombia 1997 CC Decision].

156 *Id.*

157 *Id.*

158 *Id.*

159 *Id.*

160 Colombia 1997 CC Decision, *supra* note 155.

161 *Id.*

punishment.[162] The Court also engaged in a lengthy discussion of principles of human dignity and right to life as prescribed in the country's constitution.[163] The Court summarized its philosophy as follows: "the right to live cannot be reduced to mere subsistence, but rather it implies living adequately in conditions of dignity."[164] The duty of the state to preserve life "weakens considerably due to the medical reports on which it can be assured that death is inevitable in a relatively short period of time."[165] According to the Court:

> The fundamental right to live with dignity implies, then, the right to die with dignity, since to condemn a person to continue living for a short period of time when he is not willing to and while suffering deeply is equivalent not only to a cruel and inhuman treatment […] but also to an annulment of his dignity and autonomy as a moral subject. The person would be reduced to an instrument for preserving life as an abstract value.[166]

Thus, the Court concluded that:

> [If a T]erminally ill [patient] who is under the objective considerations stated in [the mercy killing provision of the Criminal Code] considers that his life must be finished as he judges it inconsistent with his dignity, he can proceed in consequence, exercising his freedom, without allowing the state to oppose his intention or to prevent a third person from helping him to use this alternative through a prohibition or penalty.[167]

The Court proceeded to specify that the "active" person, i.e., the one doing the mercy killing, must be a physician, and that the consent of the "passive" person, i.e., the terminally ill patient, must be "free, expressed unequivocally by a person with the capacity of understanding the situation he finds himself in."[168] This safeguard includes the requirement that the person is informed about his prognosis and the

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162 *Id.*
163 *Id.*
164 *Id.*
165 *Id*.
166 Colombia 1997 CC Decision, *supra* note 155.
167 *Id.*
168 *Id.*

possibilities for treatment, and, importantly, that he have intellectual capacity to make that decision.[169]

After the decision was formally enacted through Colombia's decriminalization of medically assisted death in 2015, further steps were taken in May of 2018 to extend the availability of medically assisted death to terminally ill children.[170] Children as young as six qualify for the procedure so long as they meet the same provisions as adults—dying from a terminal illness, suffering from unmanageable pain, and having the mental capacity to consent (though the child who sparked this change did not consent, having lost the ability to do so).[171]

The government recognized the need for further safeguards with respect to consent in this situation—children ages six to twelve are required to be evaluated by either a psychiatrist or psychologist who, in turn, "concludes they understand the choice."[172] Those aged twelve to fourteen may request with parental consent.[173] Children older than fourteen may make the request even without parental consent.[174]

C. Australia—Consistent with U.S. Laws

As of October 2020, assisted suicide is legal in only one Australian state—Victoria—which enacted the Voluntary Assisted Dying Act 2017 ("VAD") on June 19, 2019.[175]

From March 1996 to March 1997, physician assisted suicide was legal in Australia's Northern Territory under the Rights of the Terminally Ill Act; in 1997, however, the government used its constitutional power to pass legislation abolishing the act, and physician assisted suicide remains illegal in the Northern Territory.[176] Victoria's law represents the first successful legal action with respect to assisted suicide since that abolishment.[177]

To be eligible to utilize the Act, a person must be eighteen or over, be an Australian citizen and resident of Victoria for at least one

169 *Id.*

170 Stephanie Nolen, *Colombia Takes Medically Assisted Death Into The Morally Murky World Of Terminally Ill Children*, GLOBE & MAIL (Mar. 1, 2019), https://www.theglobeandmail.com/world/article-colombia-takes-medically-assisted-death-into-the-morally-murky-world/.

171 *Id.*

172 *Id.*

173 *Id.*

174 *Id.*

175 *Euthanasia and Assisted Dying*, *supra* note 122.

