Euthanasia and Physician-Assisted Suicide: The Dutch and Oregon Models

Renée Sanders
Senior Thesis
April 24, 2006
Acknowledgements

I would like to give special thanks to Professor Howard Kaye for his helpful comments and criticisms. Professor Kaye’s suggestions on many drafts of this paper were instrumental in its development. I would also like to thank my father, Roy Sanders, for his valuable comments and editing.
# Table of Contents

I. **INTRODUCTION** ......................................................................................................................... 1

II. **COMPARISON OF DEATH AND DYING IN THE NETHERLANDS AND THE UNITED STATES** .......................................................................................................................... 2

III. **LEGALLY ACCEPTABLE WAYS TO APPROACH DYING IN THE UNITED STATES** ................................................................................................................................. 3

IV. **THE LEGALIZATION OF EUTHANASIA IN THE NETHERLANDS** ................................................................................................................................. 5

V. **THE ‘SLIPPERY SLOPE’ ARGUMENT** ....................................................................................... 10

VI. **IS THE ‘SLIPPERY SLOPE’ UNDESIRABLE?** .................................................................................. 11

VII. **THE DUTCH GOVERNMENT ORDERED STUDIES** ...................................................................... 12

VIII. **ADDITIONAL EVIDENCE TO SUGGEST THAT THE DUTCH ARE, IN FACT, ON A DANGEROUS SLIPPERY** ......................................................................................................................... 16

IX. **DIFFERENCES BETWEEN THE NETHERLANDS AND THE UNITED STATES** ......................... 21

   A. The Physician-Patient Relationship .......................................................................................... 21

   B. The Legal Culture .................................................................................................................. 23

   C. Basic Healthcare Systems ................................................................................................... 25

   D. The Influence of First and Second-Party Decisions on End-of-Life Care ................................. 27

   E. Socioeconomic Differences .................................................................................................. 28

X. **IS THE NETHERLANDS AN APPROPRIATE MODEL FOR THE UNITED STATES TO FOLLOW?** ................................................................................................................................. 29

XI. **THE OREGON DEATH WITH DIGNITY ACT** ............................................................................. 30

   A. Provisions of the Oregon Death with Dignity Act .................................................................. 30

   B. The Practice of Physician-Assisted Suicide in Oregon .......................................................... 35

   C. The Case of “Helen” ............................................................................................................. 41

   D. The Case of Ms. Cheney ....................................................................................................... 42

XII. **LESSONS FROM OREGON: RECOMMENDATIONS FOR OTHER STATES TO CRAFT MORE CAREFUL LAWS LEGALIZING PHYSICIAN-ASSISTED SUICIDE** ................................................................. 43

   A. Ethics Committee Oversight Before PAS is Performed ...................................................... 44

   B. Careful Psychiatric Evaluation ............................................................................................ 45

   C. Consulting Physician Must be Independent of both the Physician and Patient .................. 45

   D. Focus on Palliative Care ....................................................................................................... 46

   E. Annual State Wide Evaluations, Which Include Confidential Surveys ................................. 46

XIII. **CONCLUSION** .......................................................................................................................... 46

**BIBLIOGRAPHY** ............................................................................................................................ 49
I. Introduction

Despite significant advances in palliative care, a vast number of people die in pain and suffering each year. According to various reports, pain is inadequately treated in dying patients between 20 to 70 percent of the time.1 Yet, with proper pain management, physicians should be able to adequately relieve a patient’s pain in 95% of cases.2 Euthanasia or physician-assisted suicide (PAS) would provide benefit to people whose physical suffering cannot be relieved in any other way and who wish to die a swift and painless death.3 However, along with the legalization of euthanasia and/or PAS, we risk additional unintended consequences, such as the killing of patients who have received inadequate palliative care, are not in intense physical suffering or who face financial or other pressures to obtain euthanasia or PAS. Moreover, we also risk falling down what many have called a ‘slippery slope’: the idea that the legalization of euthanasia and PAS will inevitably lead to practices that are considered unethical, such as non-voluntary or involuntary euthanasia.

Currently, the Netherlands and Belgium are the only countries in the world where euthanasia (and PAS) is legally permitted under certain circumstances and Oregon is the only

---

2 Emanuel SII 23.

3 Euthanasia is the intentional killing of a person for his or her supposed benefit. It may be voluntary, as when the person killed has requested that he or she be killed, involuntary, as when the person to be killed has expressed his wish to the contrary, or non-voluntary, as when the person to be killed has made no request nor given his or her consent. Unless otherwise specified, when I use the term euthanasia in this paper I am referring to voluntary euthanasia. Physician-assisted suicide is when a doctor provides a patient with the information and guidance to commit suicide. (“Euthanasia Definitions,” 2 April 2006, <http://www.euthanasia.com/definitions.html>)
state in the U.S. where PAS is legal (under the provisions of the Oregon Death with Dignity Act). In considering whether or not to legalize the practice of euthanasia and/or PAS in the United States, I will examine the Netherlands and Oregon as possible models to follow. In this paper, I will (1) provide a brief overview of basic similarities between how Americans and the Dutch approach dying; (2) examine legally acceptable ways to die in the United States; (3) assess the Dutch experience with euthanasia to date and in particular use empirical evidence about the practice of euthanasia and physician-assisted suicide in the Netherlands to argue that the Dutch are in fact on a ‘slippery-slope’; (4) explain why the Dutch experience with euthanasia might be expected to work even worse in the United States, a country that in many ways is vastly different from the Netherlands; (5) turn to the Oregon experience with the legalization of physician-assisted suicide as a possible compromise that may be more appropriate for the US context; and (6) make recommendations based on Oregon’s experience with PAS that will enable other states to craft more careful legislation and therefore ensure stricter regulation of its practice.

II. Comparison of Death and Dying in the Netherlands and the United States

The Netherlands and the United States are both advanced industrial democracies with a well-developed healthcare system and an average life expectancy of over 75 years. Both are in the fourth stage of the epidemiologic transition - a stage in development in which the majority of the population die from degenerative diseases, often ones that are late onset and have a slow, gradual decline. While people do still die of influenza, pneumonia, or other acute infectious diseases, many more die from heart disease, cancer, diabetes or other chronic or degenerative

---


5 Battin 401.
diseases. Unlike diseases that are rapid in onset and progression to death, these degenerative conditions offer some degree of control over the medical timing of death and, as a result, introduce room for human decision-making. This, in addition to advanced technologies and life-sustaining treatments, and an increasingly elderly population, leave Americans and the Dutch with the common problem of how to approach complex decisions about the medical timing of death and dying.

III. Legally Acceptable Ways to Approach Dying in the United States

In the United States, the practice of withholding or withdrawing treatment is widely accepted in patients with an extremely poor prognosis. For instance, a 1988 study showed that out of the 85% of people who died in a health care institution in the US, 70% had some type of life-sustaining treatment withheld. Moreover, in recent years, the practice of “passive euthanasia” has also included the administration of very high levels of morphine (which can hasten death) as well as the use of “terminal sedation.” In some cases, the decision whether to withhold or withdraw treatment is determined by the patient. For example, the patient may refuse treatment, or already have in place a DNR order, Living Will, or Durable Power of Attorney.

In cases where the patient is not competent, the decision to withhold or withdraw treatment may be determined by a second party. In fact, during approximately the past thirty years, a number of court decisions have provided a basic legal framework, which allows the practice of withholding or withdrawing treatment for incompetent patients based on the decision

---

6 Battin 401.
7 Battin 402.
8 Battin 402.
of physicians and family members.9 Beginning with the Quinlan case in 1976, the New Jersey Supreme Court ruled that a court appointed guardian could request withdrawal of life-sustaining treatment on behalf of an incompetent person.10 The court ruled that all person’s “independent right of choice” shall be protected, even if the person is not competent to make the choice on her own behalf. In the Quinlan case, the court saw, for example, no logical distinction between the choice to withhold or withdraw treatment that cannot be expressed by an incompetent patient and the choice that could be “made by a competent patient terminally ill, riddled by cancer and suffering great pain.”11 In its decision the court was careful to note that, “There is a real and in this case determinative distinction between the unlawful taking of the life of another and the ending of artificial life-support systems as a matter of self-determination.”12 The right to self-determination as applied to withholding and withdrawing life-sustaining treatment was affirmed in most of the court decisions in other states following Quinlan.13

In 1997, the United States Supreme Court made explicit the distinction between a person’s constitutional right to refuse treatment and the practice of physician-assisted suicide, by accepting the doctrine of double effect.14 The majority opinion in Quill stated that, “in some cases, painkilling drugs may hasten a patient’s death, but the physician’s purpose and intent is, or may be, only to ease the patient’s pain.”15 When life-sustaining treatment is withheld, the patient

9 Battin 402.
11 In re Quinlan, 70 NJ 10, 24 March 2006 <http://web.lexis-nexis.com/universe/document?_m=bfecc23c6bca5a63db7f11c69b72d6f9&_docnum=1&wchp=dGLbVzb-zSkVA&md5=df87255b4cd54a5371cfb711de9e58db>.
12 In re Quinlan, 70 NJ 10.
15 Vacco v. Quill, 117 S Ct 2293 (1997); quoted in Alpers 201.
dies of the underlying disease or illness. However, if a patient obtains physician-assisted suicide, he is killed by the lethal medication.\textsuperscript{16} Thus, terminally ill patients do \textit{not} have a constitutional right to obtain assistance in dying and state prohibitions against assisted-suicide are thereby deemed constitutional. While a number of cases of assisted suicide or active euthanasia do occur “under the table,” the only legally acceptable way to die in the US (with the exception of Oregon) involves withholding and withdrawing treatment and thus passively allowing the patient to die.

