

A COMPARATIVE VIEW OF THE LAW, ETHICS, AND POLICIES SURROUNDING MEDICAL AID IN DYING IN THE UNITED STATES AND NETHERLANDS

INTRODUCTION

The Hippocratic Oath, recorded as early as the first century A.D., contains one of the oldest recordings related to the idea of medical aid in dying.¹ The classic version of the Hippocratic Oath reads: “I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect.”²

This note will compare the state of the law surrounding medical aid in dying in the United States and the Netherlands. Medical aid in dying is currently legal in eight American states and the District of Columbia.³ In all nine United States jurisdictions that currently allow medical aid in dying, the only form of medical aid in dying that is available is what is commonly known as physician assisted suicide.⁴ Physician assisted suicide is a type of medical aid in dying by which lethal means are made available to patients for their personal use at a time of their choosing.⁵ By contrast,

1 Lisa R. Hasday, *The Hippocratic Oath as Literary Text: A Dialogue Between Law and Medicine*, 2 Yale J. Health Pol’y, L. & Ethics 299, 301 (2002) (citing OWSEI TEMKIN, HIPPOCRATES IN A WORLD OF PAGANS AND CHRISTIANS 21 (1991)).

2 *Id.* at 299. It is important to note here that most doctors today do not take the Hippocratic Oath. *Id.* It is equally intriguing that the Hippocratic Oath was originally sworn to Greek mythological gods and goddesses. *Id.* It also contains several lines prohibiting doctors from performing abortions. *Id.*

3 *Death With Dignity Acts*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/learn/death-with-dignity-acts/> (last visited Sept. 22, 2018). “Existing physician-assisted dying laws mirror Oregon’s Death with Dignity Act, which is widely acclaimed as successful and which independent studies prove has safeguards to protect patients and prevents misuse.” *Id.*

4 *Id.* Physician assisted suicide is defined as what “...occurs when a physician facilitates a patient’s death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g. the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).” *Code of Medical Ethics Opinion 5.7*, AM. MED. ASSOC., <https://www.ama-assn.org/delivering-care/ethics/physician-assisted-suicide>. (last visited Sept. 22, 2019). The other common form of medical aid in dying is known as active voluntary euthanasia, which is defined as “...the administration of a lethal agent by another person to a patient for the purpose of relieving the patient’s intolerable and incurable suffering.” *Code of Medical Ethics Opinion 5.8*, Am. Med. Assoc., <https://www.ama-assn.org/delivering-care/ethics/euthanasia>. (last visited Sept. 22, 2019).

5 *What is the Difference Between Assisted Dying and Euthanasia?*, The World Federation of Right to Die Societies, <https://www.worldrtd.net/qanda/what-difference-between-assisted-dying-and-euthanasia> (last visited Sept. 22, 2019).

euthanasia entails the physician taking an active role in causing the death of the patient, typically by administering a concoction of intravenous drugs that lead to death.⁶ Due to a prohibition on active voluntary euthanasia, the patient must be able to complete, on their own, a voluntary act to self-administer the life ending medication.⁷ The Netherlands has taken medical aid in dying even further, legalizing active voluntary euthanasia.⁸ This note will explore the history of and justifications for medical aid in dying laws in the United States and the legal history surrounding the issue in the Netherlands and attempt to provide insight into how the law should develop in the future.

I. BACKGROUND

The debate surrounding medical aid in dying is not new. Dr. Jack Kevorkian, colloquially known as Doctor Death⁹ and recognized as one of the central figures surrounding the debate regarding physician assisted suicide and euthanasia in America,¹⁰ brought the debate to the national forefront in the 1990s when he famously aided in ending the lives of over 130 of his patients.¹¹ A few years after Dr. Kevorkian brought the debate to the attention of the public, Oregon became the first American state to legalize medical aid in dying when its citizens voted by a margin of just

6 *Id.*

7 *See generally* *Baxter v. State*, 224 P.3d 1211, at 1222 (Mont. 2009), Or. Rev. Stat. Ann. § 127.880 (2018), Cal. Health & Safety Code §443.14(c) (2015), Vt. Stat. Ann. Tit. 18, ch. 113 (2013), Wash. Rev. Code §70.245 (2009), Colo. Rev. Stat. Ann. § 25-48-103 (2018), Haw. Rev. Stat. § 327L-25 (2019), DC CODE § 7-661.01 (2017), N.J. Stat. Ann. § 26:16-4 (2019).

8 Wet van 1 April 2001, Stb. 2001, 194.

9 Keith Schneider, *Dr. Jack Kevorkian Dies at 83: A Doctor Who Helped End Lives*, N.Y. TIMES, (June 3, 2011), <https://www.nytimes.com/2011/06/04/us/04kevorkian.html>.

10 *Id.*

11 *Id.* He was later convicted of second-degree murder in the state of Michigan after assisting in the suicide of a woman suffering from Lou Gehrig's disease, filming it, and providing the film to the producers of the television news show *60 Minutes* (which they subsequently aired on national television) in an attempt to spread information regarding medical aid in dying and in what was obviously a purposely defiant violation of Michigan state law. *People v. Kevorkian*, 639 N.W.2d 291, at 296 (Mich. App. 2001). Jack Kevorkian was also indicted in an earlier case that went up to the Michigan Supreme Court. *See People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994). In that case, Kevorkian set up a so-called "suicide machine". *Id.* Kevorkian would attach an IV to his patients arms that would then allow his dying patients to raise their hand, releasing the deadly drugs into the IV themselves. *Id.* The Michigan Supreme Court held that a person can be convicted of murder only if they participate in the final overt act causing death. *Id.* If the person is only involved in the events leading up to the final overt act causing death, they cannot be prosecuted for or convicted of murder. *Id.*

over 1% to pass the Death with Dignity Act in 1994.¹² Although most of the developments in the law surrounding medical aid in dying in the United States started coming to fruition in the 1990s, this issue has been at the foreground of the minds of doctors and laymen alike since well before the end of the twentieth century.¹³

A. *Medical Aid in Dying in the United States*

In 1828, New York became the first American state to adopt a statute outlawing physician assisted suicide,¹⁴ with many states and territories later following New York's example.¹⁵ Around the end of the nineteenth century, people began to advocate for the use of morphine and other

12 *History of Death with Dignity in Oregon*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/wp-content/uploads/2018/07/History-of-Death-with-Dignity-in-Oregon-071118.pdf> (last visited Sept. 22, 2019). Oregon State Senator Frank Roberts, who suffered from prostate cancer, introduced three physician-assisted suicide bills in 1989, 1991, and 1993. See Barbara Coombs Lee, *A Pioneer for Death With Dignity*, N.Y. TIMES (March 18, 2015), <https://opinionator.blogs.nytimes.com/2015/03/18/a-pioneer-for-death-with-dignity/>, for more on the very interesting life and times of Oregon State Senator Frank Roberts. While none of these bills made it out of committee, their language was used to draft the Death with Dignity Act, which was approved by Oregon voters by a margin of 51.31% in 1994. *History of Death with Dignity in Oregon*, DEATH WITH DIGNITY.

13 See Hasday, *supra* note 1. As previously stated, the Hippocratic Oath is a document of ancient origin to which all medical professionals used to swear, binding them to never administering deadly drugs or even suggest their use. *Id.* Later, the rise and spread of Christianity, which throughout its history has strongly condemned suicide, reinforced the view that suicide in all forms is morally wrong. H. Tristram Engelhardt, Jr., *Physician-Assisted Suicide Reconsidered: Dying as a Christian in a Post-Christian Age*, 15 ISSUES L. & MED. 108 (1999). “[P]ost-traditional Christian and secular concerns with self-determination, control, dignity, and self-esteem make physician-assisted suicide and voluntary active euthanasia plausible moral choices. Such is not the case within the context of the traditional Christian experience of God, which throughout its two- thousand years has sternly condemned suicide and assisted suicide.” *Id.* See David A. Daigle, *Crossing the Threshold of Law with the Gospel of Life*, 37 CATHOLAW 295 (1997), for more on the Christian view on the morality of medical aid in dying laws. His Holiness, John Paul II, articulates the meaning of human dignity and affirms that all persons have a fundamental right to life; according to Pope John Paul II, “The right to life means the right to be born and then continue to live until one's natural end: ‘As long as I live, I have the right to live.’” *Id.* at 296 (quoting JOHN PAUL II, *CROSSING THE THRESHOLD OF HOPE* 205 (Vittorio Messori ed. 1994)).