176 *Id.*

177 *Id.*

year, have decision-making capacity, and be diagnosed with an incurable, advanced, progressive disease that is expected to cause death within six months, which causes suffering that cannot be relieved in a tolerable manner.[178] The tolerability of suffering-relieving measures is subjective and measured based around the patient's consideration.[179]A patient must make three separate requests, undergo two independent medical assessments, and make a written, witnessed declaration requesting access.[180] Safeguards of VAD include, but are not limited to: the provision of information regarding diagnosis and prognosis; treatment options; palliative care; risks associated with lethal injection; the establishment of a VAD Review Board; regulations regarding distribution of VAD substances; mandatory reporting requirements; and protection from criminal and civil liability for practitioners.[181]

The VAD Review Board's role is to "review every case of voluntary assisted dying, report on the operation of voluntary assisted dying and inform system-wide quality and safety improvements."[182] Membership of the board is established and appointed by ministerial order.[183] While the board reviews all assessments and forms submitted in accordance with reporting requirements for assisted death, these reviews are retrospective; the board does not itself grant or refuse applications for assisted death, nor does it participate in "coordinating or consulting medical practitioners in voluntary assisted dying assessments."[184] As of January 2020, the review board consists of judges, doctors, consumer representatives, palliative care physicians, professors, lawyers, and pharmacists.[185]

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178 *Id.*

179 *Voluntary Assisted Dying Act 2017* (Vic.) (Austl.).

180 *Euthanasia and Assisted Dying*, *supra* note 122.

181 *Id.*

182 *Terms of Reference*, VOLUNTARY ASSISTED DYING REVIEW BOARD (Sept., 2019), https://www.bettersafercare.vic.gov.au/sites/default/files/2019-09/VADRB%20-%20Terms%20of%20Reference.pdf.

183 *Id.*

184 *Voluntary Assisted Dying Review Board*, SAFER CARE VICTORIA, https://www.bettersafercare.vic.gov.au/about-us/about-scv/councils/vad-review-board (last visited Jan. 11, 2020).

185 *Id.*

IV. ETHICAL CONSIDERATIONS

Ethical and moral considerations are, of course, at the forefront of most discussions surrounding assisted suicide laws.[186] Many arguments against this legislation are rooted in religion, but those arguments can become muddled with other social policies, and thus will not be discussed in depth in this section.[187] Much of the scholarly research surrounding ethical issues takes a more medical, rather than legal, approach to the subject—the concept of "doing no harm" as it applies to the legality of assisting the death of another will be the focus of this section. While public opinion cannot be considered a foolproof measure of morality, it will help in this context to compare public opinion studies in countries with more "moral" objections to those countries that lack moral objections. Such a comparison will help determine whether ethical considerations are at the forefront of differing legalization schemes. Two chief arguments against assisted suicide are the need for better palliative care and a concern that vulnerable populations may be put at risk by increased access to assisted suicide.[188] Some of these advocates have used data from Oregon's program to support their claim that the fear of a long and painful death, a common reason for patients requesting medication utilizing assisted suicide, could instead be ameliorated by better end-of-life care.[189] Opponents also claim that while autonomy in end-of-life choices is important, the possibility that regulations and safeguards are not followed despite their inclusion in the laws could "create freedom for the few without taking away adequate safeguards for the many."[190]

Some countries regulate their prohibition on assisted suicide not through the legal system but rather by the code of ethics to which their physicians must adhere. Germany formally made illegal the "commercial promotion of suicide," in 2015, before that language was added, it was not legislative or judicial decree that governed physician's

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186 For an excellent podcast that delves into many perspectives on assisted suicide, particularly in Australia, *see generally Better Off Dead*, THE WHEELER CENTER (Nov. 2015-Apr. 2016) (downloaded using iTunes).

187 Though it is interesting to note that the country with arguably the most controversial and, in many ways, most liberal medically assisted death scheme, Colombia, is very socially conservative. Nearly 80 percent of its citizens identify as Roman Catholics, and there is a large evangelical population. Most churches vehemently oppose both euthanasia and medically assisted suicide, so it is particularly interesting that this conservative country has such a markedly liberal program.

