Assisted Dying Policies in the United States:
A Policy Analysis

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ABSTRACT

The policy of assisted dying has developed slowly over many decades in the United States, as it has around the world. While European countries were first to legalize assisted dying and protect the physicians who participated in this practice, the United States was not far behind as currently five states allow physician assisted dying and protect physicians under newly devised laws. These states were able to legalize assisted dying practices largely based upon the provisions set forth in a few key court cases that setup the framework upon which these future policy proposals could be developed. Lessons from other countries, as well as the failures and successes of assisted dying policies in the United States has shown there to be several key elements of a policy that increase its likelihood for political success. The purpose of this paper is to explore the historical development of policies of assisted dying in the U.S. and determine which policy variables must be included in order for a policy proposal to be successful, and what elements must be excluded.
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INTRODUCTION

The concept of assisted dying has been a topic of discussion for decades but as legalization of physician assisted dying practices has expanded to the United States, the debate warrants further consideration. This paper explores the political feasibility of further expansion of assisted dying policies in the United States.

The fragile nature of end of life (EOL) discussions and decisions makes it important to differentiate among the various forms of assisted dying, as all too often these meanings are used interchangeably and thus incorrectly. Physician Assisted Suicide (PAS) occurs when a physician prescribes a lethal dose of a substance with the knowledge that the patient will use it to end his or her own life. Importantly, the physician is not the one who administers the lethal drug; this scenario is considered to be a suicide, as the patient is the one who directly ends his or her life. In assisted euthanasia, the physician is the one who directly administers a lethal dose of medication that ends the patient’s life. Passive euthanasia is also seen as “letting die:” withholding or removing necessary treatments for life, such as respiratory support or nutrition (Yount, 2000). Active euthanasia is when someone other than the patient, typically a medical professional, directly causes the patient’s death. “Active euthanasia can be either voluntary (done at the sick person’s request) or involuntary (done without the person’s concurrent request or permission)” (Yount, 2000, p. 4). Notably, there are many different versions of these similar definitions and each locale in which assisted dying is debated appears to have adopted its own preferred definition. The task force of the European Association for Palliative Care (EAPC) defines euthanasia as “a doctor intentionally killing a person by the administration of drugs, at that person’s voluntary and competent request,” and physician-assisted suicide as “a doctor intentionally helping a person to commit suicide by providing drugs for self-administration, at that person’s voluntary and competent request” (Materstvedt et al., 2003, p.98).

The term “suicide,” and its accompanying negative connotations, has led many assisted dying supporters and prominent health care associations to openly reject the term in favor of
“assisted dying” or similar terms that do include the word “suicide.” The American Psychological Association (APA) highlights the important difference between “suicide,” which is commonly associated with self-destructive behavior by individuals with depression or other psychiatric illness, and important end of life decisions made by terminally ill patients which are “more accurately paralleled to a patient’s thoughtful decision to decline life-sustaining measures: a product of judgment and reason, based on the desire to maintain one’s dignity in a period where death is pending” ("Gonzales v. Oregon," 2006; Miller & Werth, 2005). A working group of The American Psychological Association reported that “It is important to remember that the reasoning on which a terminally ill person (whose judgments are not impaired by mental disorders) bases a decision to end his or her life is fundamentally different from the reasoning a clinically depressed person uses to justify suicide" (Farberman, 1997; Miller & Werth, 2005).

Significantly less controversial, but still important to understand, are the various other EOL interventions, or decisions not to intervene, that hasten death such as refusal of artificial hydration and nutrition, withdrawal of life-sustaining treatment (LST) and terminal sedation. Terminal sedation refers to the administration of enough sedatives and/or analgesic medications to sedate a terminally ill patient through the rest of his or her life so as to relieve intractable pain and other distressing symptoms, even though the time frame of this sedation is an imprecise matter of judgment. “Although this action is ostensibly taken to control pain or other troubling [symptoms], it is acknowledged to hasten the patient’s death by hindering respiratory functioning" (Rosenfeld, 2004, p. 7). Some refer to these EOL options as passive euthanasia since it is the underlying medical illness that actually causes death, yet they are subjected to significantly less public scrutiny than are other forms of euthanasia, as a physician is not actively prescribing a drug that will speed the death of the patient (Rosenfeld, 2004).

Another EOL intervention that is legal for all U.S. physicians is the “double effect,” in which a prescribing physician provides enough symptom-relieving medication, for example morphine, to alleviate a patient’s suffering, with the knowledge that such doses of morphine will
depress the patient’s respiratory drive and thereby could hasten death. The important point is that the physician’s primary objective was to relieve suffering and not to hasten death, meaning that the act is deemed permissible (Lewy, 2011). Understanding all of these nuanced differences is important for the sake of medical providers who are placed in a precarious balance between their roles as healers and the ethos of law, which includes so many gray areas that it can force them to break the law to help their patients. Justice Stevens notes in *Glucksberg*, “Because physicians are already involved in making decisions that hasten the death of terminally ill patients—through the termination of life support, withholding of medical treatment, and terminal sedation—there is in fact significant tension between the traditional view of the physician’s role and the actual practice” ("Washington v. Glucksberg," 1997).

Brief consideration of the Hippocratic Oath provides some insight regarding the ethical conflicts facing physicians with respect to EOL issues, and also provides a basis for understanding the role that society and medical practice have in the formation of health policy, or in this case, a solemn oath. It is easy to see how EOL delineations may be at odds with the Hippocratic Oath; albeit an ancient one, this oath continues to be a cornerstone of medical ethics. By taking this oath, derided by some supporters of PAS as the “hypocritical oath,” a physician makes a promise to do no harm, and more specifically, not to “give a deadly drug to anybody if asked for” or “make a suggestion to that effect” (Pence, 2004, p. 63). Interestingly, the most commonly cited, “do no harm,” is not explicitly part of the Hippocratic Oath, but the promise to “do no harm, Primum Non Nocere, is irrevocably bound to the Hippocratic principle of the sanctity of human life” ("Brief Amici Curiae of C. Everett Koop, M.D., Sc.D. et al., in support of Attorney General Ashcroft," 2002). Many opponents of legalizing PAD cite this oath as reason enough to prohibit its legalization, declaring that it would be against the role of a doctor as healer to assist in a patient’s death. Yet suffering is inherently subjective. If it is impossible to define what constitutes “harm” in a general sense, then for each suffering individual, harm can mean very different things. In the U.S. Supreme Court Case *Washington v.*
Glucksberg, Justice Stevens addresses harm in the context of PAD, “[f]or some patients, it would be a physician’s refusal to dispense medication to ease their suffering and make their death tolerable and dignified that would be inconsistent with the healing role” ("Washington v. Glucksberg," 1997). Given the complexity of this issue and the lack of broad agreement on what constitutes “harm” in the context of PAD, arguments that cite the Hippocratic Oath are attempting to apply an impossibly general definition of harm to every patient. Since dying is unquestionably the most inescapable feature of life, and if physicians are ethically and morally responsible for aiding their patients through life, it can be argued that assisting him or her in their death should not be overlooked.

Over time, this oath has been modified, as certain parts have become less relevant; the oath taken by many medical students today barely resembles the original, which included a promise to not perform abortions or surgery in addition to the pledge against euthanasia (North, 2002). One could argue that as society and medical technologies evolve simultaneously, so too should our opinions about how these two elements can work together for the greatest good. Over the course of time, and as the need for surgical interventions became apparent, the natural course of medicine led physicians away from this once highly revered code of ethics. Likewise, once the judicial and legislative systems began to assert that certain laws denied a woman’s fundamental right to control the privacy of the medical decisions regarding her own body, the legalization of abortion became another source of departure from the original ancient oath. The oath has been modified so many times that it has become barely recognizable compared to its original iteration, and many modern versions also exclude mention of physician-assisted dying (Boyle, 2004). Even before policy change allowing assisted dying practices began to spread across the U.S., it appears evident that changes in this oath may be powerful evidence representing a shift in attitudes away from strict denial of patient’s wishes for assistance in dying.
BACKGROUND AND SIGNIFICANCE

Assisted dying is legal in four European countries and five states in the U.S. Internationally, assisted dying has been legalized in Switzerland, Luxembourg, The Netherlands and Belgium, and euthanasia has been legalized in the latter three countries as well. In the U.S., passive euthanasia is legal in all states, but active euthanasia is not permitted anywhere. States enact their own laws regarding murder as well as end-of-life decisions, and the following states currently permit assisted dying: via legislation in Oregon, Washington, Vermont and New Mexico, and by court ruling in Montana. In the remaining states, assisted dying is considered illegal, with the type of crime for participating in it ranging from second-degree manslaughter to a class A felony. In some states, like North Carolina, the act of suicide is not illegal, and thus by extension there is no specific law regarding assisted suicide, leaving the legal aspects of end-of-life care much less clear ("Crime of Suicide Abolished," 1973).