\textbf{IV. The Legalization of Euthanasia in the Netherlands}

In addition to withholding or withdrawing treatment or using painkillers which may, as a side effect, hasten death, patients dying in the Netherlands have another option not legally available to most of their American counterparts: euthanasia and PAS. Although euthanasia and physician-assisted suicide were not officially legalized by Dutch statute until 2001, their practice has been “legally tolerated” as the result of a number of court rulings beginning as early as the 1970s. In 1973, a case of euthanasia first received heightened media attention in the Netherlands. The physician was prosecuted for euthanizing her seventy-eight-year-old mother, at her request, and was only conditionally sentenced to one week in jail and one year of probation. In arriving at its decision, the court relied on the testimony of an expert medical witness, “who stated that it was no longer considered right for physicians to keep patients alive to the bitter end under certain conditions.”\textsuperscript{17} The case, however, remained a notable exception to

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{16} Vacco v. Quill 117 S Ct 2293 (1997), 26 March 2006 <http://web.lexis-nexis.com/universe/document?_m=7054bf720016c7f04a837d7d0b71e209&_docnum=1&wchp=dGLbVtz-zSkVb&_md5=ea658a051ed02bad2f2d21088b551491f>.
\item \textsuperscript{17} Herbert Hendin, “The Dutch Experience,” in Kathleen Foley and Herbert Hendin, \textit{The Case Against Assisted Suicide For the Right to End-of-Life Care} (Baltimore: The Johns Hopkins University Press, 2002) 99.
\end{itemize}
\end{footnotesize}
Dutch law: from 1969 to 1980, at least three people were prosecuted for assisting in another person’s suicide, at that person’s request and sentenced to between six and eighteen months in jail.\textsuperscript{18} It was not until 1981 that the conditions under which a physician might be justified in performing euthanasia or assisted suicide were first described. In 1981, when a layperson was found guilty of assisting in a suicide, the court noted that a physician might be exempt from punishment for killing a person experiencing unbearable suffering if the patient made a voluntary request, if no reasonable alternative existed and if the physician consulted with a colleague before acquiescing to the request.\textsuperscript{19}

In 1984, although assisting in a person’s suicide remained a crime according to the Dutch Penal Code, a Supreme Court decision held that a physician who performs assisted suicide may be justified in certain circumstances on the grounds of ‘necessity.’\textsuperscript{20} According to the Dutch Penal Code, a person who “commits an offense due to a force he could not be expected to resist [overmacht] is not criminally liable.”\textsuperscript{21} The physician’s defense of ‘necessity’ stems from a conflict of duties between the preservation of life and the relief of suffering. The physician is expected to act within the norms of medically acceptable practice and to use his professional expertise to objectively weigh this conflict based on the specific circumstances of the case. If, on balance, the patient’s suffering was so unbearable that the physician had no other reasonable choice except to perform euthanasia, then his decision was justified.\textsuperscript{22} The necessity defense is not extended to laypersons, and it is the physician’s unique ability to determine medical

\textsuperscript{19} Hendin in Foley and Hendin 99.
\textsuperscript{21} John Griffiths, Alex Bood, and Heleen Weyers, Euthanasia & Law in the Netherlands (Amsterdam: Amsterdam University Press, 1998) 326.
\textsuperscript{22} Griffiths 326-27.
necessity and to provide a person with a safe and gentle death that enables him to assist in suicide or perform euthanasia. Although the patient’s voluntary request is key, it is the physician’s clinical judgment rather than the patient’s autonomy that serves as legal justification for performing euthanasia or PAS in the Netherlands.\(^\text{23}\)

Shortly after the 1984 Supreme Court Decision the courts, the Royal Dutch Medical Association (RDMA), the Ministry of Justice, and the Dutch Health Council, established criteria under which physicians could perform euthanasia and assisted suicide. According to the guidelines, a physician is justified to perform euthanasia if he determines that the patient is experiencing unbearable suffering which cannot be relieved by any other means, if the patient’s request is voluntary, well-considered, and persistent, and if at least one other physician agrees with the decision.\(^\text{24}\) The physician is expected to report euthanasia or PAS as the cause of death and to notify the medical examiner, who in turn will inform the local prosecutor. The local prosecutor has the option to further investigate and / or bring the case to court. The Dutch Minister of Justice announced that as long as a physician followed the above guidelines he would not be prosecuted. It was not until 1993 that a statute passed which explicitly stated that a physician following the guidelines would not be prosecuted for violating Dutch Law, under which euthanasia was still technically illegal.\(^\text{25}\)

In the 1994 \textit{Chabot} case, the Dutch Supreme Court significantly expanded the ‘necessity’ defense for physicians. The court ruled that Dr. Chabot, a psychiatrist, was justified in euthanizing a recently divorced fifty-year old woman, Ms. B. Ms. B’s father and two sons had all died during the past five years and Ms. B had recently attempted suicide. Dr. Chabot concluded that Ms. B “was experiencing intense, long-term psychic suffering that, for her, was

\(^{23}\) Gorsuch 1355.

\(^{24}\) Hendin in Foley and Hendin 100.

\(^{25}\) Hendin in Foley and Hendin 100.
unbearable and without prospect of improvement.” Dr. Chabot’s did admit that Ms. B condition was treatable in theory; however, in his medical judgment and that of the experts he consulted, the treatment required would be long and have a low chance of success.

The Dutch Supreme Court ruled that Dr. Chabot was at fault only because he did not have his colleagues examine Ms. B in person before acquiescing to her request for euthanasia. Dr. Chabot was not punished in any way. According to the decision, a physician is justified in performing euthanasia or assisted suicide even in a case where the patient is not physically suffering, terminally-ill, or suffering from an untreatable condition. This represents a significant expansion from the 1984 guidelines since it is now a patient’s psychological suffering and desire to commit suicide rather than a physician’s objective clinical judgment that justifies a physician’s decision to comply with her request for euthanasia or PAS. Even John Griffiths, a Professor of Sociology of Law at the University of Groningen and leading advocate for the legalization of euthanasia and physician-assisted suicide in the Netherlands, has admitted that: “[T]he decision in Chabot may later be seen as having opened the way to a legal development that accepts assistance with suicide to persons who are not ‘sick’ at all (e.g. very elderly persons who are incapacitated in various ways and simply ‘tired of life’).” While Griffiths is careful to point out that such a development is not inevitable, I would argue that euthanazing a patient suffering from a condition that was treatable in principle is just as dangerous since it suggests that patient autonomy is decisive. What, for instance, will prevent additional patients who are suicidal as the result of a treatable psychiatric disorder from obtaining euthanasia and/or PAS?

26 Griffiths 332.
27 Gorsuch 1356.
28 Griffiths 153.
In 2001 the Dutch Parliament passed a statute, which officially legalized euthanasia and physician-assisted suicide under certain conditions. Euthanasia and assisted-suicide are permitted when 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 [held] 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.\(^29\)

Under these conditions, it is not required that the patient is terminally ill, or even physically suffering, only that the physician “holds the conviction” that the patient’s suffering is “lasting and unbearable” and the patient believes that there are no reasonable alternatives for his situation. Moreover, the requirements appear to place equal emphasis on the patient’s subjective judgment and the physician’s judgment about medical necessity. As a result, it is unclear whether the patient’s or physician’s judgment should be overriding in practice. After all, it is the “patient” who must “hold the conviction that there [is] no other reasonable solution” for his situation and it is unclear whether the physician’s “conviction that the patient’s suffering is lasting and unbearable” must be based on clinical judgment or on his assessment of the patient’s subjective state. As we have seen from the Chabot case, there clearly are instances where the patient’s autonomy proves decisive. Furthermore, the standards do not require a specific waiting period between a patient’s request for euthanasia and when it is performed and the patient is not required to request PAS or euthanasia in writing.\(^30\)

\(^30\) Gorsuch 1357-58.
V. The ‘Slippery Slope’ Argument

The important question to consider then becomes whether or not the practice of euthanasia in the Netherlands has been properly regulated so that it can relieve a patient’s unbearable suffering under specific circumstances, while avoiding the problem of the so-called ‘slippery slope.’ First it is important to define what we mean by the ‘slippery slope.’ If we consider the practice of euthanasia itself to be morally acceptable in some cases, then we still must consider whether or not legalizing it will lead to additional practices that are undesirable and / or unethical. According to Griffiths et al., there are two versions of the ‘slippery slope’ argument, a logical and an empirical one.31

According to the logical version, the legalization of euthanasia may logically lead to the practice of other types of termination of life which most would consider ethically unacceptable. For instance, it may be argued that if we allow the practice of euthanasia on the basis of individual autonomy, then there is no valid reason why we should not euthanize patients who are not suffering, or whose suffering does not have a physical cause. Or, for example, if we allow the practice of euthanasia based on the principle of beneficence then one might argue that, in certain cases, there is no valid reason not to allow non-voluntary euthanasia, if doing so will relieve a person’s pain and suffering, such as killing newborn infants with an extremely poor quality of life expected or killing comatose patients.32 When evaluating the logical version of the slippery-slope argument, however, we must be careful to keep in mind that the principles of autonomy and beneficence do not always provide clear and unambiguous answers and therefore do not necessarily lead to the acceptance of morally questionable practices. For instance, based

31 Griffiths 177.
32 Griffiths 177.
on the principle of beneficence, it may also be argued that non-voluntary euthanasia is unacceptable based on the fact that it is impossible to predict another person’s quality of life.