188 Wilson, *supra* note 149.

189 *Id.*

190 Wilson, *supra* note 149 (statement of Alison Twycross).

inability to prescribe life ending medication.[191] At that time, a physician could be "held criminally responsible for not helping a patient if they witness him or her going unconscious."[192] This approach treats assisted suicide more clearly as a medical issue, rather than a legal one, and was aimed at "stopping groups or individuals creating a form of business, by helping people to die in return for money."[193] In February 2020, Germany's constitutional court overturned the ban after patients and doctors challenged the law, claiming that "normal palliative work had become [criminalized]," and had prompted terminally ill patients to go to other countries, such as Switzerland, to end their lives legally.[194] While not outright legalizing PAS, the court determined that the German parliament could not "affect the impunity of assisted suicide."[195] This change begs the question of whether countries or jurisdictions should consider the possibility that their constituents will seek out PAS regardless of its legality or where they happen to live; ethically speaking, requiring terminally ill patients to travel in order to fulfill their end of life plans could be considered more cruel than allowing it to happen within that patient's jurisdiction.[196]

A group of Oregon-based doctors and researchers studied why, according to the perceptions of family members, patients chose to request assisted suicide.[197] The 2008 study found that family members reported that the "most important reasons that their loved ones requested" assisted suicide were "wanting to control the circumstances of death and die at home, and worries about loss of dignity and future losses of independence, quality of life, and self-care ability;" these reasons were ranked with a median score of 4.5 or higher on a scale of 1-5.[198] On that same scale, no family members ranked higher than a median of two any physical symptoms at the time of request; rather, concerns about future symptoms and deterioration in quality of life appeared more important.[199] Many of the reasons that opponents raise

191 *Id.*; *German court discusses legality of assisted suicide*, THE LOCAL GERMANY (Apr. 19, 2019), https://www.thelocal.de/20190418/germany-discusses-legality.

192 Wilson, *supra* note 149.

193 *Germany Overturns Ban on Professionally Assisted Suicide*, BBC NEWS (Feb. 26, 2020), https://www.bbc.com/news/world-europe-51643306/.

194 *Id.*

195 *Id.* (The court clarified that there remained "no legal entitlement to euthanasia" in Germany).

196 *Id.*

197 Linda Ganzini et al., *Why Oregon Patients Request Assisted Death: Family Members' Views*, 23(2) J. GEN. INTERN. MED. (2008).

198 *Id.*

199 *Id.*

when voicing concerns over assisted suicide being used for the wrong reasons such as "depression, financial concerns, and poor social support" were ranked by the family members as among the least important reasons for requesting assisted suicide.[200] Though the study included family members of only eighty-three patients, it provides a stark contrast to these highly cited concerns raised by the most vocal opponents to assisted suicide.[201] In fact, the director of Health Law Institute at Hamline University, Thaddeus Mason Pope, wrote in an editorial that the safeguards put in place by Oregon's law "ensure that patients who are terminally ill make voluntary, informed decisions. There is no evidence of exploitation."[202] Presumably, the regulations surrounding physician reporting were designed for just this reason—to combat exploitation and, if found, to determine ways to fix the issues. In Switzerland, notably, one of the attributes required of those who wish to volunteer for Exit, an organization that provides assisted suicide services, is that they "must not be [enamored] by death in any way"; in this way, the organization has attempted to create a safeguard against a concern that its staff may take advantage of vulnerable persons seeking to utilize its services but who may not be suited for it.[203] This requirement may serve to assuage some concerns in the United States as to the exploitation and use of programs where the patient is suicidal, and therefore not a legitimate candidate.