Why We Need to Discuss This Now

Conversations about death were once considered distasteful and almost taboo for most Americans, but that quickly changed in the early 1970s when Elisabeth Kübler-Ross’s book On Death and Dying (1969) became a national best seller and patients’ rights movements started gaining popularity. Technological advances in medicine, coupled with an aging population, made death a widely discussed topic. Some voices in the public sphere began raising questions about the need for a better way to die as modern medicine began to extend the lives of the sick, and the traditional location of death transitioned from a person’s home to the unsettling and chaotic environment of a hospital room. From the 1970s to the 1990s, the percentage of people who died in hospitals had risen by more than ten percent (Yount, 2000). This shift in dying traditions provided the impetus for the formation of palliative care services in the form of hospice, which according to the World Health Organization definition, “affirms life and regards dying as a normal process,” and “neither hastens nor postpones death” (Humphry & Clement,
The first U.S. hospice facility was opened in New Haven, Connecticut, in 1974, as a separate building from the hospital. Hospice has evolved over time into a meaningful way to help people die comfortably at home or in places other than acute care hospitals. The growing acceptance of hospice and palliative care suggests that the nation is more comfortable with end-of-life discussion than it has been in several decades.

**The Current Debate**

The primary argument for assisted suicide is the concept of personal autonomy in life and in death; hence the name of the movement for legalization of assisted dying in the U.S., the “right to die” movement. Compassion for the suffering endured at the end of life is the driving force of many advocates’ positions, and organizations such as Compassion and Choices have embraced this idea as their primary mission (Rosenfeld, 2004). In the same vein, the lack of compassion in dying prevents terminally ill patients from retaining what independence and dignity they can have at the end of their lives as they lose their sense of self and functional capacities. By providing terminally ill patients the option to end his or her life, proponents for PAD legislation argue that the end of life suffering endured by the family members and caregivers of terminally ill patients can be lessened, and “bad deaths” can be minimized. From a policy perspective, many physicians admit to helping to hasten the death of their patients. Advocates argue that legalization of PAD, with adequate safeguards, minimizes the potential for abuse of the “double effect,” and PAD can be safely administered (Rosenfeld, 2004).

As discussed previously, the Hippocratic Oath, and the assumption that it includes the injunction to “do no harm,” is often invoked in opposition to PAS, despite the continuous rewriting of the oath and its lack of applicability to the practice of medicine today. Others who oppose PAS legalization argue that the request for hastened death is not rational, but rather a simple “cry for help” from individuals who are suffering from organic brain diseases, treatable mental health conditions or have poorly or unmanaged symptoms that can be ameliorated
through palliative care (Rosenfeld, 2004). Adversaries argue that the legalization of PAS will undermine palliative care efforts, which are already unavailable to many people. “The presumption that the demand for assisted suicide is linked to inadequate palliative care leads many writers to express concern that legalization for extreme cases of untreatable pain or symptom distress may lead to a gradual expansion of the criteria of who is eligible to hasten death and under what circumstances” (Rosenfeld, 2004, p. 10). This contributes to the assumption that if PAS is legalized, it will expand to include people who are not terminally ill but are deemed “less useful” to society, an idea known as the “slippery slope” argument. In her review of evidence about “vulnerable groups” and the fear of the “slippery slope,” Margaret Battin and her colleagues very clearly describe the concern: “The slippery-slope argument assumes that abusive pressures would operate on all seriously or terminally ill patients but would selectively disfavor patients whose capacities for decision making are impaired, who are subject to social prejudice, or who may have been socially conditioned to think of themselves as less deserving of care. These pressures would result, it is assumed, in heightened risk for physician-assisted dying among vulnerable persons compared with background populations” (Battin, van der Heide, Ganzini, van der Wal, & Onwuteaka-Philipsen, 2007, p. 591).

**ASSISTED DYING IN THE UNITED STATES**

In the 1960s and 1970s, the so called “rights culture” formed by students in Europe and America envisioned a world in which “all people could ‘do their thing’ without interference, so long as they did not harm others” (Yount, 2000, p. 11). This cultural shift later supported the right-to-die movement, “a social and political movement dedicated to guaranteeing the legal right to have some degree of control over the time and manner of one’s death, which may include the right to request a physician’s aid in dying” (Yount, 2000, p. 131). Derek Humphry is author of a book detailing how he helped his wife die rather than continuing to suffer the ravishing effects of inoperable bone cancer. He was not prosecuted for his actions and emerged
as a major leader in pushing the right-to-die movement forward. In the 1980s, after moving to the United States, he formed the Hemlock Society, a group whose sole purpose was to advance legislation legalizing physician assisted dying in the U.S.

Although the topic of physician assisted dying had already been debated around the world for some time, the passage of voluntary euthanasia laws in The Netherlands in the 1980s followed by the work of Dr. Kevorkian in the U.S. during the 1990s, sparked a tremendous surge in both public and scientific discussion regarding EOL issues. In the 1990s when the United States and other European countries joined the debate, the resulting interest in EOL dialogue echoed through academia and resulted in an exponential increase in academic literature regarding the subject, such that a database search for “euthanasia” in 1998 returned 3621 publications for the previous decade (Dickinson, Clark, Winslow, & Marples, 2005; Nilstun, Melltorp, & Hermeren, 2000). In a systematic review performed by Dickinson et al. in 2005 regarding the attitudes of US physicians to PAD or AVE, “nearly two-thirds of the studies appeared towards the end of the decade, after 1996, rather than at the beginning (67 percent of the studies were published between 1997 and 2000)” (Dickinson et al., 2005). Preceeding this surge in interest was the passage of the Oregon Death with Dignity Act in 1994, just as it was in the late 1980s after the passage of PAS and AVE legislation in The Netherlands, that the first burst of literature was published. Given this trend, it can be argued that instead of forming evidence-based policy, we are more inclined to form policy-based evidence.

The trend of increased interest and debate regarding PAD and subsequent policy development regarding its legalization and regulation has been influenced by different forces. Major policy changes allowing legalization of AD practices were based upon precedents resulting from a series of important court cases, one after another, and all seemingly based on the case of Roe v Wade. In 1973, this landmark case legalized abortion in the United States, but citing the Due Process Clause of the 14th Amendment, it also gave the individual control over one’s body, and thus the ability to make private medical decisions (Yount, 2000).
description follows of some of the key court cases that helped shape the current assisted dying policies in the United States today (see Appendix C for an overview of these cases). Additionally, the timeline in Appendix B outlines the important events that have influenced changes in policy and law, allowing the future development of PAS legislation.

**IN THE MATTER OF QUINLAN**

**THE SUPREME COURT, STATE OF NEW JERSEY**

*(355 A.2D 647, 1976)*

The first of these significant cases was *In Re Quinlan*, a high-profile New Jersey Supreme Court case in 1976, in which 22-year-old Karen Ann Quinlan became unconscious after intoxication with drugs and alcohol and failed to regain consciousness; she indefinitely remaining in a persistent vegetative state (PVS). After Karen spent months on life support, her parents requested that the hospital remove her ventilator and allow their daughter to die. The hospital refused their request, and the New Jersey courts were presented with the question of whether her parents had the right to make the decision for their daughter to remove active life sustaining treatment (LST). The parents recalled Karen making explicit comments earlier in her life about her desire to never “live” in a state of unconsciousness, but there was no written proof of this. Notably, the Quinlans were devout Catholics, and as such did not want to end their daughter’s life by actively hastening her death, but instead desired to remove the extraordinary measures that kept her alive. At that time, there was no legal precedent allowing a parent to assert a right to die for his or her incompetent child, and as such, the lower court who first heard the case appointed a physician guardian for Karen. The court-appointed guardian pledged to keep Karen alive at all costs, while the hospital’s president felt it necessary to remind the Quinlans that, “in this hospital, we don’t kill people” (Kushner, 1999, p. 127).

The precedent-setting legal battle between the hospital and the Quinlans raged on for over a year, as Karen remained unconscious and was portrayed by media throughout the world...
as a heartrending sleeping beauty who could one day regain consciousness, despite numerous physician reports to the contrary. Finally in 1976, the Supreme Court of New Jersey made an unprecedented decision by applying the “right of privacy to a case of ‘letting die,’” an important grounding of their decision in the right to privacy, and granted guardianship to the Quinlans (Yount, 2000, p. 62). After the Quinlans’ courtroom victory, they moved Karen to a nursing home and removed her respirator, where she continued to breathe on her own. As the doctrine of Catholic faith forbade them from hastening her death and only permitted the denial of extraordinary means such as a respirator to keep one alive, the family provided artificial nutrition for another decade until she finally died from pneumonia.

The major policy outcome from this case was the upsurge in the use of living wills. The concept of the “living will” was not new at the time, but these documents had previously not been given any legal merit. Six months after the Quinlan case, California signed the Natural Death Act into law, giving legal power in that state to advanced directives, which “allow competent adults to specify what kinds of medical treatment they would or would not want if they should become incompetent” (Yount, 2000, p. 63). Many legal ramifications emerged from the Quinlan case, and the right-to-die movement gained even more momentum as advocates decried the tremendous financial and emotional burden placed on the Quinlan family during the decade their child slowly died. This scenario of events offered up the concept that right-to-die not only included power to refuse LST, but to hasten death when the life that remained would be spent unconscious or spoiled by pain and degeneration (Yount, 2000, p. 64). These court proceedings had a powerful and important influence on the attention paid to EOL issues in the United States and provided precedent for future legal right-to-die arguments.
Shortly after the death of Karen Quinlan, a similar case of *Cruzan v. Director, Missouri Department of Health* was accepted for argument before the U.S. Supreme Court, the Court’s first right-to-die case. Nancy Cruzan, a 25-year-old female, had been in a PVS for five years following an automobile accident, and her parents requested permission to remove her feeding tube. This request was denied by the Missouri Supreme Court, which said “the state’s interest is an unqualified interest in life” and there was not enough irrefutable evidence that Nancy Cruzan would have wanted to have her care discontinued (Kushner, 1999, p. 171; Yount, 2000).