According to the empirical version of the slippery-slope argument, the legalization of euthanasia might cause a shift in norms, which will ultimately allow society to accept as reasonable other types of termination of life that we presently consider unethical. It may be argued, for example, that legalization will remove the taboo against killing and thus strongly undermine our sense of the value of human life, allowing us to tolerate non-voluntary euthanasia or to become quicker to accept voluntary euthanasia of patients in general.33

VI. Is the ‘Slippery Slope’ Undesirable?

Before evaluating whether or not the Dutch are presently on the ‘slippery slope’, we must first determine whether or not the slippery slope is necessarily undesirable. As Griffiths et al. point out, “the ‘slippery slope’ is itself a slippery customer, hard to pin down, usually more a bit of suggestive rhetoric than a serious argument.”34 While many have argued that the Dutch are on a dangerous ‘slippery slope,’ most fail to address what specifically about the slippery slope is problematic. Herbert Hendin, for example, argues that the legalization of euthanasia in the Netherlands has led to “an increase[d] tendency to free the physician from legal control” and has “encourage[d] involuntary euthanasia [sic].”35 An important question, though, is whether or not there is anything wrong with non-voluntary euthanasia (presumably what Hendin incorrectly calls involuntary euthanasia), either in practice or in theory.36 If the ultimate goal of legalization is, in fact, to relieve a patient’s unbearable suffering, then it might make sense to extend that

33 Griffiths 178.
34 Griffiths 299.
36 Griffiths 300.
right to patients who are not competent to request euthanasia. However, what objective criteria could be used to determine whether an incompetent patient’s suffering is unbearable and therefore euthanasia is acceptable? While there may be certain circumstances in which a physician can clearly judge that an incompetent person is in extreme physical pain, I would argue that we would be better off to continue to allow those very rare cases to occur “under the table,” or with increasing levels of morphine, if possible. D. J. Bakker, for example, writes, “Exceptions to the rule may exist but legalizing exceptions means promoting exceptions to rules and degrading rules to exceptions.” Following Bakker’s logic, if we legalize the practice of euthanasia, we risk normalizing exceptions and fundamentally altering how we deal with death and dying. Such a shift in norms would typify the empirical version of the slippery slope argument.

VII. The Dutch Government Ordered Studies

The Dutch government has commissioned three large-scale studies to assess the practice of euthanasia and physician-assisted suicide, one each in 1990, 1995, and 2001. The studies represent the first comprehensive quantitative data on the characteristics and incidence of euthanasia and PAS in the Netherlands. Gerrit van der Wal of the Institute for Research in Extramural Medicine at Vrije Universiteit in Amsterdam and Paul J. van der Maas of the Department of Public Health at Erasmus University in Rotterdam conducted all three studies and

38 Griffiths 207.
all were performed prior to the official legalization of euthanasia and PAS by Dutch statute in 2001.\textsuperscript{39}

The methods for all three studies included two parts. First, the researchers interviewed a random sample of approximately 400 physicians (both general practitioners and specialists) about their attitudes and practices regarding euthanasia and physician-assisted suicide. Second, the researchers examined a random sample of death certificates, and a follow-up questionnaire was sent to the physician indicated on the death certificate.\textsuperscript{40} A system was devised to ensure the anonymity of the physicians and patients, and physician interviews were conducted confidentially.\textsuperscript{41}

Table 1 presents the important findings of end-of-life practices from the interview studies with physicians in 1990, 1995, and 2001.

<table>
<thead>
<tr>
<th>End-of-Life Practices</th>
<th>Total Deaths (% [95% CI])\textsuperscript{†}</th>
<th>1990</th>
<th>1995</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Euthanasia</td>
<td>2447 (1.9% [1.6 – 2.2])</td>
<td>3118 (2.3% [1.9 – 2.7])</td>
<td>3088 (2.2% [1.8 – 2.5])</td>
<td></td>
</tr>
<tr>
<td>Assisted Suicide</td>
<td>386</td>
<td>542</td>
<td>140</td>
<td></td>
</tr>
</tbody>
</table>

\textsuperscript{39} Gorsuch 1359.
\textsuperscript{40} Gorsuch 1359.
\textsuperscript{42} Percentages of deaths and 95% CIs for 1990 and 1995 were based on Table 1 in van der Maas \textit{et al.} 1701. Percentages of deaths and 95% CIs for 2001 were based on Table 1 in Bregie D Onwuteaka-Philipsen, Agnes van der Heide, Dirk Koper, Ingeborg Keij-Deerenberg, Judith A C Rietjens, MetteLRurup, Astrid M Vrakking, Jean Jacques Georges, Martien T Muller, Gerrit van der Wal and Paul J van der Maas, “Euthanasia and other end-of-life decisions in the Netherlands in 1990,1995, and 2001,” \textit{The Lancet} 362 (2003): 396. The total number of deaths for each end-of-life practice in 1990, 1995, and 2001 were extrapolated from this information.
As Table 1 displays, in 1990 1.9% of all deaths in the Netherlands (or 2447 deaths) resulted from euthanasia, and an additional 0.3% (or 386 deaths) resulted from physician-assisted suicide. In 1990, a greater number of people in the Netherlands died from euthanasia than from HIV, leukemia and homicide combined (1414). By 1995, the rates of euthanasia and PAS had increased to 2.3 and 0.4 percent of total deaths, respectively (a 27 and 40 percent increase from 1990 rates, respectively). In the report of the 1990 study, Van der Wal and Van der Mass actually predicted that the overall frequency of medical decisions to end a patient’s life would increase due to the increasing percentage of the population that is elderly, the increasing age of death of the average person, the increasing percentage of deaths from cancer in comparison to total deaths, and advances in the life-sustaining technologies. While it is possible that an aging population may have contributed to the overall increase, it is difficult to believe that those variables alone could be responsible for such a large increase in the incidence of euthanasia and PAS. At the same time, however, it is also important to note the overlapping confidence intervals for each category of end-of-life practices in 1990 and 1995. Thus, while the data do suggest a trend towards higher rates of euthanasia and PAS, these results are far from conclusive.

As Table 1 displays, the frequency of both euthanasia and PAS did decrease from 2.3 to 2.2 percent and 0.4 to 0.1 percent, respectively, between 1995 and 2001, and the rate of life

<table>
<thead>
<tr>
<th>Ending Patient’s Life Without an Explicit Request</th>
<th>(0.3% [0.2 – 0.4])</th>
<th>(0.4% [0.2 – 0.5])</th>
<th>(0.1% [0.0 – 0.2])</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1030</td>
<td>949</td>
<td>842</td>
</tr>
<tr>
<td></td>
<td>(0.8%[0.6-1.1])</td>
<td>(0.7% [0.5 – 0.8])</td>
<td>(0.6% [0.4 – 0.9])</td>
</tr>
</tbody>
</table>


43 Gorsuch 1360; See also Table 1: Numbers and Rates of Registered Deaths Netherlands 1990, World Health Organization, 15 March 2006 <http://www3.who.int/whosis/mort/table1_process.cfm>.
44 Gorsuch 1360.
45 Griffiths 211.
ending without the patient’s explicit request also decreased from 0.7 to 0.6 percent. However, the validity of these claims may be called into question. In both the 1995 and 2001 Dutch reports there were “visible efforts at damage control.”\textsuperscript{46} While a substantial amount of good research was included in these reports, evidence suggests that the reports have become more defensive against claims of an increasing rate of euthanasia (both voluntary and non-voluntary) and therefore less useful in assessing trends in the frequency of euthanasia over time.\textsuperscript{47} For instance, it was reported in the 1995 study that the number of deaths that resulted from the use of large doses of painkillers for the express purpose of ending a patient’s life was significantly reduced from 16.3 percent in 1990 to 14.7 percent in 1995.\textsuperscript{48} These results, however, may be influenced by a rather significant change in the method of interrogation of the physicians: in 1995 interviewers were simply less likely than in 1990 to accept a physician’s statement that opioids were intended to kill the patient, and some even went so far as to suggest to interviewees other possible reasons a physician may use painkillers. Moreover, the methods of questioning were changed even more dramatically in the 2001 study. In 2001, interviewers simply did not ask physicians who said they had used painkillers to intentionally cause death whether it was done with or without the patient’s consent. As a result, cases of involuntary euthanasia were omitted altogether from the 2001 study and the reported incidence of non-voluntary euthanasia was also most certainly affected.\textsuperscript{49}

Perhaps even more problematic is the fact that the authors of the 1995 report do not appear to be concerned about the high number of cases of termination of a patient’s life without an explicit request. In fact, the authors of the report write that “apparently it is difficult to avoid

\textsuperscript{47} Fenigsen 78.
\textsuperscript{48} van der Mass \textit{et al.} 1701.
\textsuperscript{49} Fenigsen 78.
this kind of action”\textsuperscript{50}. As Fenigsen points out, the authors then proceed to “repeat their bizarre assertion of five years ago that it is the patient who is responsible for avoiding termination of his or her life: if he does not wish euthanasia, he should state it clearly, orally and in writing, well in advance”\textsuperscript{51}. Given the author’s assertion, it is not difficult to imagine that elderly or disabled may feel nervous about entering a hospital or nursing home in the Netherlands for fear that they might be euthanized. It is also alarming to think that not all members of society may be aware that their wish not to euthanized must be made clear both “orally and in writing” and “well in advance”. One could interpret Van der Wal and Van der Mass’ statement to mean that a physician has a right to use his clinical judgment to euthanize a patient if necessary and it is an individual’s duty to protect himself against euthanasia. The poor and uneducated, in particular, are much more likely to be disproportionately affected by such a requirement. Clearly such a right would be a significant expansion from the original ‘necessity’ defense of physicians invoked by the Dutch Supreme Court as early as 1984.

\section*{VIII. Additional Evidence to Suggest that the Dutch are, in fact, on a Dangerous Slippery Slope}

Equally alarming is the fact that a number of the leading authorities on euthanasia seem to be quite comfortable with the practice of non-voluntary and involuntary euthanasia. In fact, a 1998 study based on interviews with 28 of the leading experts in the Netherlands on euthanasia revealed that most interviewees saw no problem with the practice of hastening the death of a

\textsuperscript{50} G. van der Wal and P.J. van der Maas, “Euthanasie en andere medische beslissingen rond het levens einde: De prektiuk en de toetsing procedure [“Euthanasia and Other Medical Decisions Concerning the End of Life: The Practice of the Notification Procedure”] (The Hague, 1996); quoted in Fenigsen 75 (also translated by Feingsen).