14 Edward J. Larson, *Tales of Death: Storytelling in the Physician-Assisted Suicide Litigation*, 39 WASHBURN L.J. 159, 161 (2000). The text of the New York law read as follows: “Every person deliberately assisting in the commission of self-murder shall be deemed guilty of manslaughter in the first degree.” *Id.*, citing Act of Dec. 10, 1828, ch. 209, § 4, 1828 N.Y. Laws 19, 19.

15 Larson, *supra* note 14, at 162 (citing Thomas J. Marzen et al., *Suicide: A Constitutional Right?*, 24 DUQ. L. REV. 1, 63-100 (1985)). The state of Washington modeled their law after New York's in 1854. [cite?] These two laws were challenged in front of the United States Supreme Court in 1997 in *Washington v. Glucksberg*, 521 U.S. 702 (1997). Deleted cite to statute based on advice in Chris's email.

analgesic drugs as a means of euthanizing people in severe pain.¹⁶ In 1905, a bill was defeated in Ohio that would have legalized active voluntary euthanasia.¹⁷ In 1906, a similar bill that would have legalized the active voluntary euthanasia of terminally ill adults as well as the involuntary euthanasia of “deformed” and “idiotic” children was also defeated in Ohio.¹⁸ During the Great Depression of the 1930s, public support for mercy killings began to grow.¹⁹ However, the 1940s saw public opinion shift in the other direction.²⁰

The next major development came in the 1970s with the rise of acceptance of patients’ autonomy, and in 1972, the United States Senate held the first public hearings on euthanasia.²¹ In *in re Quinlan*, the New Jersey Supreme Court upheld the right of the parents of a woman who fell into an irreversible comatose state to cease the administration of her life sustaining medicine and remove her respirator.²² This case became a “touchstone for legal struggles in other states.”²³

16 *History of Euthanasia and Physician-Assisted Suicide*, PROCON, <https://euthanasia.procon.org/view.timeline.php?timelineID=000022> (last visited Sept. 22, 2019). I tried to delete the language that is unsupported by the source. During the late 1800s, the consideration of morphine as a life ending medication was seriously discussed in medical journals and at scientific meetings. *Id.* However, most doctors continued to hold on to the view that morphine and other analgesic drugs should be used purely for their pain relieving abilities and not to hasten death. *Id.*

17 *Id.* The debate surrounding euthanasia really started to enter the public discourse as doctors started gaining more control over universities and medical school training programs. *Id.*

18 *Id.* After 1906, the public started losing interest in the debate surrounding euthanasia and assisted suicide. *Id.*

19 *Id.* This culminated in Senator John Comstock, a Nebraskan Senator, introducing a piece of legislation that would legalize active voluntary euthanasia. *Id.*

20 *Id.* This shift in public opinion came after the world saw Adolf Hitler and his Nazi Germany employ involuntary euthanasia to carry out mass killings, as well as eugenics experiments during the Holocaust. *Id.* Early in the 1940s, many activists believed the legalization of euthanasia in the United States was imminent. *Id.* This never came to fruition. *Id.* After news of the Nazi atrocities against the mentally ill and handicapped made its way to America, the euthanasia movement found itself clamoring to defend against the argument that the right to die movement approved of the Nazis mass murdering of innocent people. *Id.*

21 *Id.* The idea of patients’ rights started to take hold and the authority of physicians began to be questioned as acceptance of personal autonomy grew. *Id.*

22 *In re Quinlan*, 70 N.J. 10 (1976). Karen Quinlan fell into a ‘persistent vegetative state’ and her parents went to court to fight for their right to end life sustaining treatment. *Id.* The New Jersey Supreme Court ruled that she could be removed from her respirator. *Id.* The case became a landmark in the right to die movement. *Id.*

23 Robert D. McFadden, *Karen Ann Quinlan, 31, Dies; Focus of '76 Right to Die Case*, N.Y. TIMES (June 12, 1985). <https://www.nytimes.com/1985/06/12/nyregion/karen-ann-quinlan-31-dies-focus-of-76-right-to-die-case.html>.

The Hemlock Society, a prominent advocacy group in the right to die movement, was formed in 1980.²⁴ By the early 1990s, the right to die movement was again gaining public support.²⁵ In 1993, Jack Kevorkian was on the cover of TIME Magazine,²⁶ and the very next year, Oregon's Death with Dignity Act was passed with the support of the majority of Oregon voters.²⁷

Despite the slight increase in public support for medical aid in dying legislation, the right to die movement in the United States has historically gained traction very slowly.²⁸ In the nearly two and a half decades since Oregon's Death With Dignity Act passed, only seven more American jurisdictions have followed Oregon's example.²⁹ Moreover, the Supreme Court ruled in *Washington v. Glucksberg*³⁰ and *Vacco v. Quill*³¹ that there

24 Sarah Childress, *The Evolution of America's Right-to-Die Movement*, PBS <https://www.pbs.org/wgbh/frontline/article/the-evolution-of-americas-right-to-die-movement/> (last visited Sept. 22, 2019). Derek Humphry first formed the grassroots pro-euthanasia organization in Los Angeles, California and it quickly grew to become one of the most prominent right to die groups in the country. *Id.* Humphry helped his wife who was suffering from terminal breast cancer end her own life. *Id.* In 1980, he founded the Hemlock Society. *Id.* The Hemlock Society, the first right to die organization in America, was based out of his garage in Santa Monica, California. *Id.* Its stated mission is to aid terminally ill people in dying peacefully and to advocate for aid in dying legislation. *Id.* Although it was started in California, the Hemlock Society quickly grew to become one of the most prominent right to die organizations in America. *Id.* Humphry is considered by many to be the father of the movement, which, eventually spawned many other similar organizations. *Id.* See THE WORLD FEDERATION OF RIGHT-TO-DIE SOCIETIES, <https://www.worldrtd.net/> (last visited Sept. 22, 2019), for more on other right to die organizations.

25 See PROCON, *supra* note 16. By the early 1990s, the shift in public opinion toward supporting the right to die movement became evident through public opinion surveys. *Id.* Public opinion polls showed that over 50% of the American public was in favor of legalizing physician assisted suicide. *Id.* This general growth in support was also made evident by the dramatic growth in the membership of the Hemlock Society. *Id.* Their membership rose dramatically to more than 50,000 individuals. *Id.*

26 See TIME MAGAZINE, May 31, 1993, <http://content.time.com/time/covers/0,16641,19930531,00.html?iid=sr-link4> (last visited Sept. 22, 2019). The cover of the magazine features a picture Kevorkian smiling at the camera with a caption reading "DOCTOR DEATH, Dr. Jack Kevorkian is back on his suicide crusade. Is he an angel of mercy or a murderer?" *Id.*

27 Or. Rev. Stat. Ann. § 127.880 (2018).

28 See PROCON, *supra* note 16.

29 See generally *supra* note 7.

30 *Washington v. Glucksberg*, 521 U.S. 702 (1997). In *Glucksberg*, the Supreme Court held that there is no constitutionally protected right under the Due Process Clause of the Fourteenth Amendment to physician assisted suicide. *Id.* The Court held that the right to physician assisted suicide has been uniformly rejected for most of our nation's history and therefore could not be called a fundamental liberty, like those protected by the Due Process Clause. *Id.* The state of Washington's actions, then, were subject to rational basis review. *Id.*

31 *Vacco v. Quill*, 521 U.S. 702 (1997). In *Quill*, the companion case to *Glucksberg*, the Court found New York's ban on physician assisted suicide to be constitutional after completing a rational basis review. *Id.* The issue in this case was whether the Equal Protection Clause of the Fourteenth

is no constitutionally protected right to die. This seemed to signal the demise of Oregon's law until, in 2006, the Supreme Court upheld the Oregon Death with Dignity Act, holding that although there is no constitutionally protected right to die, the decision should be left up to the states.³²