However, after the U.S. Supreme Court heard the case, and in the context of an outpouring of Nancy’s friends who reinforced the notion that Nancy had stated in clear and convincing language her desire to not be kept alive if unconscious, the state of Missouri dropped its case and Nancy’s feeding tube was removed. Nancy died 12 days later, on December 26, 1990. This case motivated the passage of the Patient Self-Determination Act, a federal-level, and furthered the development of EOL practices. This law makes it a “federal requirement that any health-care institution which expects to receive Medicare or Medicaid funds must inform patients upon admission of state laws governing self-determination issues,” such as advanced directives and the patient’s right to refuse medical treatment (Koch, 1992, p. 240).

Legal cases similar to those described above continue to be considered by various courts as they arise. The legal conundrums in these cases have evolved from allowing surrogate decision-makers to remove LST to cases that challenge the constitutionality of laws...
that prevent physicians from aiding in the hastening of death. Two such cases that challenge the constitutionality of laws prohibiting assisted death, *Washington v. Glucksberg* and *Quill v. Vacco*, were heard by the U.S. Supreme Court in 1997, and in both cases, it “unanimously held that physician-assisted suicide is not a fundamental liberty interest protected by the Constitution,” and that the laws prohibiting PAS are not unconstitutional as “there is generally no constitutionally protected right-to-die” (Gostin, 1997, p. 1523; Yount, 2000, p. 110). This effectively placed the decision for further legislation regarding assisted suicide in the hands of the individual states. The charge from the Supreme Court was best described by Justice O’Connor, who concurred that states should be given the option to craft laws they saw fit for their population and charged them with developing safeguards to prevent abuse of potential legal developments: “States are presently undertaking extensive and serious evaluation of physician-assisted suicide and other related issues…In such circumstances, the …challenging task of crafting appropriate procedures for safeguarding…liberty interests is entrusted to the ‘laboratory’ of the States…” (“*Washington v. Glucksberg,*” 1997) (Tucker, 2008). The proceedings of these cases not only left development of assisted dying laws up to individual state legislative bodies, but also resulted in dramatic increases in public and professional discourse about assisted dying.

This very brief review illustrates only a few of the many legal proceedings creating small but significant policy changes that led to the legalization of PAS in some states in the U.S. Because the nature of assisted dying practices is in such stark contrast to many deeply entrenched religious ideologies and ethical perspectives about how physicians and patients should interact, policy development in this arena will not come from relatively docile encounters, but rather from highly visible and bitterly fought battles.

To help illustrate the various social and legal events that paved the way to eventual legalization of assisted dying practices in the United States, the timeline in Figure 1 outlines some of the important developments.
CURRENT U.S. POLICY: THE OREGON DEATH WITH DIGNITY ACT

The Oregon Death with Dignity Act (DWDA) enacted in 1994 was the first legalization of assisted dying practices in the United States, and it has served as a template upon which future U.S. legalization of similar statutes in Washington and Vermont were based. The laws in Montana and New Mexico were produced very differently, via judicial routes whose effect came from court determinations that PAS is not illegal within the context of their current laws. Montana and New Mexico have not yet drafted complete statues in response to their court decisions, whereas the states of Oregon, Washington and Vermont created original legislation. For these reasons, the Oregon DWDA will be used as a model of current policy in the United States.

According to the Oregon DWDA, physician assistance in dying is available to “an adult who is capable, is a resident or Oregon, 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” (“The Oregon Death with Dignity Act [Ballot Measure 16],” 1994). To clarify, the patient requesting assistance in dying must be a terminally ill (less than 6 months to live), mentally competent adult (over the age of 18) and a resident of the state of Oregon (“The Oregon Death with Dignity Act,” 1995; "State of Oregon: the Oregon Death with Dignity Act [ballot measure 16]," 1994). The patient must make two oral requests for lethal medication to their attending physician no less than 15 days apart, and one witnessed written request.

The responsibilities of the attending physician include determining “whether the patient has a terminal disease… is competent… is a resident of Oregon, and, perhaps the most importantly, to ensure that the patient made an informed decision” (Boyle, 2004, p. 1391). Additionally, another consulting physician must “confirm the attending physician’s diagnosis that the patient has a terminal disease and independently determine that the patient is competent and has made a voluntary and informed decisions” (Boyle, 2004, p. 1392). If either of these physicians believes the patient is not competent to make decisions for him- or herself, or
believes the patient may have any form of mental illness or distress, the physician is required to refer the patient to a mental health professional and is not permitted to prescribe lethal medication to this patient. The attending physician is also required to counsel the patient regarding alternatives to death, specifically, palliative care and mental health care. Finally, the patient may rescind the request at any time, and there is no requirement for when the patient is to take the medication after prescribed. The patient is allowed to obtain the prescription but never take it. The laws in Vermont and Washington have these same parameters.

Much important information can be gleaned through close examination of the influence and ripple effects over the sixteen years since the passage of PAS in the Oregon Death with Dignity Act. For example, what are the characteristics of the people who have requested and received physician assisted dying? When the policy was developed, it included a provision that requires very close monitoring of the practice of PAS. The Oregon Health Authority is required to publish detailed annual reports and make them available to the general public. These reports describe many different aspects of PAS and those who pursue its options at the end of life. As a result, the Oregon experience can provide a possible template upon which to model other policy proposals elsewhere in the U.S., and also helps identify many important details about the people who request aid in dying and who died after those requests were granted.

The 2014 annual report shows data collected from 2013, as well as data collected throughout the years that the Oregon DWDA has been in effect. The following data is an aggregate of all reported data from the sixteen years of the DWDA from the 2014 Annual Report (DHHS, 2014). Since inception, 1,173 prescriptions for lethal medication have been written and 752 patients who have requested assistance have died. Of these 752 patients, 97.3% were White, 67% were college educated, and 90.1% were enrolled in Hospice. The vast majority of these patients, 78.9%, were dying of cancer, 7.2% of ALS, 1.2% of HIV/AIDS, and the remaining 12.7% of other diseases of mostly cardiovascular and respiratory etiologies. Additionally, 98% of these patients had medical insurance: 62.9% private, 35.4% government-
funded insurance (Medicare, Medicaid, or Other Governmental insurance); 1.7% were uninsured and 0.05% had unknown insurance status (DHHS, 2014). Nearly half, 46.2%, of patients were married at the time of their request for assistance, 22.6% were divorced, 22.8% were widowed and 8.4% were never married. The differences between male and female were minimal: 52.7% male and 47.3% female. The median age in years is 71 (range of 25-96) but there is no single age bracket that encompasses the majority of participants: 28.9% were between 65-74 years old, 27.4% between 75-84 years old and 20.4% between 55-64 years old (DHHS, 2014). Based on these data, it can be concluded that, based on the Oregon experience, assisted dying has not been misused and has not been imposed on vulnerable groups.

LESSONS FROM EUROPE

Cultural influences are important sources of differences in the legal framework for assisted dying in the U.S. and Europe. For example, in the U.S., debates are almost entirely about PAD, and euthanasia is rarely, if ever, mentioned either in debate or in policy proposals. All previous attempts to pass PAD bills in the U.S. that even remotely mentioned euthanasia failed to be given serious consideration. However, in some European countries, euthanasia is not only legal, but it is more frequently requested than assisted suicide. Perhaps this is because of the importance placed on individual freedom and autonomy in American culture, a fact illustrated by the “right-to-die” movement and the “right to privacy” and the “right to informed consent,” all policy imperatives that seem to indicate Americans’ need for the appearance of control. Successful policy development in the U.S. governing EOL care primarily focus on placing more control in the hands of the patients and not the physicians, a transition that began in the 1970’s with the Patient’s Bill of Rights, which included the right to refuse medical treatment (Yount, 2000). In contrast, in The Netherlands, it is more of a cultural norm to look to a physician as the primary medical decision maker, which is one explanation of why euthanasia was legalized as well as why it is more frequently sought out than assisted suicide (Rosenfeld,
It is unclear whether these cultural differences are significant enough to cloud any lessons learned from experiences of the Dutch, but they likely have some influence and should be considered when attempting to apply their experiences to similar experiences in the United States.

It is informative to look at the policies that have been implemented and augmented around the world when considering the development of future PAD policies in the U.S. On the very liberal end of the spectrum, Switzerland has been allowing PAS and euthanasia since 1942 and is the only location in the world where one can travel for “suicide tourism” (Darr, 2007). Only slightly more conservative, Belgium and The Netherlands have legalized PAS and euthanasia but have fewer apparent safeguards in place than does the Oregon DWDA. We can find some similarities between U.S. policies and those in these northern European democracies; however the general trends of PAD in European nations seems to include less restricted approaches. For example, just one year after the euthanasia bill was passed in Belgium, lawmakers proposed expanding the practice to include children, which at the time was unsuccessful, yet in 2014 King Philippe signed into law a bill allowing assisted dying for all children, making Belgium the first and only country to do this (Watson, 2014). The Netherlands first extended its assisted dying laws to include terminally ill children over the age of twelve in 2002 (De Haan, 2002). Nicole Visee, Secretary General of the National Euthanasia Commission, stated that since 2002, only five assisted deaths have been granted (Gerlin, 03/25/2014).