\textsuperscript{51} Fenigsen 75.
patient without their explicit request.\textsuperscript{52} In the study, interviewees were specifically asked the question, “Some of the most worrisome data in the two Dutch studies are concerned with the hastening of death without the explicit request of patients. There were one thousand cases (0.8\%) without an explicit and persistent request in 1990, and nine hundred cases (0.7\%) in 1995. What is your opinion?\textsuperscript{53} Most saw no problem with the practice, and noted that most of these patients have cancer, PVS, or are newborns with extreme complications or people who are suffering and are expected to die within hours or days. A number of respondents noted that physicians performing euthanasia on these patients are simply attempting to alleviate the pain and suffering of patients with an extremely poor prognosis during the end of their life.\textsuperscript{54} While these authorities are justified in arguing that in severe cases it might be necessary to replace patient autonomy with a physician’s clinical judgment (or medical necessity), the fact that they appear to be unaware of (or unwilling to admit to) the potential problems and abuses that must be safeguarded against, particularly when dealing with non-voluntary euthanasia, is rather troubling. For instance, none of the authorities surveyed questioned whether physicians who performed euthanasia were knowledgeable about palliative care and therefore able to adequately relieve a patient’s pain if medically possible. None questioned the motives of physicians or saw any reason why a physician would euthanize a patient without sufficient medical necessity. As Cohen-Almagor points out, “They argued that, of course, criminals exist in every society, in every sphere of life, but policy is not built around this small number of criminals.”\textsuperscript{55} If we are, however, to legalize exceptional practices (such as euthanasia and PAS), all possible safeguards must be in place to protect against negligence or abuse.

\textsuperscript{53} Cohen-Almagor 244.
\textsuperscript{54} Cohen-Almagor 244.
\textsuperscript{55} Cohen-Almagor 255.
Current policies regarding euthanasia of infants suggest that a legal tolerance has developed in the Netherlands which extends the right to euthanasia to infants who have an extremely poor quality of life expected. In 2002, Eduard Verhagen and Pieter Sauer, two physicians at the University Medical Center Groningen, developed the Groningen protocol, for cases of euthanasia for infants whose suffering cannot be relieved in any other way and whose expected quality of life is extremely poor. Verhagen and Sauer define three categories of infants. Group 1 infants are expected to die, even despite medical treatment. Group 2 infants are expected to die if life-sustaining treatment is withheld. These infants could survive with advanced medical treatment, but their expected quality of life is extremely low. Group 3 includes infants who are not dependent on life-sustaining technology, but “whose suffering is severe, sustained, and cannot be alleviated”. It is predicted that “life [for these infants] will be full of suffering without any hope of improvement”. In group 1 infants, treatment is considered futile and it is considered acceptable practice in Europe and the United States to withhold or withdraw treatment. In the case of group 2 infants, withholding life-sustaining treatment for an infant with an extremely poor prognosis is also considered acceptable practice in Europe and the United States. For category 3 infants, Verhagen and Sauer argue that it may be reasonable to conclude that in certain situations the death of these infants would be more humane than allowing them to live.

The Groningen protocol, which was developed in conjunction with the district attorney in 2002, provides guidelines and requirements for physicians performing euthanasia on infants with a very poor expected quality of life. According to the protocol, the following guidelines must be fulfilled:

57 Verhagen and Sauer Pediatrics 736.
The diagnosis and prognosis must be certain
Hopeless and unbearable suffering must be present
The diagnosis, prognosis, and unbearable suffering must be confirmed by at least one independent doctor
Both parents must give informed consent
The procedure must be performed in accordance with the accepted medical standard58

Infants in all three categories may be euthanized under the Groningen protocol provided they meet the above criteria. The criteria are clearly based on medical necessity, as it is the physician’s judgment that the infant is experiencing “hopeless and unbearable suffering” which justifies euthanasia. Parents are required to give informed consent; however, they need not initiate the request for euthanasia. While a physician following the Groningen protocol may still be prosecuted, it is clear from the development of this protocol that the practice of non-voluntary euthanasia of infants is being “legally tolerated” in the Netherlands. Of the 22 cases of euthanasia reported to the district attorney’s office following this protocol (as of 2005), none of the physicians were prosecuted.

The development of the Groningen protocol represents a significant expansion from the requirements for euthanasia and PAS according to the 2001 statute passed by the Dutch Parliament. Infants in category 3 (“stable infants with a hopeless prognosis, not dependent on technology”59) do have an extremely low quality of life expected. However, this does not necessarily mean “hopeless and unbearable suffering” (as the guidelines of the Groningen Protocol require). One could argue that someone with severe physical disability and mental retardation may themselves experience no amount of suffering and that the apparent hopelessness of their situation is determined solely based on judgments about expected quality of life. Verhagen and Sauer explicitly write, “Not only survival of the infant but also the condition

in which the child will survive, the quality of life, is extremely important”. Thus, to a large extent, there is a slippery slope inherent even in the definition of the third category of neonates included in the Groningen Protocol. What criteria, for example, can be used to determine if a person’s life will be one of “hopeless and unbearable suffering”? And what, if anything, will prevent decisions about euthanizing infants from moving beyond quality of life concerns to practical considerations, such as the high cost of medical care for disabled children? Already, with the exception of France, non-voluntary euthanasia of infants occurs much more frequently in the Netherlands than in other European countries. In the Netherlands and France 47 and 73 percent, respectively, of NICU physicians had administered a drug for the purpose of euthanizing an infant, while only 2-4% of NICU physicians had done so in other European countries (Italy, Spain, Germany, UK, and Sweden).61

Also noteworthy, the three categories of infants defined in the Groningen Protocol are the same categories of infants outlined in a policy statement published in 2001 by the Ethics Working Group of the Confederation of European Specialists (CESP) in Pediatrics (of which Sauer was a principal member). One of the main ethical principles articulated by the CESP was that, “Every form of intentional killing should be rejected in paediatrics. However, giving medication to relieve suffering in hopeless situations which may, as a side-effect, accelerate death, can be justified.”62 In contrast, intentional killing is justified in certain circumstances for infants in all three categories according to the Groningen Protocol. Thus, while the three

---

60 Verhagen and Sauer, Pediatrics, 737.
categories of newborns and the types of infants that fall into each category have remained the same, it is the ethical principles and standards of acceptable medical practice that have expanded.

IX Differences Between the Netherlands and the United States

How good a model is the Dutch practice of euthanasia for the United States? We have seen that the Dutch experience with the legalization of euthanasia has produced a number of undesirable consequences in the Netherlands, which I have argued make the practice of voluntary euthanasia beyond effective control. As a country facing the question of whether or not to legalize euthanasia, we must consider whether the Dutch model would be both appropriate and effective in the US context. Important cultural, social, and healthcare differences between the US and the Netherlands, suggest that the Dutch model would produce an even greater number of undesirable consequences if applied to the United States.

A. The Physician-Patient Relationship

The nature of the physician-patient relationship is very different in the Netherlands and the United States. In the Netherlands a *huisarts* (literally meaning house doctor) acts as the general practitioner or family physician. The *huisarts* generally lives in the neighborhood, has offices in his or her home, and makes house calls for patients on a regular basis. The *huisarts* typically is the doctor for all family members and for most neighbors, and will stay with the family until he or she retires.⁶³ Moreover, approximately 50 percent of people in the Netherlands die at home. During this time, the *huisarts*, in addition to a visiting nurse and other staff, will typically make frequent house calls and provide continuous care in the patient’s home, usually

---

⁶³ Battin 411.
after it is determined that aggressive treatment in the hospital setting has become futile and the
patient has returned home to die.\textsuperscript{64}

In contrast, approximately 80 percent of Americans die in a hospital or other institution.\textsuperscript{65}

In the US it is very rare that a physician will make a house call and many people, especially the poor, do not even have a long-term primary care physician. Instead these patients often receive medical care from staff at a clinic, emergency room physicians, or residents or interns rotating through a hospital.\textsuperscript{66} As a result, American physicians generally do not achieve as great a continuity of care with dying patients and their families as their Dutch counterparts. Clearly, the difference in the dynamics of the doctor-patient relationship would dramatically affect how well physicians know a patient and understand his request for euthanasia. Presumably, Dutch physicians are in a better position than American physicians to determine if a patient’s request for euthanasia is the result of a rational, well thought-out choice. The Dutch physician may be more likely than his American counterpart, for instance, to know if there are additional factors influencing a patient’s decision to request euthanasia or PAS, such as home life or financial concerns. Furthermore, Dutch physicians also appear to be less likely to accept concerns about financial matters and being a burden on family as justification to provide increasing morphine or PAS to a patient. According to a study published in the \textit{Archives of Internal Medicine}, 24 percent of Oregon physicians found it acceptable to increase morphine to a patient who was fearful of being a burden on family and/or friends, whereas only 6 percent of Dutch physicians agreed. Moreover, 24 percent of Oregon physicians found it acceptable to provide PAS to a patient who “has well-controlled pain and can continue self care but is increasingly concerned

\textsuperscript{64} Margaret Pabst Battin, “Should We Copy the Dutch? The Netherlands’ Practice of Voluntary Active Euthanasia as a Model for the United States,” in Robert I. Misbin, \textit{Euthanasia: The Good of the Patient, the Good of Society} (Frederick: University Publishing Group Inc., 1992) 98.

\textsuperscript{65} Battin in Misbin 98.

\textsuperscript{66} Battin in Misbin 98.
over the burden that deterioration and death will place on his or her family”, whereas only 9 percent of Dutch physicians agreed. This suggests that differences in the doctor-patient relationship or other differences between the US and the Netherlands may influence a physician’s likelihood of acquiescing to a patient’s request for PAS. In particular, it appears that American physicians may place greater emphasis on patient autonomy, rather than medical necessity in determining whether or not to acquiesce to a patient’s request for PAS.