Since Oregon voted to legalize physician assisted suicide in 1994, Washington, Vermont, The District of Columbia, Colorado, Hawaii, and California have passed similar laws.³³ Montana is the only jurisdiction that has legalized medical aid in dying through court ruling, and still has no statute presently recorded.³⁴ California's medical aid in dying law, the "End of Life Options Act,"³⁵ took effect in 2016 after the highly publicized end of life journey of 29 year old Californian, Brittany Maynard. Maynard, suffering from terminal brain cancer moved from California to Oregon, leaving her home and family behind, in order to be free to utilize Oregon's medical aid in dying legislation at what she decided was the proper time.³⁶ Her story gained national attention after People magazine posted a highly popular article about her life on their website³⁷ and she completed a video campaign with the activist organization Compassion and Choices.³⁸

Amendment was violated by such a ban. *Id.* The Court held that the Equal Protection Clause did not invalidate New York's law because the law applied to every citizen in the same way. *Id.* The Court held that there was a clear distinction between the cessation of life support and assisting in suicide. *Id.* The distinction was not an arbitrary one and therefore applied to everyone in the same way. *Id.*

32 *Gonzales v. Oregon*, 126 S. Ct. 904 (2006). The issue in this case was whether the Controlled Substances Act (Pub. L. No. 91-513, 84 Stat. 1242, as amended, 21 U.S.C. §§ 801-971 (1994 & Supp. II 1996) authorized "the United States Attorney General to prohibit doctors from prescribing regulated drugs for use in physician assisted suicide, notwithstanding a state law permitting the procedure." *Id.* at 911. This was an issue of statutory interpretation, and the Court ultimately held that the Attorney General did not have such a power. *Id.*

33 *See generally supra* note 7.

34 *See Baxter, supra* note 7. The Supreme Court of Montana avoided answering the question of whether the right to medical aid in dying was guaranteed under the Montana Constitution, deciding the case on other grounds. *Id.* They held that allowing a patient medical aid in dying was not against public policy. *Id.*

35 Assemb. B. 15, 2015-2016 (Cal. 2015).

36 Nicole W. Egan, *Terminally Ill 29-Year-Old Woman: Why I'm Choosing to Die on My Own Terms*, PEOPLE (Oct. 24, 2016), "My entire family has gone through a cycle of devastation," she says. "I'm an only child – this is going to make tears come to my eyes. For my mother, it's really difficult, and for my husband as well, but they've all supported me because they've stood in hospital rooms and heard what would happen to me." *Id.*

37 *Id.*

38 *Id.* *See also, The Brittany Maynard Story*, COMPASSION AND CHOICES, <https://compassionandchoices.org/stories/brittany-maynard/> (last visited Sept. 22, 2018).

Maynard's story garnered a lot of attention for the right to die movement in California and around the country.³⁹ As of February 28, 2020, there are sixteen states considering adopting medical aid in dying legislation.⁴⁰ Publication of Brittany Maynard's story is correlated with increased support for the Death with Dignity movement.⁴¹

All of the American jurisdictions that have legalized medical aid in dying have done so through slow, methodical, and thoughtful processes, being careful to place severe restrictions on the use of lethal prescription drugs. The Oregon Death with Dignity Act ("The Act") served as the model for the states that have passed similar laws subsequently.⁴² While some differences, of course, exist between the state statutes, for the purposes of this note, I will examine only the Oregon law in detail, introducing only briefly the laws of other states in order to point out any distinctive characteristics.

The Act defines who is eligible to end their life through the use of a combination of lethal prescription drugs as well as the process for obtaining those life ending prescriptions.⁴³ An eligible patient is a capable adult who is over the age of 18, is a resident of the state of Oregon, has been determined by their physician and a consulting physician to be suffering from a terminal disease, and has voluntarily expressed his or her wish to die.⁴⁴ The patient must receive a terminal diagnosis from an attending physician and be referred to a consulting physician who concurs with the primary physician's diagnosis.⁴⁵ If either the attending physician or consulting physician find the patient is suffering from a psychiatric or psychological disorder or depression, either physician may refer the

39 See the video entitled "The Brittany Maynard Story" on Compassion and Choices' You[T]ube channel for more information on Brittany. The video has over 12,068,000 views as of February, 2020. [CompassionChoices], *The Brittany Maynard Story*, YOUTUBE (Oct. 6, 2014), <https://www.youtube.com/watch?v=yPfe3rCcUeQ&t=15s>.

40 *Take Action in Your State*, DEATH WITH DIGNITY, <https://www.deathwithdignity.org/take-action/> (last visited Sept. 22, 2018) (last updated Oct. 26, 2019).

41 [See] Andrew Dugan, *In U.S., Support Up for Doctor-Assisted Suicide*, GALLUP (May 27, 2015), <https://news.gallup.com/poll/183425/support-doctor-assisted-suicide.aspx>. In May of 2015[,] Gallup released the results of a poll in which 68% of those surveyed agreed that doctors should be able to end terminally ill patients' lives in a painless way. *Id.*

42 [Wash. Post Editorial Bd., Editorial,] *Oregon's Death With Dignity Act a [M]odel for [O]ther [S]tates.*, (Jun. 22, 2015), OREGON LIVE, https://www.oregonlive.com/opinion/2015/06/oregons_death_with_dignity_act.html (last visited Sept. 22, 2019).

43 See Or. Rev. Stat. Ann. § 127.800 et seq. (2018), *supra* note 7.

44 *Id.* at § 127.805.

45 *Id.* at §§ 127.815-820.

patient for counseling.⁴⁶ No life-ending medication may be used until the counselor determines the patient is not suffering from a psychiatric or psychological disorder causing impaired judgment.⁴⁷ Once it has been confirmed the patient is terminally ill by two physicians, is of sound mind, and voluntarily wants to end their life, the patient may request a life-ending prescription.⁴⁸

The written request for the life ending medication must be witnessed by two people who testify that the patient is capable, acting voluntarily, and not being coerced.⁴⁹ At least one of the witnesses cannot be a relative, a person who is entitled to any of the patient's estate, or an employee of the health care facility where the patient is receiving his or her treatment.⁵⁰ In addition, the primary physician cannot sign as a witness.⁵¹ The Act also establishes waiting periods to ensure the patient has time to reconsider their choice to end his or her life.⁵²

46 *Id.* at §127.825.

47 *Id.* The request by the patient follows this format:

"I, _____, am an adult of sound mind. I am suffering from _____, which my attending physician has determined is a terminal disease and which has been medically confirmed by a consulting physician.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care and pain control.

I request that my attending physician prescribe medication that will end my life in a humane and dignified manner.

INITIAL ONE:

I have informed my family of my decision and taken their opinions into consideration.

I have decided not to inform my family of my decision.

I have no family to inform of my decision.

I understand that I have the right to rescind this request at any time.

I understand the full import of this request and I expect to die when I take the medication to be prescribed. I further understand that although most deaths occur within three hours, my death may take longer and my physician has counseled me about this possibility.

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

Signed: _____ Dated: _____"

48 *Id.* at § 127.897.

49 *Id.*

50 *Id.*

51 *Id.* The witnesses must use the following format:

"DECLARATION OF WITNESSES

We declare that the person signing this request:

(a) Is personally known to us or has provided proof of identity;

The other jurisdictions that have enacted legislation legalizing physician assisted suicide have, for the most part, modeled their own laws on Oregon's Death with Dignity Act. Of these jurisdictions, the State of Montana is the only state to have legalized physician assisted suicide through court ruling.⁵³ The Montana State Supreme Court, however, did not answer the broader question of whether the right to access to physician assisted suicide is a right guaranteed by the State of Montana's constitution, choosing to decide the case on narrower grounds.⁵⁴

The California End of Life Option Act,⁵⁵ modeled heavily on the Oregon Death With Dignity Act, contains a unique "sunset" clause, which states: "This part shall remain in effect only until January 1, 2026, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2026, deletes or extends that date."⁵⁶ This means that ten years after its enactment, the law will either have to be revised or extended.⁵⁷

B. *Medical Aid in Dying in the Netherlands*

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- (b) Signed this request in our presence;
 - (c) Appears to be of sound mind and not under duress, fraud or undue influence;
 - (d) Is not a patient for whom either of us is attending physician.