One of the biggest ethical issues many must overcome in their consideration of assisted suicide, is the concept of suicide as generally being morally wrong. If it is, and someone such as a physician acting solely on a patient's wishes, assists, then the fact that that person is a doctor and that the person is terminally ill is morally wrong as well. Whether or not a doctor's duty of care towards his or her patients is breached by the lawful prescription of lethal medication at the wishes of a competent, terminally ill patient who has requested it is the central debate.[204] This brings in the issue of euthanasia as well—and many opponents use a "slippery slope" argument to say that if assisted

200 *Id.*

201 *Id.*

202 Thaddeus Mason Pope, *Oregon Shows That Assisted Suicide Can Work Sensibly and Fairly*, N. Y. TIMES (Oct. 7, 2014), https://www.nytimes.com/roomfordebate/2014/10/06/expanding-the-right-to-die/oregon-shows-that-assisted-suicide-can-work-sensibly-and-fairly.

203 Stephen J. Ziegler & Georg Bosshard, *Role of Non-Governmental Organisations in Physician Assisted Suicide*, 334 BMJ 295-298 (Feb. 10, 2007), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1796670/.

204 *Id.; see generally* L.W. SUMMER, ASSISTED DEATH: A STUDY IN ETHICS AND LAW (Oxford University Press, 2011).

suicide is legalized, voluntary euthanasia will be next, followed by involuntary euthanasia, and so on.[205]

Colombia took an interesting moral approach to the issue, with its Constitutional Court holding in 1997, that to uphold criminal penalties would be a breach of the right to equity and would amount to discrimination against the seriously ill.[206] The decision went on to categorize the penalties as making the "value of human life relative," and accused it of creating "diverse citizen categories in Colombia."[207]

The more explicit role of money in Switzerland's approach to PAS is an ethical issue more unique to Switzerland than other countries that have legalized PAS. Since every instance of assisted suicide in Switzerland results in an investigation, which, according to a paper in the Journal of Medical Ethics, costs approximately 3,000 CHF.[208] These fees are the responsibility of the canton of Zurich and are not ameliorated by the fees paid to organizations like DIGNITAS and Exit, which provide the service. To assuage this, bills have been drafted to impose residency and durational requirements on those utilizing the services of those organizations, but all such bills have failed as of October 2020.[209]

In the United States, major medical organizations have taken somewhat differing approaches on whether they support legalization of assisted dying. The American Medical Association ("AMA"), the largest national organization of physicians in the country, while not explicitly taking a side for or against assisted dying, expresses a nuanced view through multiple published opinions on the AMA Code of Medical Ethics.[210] The group's Code of Medical Ethics Opinion 5.7 "powerfully expresses the perspective of those who oppose physician-assisted suicide," calling it "fundamentally incompatible with the physician's role as healer."[211] The opinion also expresses that assisted dying would be "difficult or impossible to control, and would pose

205 *See generally* Summer, *supra* note 204.

206 Colombia 1997 CC Decision, *supra* note 155.

207 *Id.*

208 As of November 7, 2019, 3000 Swiss Francs is equivalent to approximately $3015 United States dollars; See Saskia Gauthier, Julian Mausbach, Thomas Reisch, & Christine Bartsch, *Suicide Tourism: a Pilot Study on the Swiss Phenomenon*, 41(8) JOURNAL OF MEDICAL ETHICS 611-17 (2015), https://jme.bmj.com/content/41/8/611.

209 *Id.*

210 *Physician-Assisted Suicide*, AMERICAN MEDICAL ASSOCIATION, https://www.ama-assn.org/delivering-care/ethics/physician-assisted-suicide (last visited Jan. 5, 2019) [hereinafter, AMA Opinion 5.7].

211 *Id.*

serious societal risks," and goes on to suggest that instead of assisting patients who wish to end their lives, physicians should "aggressively respond to the needs of patients at the end of life."[212] This includes providing emotional support and communication, along with comfort care and pain control, while also "respect[ing] patient autonomy."[213] The reference to patient autonomy is notable—a desire for autonomy at the end of their lives is the foremost reason patients listed for choosing the option of assisted suicide where legal.[214]