B. The Legal Culture

A second difference concerns the legal systems in the United States and the Netherlands. In the US lawyers play a much greater role in the medical climate, and the rate of malpractice is significantly higher than in the Netherlands. As a result, fears of medical malpractice color the decisions physicians make in managing a patient’s care, including the medical timing of death, to a much greater extent in the United States than in the Netherlands. American physicians, for example, are much more likely than their Dutch counterparts to continue to treat patients even when the medical efficacy of the treatment remains questionable or when the patient’s desires are not clear.

Additionally, the Dutch and American legal systems are structured differently. In the Netherlands, a single set of statutes applies to the entire country. As Eugene Sutorius, a Dutch lawyer and leading advocate for the legalization of euthanasia, describes the Dutch legal system: “The system of criminal justice is centralized under the Ministry of Justice, [which] has broad discretion… Prosecutions are not necessarily adversarial; prosecutors may bring cases to

---

68 Battin in Misbin 98.
establish legal precedents [rather than to punish wrongdoing].” The conditions of due care for performing PAS and euthanasia developed as the result of a series of court decisions, which established legal precedents based on criminal cases. The centralization of the criminal justice system enabled the Dutch to conduct a nationwide trial period before the official legalization of euthanasia and PAS, during which physicians would not be prosecuted for assisting in another person’s suicide (which is prohibited according to article 294 of the Dutch Criminal Code) as long as they followed the conditions of due care. In contrast, the legal system in the United States does not appear to make a nationwide trial period possible. In the US the civil and criminal justice systems are decentralized. Local, state and federal branches have the power to make and enforce laws. The United States Constitution supersedes all laws in violation of it, but laws on the federal, state, and local levels may vary widely, even among states. Thus, individual states in the US may choose to formally legalize physician-assisted suicide, and Oregon is the only state where PAS is currently legal. Questions, however, remain about how representative Oregon is of the rest of the nation, and it is thus difficult to generalize Oregon’s experience with PAS to the nation as a whole. For instance, almost 87 percent of the Oregon population is white (as opposed to 75% of the US population). It is possible, for example, that when physicians and patients have different cultural backgrounds it is more difficult to discuss end-of-life issues such as PAS and euthanasia. In a large city, such as New York, with a high population of minorities the practice of PAS and euthanasia might be dramatically different than in the state of Oregon. The nationwide test in the Netherlands therefore provides a more accurate prediction of the consequences of legalizing euthanasia and PAS on a national scale in

---

70 Smith 112.
the Netherlands than the Oregon experience or any other “experiment” that would be possible in the United States.

**C. Basic Healthcare Systems**

The basic healthcare systems of the United States and the Netherlands are fundamentally different. The Netherlands has a system of universal healthcare coverage, whereas approximately 15.7 percent of the American population (or 46 million Americans – more than double the entire Dutch population) are currently uninsured.72 In the Netherlands, health insurance includes a mix of both private and public insurance. The system is structured based on a person’s ability to pay. Those who cannot afford health insurance are provided free governmental coverage, while those beyond a certain annually determined income level must obtain health insurance on a voluntary basis.73 Of the total population, approximately 69 percent have public health insurance and 31 percent obtain mandatory private insurance. More than 85 percent of healthcare expenditure comes from public funds (social insurance, private insurance, and tax subsidies), approximately 4 percent comes from general taxes, and 8 percent is obtained through co-payments.74

Since patients in the Netherlands do not directly pay for medical treatment, personal finances are unlikely to play a role in decisions about euthanasia or terminal care. Nevertheless, economic concerns of those who are paying for healthcare, whether through public funds or private insurance, may play a role in policy decisions. In the Netherlands, when restrictions are

---

applied to medical care a patient may receive, those restrictions are uniformly applied, regardless of a patient’s ability to pay. Thus, while it is still possible that the high cost of treatment will place societal pressures on patients to obtain and / or physicians to recommend euthanasia and PAS, additional pressures on vulnerable minority groups (such as the poor or uneducated) is largely nonexistent in the Netherlands. Moreover, in the Netherlands, many services for patients related to end-of-life or terminal care are covered by insurance, such as at-home physician and nursing care, home respite care, physical therapy, and more. In contrast, in the United States, even for patients with adequate health insurance, many services are not covered or have high co-pays. 75 Thus, individuals dying in the Untied States, are often forced to take financial constraints into account in a way that people in the Netherlands are not, and as a result, both patient choices and physician recommendations about treatment options may be colored by financial concerns. 76 Since euthanasia or PAS is generally the least expensive option, some may feel financial pressures to be euthanized or obtain PAS.

In a society that lacks national health insurance, the costs of end-of-life care simply cannot be ignored. According to 1996 figures, approximately 10 to 12 percent of the total health care budget and 27% of Medicare budget were spent on end-of-life medical care. 77 In fact, more than 2 out of every 8 dollars expended on Medicare is used during the last year of a person’s life, and as much as 1 out of every 8 dollars is used during the last month. 78 Furthermore, according to 1995 figures, Medicare expends, on average, $30,397 during the last year of a cancer patient’s life, assuming that they receive conventional medical care. Of that $30,397, 33 percent (or

75 Battin 412.
76 Battin 412.
78 Felicia Cohn and Joanne Lynn, “Vulnerable People: Practical Rejoinders to Claims in Favor of Assisted Suicide,” in Foley and Hendin 238.
$10,118) is spent in the month preceding death, and 48 percent (or $14,507) in the last two months of life.\textsuperscript{79}

Health insurance providers are forced to ration medical resources in order to maximize profits (as is the case for private companies) or to meet yearly budgets (as is the case for Medicare and Medicaid). Considering the high cost of care during the final stage of a person’s life, the elderly and terminally ill may be disproportionately targeted by efforts to save money. While efforts to eliminate futile and unnecessary treatments for terminally-ill and elderly patients may very well be beneficial, by legalizing euthanasia we normalize its practice and thereby run the risk that subtle coercion may be placed on patients to request euthanasia. While those with substantial personal savings may be able to pay out of pocket for services not covered by insurance, “[t]hose without such resources… may have to choose among recommended services, face bankrupting their families, or go without much-needed health care altogether”.\textsuperscript{80} It is therefore an unfortunate reality that some people facing the end-of-life may feel as if they have a duty to die in order to relieve family members of financial burdens. While financial considerations may play a role in policy decisions in the Netherlands, this will arguably be worse in the United States where individual companies must compete in order to make a profit.

\textbf{D. The Influence of First and Second-Party Decisions on End-of-Life Care}

Another substantial difference between the Netherlands and the United States concerns the types of cases that have been brought before the lower and supreme courts regarding end-of-life issues. In the Netherlands the significant court cases, which established and / or refined


\textsuperscript{80} Cohn and Lynn in Foley and Hendin 239.
guidelines under which euthanasia and PAS are permitted, have primarily involved physicians aiding patients who are competent to make autonomous decisions about the medical timing of their death. In contrast, in the US almost all significant court cases have involved second party decisions. The legal precedents beginning with Quinlan in 1976 and continuing with Saickewicz, Spring, Eichner, Storar, Conroy, Brophy, Jobes, and Cruzan have all involved end-of-life decisions about another person’s life. In each case, the patient was incompetent and it was therefore necessary that another person make the decision about whether or not to withhold or withdraw treatment. While many of these cases do consider what the patient would have wanted if he were able to communicate his desire, all of these cases went beyond the range of autonomous decisions a competent patient could legally make about the medical timing of his death and established in law that second parties can make requests to withhold or withdraw life support for incompetent patients. As we have seen, in recent years the legally acceptable practice of euthanasia in the Netherlands has been extended in certain circumstances to patients who are not competent to make a first-party decision, such as infants with an extremely low quality of life expected. Given the legal precedents in the United States, it is possible that the extension of a right to euthanasia and PAS to incompetent patients would be likely to occur with just as high a frequency, or perhaps an even greater frequency, in the United States than in the Netherlands.

E. Socioeconomic Differences

There are a number of differences in socioeconomic factors between the Netherlands and the United States that influence the practice of euthanasia. First of all, there is much larger economic inequality between the rich and poor in the United States. Along with such disparities

---

81 Battin in Misbin 100.
come differences in the quality of healthcare a patient receives (including access to preventative care), general nutrition, knowledge about healthcare, and others. In comparison to the United States, the Netherlands is a much smaller, more homogeneous nation, which tends to be more tolerant of alternate lifestyle choices or points of view. The United States has a much greater amount homelessness, racism, disparities between rural and urban living conditions, and language barriers between physicians and non-English speaking minorities than the Netherlands. As a result, the Dutch model cannot accurately predict the impact that the legalization of euthanasia and PAS will have on disadvantaged groups in the United States. It is possible, for example, that disadvantaged groups in the US will feel extreme financial pressures to be euthanized or obtain PAS. Alternatively, it is also possible that the rate of euthanasia and PAS will be extremely low among minority groups due to mistrust of medical authority among certain groups, such as African Americans, and the absence of a well-established relationship of individual members of minority groups with a single primary care physician. Additionally, because of concerns about becoming vulnerable to lawsuits, some American physicians may actually be reluctant to euthanize a patient or comply with a request for PAS due to the patient’s ethnic, racial, or religious background.

X. Is the Netherlands an Appropriate Model for the United States to Follow?

Differences between the Netherlands and the United States in the nature of the physician-patient relationship, the legal culture surrounding medical decisions, the basic healthcare systems which colors the extent to which patients and physicians must consider financial constraints when making medical decisions, the influence of first and second-party decisions on end-of-life care, and basic social differences are rather significant. As a result, the Dutch model cannot

---

82 Battin in Misbin 101.
accurately predict the consequences of legalizing euthanasia and PAS in the US. The Netherlands therefore might not provide an appropriate model for the United States to follow. Does this mean, however, that both euthanasia and PAS should not be legalized in the United States? Next, we will turn to the practice of physician-assisted suicide in Oregon (the only state in the United States where it is currently legal) as a possible model to follow that may be more appropriate for the US context.