_____ Witness 1/Date
 _____ Witness 2/Date". *Id.*

52 *Id.* at § 127.850. The Act states "no less than fifteen days shall elapse between the patient's initial oral request and the writing of a prescription..." *Id.* Additionally, "[n]o less than 48 hours shall elapse between the patient's written request and the writing of a prescription [for the life ending medications]." *Id.*

53 *See Baxter v. State, supra* note 7. The Montana Supreme Court case *Baxter v. State* addressed the issue of whether physicians should be held criminally liable for helping their terminally ill patients die. *Id.* at 1214. In a 5 – 2 decision, the Montana State Supreme Court ruled that state law protects doctors from prosecution for helping terminally ill patients die. *Id.* In the majority's opinion, Justice W. William Leaphart wrote that physicians are protected from prosecution. *Id.* He based this conclusion on the fact that there was legislation passed in 1985 that addressed the withdrawal of treatment for terminally ill patients that created a "public policy" that shielded a physician from prosecution for helping hasten the death of a consenting, mentally competent, and terminal adult patient. *Id.* Montana is the only state to have legalized physician assisted suicide through court decision. *Supra* note 41.

54 Kirk Johnson, *Montana Ruling Bolsters Doctor-Assisted Suicide*, N.Y. TIMES (Dec. 31, 2009). <https://www.nytimes.com/2010/01/01/us/01suicide.html>.

55 *See* Cal. Health & Safety Code § 443.14(c) (West 2015), *supra* note 5.

56 *Id.* at § 443.215.

57 Andrew Schwartz, *Making Sense of California's End of Life Option Act*, SCIENCE OF CARING, <https://scienceofcaring.ucsf.edu/policy/making-sense-california%E2%80%99s-end-life-option-act> (last visited Sept. 22, 2019). Andrew Schwartz offers an in-depth analysis of the California law, lays out all of its requirements in layman's terms, and considers questions regarding the role of palliative care providers. *Id.*

The Dutch people have taken medical aid in dying much farther than the few American jurisdictions that have legalized it in some way. In the Netherlands, not only is physician assisted suicide legal, but active voluntary euthanasia is, as well.⁵⁸ Euthanasia, which is defined as, “the deliberate termination of the life of a person on his request by another person,”⁵⁹ has been legal in the Netherlands since 2001⁶⁰ and is regulated by the Termination of Life on Request and Assisted Suicide (Review Procedures) Act (“The TLRASA”).⁶¹ The TLRASA excludes physicians who assist their patients in ending their own lives, or who actively euthanize their patients, from criminal prosecution if they comply with a strict set of requirements and guidelines.⁶² The TLRASA, like the laws in the American jurisdictions allowing for physician assisted suicide, places severe restrictions on the use of the practices of physician assisted suicide and euthanasia.⁶³ For example, the physician must get the opinion of at least one other independent physician,⁶⁴ and the physicians must be convinced that the patient’s choice to end their life is well and thoughtfully considered and voluntary and that the patient is in a state of hopeless and unbearable suffering, among many other requirements.⁶⁵ The Dutch law surrounding medical aid in dying is broad, but it has not always been that way (at least formally). The historical background is important for successful comparison of the law in the two countries.

58 *Holland’s Euthanasia Law*, PATIENTS’ RIGHTS COUNCIL, <http://www.patientsrightsCouncil.org/site/hollands-euthanasia-law/> (last visited Jan. 12, 2019). See also *Review procedures for the termination of life on request and assisted suicide and amendment of the Criminal Code and the Burial and Cremation Act (Termination of Life on Request and Assisted Suicide (Review Procedures) Act)*, PATIENTS’ RIGHTS COUNCIL http://www.patientsrightsCouncil.org/site/wp-content/uploads/2012/05/Dutch_law_04_12.pdf (last visited Sept. 22, 2019), to read the full text of the Dutch euthanasia law in English.

59 Sjeff Gevers, *Euthanasia: Law and Practice in The Netherlands*, 52 BRIT. MED. BULL. 326 (1996).

60 See Patients’ Rights Council, *supra* note 59.

61 Wet van 1 April 2001, Stb. 2001, 194.

62 *Id.*

63 *Id.*

64 *Id.*

65 *Id.* One major aspect of the Dutch law, and perhaps shocking to most Americans, is that the TLRASA applies to patients over the age of only twelve years old. *Id.* Patients between the ages of twelve and sixteen need approval from their parents before exercising their choice to end their lives. *Id.* All of the other requirements remain the same for minor patients as they are for patients who have reached the age of majority. *Id.* “For patients between age twelve and sixteen, the parent(s) or guardian(s) have an absolute right to veto their child’s decision to be euthanized. In order to meet the requirements of due care in such situations, the physician must be sure that the parental guardian(s) “agree” to the termination.” See Jonathan T. Smies, *The Legalization of Euthanasia in The Netherlands*, 7 GONZ. J. OF INT’L. L. (2003-04), <http://www.gonzagajil.org/> (quoting Termination of Life on Request and Assisted Suicide (Review Procedures) Act, Article 2, Section 4.

The Netherlands is often seen as a nation on the forefront of many progressive social movements.⁶⁶ Medical aid in dying is no exception to this rule. Active voluntary euthanasia was practiced in the Netherlands for quite some time before The TLRSASA resolved the issue of the legal ambiguity surrounding the issue.⁶⁷

The Dutch Society for Voluntary Euthanasia was formed in 1973.⁶⁸ That very year, the debate surrounding medical aid in dying in the Netherlands was brought to the public consciousness of the Dutch people by the criminal prosecution of a woman, a licensed medical doctor, who was tried for the crime of ending the life of her mother after her mother had fallen victim to a severe cerebral hemorrhage.⁶⁹ The woman was found guilty, but the court handed down a mere one week suspended sentence and one year of probation.⁷⁰ This case sparked much public debate and the interest of the public.⁷¹

The next major development in the law surrounding medical aid in dying in the Netherlands came in the form of a 1984 Supreme Court case (“the Alkmaar case”).⁷² In the Alkmaar case, a 95 year old woman who was terminally ill finally, after much pleading, convinced her doctor to euthanize her after she lost and regained consciousness and articulated that

66 Along with pioneering medical aid in dying legislation, The Netherlands is home to some of the most liberal prostitution regulations and laws surrounding the use of recreational marijuana. *See also*, Herbert Hendin, *The Dutch Experience; Euthanasia*, 17 ISSUES L. & MED. 223 (2002). Since the 1600s, the Netherlands have been home to people from many different cultures and religions, thus forcing acceptance of those cultures and religions and promoting the development of an open mind. *Id.* The Dutch have also historically embraced the idea of personal autonomy. *Id.*

67 *See* Ybo Buruma, *Dutch Tolerance: On Drugs, Prostitution, and Euthanasia*, 35 CRIME J. 73 (2007). Buruma provides a fascinating history of the Dutch acceptance of certain technically criminal behaviors, including euthanasia. *Id.* “Regarding euthanasia, there was first discussion in 1973-84, then acceptance by the Medical Association and the Supreme Court in 1985-90, followed by promises of tolerance from prosecutors after negotiations with the Medical Association in 1990-2001, and followed then by a change of law.” *Id.* at 100.

68 *See* Gevers, *supra* note 59, at 327.

69 *Id.* The mother had become partially paralyzed and deaf after suffering the hemorrhage and could no longer speak properly. *Id.* The daughter gave her mother an overdose of morphine after her mother had repeatedly expressed her desire to die. *Id.*

70 *Id.* The court of Leeuwarden found the physician guilty not because she had accelerated her mother’s eventual death, but because she had instead directly ended her mother’s life. *Id.* In subsequent cases, the Dutch courts no longer exclude that doctors can bring about death of their patients in a direct way. *Id.* However, they have elaborated on the reasoning laid down by the court of Leeuwarden in this decision. *Id.* On top of elaborating on this decision, the cases that followed added additional requirements. *Id.*

71 *Id.*

72 *Id.*

she never wanted to undergo such an experience again.⁷³ The Court of Appeals for Amsterdam convicted the woman's doctor,⁷⁴ but on appeal, the nation's Supreme Court overturned that conviction.⁷⁵ Later, "the case was referred to the Court of The Hague which acquitted the doctor."⁷⁶

Seeing the growing public support for medical aid in dying, the Executive Board of the Royal Dutch Medical Association (*Koninklijke Nederlandse Maatschappij Ter Bevordering Der Pharmacie*) issued a statement in 1984 on euthanasia which listed several criteria modeled after those previously employed by the courts.⁷⁷

The Dutch courts had ruled that active voluntary euthanasia was acceptable, but the Dutch penal code still stipulated that doctors could be prosecuted for euthanizing their patients.⁷⁸ The State Commission on Euthanasia, which was formed in 1985 to advise the government on the development of medical aid in dying jurisprudence,⁷⁹ proposed an amendment to Article 293 of the Dutch Penal Code.⁸⁰ This sort of

73 *Id.* The woman was also known to be seriously ill and it was clear that she had no chance of future recovery. *Id.* The weekend before she died, she suffered substantial deterioration in her condition and was unable to eat or drink. *Id.*

74 *Id.* at 328.