The European example may offer some guidance or at least some data. In the U.S., previously unsuccessful attempts to legalize assisted dying have often been attributable to a lack of understanding of the variables necessary for policy success. First, the inclusion of euthanasia in any sense in a proposal will undoubtedly lead to its failure. When Washington and California failed to pass legislation in the early 1990s, it is likely because their proposals lumped euthanasia together with PAS into a proposal for “assisted dying” (Weir, 1997). In contrast, Oregon was successful in passing AD legislation for presumably the precise reason its
neighboring states failed. Oregon proponents omitted euthanasia from their policy proposal. The once named Hemlock Society, spearheaded by Derek Humphry, previously attempted some of the earliest legislative efforts in 1986 with a model called the Humane and Dignified Death Act. This proposal contained provisions allowing for PAS and voluntary euthanasia for terminally ill individuals as well as non-terminally ill patients, such as those with Amyotrophic Lateral Sclerosis (ALS), and even adults who, when in the early stages of Alzheimer's disease, could appoint a surrogate to assist in their death when they later became incompetent (Yount, 2000). This proposal never gained enough public support to make it very far in the legislative process, nor did their next attempt a few years later that did not include euthanasia or the Alzheimer's component. The latter attempt lacked safeguards many deemed necessary to consider the proposal, such as a mandatory psychiatric screening for all patients and a waiting period between the time the patient initially makes the request for assisted death and when that request is then granted (Yount, 2000)

In the systematic review by Steck et al. in 2013, the evidence from Europe showed that it was not the older, sicker individuals who were requesting assisted suicide the most often, which has been a common fear of elderly and disabled advocates. On the contrary, “In the Netherlands and in Flanders (Belgium), the highest percentage of assisted death requests (3.5%-5.6% and 4.2%, respectively) was seen in individuals under 64 years of age, followed by 65-79 years of age (2.1% - 4.0% and 2.5%, respectively) and those over 80 years of age (0.8% - 1.4% and 0.8%, respectively)” (Steck, Egger, Maessen, Reisch, & Zwahlen, 2013, p. 942). Similarly, in Oregon for the first two years the physician-assisted suicide program operated legally, the majority of people requesting assisted dying were younger. Steck et al. found that “physician-assisted suicide was most common among those aged 25-34 years (140.8 per 10,000 deaths from the same underlying disease), and least common in those aged 85 years and older (11.5-15.2 per 10,000 deaths form the same underlying disease)” (Steck et al., 2013). In addition, “most people dying assisted deaths were married,” as opposed to the opposition
leaders’ contention that the practice of PAS will influence the socially disenfranchised individuals to request death (Steck et al., 2013, p. 942). Furthermore, reports from Oregon’s program after two years of legalization shows that individuals with higher education tend to request assisted dying more than those with less than a high school degree (Hedberg, Hopkins, & Kohn, 2003; Hedberg, Hopkins, Leman, & Kohn, 2009; Steck et al., 2013).

LESSONS FROM DR. JACK KEVORKIAN: AN EXAMPLE OF WHAT NOT TO DO

Dr. Jack Kevorkian, a highly controversial advocate of physician assisted suicide (PAS), thrust end of life decision-making policies into the public eye with his often flamboyant practices of assisting patients in suicide. The avant-garde actions undertaken Dr. Kevorkian in the early 1990s to assist patients with dying had negative effects at the time, but now provide valuable insight about how not to proceed with policy change. His blatant disregard for the law gave the opposition perfect ammunition against the efforts of people like Derek Humphry, the Hemlock Society/Compassion and Choices founder (Yount, 2000). Humphry openly commended Kevorkian’s work as it brought tremendous attention to the cause; however he voiced concern that Kevorkian’s “maverick methods would backfire and discredit the entire movement” (Yount, 2000, p. 26). For example, Dr. Kevorkian broadcasted the assisted death of a patient on national television and was subsequently arrested and incarcerated for murder. His fanatical behavior earned him sobriquets such as “Dr. Death” and “Jack the Dripper” or even “Jeffrey Dahmer in a lab coat” (Yount, 2000, p. 26). The bad publicity his acts generated proved to be harmful to the PAS movement. It was clear that public opinion regarding PAS played a critical role in future policy changes, and Dr. Death’s methods seemed to stoke the worst fears about euthanasia.

Another important consideration brought to light after Dr. Kevorkian’s acts was the need for the patient requesting assisted suicide to have a diagnosis that included a terminal illness. Many of Dr. Kevorkian’s patients were not terminally ill and at this point in history, Americans
were not yet able to consider incurable suffering from debilitating diseases such as multiple sclerosis as enough reason to end one’s life. Most people, even those who supported PAS, were not prepared to accept assisting death for people who were not terminally ill, and found it concerning to witness the ease with which Dr. Kevorkian offered to assist these people in suicide (Yount, 2000). This harkens back to the slippery slope of euthanasia that has made opposition to PAD so effective and reinforces the concerns of “advocates for the disabled, who had always been fearful that the non-terminally ill disabled would be pressured to kill themselves or even killed against their will if any kind of euthanasia became legal” (Yount, 2000, p. 26). There was growing apprehension that this approach to assisted suicide would result in a Nazi Germany style campaign for euthanasia of those seen unfit for society. In the U.S. where PAS is legal, physician protocol requires a diagnosis inclusive of a terminal illness with a prognosis of six months or less to live. This is a necessary safeguard to assure the public that they do not need to fear the intentions of the physicians, and that elderly and disabled people will not be harmed by passage of laws legalizing PAS.

Another variable to be studied in any future legislative attempt is a thorough psychiatric evaluation of patients requesting assisted death. When autopsies of some of Dr. Kevorkian’s patients showed no sign of disease at all, it was presumed these people suffered from psychological illnesses such as depression that could at least have been addressed, and likely treated (Yount, 2000). Research into this association had already been performed by Brown and colleagues in a 1986 study that found “suicidal thoughts and desire for death appear[ed] in [their] patient group to be linked exclusively to the presence of a mental disorder” (Brown, Henteleff, Barakat, & Rowe, 1986, p. 210). Although their study had limitations that affected its validity resulting from a large number of patients that were lost to follow-up, their findings can only be suggestive, but they conclude that if “their findings can be generalized, it would appear that patients with terminal illness who are not mentally ill are no more likely than the general population to wish for premature death” (Brown et al., 1986, p. 210). Needless to say,
depression had already been considered as a major factor to consider when a patient requests assisted suicide. In states with legalized PAS in the U.S., physician protocol does not currently require a formal psychiatric evaluation, but rather states that the attending physician, and one other physician, must “certify that the patient is mentally competent to make and communicate health care decisions,” and if “either physician determines that the patient’s judgment is impaired, the patient must be referred for a psychological examination” (“The Oregon Death with Dignity Act [Ballot Measure 16],” 1994). While these laws incorporate psychiatric evaluations, they are not required, and arguably a more rigorous mental health component should be part of the policy. The average physician is not as well trained as are mental health professionals in the nuances of diagnosing depression, and so for future policy considerations, a greater emphasis on formal psychological counseling might be a feature of further legalization of assisted suicide.

Dr. Kevorkian often did not know his patients at all, or had only met them briefly, which likely contributed to his lack of understanding of their disease state as well as his lack of attention to the patients’ mental status. While he did not coerce patients into choosing death, he did not offer them other choices. This suggests another important consideration for PAS policy that would require a physician to offer patients alternatives to death, including palliation and mental health services. Palliative care supporters in the past have opposed legalization of PAS, believing there are alternatives to hastening death. However the concerns of these groups, “that assisted death would displace palliative care has been proved groundless…as wherever legislation has been enacted allowing PAS or euthanasia, the provision of palliative care has been increased,” such as in the Netherlands (Lewy, 2011, p. 148). In a study published in JAMA of patients offered PAS in Oregon, over the course of several months after their initial request for PAS, more than half of the patients retracted their request and no longer wanted assisted death. The study attributes this to the patients’ ability to receive palliative care in order to feel less a burden to loved ones, coupled with professional treatment of depression (Emanuel, Fairclough, & Emanuel, 2000). This highlights the importance of considering the PAS process in
more depth than Dr. Kevorkian’s methods allowed, in order to allow for all attributes of the patient, including whether the patient has had a chance to explore palliation and has received proper mental health support. In U.S. states with legalized PAS, the attending physician is required to inform the patient of options to enhance the care of serious/terminal illness, such as mental health care and palliative care. Thus, future legislation must also include these measures, preferably with more expansive mental health counseling, in order to be successful.

These aforementioned shortcomings of Dr. Kevorkian’s efforts can be considered both successful and unsuccessful, as they helped identify how not to proceed with advancing policy for PAS implementation. As a result, we now know several important variables that must be considered when assessing the feasibility of further PAS legislation. They include the expectation that policy will require a diagnosis of a terminal illness; that the patient must have a formal psychological evaluation and if mental illness is found, reversible causes such as depression should be treated; and that the physician must make the patient requesting PAS aware of options that can enhance their care, such as palliative care and mental health treatment.