**XI. The Oregon Death with Dignity Act**

In November 1994, Oregon voters passed the Death With Dignity Act by a narrow margin of 51% to 49%. Implementation, however, was initially postponed due to a series of legal challenges. In the November 1997 general election, when a measure was placed on the ballot to repeal the Death with Dignity Act, sixty percent of Oregon voters rejected the measure, thus retaining the Death with Dignity Act. Currently, Oregon is the only state in the US where physician-assisted suicide is legal.\(^{83}\) As we will see in the next section, the Oregon law differs from that of the Netherlands in two fundamental ways: only physician-assisted suicide (and not euthanasia) is legal in Oregon and intolerable suffering (a basic condition that must be met in the Netherlands) is not required in Oregon.\(^{84}\)

**A. Provisions of the Oregon Death with Dignity Act**

The Oregon Death with Dignity Act permits a physician to prescribe lethal medication to a competent, terminally ill patient at his request. The act legalizes PAS under certain

---

\(^{84}\) Foley and Hendin, “The Oregon Experiment” in Foley and Hendin 144.
circumstances, but explicitly prohibits euthanasia. In order to qualify for PAS under the Death with Dignity Act, a patient must be a resident of Oregon over the age of eighteen. In addition, the patient must be “[a]n adult who is capable… and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die”. In the statute, “capable” is defined to mean “that in the opinion of the court or in the opinion of the patient’s attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to communicate health care decisions to health care providers.” A “terminal disease” is defined to mean, “an incurable and irreversible disease that… will, within reasonable medical judgment produce death within six months.”

A patient who meets these criteria must make a written request for medication to end his life in a “humane and dignified manner” by filling out a patient request form. The signing of the request form must be “witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request”. At least one of the witnesses cannot be a relative, cannot stand to inherit anything from the patient’s estate, and cannot be an employee of the hospital or facility where the person is a patient.

---

87 Oregon Review Statute § 127.805(1); quoted in Gorsuch 1371.
88 Oregon Review Statute § 127.805(3); quoted in Gorsuch 1371.
89 Oregon Review Statute § 127.805(12); quoted in Gorsuch 1371.
90 Oregon Review Statute § 127.805(1); quoted in Gorsuch 1371.
The law stipulates that an attending physician must initially determine that the patient has a terminal disease, is capable of making a request, and has requested PAS voluntarily. The attending physician must inform the patient of:

(a) his or her medical diagnosis;
(b) his or her prognosis;
(c) the potential risks associated with taking the medication to be prescribed;
(d) the probable result of taking the medication to be prescribed;
(e) the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.\(^{92}\)

The attending physician must then refer the patient to another physician who must confirm each of these assessments. If either the attending or consulting physician determines that the patient may be depressed or suffering from a psychiatric or psychological disorder the patient must be referred for counseling and lethal medication cannot be prescribed until “the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.”\(^{93}\)

Once the above conditions are met, the attending physician may prescribe a lethal dose of medication. The patient must make at least two oral requests to end his life “in a humane and dignified manner” spaced at minimum fifteen days apart, as well as a written request at least forty-eight hours before the physician’s prescription. The patient has a right to rescind his request at any time and the physician must explicitly ask the patient if he wants to rescind his request before he writes the lethal prescription.\(^{94}\) All physicians who comply in good faith with the provisions of the Death with Dignity Act are protected from criminal prosecution and professional sanctions for assisting in a patient’s suicide.\(^{95}\) Good faith compliance, for example,

\(^{92}\) Oregon Review Statute 127.815 §3.01 in Haley and Lee 58.
\(^{93}\) Oregon Review Statute § 127.825; quoted in Gorsuch 1371.
\(^{94}\) Oregon Review Statute 127.840 §3.07 in Haley and Lee 58.
\(^{95}\) Gorsuch 1372; see also Oregon Review Statute 127.865 §3.11 via LexisNexis <http://web.lexis-
allows the physician to be present when the patient ingests the lethal medication, even though this is technically illegal according to the definition of PAS.\textsuperscript{96} Beyond this, however, it is unclear what constitutes “good faith compliance” with the Act.\textsuperscript{97}

The attending physician is required to maintain records for each patient who obtains a lethal prescription, including each written and oral request for PAS, the patient’s diagnosis and prognosis, determination that the patient was capable, voluntarily requested PAS, and was fully informed about his or her condition and treatment options, determinations from the consulting physician, and reports of counseling, if relevant. According to the Death with Dignity Act, the Oregon Department of Human Services is required to review a sample of these records on an annual basis.\textsuperscript{98} As mandated by the Oregon Department of Health Services (DHS), each time a physician writes a lethal prescription, he is required to submit information to DHS, which documents that he has complied with the Death with Dignity Act. The Oregon Department of Health Services claims that it reviews all physicians’ reports and, if necessary, will speak to the physician to clear up any “missing or discrepant data”.\textsuperscript{99}

Although the Oregon law is very detailed, a number of practical questions still remain. For instance, it is unclear from language of the Act whether or not a physician who determines that a patient has less than six months to live must do so under the assumption that a patient will receive standard medical care.\textsuperscript{100} Can, for instance, a physician legally provide PAS to a cancer patient who refuses chemotherapy, but would have a relatively high chance of survival if he

\textsuperscript{96} ORS 127.885 §4.01 in Haley and Lee 59.
\textsuperscript{97} Haley and Lee 51.
\textsuperscript{98} Gorsuch 1372.
\textsuperscript{100} Gorsuch 1372.
underwent treatment? The legal principle of an individual’s right to refuse life saving treatment suggests that a physician can provide PAS under such circumstances. The case of “Helen” (described further in part C of this section) further supports that a physician can diagnose a patient as “terminally ill” under the Oregon Death with Dignity Act, even if the patient chooses to forgo currently available treatment. Also of concern, physicians often report that it is very difficult to accurately predict how long a patient has to live, one of the fundamental requirements of the Act. Of Oregon physicians surveyed who were not morally opposed to the practice of PAS, fifty percent were not confident in their ability to predict that a patient will die within six months.\(^{101}\) Thus it is not surprising that in 2005 as long as 1009 days (or approximately 33 months) elapsed between one patient’s first request for PAS and subsequent death.\(^{102}\)

Under the Oregon law, a physician must mention comfort care, hospice care, and pain control as reasonable alternatives to PAS before acquiescing to a patient’s request for a lethal prescription. However, the physician is not required to be knowledgeable about palliative care for terminally ill patients. The Death with Dignity Act does not require any course or certification exam for Oregon physicians in palliative care, pain management or the detection of depression or other psychological disorders. This is particularly alarming considering that twenty eight percent of Oregon physicians surveyed who were not morally opposed to the practice of PAS indicated that they were not confident in their ability to diagnose depression in a patient who requested PAS.\(^{103}\) Moreover, attending physicians are not even required to consult with a physician that is knowledgeable about palliative care for terminally ill patients. Without

---


\(^{103}\) Lee 312.
adequate knowledge or consultation it seems unlikely that most physicians would be able to effectively communicate alternatives to patients.\(^{104}\)

Under these conditions, informing a patient about palliative care is seen as a legal requirement that must be fulfilled, and not necessarily an important part of the attempt to treat a patient’s pain so that PAS does not appear to be the only alternative.\(^{105}\) In fact, while the Netherlands law requires that a patient’s suffering is lasting and unbearable, the Oregon law does not even stipulate that a patient must be in any pain or suffering, only that he has less than six months to live. Thus, although many proponents of legalization have pointed to Oregon’s Death with Dignity Act as a way to relieve the unbearable pain and suffering of dying patients, Oregon’s law does not even require the existence of pain or suffering of any kind, let alone pain that cannot be relieved in any other way.\(^{106}\)

Under the Oregon law a second physician must be consulted. However, the consulting physician may be related personally or professionally to either the attending physician or patient. Therefore, the consultant may not necessarily provide a free and unbiased judgment. In contrast, even in the Netherlands, a basic requirement for euthanasia or PAS includes consultation with an independent physician.\(^{107}\)

**B. The Practice of Physician-Assisted Suicide in Oregon**

Each year the Oregon Health Division (OHD) is legally required to monitor physician compliance with the Death with Dignity Act, collect data about the physicians who prescribe and

---

\(^{104}\) Foley and Hendin in Foley and Hendin 145.

\(^{105}\) Foley and Hendin, in Foley and Hendin 146.

\(^{106}\) Gorsuch 1372.

\(^{107}\) Gorsuch 1372.
patients who obtain PAS under the Act, and publish these results.\textsuperscript{108} The published reports present only general epidemiological data and the information is obtained through interviews with the prescribing physicians, death certificates, and physician’s reports.\textsuperscript{109} Of note, physicians who refused patient’s requests for PAS are not interviewed, and neither are nurses or social workers.\textsuperscript{110} In the second annual report the OHD retrospectively surveyed family members of a few patients who died by PAS, but that method was not included in the first report or in any subsequent annual report, of which their have been seven to date.\textsuperscript{111}

The OHD does not conduct any interviews confidentially and thus all information is collected “on the record” (this is in contrast to the government ordered studies in the Netherlands). It is highly unlikely that a physician will admit to noncompliance with the Oregon law under such circumstances. Moreover, not all collected information is published in the annual report, and the OHD maintains that this is necessary in order to protect the confidentiality of patients and physicians. No independent researcher or organization is allowed to study the available data.\textsuperscript{112} Thus, while Oregon has often been described as a “laboratory” or “experiment” to see if PAS should be legalized in other states, the Oregon statue was crafted in such a manner that limits the amount of valid and unbiased data available.\textsuperscript{113}

According to the data published by the OHD, a total of 390 lethal prescriptions were written under the Death with Dignity Act from 1998 to 2005. Table 2 presents the important demographic data presented in the OHD’s eight annual reports to date on Oregon’s Death with Dignity Act.