The second opinion, Code of Medical Ethics Opinion 1.1.7, opines that physicians, while expected to "uphold the ethical norms of their profession," are not "defined solely by their profession," and rather are "moral agents in their own right and, like their patients, are informed by and committed to diverse cultural, religious, and philosophical traditions and beliefs."[215] This opinion calls for physicians to choose whether to act or refrain from doing so in "accordance with the dictates of conscience in their professional practice," and calls for "considerable latitude" to act as they see fit.[216] It also expresses that this freedom—to act—is not unlimited and thus, decisions should be made with thoughtful consideration, communication with the patient, the mindfulness that their choices may burden fellow physicians, and the continuation of providing ongoing care.[217]

The American College of Physicians ("ACP"), the second largest physician group in the country, is explicitly opposed to the legalization of assisted suicide. Most recently, in 2017, the ACP reaffirmed their opposition in a paper,[218] which called for the focus of physicians to be on "efforts to prevent or ease suffering and on the often unaddressed needs of patients and families."[219] The paper notes that rules and norms of medical ethics sometimes establish duties of physicians to their patients "to a greater extent than the law."[220] The ACP

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212 *Id.*

213 *Id.*

214 *Id.*

215 *Id.*

216 AMA Opinion 5.7, *supra* note 210.

217 *Id.*

218 *American College of Physicians Reaffirms Opposition to Legalization of Physician-Assisted Suicide*, AMERICAN COLLEGE OF PHYSICIANS (Sept. 19, 2017), https://www.acponline.org/acp-newsroom/opposition-to-legalization-of-physician-assisted-suicide.

219 *Id.*

220 Lois Snyder Sulmasy, JD, Paul S. Mueller, MD, MPH, *Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper*, ANNALS OF INTERNAL MEDICINE (Oct. 17, 2017),

acknowledges that both the law and medical ethics support patients' rights to refuse treatment, resulting in death, but draws the line at assistance in dying by physicians.[221] Since medicine cannot eliminate death, postulates the paper, it is not "reasonable to ask medicine to relieve all human suffering."[222]

V. POLICY RECOMMENDATIONS FOR U.S. IMPLEMENTATION—COMPARATIVE APPLICATION

The United States has been slow to update its nationwide policies on assisted suicide despite an uptick of legislation in recent years. Notably, most of the states that continue to oppose even the consideration of such policies tend to be more conservative both politically and religiously. Because of this, an approach similar to the one taken by Colombia may be a useful blueprint for a path forward. Colombia's "panel" safeguard may represent a potential way to assuage those whose primary ethical objection to physician assisted suicide is concern for the patient's being taken advantage of; when authorization must be received from a group of specialists, lawyers, and mental health professionals, the likelihood that a patient is not exercising his or her will is diminished.[223]

Utilizing Colombia's method in combination with Switzerland's "nonprofit approach" to physician assisted suicide is another potential avenue to a wider and more uniform U.S. approach to legalization, especially given Supreme Court precedent.[224] Given the Court's reluctance to accept a government-approved right to end one's life, use of a non-profit may likely serve to work around these holdings and allow for a new path forward. Of course, this approach would have to be combined with legislative changes as to the classification of such acts as criminal, as Switzerland has done (i.e., lessening criminal penalties for assisting in suicide upon determination of a non-selfish motive by the assistor).[225]

A major difference between Switzerland's approach and the United States' approach, however, is that the issue of PAS is treated

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https://annals.org/aim/fullarticle/2654458/ethics-legalization-physician-assisted-suicide-american-college-physicians-position-paper?_ga=2.228396312.426427932.1579231610-1761783360.1579231610.

221 *Id.*

222 *Id.*

223 Tegel, *supra* note 153.

224 *See Vacco*, 521 U.S. at 797; *see also* Glucksburg, *supra* note 11.