**RECOMMENDATIONS FOR FUTURE POLICY**

In order to implement a successful assisted dying policy, a few vital recommendations should be considered. *First, the burden of responsibility on physicians needs to be lowered*. This can take the form of reducing the amount of administrative work necessary to fulfill requests for assisted dying, or lightening the responsibilities of determining who is eligible for assisted dying by the utilization of mental health professionals.

A very successful model of a PAD program was implemented at the Seattle Cancer Care Alliance, a comprehensive cancer center in Washington. Unique to this program was the use of licensed clinical social workers who are assigned to all patients upon referral to the center. The social worker serves as an advocate for the patient and their family, and works as a care
coordinator throughout the patient’s entire multistep course of care (Loggers et al., 2013). Many of the burdensome assisted dying responsibilities placed on physicians are assumed by the advocates, allowing physicians to focus on patient care as well as relieving many of the concerns doctors have about accurate diagnosis of patient competence, capacity, depression and other mental health issues. Some, but certainly not all, of the advocate’s responsibilities are delineated below.

1. “Prospectively track[s] compliance with required documentation [to submit] to the Washington Department of Health.”
2. “Describes the Death with Dignity process and the alternatives (specifically, palliative care and hospice, with these services offered as additions to, or in lieu of, Death with Dignity).”
3. “Assesses the patient’s rationale for an interest in further participation”
4. “Conducts a preliminary chart review to confirm documentation of the terminal prognosis or, if absent to request that the attending physician document the prognosis explicitly.”
5. “Verifies the patient is a Washington resident.”
6. “Completes a psychosocial assessment,” in accordance with the policy at Seattle Cancer Care Alliance, “social workers provide the first line of psychological evaluation for all patients, regardless of whether or not they are participating in the Death with Dignity program, using interview-based techniques and standardized assessments (e.g., The Patient Health Questionnaire 9 and the Generalized Anxiety Disorder 7 questionnaire).” Of note, physicians “retain the responsibility to evaluate patients for depression and decision-making capacity.”
7. “Refer patients to the Psychiatry and Psychology Service if there is any history of, or positive screening for, a mental health disorder or impaired decision-making capacity”
8. “Collects copies of the Physician Order for Life-Sustaining Treatment,” (the center’s version of an advanced directive which the advocate helps to complete, if desired by the patient)

9. “Provides grief support and legacy support through periodic calls or visits”

10. “Requests that the family informs [them] when the patient has ingested the medication, so that [they] can provide assistance in the case of complications, offer bereavement support, and aid the prescribing physician in completing the required after-death reporting forms.”

(Loggers et al., 2013, p. 1419-20)

The advocate is just one team member in this successful program. Once the patient has completed all necessary steps and is scheduled to receive the lethal medication, a pharmacist meets with the patient and any family members to discuss how to prepare and administer the medication, potential side effects, and how these may be countered with antiemetic drugs if necessary, thus minimizing any complications or confusion regarding its administration (Loggers et al., 2013). Additionally, frequent, random chart audits are performed, leading to the center’s outstanding “100% compliance with the completion of mandated forms and processes, with the exception of one unintentional failure to observe the full waiting period early in [the] program” (Loggers et al., 2013, p. 1420). This program was very well-conceived and has been well-accepted, with more physicians agreeing to participate as the program has evolved.

One lesson of the Seattle program is that a way to minimize provider hesitancy to participate is to reduce the burden required of general practitioners to determine the mental health status of a patient requesting assisted dying services from them. A large and well-powered meta-analysis by Mitchell et al. found that “clinicians inaccurately identify depression in primary care with only one in three people diagnosed correctly” (Mitchell, Rao, & Vaze, 2011). Given that general practitioners are neither comfortable with the responsibilities of determining mental capacity and competence nor are they well-suited to diagnose depression,
future policy makers should strongly consider requiring each patient requesting assisted dying to undergo a formal psychological evaluation performed by a mental health professional. The Seattle Cancer Care Alliance program’s use of appropriately trained advocates who conduct in-depth and standardized psychological interviews with the patients is a clear solution to the significant problem of physicians’ reluctance or inability to perform mental health assessments (Loggers et al., 2013).

FUTURE RESEARCH

Many studies illustrate the difficulty of conducting research in this field, and even more of them expressor investigator frustration. This is very apparent in Dickinson’s and colleagues’ systematic review by Dickinson. They could not find even a handful of studies that used a research instrument that was similar enough to allow for considerable external validity. “By using the same research instrument, the problem of trying to compare results of studies based on varied instruments could be eliminated. By conducting one large study at one point in time and using the same operational definitions, a much clearer picture could emerge regarding medical doctors’ opinions towards euthanasia” (Dickinson et al., 2005, p. 50). The inherent subjectivity in this sensitive nature field makes it difficult to adapt one model or research design to suit the gamut of necessary nuances. However, to initiate the process, the scientific community should determine concrete definitions for the variety of end-of-life options which can form the basis to create “uniform or at least comparable and unambiguously worded questions” which are “indispensable for these studies” (Emanuel, 1998, p. 151). Evidence generated by using commonly agreed upon definitions could then be a real aid to policy formation.

CONCLUSION

In 2014, a terminally ill patient has the legal right to choose their time of death in eight countries and in five U.S. states. Despite growing public support for assisted dying in the U.S.,
the topic remains hotly debated between proponents and opponents alike, and their arguments sweep across a broad spectrum of ethical and religious tenets. The issue has become a more pressing one as life-sustaining treatments have substantially extended the life expectancy of our aging population and raised concern about losing control over the dying process, but have not exponentially improved the quality of life of that population.

Exhaustive research into assisted dying policies highlights the need for the formation of public policy that goes beyond do-not-resuscitate laws and the health care proxy to address a patient’s right to die. A proposal for change in current policy governing PAS issues should be informed by the formation and outcomes of the European and U.S. examples of legal assisted dying. An accepted vernacular for assisted dying policy needs to be determined. Well-delineated and regulated guidelines for the implementation of PAS policy should consider successful models of PAD, such as the Seattle Cancer Care Alliance, detailed previously. A PAD program that lessens the responsibility placed on attending physicians through the utilization of patient advocates and mental health professionals will likely strengthen their support of future policy change. Significant consideration of the roles of physicians and the need to delegate mental health responsibilities to the mental health professionals is vitally important. One of the largest barriers to implementation is the fear that this policy would unfairly target individuals who are vulnerable in society for any number of reasons, a main one being mental illness. If policy makers wish to be successful in implementing new assisted dying policies in the U.S., the variables for inclusion and exclusion outlined on the pages above will provide a valuable framework upon which to build a successful policy.
REFERENCES


Gonzales v. Oregon, No. 04-623, 546 243 (U.S. Supreme Court 2006).


Watson, R. (2014). Belgium extends euthanasia law to children. *Bmj, 348*, g1633. doi: 10.1136/bmj.g1633


Note: Items above the timeline noted in green represent developments that advanced the policies of assisted dying practices; items below the line and noted in red represent developments that worked against policy development.
APPENDIX A: A LIMITED SYSTEMATIC REVIEW OF THE LITERATURE

INTRODUCTION

In order to successfully expand the practice of physician assisted dying in the United States, key variables to successful policy proposals must be identified.

METHODS

I performed a literature search for relevant articles using the PubMed (MEDLINE) database on May 28, 2014 using the following search string: "Suicide, Assisted"[Mesh]) OR "Right to Die"[Mesh]) OR "Euthanasia"[Mesh]) AND "Physicians"[Mesh]) AND "Humans"[Mesh]) AND "Policy"[Mesh]) OR ("Suicide, Assisted"[Mesh]) OR "Right to Die"[Mesh]) OR "Euthanasia"[Mesh]) AND "Physicians"[Mesh]) AND "Humans"[Mesh]) OR ("Suicide, Assisted"[Mesh]) OR "Liability, Legal"[Mesh]) AND ( "Suicide, Assisted/ethics"[Mesh] OR "Suicide, Assisted/legislation and jurisprudence"[Mesh] OR "Suicide, Assisted/trends"[Mesh] ) AND English[lang]) OR "death with dignity"[Text Word]) OR hasten death[Text Word]. I limited the search to articles written in the English language, those pertaining to adults (ages 19+), and articles only regarding euthanasia or assisted suicide in humans.

The search strategy is outlined in Figure 2 and involved four stages: identification of articles through database searches, screening of the articles on the basis of titles and abstract, a full-text assessment of articles for eligibility and finally inclusion in final qualitative review. The first stage of this strategy yielded 826 unique articles after 11 duplicates were removed. Additionally, the bibliographies of key articles returned from the MEDLINE search, as well as other articles that cited those key articles, were then searched the Web of Science database and reviewed for inclusion. This yielded an additional 75 articles for review. Collectively, the MEDLINE search and Web of Science database search for additional articles returned 901
articles. After the duplicates were removed, the final result of stage one of the search resulted in 892 unique articles available for further screening in stage two.