75 *Id.* They held that the Court of Appeals for Amsterdam had not given sufficient reason for convicting the doctor and that they should have completed a necessity analysis. *Id.* In turning over the conviction, the Court thought that it should have been considered whether it was expected that the patient would soon not have the choice of dying with dignity in the circumstances that human beings are worthy of. *Id.*

76 *Id.*

77 *Id.* The circumstances the letter listed under which euthanasia could be acceptable were as follows:

- "the request for euthanasia must come from the patient and be entirely free and voluntary, well considered and persistent,
- the patient must experience intolerable suffering (physical or mental), with no prospect of improvement and with no acceptable solutions to alleviate the patient's situation,
- euthanasia must be performed by a physician after consultation with an independent colleague who has experience in this field." *Id.*

See also, KNMG [Royal Dutch Medical Association], *Standpunt inzake euthanasia* [Position on Euthanasia], MEDISCH CONTACT 990 (1984).

78 The American Series of Foreign Penal Codes, The Dutch Penal Code 200 (Louise Rayar & Stafford Wadsworth trans., 1997). *See also* Jeroen Chorus, et al. eds., INTRODUCTION TO DUTCH LAW FOR FOREIGN LAWYERS 313 (1993). The Dutch penal code, with its roots in the French penal code, applies nationally. *Id.*

79 *See* Gevers, *supra* note 59.

80 *Id.* *See also*, Proposed Article 293, *Staatscommissie Euthanasie* [State Commission on Euthanasia], *Rapport van de Staatscommissie Euthanasie* [Report of the State Commission on Euthanasia], The Hague, 1985, translated in John Griffiths, Alex Bood, & Heleen Wyers, Euthanasia

amendment would have decriminalized a doctor ending a patient's life as long as it was at the patient's request and the patient had no chance for improvement.⁸¹ This proposed amendment marks the first attempt to draft legislation incorporating the judicial developments into the Dutch criminal law.⁸² However, the proposed amendment was not adopted.⁸³ Political considerations prevented the Dutch Parliament from adopting such legislation.⁸⁴ The state of the law remained the same until the Dutch Parliament voted to legalize voluntary euthanasia in the early part of the next century.⁸⁵

The TLRASA was largely a codification of prior judicial rulings recognizing several exceptions from criminal prosecutions for physicians.⁸⁶ After the law made it through both houses of the Dutch Parliament, the TLRASA became national law and went into effect on March 15, 2002.⁸⁷ The TLRASA made it so that a physician could not be punished for ending the life of one of their patient's upon that patient's request as long as the physician reported the death in the proper manner and had met all of the necessary requirements of due care, as laid out in the TLRASA.⁸⁸

II. FEDERALISM LEADS TO A DISJUNCTION OF LAWS AND UNFAIR OUTCOMES

and Law in the Netherlands 4 (Amsterdam University Press 1998) at 314-15. *See also*, Jeroen Chorus, et al. eds., *Introduction to Dutch Law for Foreign Lawyers* 313 (1993).

81 *See* Gevers, *supra* note 59. (citing Final report of The Netherlands State Commission on euthanasia: an English Summary. BIOETHICS 1987; 1: 163-74).

82 *See* Smies, *supra* note 65.

83 *See* Gevers, *supra* note 59. In fact, that proposal by the State Commission on Euthanasia never resulted in an amendment of the penal Code. *Id.* at 328.

84 *See* Smies, *supra* note 65.

85 *See* Gevers, *supra* note 59.

86 *See* Smies, *supra* note 65.

87 *See* Wet Van, *supra* note 8.

88 *Id.* The requirements of due care are laid out in Article 2, section 1 of the TLRASA. The sections provides that due care means the physician:

- “a. holds the conviction that the request by the patient was voluntary and well-considered,
- b. holds the conviction that the patient's suffering was lasting and unbearable,
- c. has informed the patient about the situation he was in and about his prospects,
- d. and the patient hold the conviction that there was no other reasonable solution for the situation he was in,
- e. has consulted at least one other, independent physician who has seen the patient and has given his written opinion on the requirements of due care, referred to in parts a - d, and
- f. has terminated a life or assisted in a suicide with due care.” *Id.* Available at <https://wetten.overheid.nl/BWBR0012410/2012-10-10>.

Watching a loved one's health fail can be a very challenging process. People who have had such experiences firsthand have chronicled their stories to help others understand what it is truly like. Sarah Lyall wrote for the New York Times, "Right now my mother is in bed across the hall, in the endgame of Stage 4 lung cancer. She is nearly 83, she has had enough, and she is ready to die."⁸⁹ Like many others, Lyall was faced with the prospect of watching her mother suffer a slow and painful death.⁹⁰ Lyall further wrote:

Lung cancer is a frightening illness. In its final stages, it can make you feel as though you're drowning, or suffocating. A formidable pharmacological stew of medications can help to suppress the symptoms, but no pill can take away the pain of waking up each day and remembering all over again that you are about to die.⁹¹

This description of what Lyall's mother was experiencing explains what many others go through every day. Some sick people know that they are too sick to be cured and are left in a sort of limbo waiting for their illness to finally win the war it is waging against them while their families are left to look on and experience emotional suffering of their own.⁹² Moreover, some people who desire a medically facilitated death must make the impossible choice of moving to a state where they can receive such treatment and staying in the comfortable and familiar surroundings of their own homes with their families and loved ones.⁹³

In addition to personal pain, suffering, and loss of freedom, these cases of slow acting terminal illness are often financially burdensome and cause the patient's family members a great deal of emotional suffering.⁹⁴ Most people would rather not talk or think about subject until they are in the situation themselves.⁹⁵ It may seem like the stories about people like

⁸⁹ Sarah Lyall, *The Last Thing Mom Asked*, N.Y. TIMES (Aug. 31, 2018) <https://www.nytimes.com/2018/08/31/sunday-review/mother-death-euthanasia.html?rref=collection%2Ftimestopic%2FAssisted%20Suicide>. See *How to Die in Oregon* (2011), Directed by P. Richardson, for more personal stories from people who have struggled with decisions like these and a general background on Oregon's Death with Dignity Act.

⁹⁰ See Lyall, *supra* note 89.

⁹¹ *Id.*

⁹² *Id.*

⁹³ See Egan, *supra* note 36.

⁹⁴ See Ethics Guide, *infra* note 99.

⁹⁵ See, e.g., Tim Kreider, *You Are Going to Die*, N.Y. TIMES (Jan. 20, 2013), <https://opinionator.blogs.nytimes.com/2013/01/20/you-are-going-to-die/>.