\textsuperscript{109} Chin 578.  
\textsuperscript{110} Hendin and Foley in Hendin and Foley 145.  
\textsuperscript{111} Hendin and Foley in Hendin and Foley 145.  
\textsuperscript{112} Hendin and Foley in Hendin and Foley 145.  
\textsuperscript{113} Gorsuch 1375.
Table 2: 
Demographics of Oregon PAS Cases: 1998-2005\(^{114}\)

<table>
<thead>
<tr>
<th>Year</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Lethal Prescriptions Written</td>
<td>24</td>
<td>33</td>
<td>39</td>
<td>44</td>
<td>58</td>
<td>68</td>
<td>60</td>
<td>64</td>
</tr>
<tr>
<td>Total Deaths from PAS</td>
<td>16</td>
<td>27</td>
<td>27</td>
<td>21</td>
<td>38</td>
<td>42</td>
<td>37</td>
<td>32</td>
</tr>
<tr>
<td>Percent Change in Total Death from PAS from Previous Year</td>
<td>-</td>
<td>+69%</td>
<td>0%</td>
<td>-22%</td>
<td>+81%</td>
<td>+11%</td>
<td>-12%</td>
<td>-14%</td>
</tr>
<tr>
<td>Median Age in Years (Range)</td>
<td>69 (25-94)</td>
<td>71 (31-87)</td>
<td>69 (51-93)</td>
<td>68 (51-87)</td>
<td>69 (38-92)</td>
<td>73 (40-93)</td>
<td>64 (34-89)</td>
<td>70 (42-90)</td>
</tr>
<tr>
<td>Race – Percent White*</td>
<td>100</td>
<td>96</td>
<td>96</td>
<td>95</td>
<td>97</td>
<td>98</td>
<td>100</td>
<td>95</td>
</tr>
<tr>
<td>% with Cancer*</td>
<td>87</td>
<td>63</td>
<td>78</td>
<td>86</td>
<td>84</td>
<td>83</td>
<td>78</td>
<td>84</td>
</tr>
</tbody>
</table>

*Percentages are calculated based on the total number of deaths from PAS

As displayed in table 2, the number of deaths from PAS appears to have dramatically increased the year after legalization, from 16 deaths in 1998 to 27 in 1999. While the total number of deaths from PAS generally increased from 1999 to 2003 (with the exceptions of 2000 and 2001), the number of deaths appear to have leveled off and even decreased slightly in 2004 and 2005.

As displayed in table 2, the average age of patients who obtain PAS has remained relatively constant around 64 to 70 years, with a minimum age of 25 in 1998. Patients who died by PAS were predominately white and the most common cause of death was cancer. Among cancer patients, a recent review article published in *CA: A Cancer Journal for Clinicians* shows that clinicians are often unable to recognize, assess and address the psychological distress that many patients feel as a result of their illness. Approximately 25% of all cancer patients become...\(^{114}\)

severely depressed, with an increasing frequency of depression among patients with more severe pain and disability.\textsuperscript{115} Among cancer patients untreated depression may increase their burden of suffering and lead to a significant decline in quality of life, which may cause some to turn to euthanasia and / or PAS.

Of related concern, the OHD data show that Oregon physicians have become increasingly unlikely to refer a patient for consultation with a psychiatrist or psychologist before acquiescing to a request for a lethal prescription.\textsuperscript{116} In 2005 only 5\% of patients (2 of 38) were referred for a psychiatric evaluation, compared to 31\% of patients (5 of 16) in 1998, 37\% (10 of 27) in 1999, 19\% (5 of 27) in 2000, 14\% (3 of 21) in 2001, 13\% (5 of 38) in 2002, 5\% (2 of 42) in 2003, and 5\% (2 of 37) in 2004.\textsuperscript{117} In light of the fact that twenty eight percent of surveyed Oregon physicians not morally opposed to the practice of PAS did not feel competent to diagnose depression, this trend is particularly alarming.\textsuperscript{118} The declining trend in the rate of psychiatric consult may indicate a reduced rigor on the part of physicians in evaluating patients before prescribing lethal medication. This reduced rigor may be due in large part to the criterion of “good faith” required to perform PAS in Oregon. The “good faith” criterion is substantially less demanding than in any other area of medical practice and leaves physicians in part shielded from the normal laws of malpractice. Moreover, even among patients referred for psychiatric evaluation, a large number are referred to psychiatrists who are affiliated with physician-assisted suicide advocacy groups.\textsuperscript{119} As Ganzini et al. point out, since the majority of psychiatrists who

\textsuperscript{116} Gorsuch 1378.
\textsuperscript{117} Gorsuch 1378; Updated years 2003 – 2004 using Oregon Department of Human Services, Oregon Death with Dignity Act Annual Reports, Years 5 and 6, 12 March 2006 <http://egov.oregon.gov/DHS/ph/pas/ar-index.shtml>
\textsuperscript{118} Lee 312.
\textsuperscript{119} Gorsuch 1378-79.
evaluate patients also support the Oregon Death with Dignity Act “a bias may be introduced into
the competency evaluation. On balance, the psychiatrists’ conclusions may reflect personal
values and beliefs more than psychiatric expertise.”

As displayed in Table 3, Oregon residents requested PAS for a variety of reasons, most
commonly loss of autonomy, decreased ability to participate in activities that make life
enjoyable, and loss of control of bodily function. Also of note, a number of individuals also
cited concerns about being a burden on family or friends, inadequate pain control, and even
financial constraints.

<table>
<thead>
<tr>
<th>Table 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>Financial implications of treatment</td>
</tr>
<tr>
<td>Inadequate pain control</td>
</tr>
<tr>
<td>Burden on family, friends, and caregivers</td>
</tr>
<tr>
<td>Losing control of bodily functions</td>
</tr>
<tr>
<td>Decreasing ability to participate in activities that make</td>
</tr>
</tbody>
</table>

121 Adapted from Gorsuch 1380; Added years 2003 to 2005 using Oregon Department of Human Services, Oregon Death with Dignity Act Annual Reports, Years 5-7, 12 March 2006 <http://egov.oregon.gov/DHS/ph/pas/ar-index.shtml>
Recall that these data were collected by interviews conducted with prescribing physicians by the DHS non-confidentially after PAS was performed. The DHS has not commented on the amount of time that elapses between the patient’s death and when the physician is contacted for an interview. Additionally, patients may not ingest the lethal medication immediately after it is prescribed. Thus a significant lag time may result from when the physician prescribes lethal medication and the time of his interview. It is therefore quite possible that physicians may inaccurately recall a patient’s reasons for requesting PAS. This fact aside, the findings remain rather troubling. Fears about inadequate pain control motivated 22% of requests for PAS. Given physicians inability to control a dying patient’s pain between 20 to 70 percent of the time, this finding suggests that in some instances PAS may replace adequate palliative care. Moreover, a survey of Oregon physician who received PAS requests in 1999 by Ganzini et al. shows that inadequate pain control influenced a patient’s desire to request PAS in 43% of cases. (Note that this contradicts the official state numbers). The Ganzini et al. study also reveals that prescribing physicians recommended that the patient see a palliative care specialist in only 13% of cases. Of further concern, 37% of patients cited concerns about becoming a burden on friends and family and 2% noted financial considerations as a motivating factor to request PAS. As Gorsuch points out, Oregon is one of the more affluent states in the US and it would therefore be expected

<table>
<thead>
<tr>
<th></th>
<th>80%</th>
<th>63%</th>
<th>93%</th>
<th>94%</th>
<th>84%</th>
<th>93%</th>
<th>87%</th>
<th>79%</th>
<th>86%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Losing autonomy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

122 Emanuel SII 23.
123 Gorsuch 1380-81.
that financial considerations would have an even larger impact if PAS is legalized in other states.\textsuperscript{124}

**C. The Case of “Helen”**

“Helen” was the first person to obtain a lethal prescription under the Death with Dignity Act. Helen’s case clearly illustrates some of the problems and concerns that have arisen under the act. Helen was an elderly woman in her mid-eighties, who suffered from breast cancer. During her late seventies, Helen underwent a mastectomy. When she developed a second tumor at age 82, she underwent a lumpectomy, but refused all subsequent treatment. Helen’s regular physician refused PAS, stating that he was about to move his practice, but would refer her to another primary care physician. The second physician refused to perform assisted suicide, noting that although Helen’s life expectancy was short, she was also “probably depressed”.\textsuperscript{125} Next, Helen’s husband called Compassion in Dying, which subsequently recommended a third physician, Dr. Reagan. Dr. Reagan describes Helen as “elderly, frail, and hooked to oxygen, but completely astute, with a delightful twinkle”.\textsuperscript{126} Dr. Reagan arranged for a consult with a psychiatrist, who visited Helen in her home only once and determined that she was not depressed. A second psychiatrist was not consulted (even though there was a discrepancy between the psychiatrist and the second primary care physician about Helen’s depression). Dr. Reagan never contacted Helen’s primary care physician and he had only a very brief conversation with the second physician who refused to write Helen a prescription. About one week later, Helen confirmed her desire to end her life and stated that “she didn’t see the point in

\textsuperscript{124} Gorsuch 1381.
\textsuperscript{126} Reagan 1265.
further personal indignities, or in burdening her friends and family with care". After making one final house call, Dr. Reagan agreed to write Helen a lethal prescription, and returned to her house the next evening to remain with Helen and her family when she ingested the medication.