The second stage of this review required a brief screening of the titles and abstracts of all 892 publications for relevance to the question. Publications from this screening stage were excluded for the following reasons: 1) not related to assisted suicide/euthanasia, 2) not relevant to the research question (not related to variables necessary for policy development), 3) opinion article, commentary, or review of another article, 4) specific to subpopulation (e.g. HIV, ALS), 5) multiple publications (e.g. same author/title/topic), 6) original article published in a language other than English, 7) remaining duplicates that were not screened out from stage one, 8) news reports, 9) study conducted in countries other than the United States, The Netherlands, Belgium, Luxembourg, Switzerland, Australia, Canada or Japan, 10) law journal pertaining only to a specific court case, 11) non-stakeholder opinion, 12) article not available for review. This screening stage yielded 121 unique articles for further review.

The third stage of review involved a careful full-text screening of these 121 articles for eligibility based on the exclusion criteria outlined in stage two. This stage resulted in exclusion of 114 articles, leaving 7 publications for qualitative analysis.

RESULTS

Critical appraisal of these articles can be found in Table 1. Included in these thirteen publications are three systematic reviews, one implementation study, one aggregate observational study and two survey studies.

The first systematic review by Steck et al. examined characteristics of the various practices of physician assisted dying in areas of the world where it is legal (Steck et al., 2013). They found that the overall percentage of deaths attributable to physician assisted dying was very low, even in The Netherlands where this practice has been legal for the longest period of time (more than 20 years). Across all the different sites, the majority of patients who have used
assisted dying have been between the ages of 60-85 (±50%); however, there was considerable variability among sites. In Oregon, up until 2011, the most common age group was 25-34 years (140.8/10,000 deaths; 2011), in the Netherlands most commonly in individuals under 64 years (3.5%-5.6%), and elderly group (ages 80 years or older) in Brussels had the highest percentage (1.7%). Across all sites, the most common diagnosis was cancer (60-100%), with conditions such as ALS, multiple sclerosis and cardiovascular disease being less common worldwide (Steck et al., 2013). Variables evaluated for inclusion in the policies in the U.S. included patient-physician relationship, requirement for terminal illness, requirement for patient to be terminally ill adult and for there to be accurate annual reporting of assisted dying to the authorities.

The systematic review by McCormack et al. evaluate the role of psychiatrists and to determine the relevance of mental capacity, “suffering”, and mental disorders in assisted dying policies around the world (McCormack & Flechais, 2012). This review included data from official statistical reports and assisted dying acts from Belgium, The Netherlands and Luxembourg internationally, and the states of Washington and Oregon in the U.S. The authors found that the requirements for mental health evaluations for patients who request assisted dying are extremely variable across policies and across geographic locations. This study is limited by lack of data from The Netherlands and Luxembourg or any unofficial records.

A systematic review regarding stakeholder opinion in assisted dying performed by Dickinson et al. in 2005 sought to determine the attitudes of physicians in the United States, between 1991 and 2000, towards Active Voluntary Euthanasia and physician assisted death (PAD). The authors performed an electronic search of multiple databases and found that on average, 54.7% of physicians support legalization of PAD, 51.4% support legalization of AVE, while only 47.9% and 39.2% of physicians approve of PAD and AVE, respectively (Dickinson et al., 2005). The significance of the results are limited by the lack of uniformity in the questionnaires reviewed as well as the lack of external validity due to exceedingly different
study designs and variable response rates. Nonetheless, the authors did find that many more US physicians agreed that legalization of PAD was more feasible than AVE, more were willing to accept the idea of PAD than were willing to accept any notion of euthanasia. A major limitation of this study is the large variability of the data precluded a meta-analysis and resulted in very heterogeneous data, which made external validity difficult to assess.

The implementation study conducted by Loggers et al. illustrates how to successfully implement a death with dignity program at a cancer treatment facility (Loggers et al., 2013). The authors outlined and implemented a death with dignity program based directly on the Oregon DWDA. The use of ancillary staff, such as social workers who function as patient advocates and are intricately involved with guiding the patient and their families through the process of assisted dying. The important variables for policy development found in this review include: requirement for diagnosis of a terminal illness, importance of psychological evaluation, need for patient to be a resident of the state in which assisted dying is requested. Additionally, the very accurate and detailed reporting procedures helped to ease tension and fear found in those who were initially wary of participation. The authors were able to clearly illustrate policy procedures to assist other institutions in implementing a similar program, or for state health care systems that are making preparations to implement assisted dying policies. While many studies show the majority of patients requesting assisted dying are suffering from terminal cancer, this study is still limited to only cancer patients at a specific cancer center and so generalizability is quite limited.

Battin et al. performed an aggregate observational study in 2007 to address the concerns outlined by the “slippery slope” argument, and more specifically, to determine if evidence exists to suggest that legalization of assisted dying results in more frequent use of assisted dying by members of society’s vulnerable populations as compared to members of the background population (Battin et al., 2007). The authors compared data from Oregon and The
Netherlands regarding the use of AD in predetermined groups of vulnerable people, such as those with low socioeconomic status, the elderly and those with chronic mental or physical disabilities. Other than individuals with AIDS in the United States, no other “vulnerable group”, either in the U.S. or in The Netherlands was found to be at a heightened risk for death from assisted dying practices. While the authors made a concerted effort to control for heterogeneous study designs, a major limitation of this study is the many different methods of data sources and collection methods, which decreases certainty of incidence of AD in some groups. Also, the very different laws in different areas where AD is legal make comparisons difficult and thus applicability equally difficult.

The purpose of the survey study conducted by Meier et al. in 1998 was to improve national data on physician assisted dying and euthanasia in the United States (Meier et al., 1998). The received surveys from approximately 40% of the practicing physicians under the age of 65 years in ten specialties selected to be most likely to directly deal with end of life medical care. At that time when there was no legalization of assisted dying practices in the United States (1996), 11% of surveyed physicians would be willing to participate in physician assisted suicide, and 7% would be willing to participate by administering a lethal injection to a patient (PAS) (Meier et al., 1998). If the practice of PAD became legal, 34% and 24% of surveyed physicians reported they would participate in PAS and AVE, respectively (Meier et al., 1998). Limitations of this study include a response rate of 60% suggesting possible differences between respondents and non-respondents.

Finally, the last survey study was conducted by Smets et al. in 2011 and sought to qualify the attitudes of Belgian physicians towards assisted dying laws and practices (Smets et al., 2011). The authors sent surveys to a sample of 3006 medical doctors in Belgium that were in specialties most likely to be involved in end of life care and decisions. The authors found assisted dying practices to be generally supported by doctors who participate in EOL care (90%
of surveyed physicians in accordance) (Smets et al., 2011). Additionally, 66% of surveyed physicians believed the law in place helps to regulate how this practice is carried out and that the law itself helps improve palliative care, while 33% of physicians considered the law to be too intrusive into their practice and would prefer less governmental regulation of their practice of EOL medicine (Smets et al., 2011). Limitations of this study included a very low response rate of 34%, which limits generalizability and suggests a potentially weak sampling strategy as they had a high non-response rate. Additionally, this study was conducted entirely in Belgium and the cultural differences make applicability of these findings to U.S. physicians theoretical at best.

**DISCUSSION**

The purpose of this limited systematic review was to determine whether the current literature regarding various euthanasia and PAS policies around the world contains valuable evidence regarding the variables necessary to advance the policy of PAS in the United States. Are there specific variables necessary to include and exclude from future assisted dying policy development proposals in the United States if they are to be successful in the United States? This limited systematic review reflected very similar themes from much of the data available about what aspects of policy development have and have not been successful in this field.

Steck et al. conducted a fairly well powered systematic review which resulted in the description of some important variables necessary for policy development in the United States, including: the requirement for terminal illness in a mentally competent adult, the need for some sort of physician-patient relationship and the need for thorough reporting to the authorities. Also, Switzerland was shown to be a very poor model for the U.S. to base policy procedures on. For example, foreigners are allowed to travel to Switzerland for the sole purpose of receiving assistance in dying. In all other countries, as well as the reported U.S. States, a patient is required to have permanent residence in the state or country in which they desire assistance in
dying. Additionally, the Swiss law does not require the patient and the doctor to have had any previous encounters, nor for the patient to have been proven to be mentally competent. None of these policies are amenable to policy development in the United States. Mental health concerns need to be fully recognized and appropriately evaluated by mental health professionals, not general practitioners who are not skilled in this field. Moreover, mental health patients and other members of the so called “vulnerable populations”, such as the disabled and the elderly must be extremely protected by safeguards built into the policies.

Dickinson et al. discovered the difficulty inherent in studying opinions about issues that have yet to establish common definitions to describe them. While the investigators made a decent effort to control for these limitations by detailing the sampling procedures as well as the response rates to the various inquiries, the large variability of the data collected precluded performing a meta-analysis and they resulted to comparisons and inferences among a very heterogeneous dataset, which made their conclusions more hypothetical than factual. This study highlighted the dire need for unambiguous definitions for end of life options as well as for research that can more accurately compare physician opinions on this topic.

Meier et al. found that despite the modest support the authors found for legalization of PAD, very few physicians reported a willingness to participate in the activities should they become legalized. Smets et al. found similar support for the legalization and practice of assisted dying, yet in Europe, many physicians believe the regulation of the practice by the government is too strict and they should be allowed to practice EOL interventions more freely. This highlights the importance of taking American values into consideration when drafting policy proposals, as the lessons we have learned from Europe are typically more liberal in nature and serve as lessons that often take too much of a liberal approach to be welcomed by Americans at this time. For example, the U.S. is not ready for euthanasia in any form, as any previous attempts to
legalize this have made no political progress to speak of. This limited review has provided key variables that must be incorporated into policy in order for it to become law in the United States.