Lyll's mother⁹⁶ and others who face cruel illnesses are worst-case-scenario outliers that are advanced by proponents of medical aid in dying solely to tug on the heart strings of others. However, death is something that we will all eventually face.⁹⁷ We will all eventually come to face not only the physical and mental effects, but sometimes seemingly insurmountable financial burdens that are placed on patients, their family members, and the health care system as a whole.⁹⁸

Some argue it is illogical that these resources are diverted to people who have no chance of recovery and do not wish to continue living,⁹⁹ proving that this is not a purely emotional issue, but also an economic one.¹⁰⁰ On the other hand, opponents of medical aid in dying argue that life needs to be cherished regardless of its quality.¹⁰¹ As long as a person's

"The mortality rate is holding at a scandalous 100 percent. Pretending death can be indefinitely evaded with hot yoga or a gluten-free diet or antioxidants or just by refusing to look is craven denial." *Id.*

96 See Lyll, *supra* note 89.

97 *Id.*

98 Michael Ollove, *Why Some Patients Aren't Getting Palliative Care*, PEW (July 10, 2017), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2017/07/10/why-some-patients-arent-getting-palliative-care>. Studies have revealed that homebound, terminally ill patients who visited the emergency room at least once in the past year, "found that the average cost of care for those receiving palliative care services — \$95.30 per day — was less than half the cost for those without palliative care — \$212.80." *Id.* Moreover, between 15 and 21% of Medicare spending goes toward providing care toward the 5% of Medicare recipients who are in the last twelve months of their lives. Chuck Dinerstein, *The True Cost Of End-of-Life Medical Care*, AMERICAN COUNCIL OF SCIENCE AND HEALTH, (Sept. 28, 2018), <https://www.acsh.org/news/2018/09/28/true-cost-end-life-medical-care-13454>. The simple reason for that is that we spend a lot of money on those people who are very sick. *Id.*

99 *Ethics Guide: Pro-Euthanasia Arguments*, BBC, http://www.bbc.co.uk/ethics/euthanasia/infavour/infavour_1.shtml (last visited Sept. 22, 2019). It is argued that allowing terminally ill people who wish to die to have access to medical aid in dying would not only allow them to act out their own desires, but would also free up valuable, and scarce medical resources. *Id.* This argument has not been advanced publicly by any government or health organization. *Id.* However, it is important to note its existence, because most countries suffer from a shortage of health resources. *Id.* If these resources are being used on people who cannot be cured and who, for personal reasons, do not wish to continue living, then they should be free up and put to more efficient use. *Id.*

100 *Id.*

101 The so-called "sanctity of life" arguments can be summarized as follows: "All human beings are to be valued, irrespective of age, sex, race, religion, social status or their potential for achievement ... Therefore the deliberate taking of human life should be prohibited except in self-defen[s]e or the legitimate defen[s]e of others." *Ethics Guide: Anti-Euthanasia Arguments*, BBC, http://www.bbc.co.uk/ethics/euthanasia/against/against_1.shtml (last visited Sept. 22, 2019).

heart continues to beat, their life is worth fighting for and worth all of the money and resources that can be put toward preserving it.¹⁰²

The problem in the United States is best exemplified by the previously discussed situation of Brittany Maynard, the 29-year-old Californian with brain cancer who left her home to take advantage of Oregon's Death With Dignity law.¹⁰³ The legal makeup of the United States as it stands puts people like Brittany Maynard in the unfortunate position of having to decide between a slow, agonizing, painful, and unwanted last few months leading up to death and leaving their family, friends, and home behind.¹⁰⁴ There is a better way to regulate medical aid in dying. The Netherlands is on the right track, and with some of the restrictions in place in the various American jurisdictions,¹⁰⁵ a federal law like that in place in the Netherlands could prevent people from having to make the decision that Brittany Maynard was forced to make.¹⁰⁶

Proponents of medical aid in dying believe in patient autonomy, arguing that patients have the right to choose when and in what way they should die.¹⁰⁷ However, it is easy to understand why this issue makes people uncomfortable. There is a slippery slope argument to be made.¹⁰⁸

102 *Id.* Unfortunately, there are cases where the quality of life is so diminished that the person suffering may decide that life is not worth continuing. *See generally* Egan, *supra* note 36 and Lyall, *supra* note 90.

103 *See Oregon's Death with Dignity Act a Model for Other States: Washington Post Editorial supra* note 43.

104 *Id.*

105 *See supra* notes 54-58.

106 *See Oregon's Death with Dignity Act a Model for Other States: Washington Post Editorial, supra* note 42.

107 *Ethics Guide: Pro-Euthanasia Arguments, supra* note 99.

Many people think that each person has the right to control his or her body and life and so should be able to determine at what time, in what way and by whose hand he or she will die. Behind this lies the idea that human beings should be as free as possible - and that unnecessary restraints on human rights are a bad thing.

Id.

108 *Ethics Guide: Anti-Euthanasia Arguments, supra* note 101.

Many people worry that if voluntary euthanasia were to become legal, it would not be long before involuntary euthanasia would start to happen.... This is called the slippery slope argument. In general form it says that if we allow something relatively harmless today, we may start a trend that results in something currently unthinkable becoming accepted.

Id. The response to this argument is that narrowly drafted legislation can guard against falling down the slippery slope. *Id.*

Critics of medical aid in dying believe that the Dutch law allowing doctors to euthanize patients went too far.¹⁰⁹ In 2016, a new law was proposed in The Netherlands that would allow “assisted suicide for older people who are generally healthy but feel they have led a full life.”¹¹⁰ Proponents of that law argued that people should “have the right to end their lives with dignity” whenever they choose to do so, no matter what their reason.¹¹¹ The law was proposed with older people who have lost mobility and independence and who are suffering from a sense of loneliness in mind.¹¹² However, opponents of the law said that it was likely “to lead the country down a perilous moral and ethical path.”¹¹³ It is understandable how this law, which could be considered an extension of the TLRASA, could be seen as encouraging people to end their lives whenever they feel down instead of finding a way to deal with their problems.¹¹⁴

In addition to being an emotional and economic issue, medical aid in dying is a moral and ethical issue that is will be more prevalent for doctors in the future.¹¹⁵ For example, physicians now face an increasing number of difficult moral and philosophical dilemmas:

Due to an aging population, sociocultural developments and the increasing potential of medical technology to prolong life, physicians (in The Netherlands and elsewhere) have increasingly [sic] to face difficult dilemmas, first of all on whether or not to withhold (or refrain from) treatment. Also in The Netherlands (as in Britain, the USA, and other countries) there is much discussion on non-treatment decisions, in particular when incompetent patients (severely handicapped newborns, comatose patients, patients with sever[e] dementia, or others) are concerned.¹¹⁶

109 Dan Bilefsky and Christopher F. Schuetze, *Dutch Law Would Allow Assisted Suicide for Healthy Older People*, N.Y. TIMES (Oct. 13, 2016), <https://www.nytimes.com/2016/10/14/world/europe/dutch-law-would-allow-euthanasia-for-healthy-elderly-people.html>.

110 *Id.* This bill would seem to bolster the so-called slippery slope argument, but the proposed law was never passed. *Id.*

111 *Id.*

112 *Id.*

113 *Id.*

114 As of the writing of this note, no such law has been adopted in The Netherlands.

115 See Gevers, *supra* note 59, at 326. As the population ages and the average life expectancy continues to grow along with the abilities of the field of palliative care, doctors will face more patients with terminal illness who may want to end their lives. *Id.*

116 *Id.* at 326.

This debate has been slow-moving worldwide as demonstrated by the history provided in Section I.¹¹⁷ This debate will not go away soon, because it is likely that the issues surrounding medical aid in dying will remain controversial for some time to come. In *Washington v. Glucksberg*, the Supreme Court held that states have the right to make individual decisions about medical aid in dying¹¹⁸ by unanimously holding that the right to assisted suicide is not protected by the Constitution.¹¹⁹ Unless that decision is overturned, or some other solution is reached, this state-by-state decision making will likely continue for many years.

There are stark differences in policy consideration and choices between the United States and the Netherlands. There are many states where any form of medical aid in dying is illegal while, on the other end of the spectrum, active euthanasia is legal in The Netherlands. These decisions were made with ethical and political considerations in mind.

The American and Dutch systems differ in several major ways, the biggest difference obviously being the system of federalism in America¹²⁰ which has led to a patchwork of state laws¹²¹ as opposed to the nationwide law that exists in the Netherlands.¹²²

This, of course, is an issue that has serious moral, ethical, and political implications. The debate, at its core, is about whether a physician providing the means and information necessary for a patient to end their

117 See *supra* Section I.

118 521 U.S. 702, 705-06.

119 *Id.*

120 *Federalism, Constitution USA with Peter Sagal*, PBS (last visited Sept. 22, 2019). Federalism is defined as, "...the sharing of power between national and state governments." *Id.*

121 See DEATH WITH DIGNITY, *supra* note 3. This system of federalism is what has led to America being confronted with the issue of people like Brittany Maynard, the 29 year old woman who fell victim to terminal brain cancer and made the decision to leave her family and move from California to Oregon to be able to utilize their death with dignity law. See Egan, *supra* note 36. Asking someone undergoing intense medical treatment and the symptoms of terminal illness, and mounting medical bills, to leave their homes and families months before they die throws a wrench into that argument that is not present when discussing most other controversial issues that are decided on a state to state basis. One of the biggest criticisms of Federalism is that Federalism is now faced with issues that transcend local jurisdictions, and that, "it is an anachronistic form of government that makes it increasingly difficult for modern governments to cope with issues that were deemed local in another age but today transcend state or even national boundaries." Keith S. Rosenn, *Federalism in the Americas in Comparative Perspective*, 26 U. MIAMI INTER-AM. L. REV. 1, 7 (1994). In fact, this leads to a decrease in stability; "...federalism tends to be unstable, sometimes fragmenting into several nations or requiring military force to preserve the union." *Id.* at 8.