225 STRAFGESETZBUCH, *supra* note 36; Hurst, *supra* note 137.

as a matter of human dignity in Switzerland and not in the United States.[226] The Swiss constitution contains a provision ensuring that "every person has the right to personal liberty and in particular to physical and mental integrity," along with an article that states simply that "human dignity must be respected and protected."[227] The United States Constitution does not contain any such language affirming commitment to human dignity or physical and mental integrity.[228] Indeed, Justice Rehnquist's majority opinion in *Glucksberg* left open the door for states to legalize PAS.[229] His opinion relied in part on state legislative history, which has clearly changed since 1997 (if only by nine jurisdictions, though more have considered the issue since that time).[230]

United States has considerable division on the topic, as evidenced from the wide variety in approaches state-by-state. In more states with large populations of Christian individuals, particularly the Southern United States, concerns regarding the "sanctity of life" (echoing concerns regarding another controversial topic, abortion) tend to dominate discussions of ethical and legal concerns surrounding PAS.[231] For this reason, and the history of difficulty pushing legislation through to enactment, a governmental hands-off approach, per the Swiss scheme, would likely provide the smoothest transition to legality, in combination with a "panel" approach, per Colombia.[232] A panel of experts that perhaps consult with private PAS providers may prove to be the most rational manner in which the United States could see a legal PAS scheme.

This combination could also help to assuage concerns that would arise from non-uniform treatment of PAS throughout the states. It would require federal recognition of one's right to choose assisted death and state legislation specifying that no criminal penalties would be levied upon a physician who chose to offer the service. Whether or not this is plausible remains a question that will likely be answered in the event that another case such as *Glucksberg* is raised.

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226 Bundesverfassung Apr. 18, 1999, SR 101, art. 10, para. 2; Bundesverfassung Apr. 18, 1999, SR 101, art. 7.

227 *Id.*

228 *See generally* U.S. CONST.

229 *Infra* section 11(b).

230 *Id.*

231 *See, e.g.,* Chapter 5 – The Ethical Debate, NEW YORK STATE DEPARTMENT OF HEALTH, https://www.health.ny.gov/regulations/task_force/reports_publications/when_death_is_sought/chap5.htm (last accessed February 4, 2021).

232 Tegel*, supra* note 153.

VI. CONCLUSION

If there is to be a way forward for legalized assisted suicide in the United States, it will not only take time but a conscious effort by legislators and activists to consider all avenues and balance ethical arguments and existing federal legal frameworks. This country should look toward others in order to create more cohesive policy and thereby factor in multiple viewpoints—legal, medical, and ethical—on the issue.

It is important to consider that when research for this note began, the political climate, while fraught, was less volatile than it was at the completion of research. As of October 2020, the death of Justice Ruth Bader Ginsburg, the de facto leader of the liberal wing of the Supreme Court, resulted in a vacancy that has been filled by Justice Amy Coney Barrett.[233] Though Justice Barrett has not made any explicit statements regarding physician assisted suicide, it is well-documented that she is a devout Catholic with who has supported conservative social policies.[234] The most significant barrier to federal action on topic of physician-assisted is a conservative majority Court and Senate.[235] Thus, the political climate and the general volatility of American social policies likely means that the policy recommendations made in this note are more theoretical than practical. If and when the country is ready for concrete legislative or judicial action to move forward, however, the combination of existing state regulations, a panel system, and a decentralized non-profit approach could prove to be the most rational path.

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233 *Senate Confirms Amy Coney Barrett for Supreme Court*, THE WHITE HOUSE, Oct. 26, 2020.

234 Tom Gjelten, *Amy Coney Barrett's Catholicism is Controversial But May Not Be Confirmation Issue*, NPR (Sept. 29, 2020), https://www.npr.org/2020/09/29/917943045/amy-coney-barretts-catholicism-is-controversial-but-may-not-be-confirmation-issu (noting that Barrett's "Catholic faith appears to be of unusual intensity and character").

235 While not all political conservatives are opposed to PAS, social conservativism has been cited by Republican politicians in voting against legalization, *see, e.g.,* Lacey Johnson, *U.S. Representatives Vote Against D.C. Assisted Suicide Law*, REUTERS (Feb. 13, 2017), https://www.reuters.com/article/us-washingtondc-euthanasia/u-s-representatives-vote-against-d-c-assisted-suicide-law-idUSKBN15T09B (including Jasson Chaffetz, R-UT calling PAS "fundamentally wrong.").