**FIGURE 2. Systematic Review Flow Diagram**

Systematic Review Flow Diagram

<table>
<thead>
<tr>
<th>Citation</th>
<th>Study/Paper purpose</th>
<th>Study Design</th>
<th>Methods</th>
<th>Results</th>
<th>Quality Rating; Strengths (+) Limitations (-)</th>
<th>Overall Conclusions: Lessons learned, Recommendations</th>
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<tr>
<td>Battin (2007)</td>
<td>To determine the validity of &quot;slippery slope&quot; concerns expressed by opponents of AD legislation. Is there evidence that where assisted dying is legal, the lives of the vulnerable populations are more frequently ended via AD than those of the background population?</td>
<td><em>Observational (Aggregate)</em> Compared data from Oregon and the Netherlands (the two principal locales where PAD is legal and data has been collected over a long period of time)</td>
<td>-Oregon data from all annual/cumulative DHS reports (1998-2006) &amp; 3 independent studies -Netherlands: all 4 gov't commissioned nationwide studies (1990, 1995, 2001, 2005) -Collected evidence of disproportionate use of AD on 10 groups of &quot;vulnerable&quot; patients and compared with background population</td>
<td>-No heightened risk for AD in the following vulnerable groups compared to background populations (RR=Rate Ratio; US, NTH): Elderly (1.0,1.0), women (1.0,1.0), uninsured (US only: 2%), low education (US only: 1.4), low SES(NTH only: 1.0), racial/ethnic minorities (US only: 0.9), chronic physical/mental disabilities or chronic non-terminal illness(US-illegal; NTH: no data), minors (NTH only: 1.6% all deaths 1-16 yo), psych illness (depression, Alzheimer's)(No data) -Group w/ heightened risk: people with AIDS (US: 30.3; NTH: 7.9)</td>
<td>Quality: Good (+) Good control for heterogeneous study designs (+) Directly addresses concerns of vulnerable groups and their advocates (-) Different methods of data sources--decreases certainty of incidence of AD in some groups. (-) No data from NTH re: education, race, chronic mental/physical disability (-) Very different laws make comparisons difficult</td>
<td>-Where AD legal- No clear evidence for disproportionately affecting vulnerable populations -Need to understand safeguards in place where legal and develop them further to make policy proposals more acceptable -Need for more standardization regarding mental health issues -Comparative research b/n US and Europe very difficult--recurring theme--studies have different methods, different time periods, different strengths all presumably due to variability between jurisdictions/culture/reporting protocols.</td>
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<td></td>
<td>-Database search returned 54 articles; 39 fit inclusion criteria)</td>
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<td>-Response rate range 20-100%</td>
<td>-Response rate range 20-100%</td>
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<td>-Pro legalization PAD: 54.7%</td>
<td>-Pro legalization PAD: 54.7%</td>
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<td>(avg. response rate 62.4%);</td>
<td>(avg. response rate 62.4%);</td>
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<td>AVE: 51.4% (avg. resp. rate 74.3%)</td>
<td>AVE: 51.4% (avg. resp. rate 74.3%)</td>
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<td>-Approval PAD: 47.9% (avg. resp. rate 54.3%); AVE: 39.2% (avg. resp. rate 61.5%)</td>
<td>-Approval PAD: 47.9% (avg. resp. rate 54.3%); AVE: 39.2% (avg. resp. rate 61.5%)</td>
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<td>-Prior requests for PAD: 37% (avg. resp. rate 61.8%); for AVE 42.67% (avg. resp. rate 65.0%)</td>
<td>-Prior requests for PAD: 37% (avg. resp. rate 61.8%); for AVE 42.67% (avg. resp. rate 65.0%)</td>
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<td>-If legal, would participate in PAD: 36.07% (avg. resp. rate 51.5%); AVE: 29.5% (avg. resp. rate 56.5%)</td>
<td>-If legal, would participate in PAD: 36.07% (avg. resp. rate 51.5%); AVE: 29.5% (avg. resp. rate 56.5%)</td>
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<td>-Has participated in PAD: 12.4% (avg. resp. rate 59.0%); AVE: 3.7% (avg. resp. rate 57.3%)</td>
<td>-Has participated in PAD: 12.4% (avg. resp. rate 59.0%); AVE: 3.7% (avg. resp. rate 57.3%)</td>
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<td>*some studies only under certain conditions</td>
<td>*some studies only under certain conditions</td>
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<td>Quality: Fair (+) Focuses only on U.S. physician attitudes (+) Well documented sampling procedures and response rate--helps determine external validity of each question (-) Large variability of data base precluded meta-analysis; resulted in very heterogeneous data (-) Research instruments not available and likely very different-hard to make comparisons (-) Inconsistent questionnaires produced small # of studies asking same question (-) External validity difficult to assess</td>
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<tr>
<td>Loggers (2013)</td>
<td>To illustrate an institutional response to implementation of new policies allowing physician assisted dying in order to prepare other institutions for a future where this policy may become law in elsewhere</td>
<td>Implementation Study</td>
<td>-Implemented a Death with Dignity (DWD) program at a cancer center in Seattle, WA from 3/2009-12/2001. Modeled from law in OR, WA: Institution level data compared w/public data on DWD Programs in OR &amp; WA; added safeguards; patients assigned an advocate that coordinates whole care team &amp; pt. course</td>
<td>-40 people received a lethal Rx. (35.1% of the 114 patients who inquired about the program; 15.7% of all WA DWD participants), all died, 24 after medication ingestion (60% of those obtaining Rx's).</td>
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<td>Stages of implementation examined: -Program installation -Initial implementation -Full operation</td>
<td></td>
<td>-White: 72.5% (WA: 95.2%, OR: 97.6%); High-school or higher education: 97.5% (WA: 94.1%, OR:93.2%); Had medical insurance: 90% (WA: 97.3%, OR: 98.3%)</td>
<td>-White: 72.5% (WA: 95.2%, OR: 97.6%); High-school or higher education: 97.5% (WA: 94.1%, OR:93.2%); Had medical insurance: 90% (WA: 97.3%, OR: 98.3%)</td>
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<td>-Reasons for participation: Loss of autonomy (97.2%), inability to enjoy activities (88.9%), loss of dignity (75.0%).</td>
<td>-Reasons for participation: Loss of autonomy (97.2%), inability to enjoy activities (88.9%), loss of dignity (75.0%).</td>
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<td>Quality: Good (+) Representative of WA, OR DWD (+) Clear policy strategies were implemented well and clearly documented</td>
<td>Quality: Good (+) Representative of WA, OR DWD (+) Clear policy strategies were implemented well and clearly documented</td>
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<td>(-) Limited to cancer patients at specific care center--limits generalizability (however, most patients of OR, WA DWD programs are cancer patients (80.5% &amp; 77.9%, respectively)--appropriately limited for most represented patient population</td>
<td>(-) Limited to cancer patients at specific care center--limits generalizability (however, most patients of OR, WA DWD programs are cancer patients (80.5% &amp; 77.9%, respectively)--appropriately limited for most represented patient population</td>
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</tbody>
</table>