122 See Wet Van, *supra*, note 8.

lives serves a “legitimate medical purpose.”¹²³ However, there are policy implications that must be considered outside of the light of that emotionally heavy ethical argument. In particular, it is argued that legalizing medical aid for dying could lead to many patients choosing to end their lives prematurely, not because they necessarily want to die, but because they do not want to be an emotional or economic burden on others.¹²⁴

There is another school of thought that argues that doctors should always have “clean hands,” doctors are meant to protect life, not take it away.¹²⁵ Therefore, it is concluded, active euthanasia is immoral and implicates the doctor while a doctor simply prescribing medication for a patient to take on their own is acceptable.¹²⁶ They are able to write a prescription and simply walk away, thus leaving the patient to make their own decision. However, it can be argued that there is no real moral or ethical difference between the two.¹²⁷

Probably the most commonly heard argument against legalizing physician assisted suicide is that it will lead us down a slippery slope to mass suicide and doctors arbitrarily deciding which patients are and are

123 See *Gonzales v. Oregon*, *supra* note 33 (quoting 21 U.S.C. § 830(b)(3)(A)(ii) (2000) and 21 C.F.R. § 1306.04 (2005)).

124 This is sometimes referred to as the “Undue Pressure Argument.” See, Ken Levy, *Gonzales v. Oregon and Physician-Assisted Suicide: Ethical and Policy Issues*, 42 TULSA L. REV. 699, at 724 (2007). There are, of course, further policy considerations that must be looked at seriously as the legalization of medical aid in dying becomes a possibility. For example, there is a strong argument that such laws would work in a way as to encourage poor and elderly people to end their lives more strongly than other groups. *Id.* at 707. This is an extremely complicated debate and one that has many arguments on both sides. *Id.* at 723. For the sake of space, this article will only consider a few ethical and policy arguments. See NEIL M. GORSUCH, *THE FUTURE OF ASSISTED SUICIDE* (Princeton University Press) (2006), and RONALD DWORKIN ET AL., *ASSISTED SUICIDE: THE PHILOSOPHERS’ BRIEF*, (New York Review of Books 44) (1997) for a full view of the landscape of this debate.

125 This argument stems from the long-ingrained history of doctors taking the Hippocratic Oath. See *supra*, note 1. The ancient version of the Hippocratic Oath blatantly states that doctors shall not administer poison when asked to do so. *Id.* The modern version, however, takes a slightly less strict view: “Most especially must I tread with care in matters of life and death. If it is given to me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.” Levy, *supra* note 124, at 714.

126 See generally Levy, *supra* note 124.

127 This argument lines up parallel that the withholding of life saving medical services is acceptable, but physician assisted suicide is not. The consensus seems to be that three differences exist between withdrawal or withholding of life saving medical services and physician assisted suicide: intent, causation, and the consequences of prohibition. *Id.*

not fit to live.¹²⁸ The problem with the argument is that it simply has not turned out to be true.¹²⁹

Furthermore, one large difference between the political and social landscapes in the United States and the Netherlands is that the Dutch have access to affordable, universal health insurance under their national plan.¹³⁰ Thus, Dutch citizens all have the comfort of having access to medical care without becoming the victim of an insurmountable financial burden.¹³¹ This effectively gets rid of the policy argument against medical aid in dying in the United States that elderly and poor people will be pressured into ending their lives as to no longer be a financial burden on others.¹³² Additionally, another major difference between the healthcare systems in the United States and the Netherlands is that in the Netherlands, patients often have close, long term relationships with their general practitioners.¹³³

Furthermore, the systems of government present in the two countries differ widely. When discussing the issue, the varying state laws

128 “The Slippery Slope Argument predicts that if physician-assisted suicide is legalized, then both the message of this legal measure itself as well as the fact that some or many physicians will end up killing their patients will ultimately change society’s view of physicians and generate devastating psychological and sociological problems.” *Id.* at 727. (citing Erich H. Loewy and Roberta Springer Loewy, *THE ETHICS OF TERMINAL CARE: ORCHESTRATING THE END OF LIFE* 107 (Kluwer Academic/Plenum Publishers 2000)).

129 See OREGON LIVE, *supra* note 42. “Oregonians have made sparing use of the law, with 859 deaths as of Feb. 2. The state collects data on each case, and there have been no reports of coerced or wrongly qualified assisted deaths.” Oregon’s law has now been in effect for almost a quarter of a century and several states have followed in passing their own legislation. *Id.* However, the so called “slippery slope” leading from legalizing assisted suicide, to passive euthanasia, to active euthanasia, and finally to involuntary euthanasia has simply not come to fruition. *Id.*

130 See Griffiths, et al., *supra* note 80, at 31-35. Dutch citizens have access to health coverage under the Dutch national plan. *Id.* About 35% of the population chooses to forgo the public health plan and opt for private health insurance coverage instead. *Id.*

131 See generally Griffiths, et al., *supra* note 80.

132 There is an argument to be made that medical aid in dying discriminates against the poor and vulnerable patients and that the availability of physician assisted suicide could lead to poor patients being coerced into taking their own lives. Matt Hardo, *How Assisted Suicide Discriminates Against the Poor and Disabled*, CATHOLIC NEWS AGENCY, (last visited Feb. 11, 2019).

133 See generally Griffiths, et al., *supra* note 80. Patients in the Netherlands are required to see their assigned general practitioner before being referred to any specialists or to the hospital. *Id.* at 37. Also, general practitioners often treat entire families over long periods of time, and 17% of their visits are made in the patient’s home. *Id.* This close relationship between doctor and patient is not as common in places like the United States where patients often “shop” for doctors. *Id.* at 31-35. Another marked difference between the two countries is that the Netherlands benefitted from a common law and national medical association that supported legalization of medical aid in dying, as opposed to Oregon, which pioneered the legalization of medical aid in dying in the United States without support of the country at large or any major medical organizations. See DEATH WITH DIGNITY, *supra* note 12.

surrounding medical aid in dying, in the United States, federalism concerns must be addressed. The United States has a federal system of government.¹³⁴ The Netherlands, on the other hand, is a Constitutional Monarchy and has been since 1815.¹³⁵ The Netherlands is part of the Kingdom of the Netherlands,¹³⁶ which includes the European country as well as several Caribbean islands.¹³⁷ Generally, the Dutch municipalities and provinces enjoy great freedom and autonomy as long as their actions comply with national law.¹³⁸ That being said, the central government can legally interfere at any time in the workings of the local and provincial governments and may demand compliance with nationwide policies.¹³⁹

This is an area where the states have traditionally been the ones to make the laws, starting in 1828 when New York became the first American state to adopt a statute outlawing physician assisted suicide.¹⁴⁰ In *Washington v. Glucksberg*, the Supreme Court held that the right to assistance in committing suicide is not a fundamental liberty and thus is not a right that is protected by the Due Process Clause of the Fourteenth Amendment to the federal Constitution.¹⁴¹ *Glucksberg* and the cases that followed it are what have led to the piecemeal system of state laws regarding the right to assistance in ending one's own life in the United States.

Under the doctrine of stare decisis, it may seem that this issue is settled. Stare decisis is a Latin term, which means to stand by prior

134 Peter H. Schuck, *Federalism*, 38 CASE W. RES. J. INT'L L. 5, 8 (2006). The United States' federal system was formed when the pre-existing thirteen colonies decided to federate. Federalism can be defined as, "a system that divides political authority between a nation-state and sub-national polities within its territory so that both the national and sub-national polities directly govern individuals within their jurisdiction, and that confers both national and sub-national citizenships." *Id.* at 5. This means that in the United States, the individual states govern their own citizens, unless trumped by the Federal Constitution, federal laws, or a federal treaty. *Id.*

135 POLITICAL SYSTEM OF NETHERLANDS, AMSTERDAM.INFO (last visited Sept. 22, 2019). While the Dutch system is technically a constitutional monarchy, the monarch is widely considered to act primarily as a figurehead. *Id.* The Dutch people also enjoy a parliamentary democracy, which has been in place in Holland since 1848. *Id.*

136 *Kingdom of the Netherlands: One Kingdom – Four Countries; European and Caribbean*, MINISTRY OF FOREIGN AFFAIRS, (last visited Sept. 22, 2019).