After Helen’s death, Dr. Reagan explained the pressure he felt to prescribe Helen lethal medication. Even though Dr. Reagan felt the prospect of Helen dying by PAS was “almost too much to bear”, he “found even worse the thought of disappointing this family. If I backed out, they’d feel about me the way they had about their previous doctor, that I had strung them along, and in a way, insulted them.” As Dr. Reagan’s comment emphasizes, by legalizing PAS we normalize its practice and therefore run the risk that it will become viewed as a right of all dying patients, so fundamental that physicians may feel societal pressure to acquiesce to a patient’s request.

D. The Case of Ms. Cheney

Ms. Cheney is a very interesting case because of the role her HMO played in allowing her to obtain physician assisted suicide. Cheney was an eighty-five-year-old widow who, accompanied by her daughter Erika, sought a prescription for lethal medication under the Oregon Death with Dignity Act. Erika thought that Cheney’s first physician seemed “dismissive” to the idea of PAS, and Cheney’s HMO subsequently agreed to pay for Cheney to see a second doctor. The second physician consulted with a psychiatrist, who determined that Cheney “did not seem to be explicitly pushing for assisted suicide,” and lacked “the very high level of capacity to weigh options about it.” The psychiatrist reported that Cheney accepted his determination;

---

127 Reagan 1266.
128 Reagan 1266.
129 Reagan 1266.
130 Gorsuch 1382.
however, Ericka became angry. Erika then called her mother’s HMO and they agreed to pay for a second psychiatric evaluation. While the second psychologist thought Erika was “‘somewhat coercive,’” he nevertheless determined that she was competent to request PAS. At this time, Cheney obtained a lethal prescription, which was given to her daughter Erika to hold. As time passed, Cheney became weaker and ate poorly, “and to afford Erika and her husband a respite, went to a nursing home on a temporary basis to regain her strength”. 131 It was on the day Cheney came home that she said “that something had to be done given her declining health”. 132 She would not return to the nursing home and would like to use the lethal prescription. Shortly after this request, Cheney ingested the pills and died. 133 The case of Cheney is particularly troubling, not only because one of the primary reasons she ingested the lethal prescription was because she did not wish to return to a nursing home, but also because it appears that the economics of HMOs do play a rather significant role in a patient’s ability to obtain PAS.

**XII. Lessons from Oregon: Recommendations for Other States to Craft More Careful Laws Legalizing Physician-Assisted Suicide**

Clearly Oregon’s “experiment” with the legalization of PAS has led to a number of undesirable consequences, including but not limited to, patients who seek PAS due to concerns about being a burden on family and/or friends, financial considerations and low consultation rates with psychiatrists. The important question then becomes whether the problems that arose in Oregon were an inevitable result of the legalization of PAS, or a more direct result of how the Oregon Death with Dignity Act, in particular, was crafted. In other words, would more careful and unambiguous legislation afford better protection against abuses of physician-assisted suicide.

---

131 Foley and Hendin, in Foley and Hendin 157
132 Foley and Hendin, in Foley and Hendin 157.
133 Foley and Hendin, in Foley and Hendin 157.
if it were to be legalized in other states? In the following section, I will propose potential solutions for each of the concerns raised in the case of Oregon in order to argue for more tightly crafted legislation to ensure that suicide is a rational decision.

**A. Ethics Committee Oversight Before PAS is Performed**

One of the main concerns raised in the case of Oregon (as well as the Netherlands) is that physicians must report cases of PAS only after they are performed. This lack of regulatory oversight *before* the fact shifts the focus away from protecting patients from cases of unnecessary PAS. Only the physician is in a position to explain how and why PAS was performed and there is no one else with the scientific and medical expertise to adequately check-up on them. The amount of professional autonomy afforded to physicians is unprecedented in comparison to other end-of-life decisions, such as withholding and withdrawing treatment. For instance, the decision to withdraw or forgo treatment most often takes place in a hospital setting, and thus a great deal of consultation with ethics committees and other physicians occurs *before* the decision is made.\(^\text{134}\) In contrast, with assisted suicide, the majority of patients die at home, and while the physician is required to consult with one other physician, the interaction is usually not as extensive. While the process of review by ethics committees and consultation in the hospital setting is far from perfect, it is an added level of regulation that is absent or lacking in cases of PAS. Thus, I would recommend that an attending physician must present the facts of each potential case of assisted suicide before an ethics committee. Approval of the ethics committee would be required before a physician could write the lethal prescription.

B. Careful Psychiatric Evaluation

Despite the fact that a psychiatric evaluation is the most reliable way to distinguish between patients who are depressed or suicidal and those who are capable of making a rational decision, it is not a requirement under the Oregon regime. Future legislation should safeguard against the possibility of depressed or psychologically unstable patients obtaining PAS by requiring that at least one (or possibly two) psychologists or psychiatrists evaluate the patient. Such evaluation should be thorough and consist of multiple sessions. A study published by Ganzini et al. in the American Journal of Psychiatry demonstrated that only 6% of psychiatrists were confident in their ability to accurately detect depression in a terminally ill patient through a single consultation. Additionally, educational efforts should be targeted at making psychiatrists and psychologists more knowledgeable about detecting depression disorders in severely ill patients.

C. Consulting Physician Must be Independent of both the Physician and Patient

Future legislation should require that the consulting physician is independent of both the patient and attending physician, both personally and professionally. This will help to ensure an unbiased evaluation. As is the case with the psychiatric consult, the physician should evaluate the patient on multiple occasions before providing an assessment of the patient’s competency. Note that this requirement is in keeping with the Dutch guidelines and in contrast to those of the Oregon statute.

135 Ganzini et al. 1474.
D. Focus on Palliative Care

Future legislation should require not only a diagnosis of less than six months to live, but also the presence of physical pain and suffering that cannot be relieved in any other way. This would help to shift the focus towards palliative care and pain control in terminally ill patients. As previously noted, although physicians should be able to relieve a patient’s pain in 95% of cases, pain is inadequately treated in dying patients between 20 to 70 percent of the time. Thus, it is imperative that educational efforts be made to ensure that physicians improve their knowledge of palliative care and pain control in terminally ill patients. In particular this paper recommends that physicians should be required to pass an examination that tests their understanding of palliative care. Physicians who do not pass should be required to attend educational seminars on the topic.

E. Annual State Wide Evaluations, Which Include Confidential Surveys

Most importantly, future legislation must have a mechanism in place to effectively monitor the adherence of physicians to the proposed guidelines. Such a mechanism should include confidential surveys with physicians and other healthcare workers, so that physicians and others can anonymously report on the cases of PAS. Only then can a state claim to provide unbiased feedback about the effects of legalization.

XIII. Conclusion

In this paper, I have pointed to many of the negative consequences that may result from the legalization of euthanasia and / or PAS. I do not, however, want to discount the benefits that would result from legalization. Clearly for patients with an untreatable, terminal condition who

136 Emanuel SII 23.
experience unbearable pain and suffering or simply wish to end their life in a swift and dignified manner, PAS and / or euthanasia would be of benefit. Also, even for incompetent patients there are certain instances in which euthanasia would be more humane than withholding or withdrawing treatment. For example, a lethal injection is more humane than allowing a severely deformed infant to die from dehydration.

When crafting policy decisions, however, we must find a way to deal with the tragic cases, while at the same time minimizing the risks associated with making a policy decision around those sorts of exceptional cases. As the Dutch model clearly illustrates, if we legalize euthanasia in specific circumstances, the standards of acceptable medical practice may shift and the guidelines for euthanasia may subsequently expand, allowing as in the Dutch example, euthanasia of infants on a wide scale. While acts of non-voluntary euthanasia based on medical necessity may not be unethical, they remain exceptional cases and probably should be treated as such, not legalized. Physicians have found ways to intentionally end a patient’s life even though the practice is technically illegal and they will continue to do so in the future. Moreover, due to significant cultural differences between the US and the Netherlands, we cannot accurately predict how the Dutch model would play out in the US context, and, if anything, we have reason to suspect that it may be even more inadequate in the US context.

As we turn instead to the Oregon “experiment,” we find that physician-assisted suicide appears to be used relatively infrequently and there is little reported evidence of abuse of its practice. However, we also notice that as the practice of PAS becomes more routine physicians may become less rigorous about the standard of medical care patients receive, providing, for example, less frequent consults with a psychiatrist before performing PAS. Despite these risks, it appears that some of the problems of legalization that surfaced in Oregon may have been a
direct result of how the legislation was crafted rather than the act of legalization itself. Based on the case of Oregon, this paper has made the following recommendations for additional requirements to be included in future legislation for the legalization of PAS: consultation with an ethics committee before PAS is performed, multiple-session psychiatric evaluation, consultation with a physician who is independent of both the physician and patient, the presence of physical pain and suffering that cannot be relieved in any other way, and annual state-wide evaluation, which includes confidential surveys. Such a refined model would deal with some of the apparent flaws in the Oregon legislation. This would help to accurately determine if the legalization of PAS is appropriate and desirable in the US. My suspicion is that with proper regulatory guidelines the benefits of the legalization of PAS would substantially outweigh the costs. However, we can only wait and see if more careful legislation is adopted by a state.
Bibliography


Kathleen Foley and Herbert Hendin. The Case Against Assisted Suicide For the Right to End-of-Life Care. (Baltimore: The Johns Hopkins University Press, 2002).


In re Quinlan, 70 NJ 10, 24 March 2006 <http://web.lexisnexis.com/universe/document?_m=bfeec23c6bca5a63db7f11c69b72d6f9&_docnum=1&wchp=dGLbVzb-zSkVA&_md5=d87255b4cd54a5371cfb711de9e58db>.


Vacco v. Quill 117 S Ct 2293 (1997), 26 March 2006 <http://web.lexisnexis.com/universe/document?_m=7054bf720016c7f04a837d7d0b71e209&_docnum=1&wchp=dGLbVtz-zSkVb&_md5=ea658a051ed02bad2fd21088b551491f>.