137 Four autonomous Countries compose what is known as the Kingdom of the Netherlands: the Netherlands Aruba, Curaçao and St Maarten. *Id.* "The country of the Netherlands consists of a territory in Europe and the islands of Bonaire, Saba and St Eustatius in the Caribbean." *Id.*

138 *Id.*

139 *Id.*

140 See *Glucksberg*, *supra* note 30. Physician assisted suicide and euthanasia were areas that were of unsure Constitutional standing in the United States until the late 1990s. *Id.*

141 *Id.*

decisions.¹⁴² The doctrine of stare decisis only stands when the exact issue arising in litigation has already been decided.¹⁴³ The exact legal determination made by the Supreme Court in *Glucksberg* was that, “prohibition against ‘caus[ing]’ or ‘aid[ing]’ a suicide does not violate the Due Process Clause.”¹⁴⁴ Then, when the Supreme Court decided *Gonzalez v. Oregon*, they held that the Controlled Substances Act did not give the United States Attorney General the power to prohibit the doctors from prescribing lethal medications in states where physician assisted suicide had been made legal.¹⁴⁵ *Gonzalez* discussed medical aid in dying, but hinged almost entirely on issues of statutory interpretation and the legitimate role of the United States Attorney General.¹⁴⁶ Nonetheless, these two cases, taken together, effectively mean that, although there is no constitutionally protected right to medical aid in dying, the decision is one that should be left up to the states. The doctrine of stare decisis leads to the conclusion that if any district court, court of appeals, or the Supreme Court itself were to decide another case that questioned the constitutionality of a ban on physician assisted suicide, they would quickly be able to make their decisions based on prior cases. This is the issue facing advocates of medical aid in dying. However, stare decisis is not always the winning conclusion, especially in cases involving social issues.¹⁴⁷

At the end of our examination of this complicated, emotionally driven debate, we are left with a few key questions to consider: Is this an issue that should be dealt with nationally? Is restricting medical aid in dying to physician assisted suicide rather than euthanasia an important impediment or regulation? Is there a significant moral distinction between physician

142 *United States v. Quick*, 74 M.J. 332, 343 (C.A.A.F. 2015) (Stucky, J., joined by Ohlson, J., dissenting) (brackets in original) (citations omitted). “Stare decisis is defined as,

‘[t]he doctrine of precedent, under which a court must follow earlier judicial decisions when the same points arise again in litigation.’ The doctrine encompasses at least two distinct concepts ... : (1) ‘an appellate court[] must adhere to its own prior decisions, unless it finds compelling reasons to overrule itself’ (horizontal stare decisis); and (2) courts ‘must strictly follow the decisions handed down by higher courts’ (vertical stare decisis).” *Id.* (citations omitted).

143 *Id.*

144 See *Glucksberg*, *supra* note 30.

145 *Id.*

146 See *Levy*, *supra* note 124.

147 See generally *Brown v. Board of Ed. of Topeka, Shawnee County, Kan.*, 347 U.S. 483 (1954); *Mapp v. Ohio*, 367 U.S. 634 (1961); *Obergefell v. Hodges*, 367 U.S. 643 (2015). These three cases are arguably three of the most widely known cases of the Supreme Court going against precedent.

assisted suicide, euthanasia, and withdrawal of lifesaving medical treatment?

III. A NEEDED CHANGE

In order to affect change that will result in fair treatment of people across the country, there is a need for a uniform, national law legalizing physician assisted suicide and active voluntary euthanasia for mentally competent adults in America. However, permitting doctors to opt out of providing these services and incorporating a sunset provision like the one in California's law will allow for protection against the slippery slope and allow physicians to keep their hands 'clean.'

This is an issue of such fundamental importance, that it should not be left up to the states to determine. Public opinion has changed; in fact, it has been shown that the majority of the American public support the legalization of medical aid in dying.¹⁴⁸ Further, the restriction from euthanasia to physician assisted suicide really serves no health or safety purposes, and most American citizens do not believe there is any moral difference between physician assisted suicide and active voluntary euthanasia.¹⁴⁹ The only point that is furthered by such a regulation is that doctors are given "clean hands." However, some doctors would face no moral conflict if tasked with actively euthanizing someone, and that should be left up to the doctor and the patient. Physicians, of course, should not be forced to participate in these types of treatments. Allowing for euthanasia, furthermore, will allow people who have neuron diseases like amyotrophic lateral sclerosis (also known as ALS or Lou Gehrig's disease) to take advantage of medical aid in dying. For some people with these types of diseases, it becomes impossible for them to swallow on their own, thus introducing the need for accessible euthanasia if they choose to end their lives.

This being said, the restrictions in the state laws allowing for only adults to take their own lives and excluding children from the right to

¹⁴⁸ See generally, Timothy E. Quill et al., *The Debate Over Physician-Assisted Suicide: Empirical Data and Convergent Views*, 128(7) ANNALS OF INTERNAL MED. 552 (1998). Surveys have shown that somewhere between two thirds and three fourths of Americans are in favor of the legalization of medical aid in dying. *Id.* They also show that many Americans do not feel as though physician assisted suicide and active, voluntary euthanasia are morally distinct actions. *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.

¹⁴⁹ See Quill et al., *supra* note 148.

medical aid in dying should stay in place. There are many rights in America that adults have and children do not. This is based on mental development and unfortunately, there is no way to test whether someone is mature enough to make a decision like this, so the line has to be drawn somewhere. The law in the Netherlands drew that line at 12, but it is likely that in a more conservative country like America, allowing medical aid in dying for minors would cause much outrage. Additionally, the recent consideration of allowing euthanasia for mentally ill, depressed, and demented patients is highly controversial and perhaps pushing medical aid in dying too far. Such a law should be restricted to people with terminal illnesses.

The Netherlands takes a unified position on medical aid in dying, but there are some component parts of the various American laws that are beneficial and could serve the Netherlands or any other country grappling with the issue. For example, a sunset provision, requiring after ten years a re-affirmation process for the law, could be very beneficial in making sure that such laws stay current with public opinion and policy. Similarly, other American states or any other countries considering physician assisted suicide might find that such a provision in the law would make it easier to pass.

CONCLUSION

Physician assisted suicide and euthanasia have been considered acceptable in the Netherlands dating as far back as the 1970s.¹⁵⁰ This should be considered in stark contrast to the United States where physician assisted suicide has only been practiced in a handful of American jurisdictions since the 1990s.¹⁵¹

Moreover, there exist certain cultural and political dissimilarities between the two countries that have shaped the differing political landscapes. The United States deals with a federal system¹⁵² that does not exist in the Netherlands.¹⁵³ The Dutch as a whole are widely considered a

150 See Gevers, *supra* note 59.

151 See *supra* note 1.

152 See PBS, *supra* note 120.

153 See PBS, *supra* note 120. See also Wet Van, *supra* note 8.

more liberal, progressive people.¹⁵⁴ Medical aid in dying in the Netherlands is bolstered by a healthcare system where patients can afford treatment and often have meaningful relationships with their doctors.¹⁵⁵

Although the governmental systems and political landscapes of the two countries differ widely, both countries medical aid in dying laws provide sufficient safeguards to protect against opponents' concerns. Medical aid in dying is a controversial and emotional issue and not one that many people enjoy talking about. However, analyzing these issues can provide insight into how the law should develop in the future. After careful analysis of the history and existing law, it is clear there is a need for reform in the United States.

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154 *Why is Amsterdam so Tolerant?*, DUTCH AMSTERDAM, <http://www.dutchamsterdam.nl/171-why-is-amsterdam-so-tolerant> (last visited Sept. 22, 2019). "Dutch policies on recreational drugs, prostitution, same-sex marriage and euthanasia, are among the most liberal in the world." *Id.*

155 *See* Schuck, *supra* note 134.

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