<p>| Lessons learned: | Poor support for PAD, AVE in physician community as of 2000 | Good recommendations for policy implementation. Patient advocate is suggestion for minimizing MD burden |
| Variables:       | -Terminal Diagnosis -Patient desire for autonomy -Psych eval very important (rec for standardization to determine competency) | Good recommendations for policy implementation. Patient advocate is suggestion for minimizing MD burden |
|                  | -Resident of WA -Accurate documentation/reporting to authorities; regular QI | Good recommendations for policy implementation. Patient advocate is suggestion for minimizing MD burden |</p>
<table>
<thead>
<tr>
<th>Year</th>
<th>Study Title</th>
<th>Study Details</th>
<th>Methods</th>
<th>Findings</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>Meier</td>
<td>To evaluate the role of psychiatrists in AD where legal- Belgium, The Netherlands, Luxembourg, and the states of Washington and Oregon in the USA</td>
<td>Systematic Review - Assisted Dying Acts and official statistical reports from Belgium, The Netherlands, Luxembourg, and the states of Washington and Oregon</td>
<td>Extracted data related to: -The role of psychiatrists in assisted dying practices -Relevance of capacity, 'suffering', and mental disorder</td>
<td>Good</td>
</tr>
<tr>
<td>2012</td>
<td>McCormack</td>
<td>To establish the relevance of mental capacity, &quot;suffering&quot;, mental disorder</td>
<td>Survey - 3102 Physicians (representative of 40% all practicing MDs &lt;65 yo.)</td>
<td>-Self-administered, anonymous surveys -# requests for aid in dying (explicit vs. implicit requests)/# requests honored -Multiple logistic-regression analysis relationship b/n characteristics of MDs &amp; views/actions re: AD -Single-variable analysis (specialty vs. predictor variable; Religion, specialty forced into all models (religion to control effect of religious affiliation on freq. prayer; specialty= stratification variable) -Received 1902 completed questionnaires (response rate, 61 %) -Willing to assist dying w/ current legal restraint(from 1996–not legal): 11% by prescription, 7% by lethal injection -If legal: 34% by prescription, 24% by lethal injection -18.3% of MDs- received request for assistance with suicide &amp; 11.1 % received request for a lethal injection. -16% of those who received requests (3.3% of entire sample) -written ≥1 Rx to hasten death; 4.7% administered ≥1 lethal injection</td>
<td>Good</td>
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<td>-Lack of policy anywhere requiring Ψ eval. by mental health professional may mean reversible psychopathology is missed &amp; decisions to hasten death may result from treatable mental disorder -Recommendations: Mandatory involvement of mental health professionals in evaluation of all applicants for AD</td>
<td>Quality: Good (+) Appropriate design, methods, and execution of methods (+) Weighted results - nationally representative data (+) comprehensive data (+) included patient and physician characteristics (+) few other studies included many specialties (-) 60% response rate possible differences in respondents v. non-respondents (-) specialty selection increases probability request for assisted death overestimates general MD population</td>
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<td>-Variables: Ψ component very important for policy development</td>
<td>Patient characteristics closely resemble OR DWD patients -Cancer dx: 93% -98% &lt;6 mo to live -85% ≥ 16 yrs education -Important burden on physicians who are attempting to give best EOL care to patients and are knowingly assisting in dying when it is not legal</td>
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<td></td>
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<td>-Variables: Terminal diagnosis, Doctor/patient relationship (≥12 mo in 75% cases), MD choice to participate</td>
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<td>Smets (2011)</td>
<td>To study the attitudes of Belgian MDs re: Assisted Dying Laws &amp; Practices</td>
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<tr>
<td><strong>Survey</strong></td>
<td>Sample of 3006 Belgian physicians likely to be associated with EOL care based on specialty; 914 questionnaires returned and selected for study</td>
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<td>-Self-administered, anonymous questionnaire sent to sample of Belgian physicians (based on specialty-more likely to be involved in the care of the dying); stratified by province and specialty- for each province, a random proportional sample was drawn for each specialty. -Weighting factor corrected for stratification; Separate multivariate ordinal logistic regression fitted for each statement to estimate assoc. w/ MD specialty-SDS/work related characteristics, experiences w/ EOL care/euthanasia, religiosity.</td>
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<td>-Response rate =34%. -90% accepting euthanasia for terminal patients w/ uncontrollable pain -66% agreed euthanasia law improves quality of EOL care/ carefulness of MD's behavior -10% agreed law impeded development of palliative care; MDs trained in palliative care less likely to agree law impedes dev. palliative care than non-trained MDs -Geographic region, religious affiliation= strong predictors of MD attitude -19.7% had performed euthanasia (more likely to be nonreligious, older, specialists, trained in palliation, more experience in EOL care)</td>
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<td>Quality: Fair (+) Superior methods for anonymity- via lawyer as intermediary- inspires truthful responses, especially for illegal actions performed (+) Careful assessment of non-responders showed 1/3 not involved in EOL care (+) Comprehensive questionnaire (+) Findings are in line with previous studies (-) Low response rate-limits generalizability (-) Possibly weak sampling strategy resulted in high rate of non-response (-) Non-responders more likely to oppose euthanasia-potential for response bias</td>
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<table>
<thead>
<tr>
<th>Steck (2013)</th>
<th>To examine the characteristics of the various practices of PAS and euthanasia in areas of the world where it is legal</th>
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</thead>
<tbody>
<tr>
<td><strong>Systematic review</strong></td>
<td>1043 publications retrieved; 25 retained</td>
</tr>
<tr>
<td>-Review of Medline and Embase from inception until 2012; searched websites of health authorities of eligible countries/states for reports on PAS and euthanasia. -Total # assisted deaths -Its proportion in relation to all deaths -Socio-demographic &amp; clinical characteristics of AD patients</td>
<td></td>
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<tr>
<td>-Percentage of physician-assisted deaths among all deaths: 0.1% - 0.2% in the US &amp; Luxembourg, and 1.8%-2.9% in the Netherlands</td>
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<tr>
<td>Characteristics of those requesting assisted dying: -Cancer diagnosis (60-100%) -Sex- poor reporting/measuring -Ages 60-85 (±50%) overall; Oregon- most common in 25-34 yr olds (140.8/10,000 deaths; 2011); Netherlands- under 64 yr old (3.5%-5.6%)</td>
<td></td>
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<tr>
<td>Quality: Fair (+) Highlighted important variables (+) Describes model systems (+) High power (-) Limited reporting from some areas (Montana=0; Switzerland=1) (-) Poor reporting in some countries skewed data to represent others more; many important qualities undermined (-) Unclear data analysis</td>
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</table>

Variables necessary for US policy: -No euthanasia allowed -Diagnosis of terminal illness -Mentally competent -Reporting cases to the authorities (poorly done in Europe) -Switzerland is a poor model for the U.S. as its practice are very extreme and lack the important safeguards necessary for assisted dying policy in the US.
References for Limited Systematic Review:


# APPENDIX B: TIMELINE OF EVENTS INFLUENCING POLICY AND LAW OF PAS LEGISLATION

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1828</td>
<td>New York makes assisting suicide illegal</td>
<td>First state law in U.S that expressly makes assisting suicide a criminal act</td>
</tr>
<tr>
<td>1906</td>
<td>Ohio makes 1st attempt to legalize euthanasia in the U.S.; failed</td>
<td>The bill was introduced to the Ohio legislature to legalize physician assisted voluntary euthanasia for the terminally ill. Failed vote by 78 to 22.</td>
</tr>
<tr>
<td>1936</td>
<td>1st euthanasia bill introduced in Great Britain; failed</td>
<td>House of Lords votes down bill, 35 to 14</td>
</tr>
<tr>
<td>1940s</td>
<td>Nazi Germany- forced involuntary euthanasia changes public perception of euthanasia in the U.S.</td>
<td>Public perception of euthanasia is destroyed</td>
</tr>
<tr>
<td>1950s</td>
<td>WMA and AMA condemn euthanasia</td>
<td>Polls show public support for euthanasia is down by &gt;10% from the 1930s</td>
</tr>
<tr>
<td>1950s-1960s</td>
<td>Advances in medical science prolong lives through development of feeding tubes and respirators</td>
<td>Need for society to address end-of-life issues becomes more pressing</td>
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<tr>
<td>1967</td>
<td>First Living Will is written by attorney Luis Kutner</td>
<td>The first form of advance health care directive is introduced- allows competent adults to specify medical proceedings for the end of life if they become incapacitated</td>
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<tr>
<td>1968</td>
<td>Irreversible coma is defined as a criteria for death</td>
<td>Harvard Medical School Committee publishes definition in JAMA</td>
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<tr>
<td>1969</td>
<td>Elisabeth Kubler-Ross publishes On Death and Dying</td>
<td>Opens discussion in Western society about the previously taboo subject of death</td>
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<tr>
<td>1969</td>
<td>Voluntary euthanasia bill introduced in Idaho fails to pass</td>
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<td>Year</td>
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<tr>
<td>1973</td>
<td>AHA issues the Patient's Bill of Rights</td>
<td>Includes informed consent and the right to refuse medical treatment</td>
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<tr>
<td>1973</td>
<td><em>Roe v. Wade</em> landmark case</td>
<td>Many future legislative efforts for PAS cited this case as precedence for a right to privacy under the due process clause of the 14th amendment</td>
</tr>
<tr>
<td>1976</td>
<td>In Re Quinlan: Supreme Court of NJ rules a respirator can be removed from a comatose patient</td>
<td>Drew national attention to EOL issues---&gt; upsurge in living wills</td>
</tr>
<tr>
<td>1976</td>
<td>California Natural Death Act is passed giving legal merit to living wills</td>
<td>First legal force given to advanced directives. Grant individuals right to authorize withdrawal of LST when death is imminent and provided legal protection for doctors who assisted in this process; 10 more states followed suit later that year</td>
</tr>
<tr>
<td>1977</td>
<td>8 states have right to die bills signed into law</td>
<td>CA, NM, AK, NV, ID, OR, NC, TX</td>
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<tr>
<td>1980</td>
<td>Pope John Paul II give <em>Declaration on Euthanasia</em></td>
<td>Allows refusal of LST or use of pain controlling drugs that may shorten life; Opposes mercy killing but allowed Christians and Catholics a chance to participate in the national rhetoric on EOL issues</td>
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<tr>
<td>1980</td>
<td>Hemlock Society founded</td>
<td>dedicated to legalization of PAS and voluntary euthanasia for competent, terminally ill adults</td>
</tr>
<tr>
<td>1984</td>
<td>Voluntary euthanasia approved in The Netherlands under certain circumstances-not legalized, but doctors won't be prosecuted</td>
<td>Euthanasia and PAS not legalized; physicians participating must follow guidelines established by the Royal Dutch Medical Society</td>
</tr>
<tr>
<td>1990</td>
<td>Public Opinion Survey shows &gt;50% of Americans support PAS (Woodman)</td>
<td>Leads to upsurge of EOL court activity, medical journals regarding and individual acceptance of PAS</td>
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<tr>
<td>1990</td>
<td>Dr. Jack Kevorkian assists in the death of his first patient</td>
<td>Focused public on voluntary euthanasia and the right to assisted suicide</td>
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<td>Year</td>
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<tr>
<td>1990</td>
<td>The U.S. Supreme Court rules on its first right-to-die case: <em>Cruzan v. Director, Missouri Dept. of Health</em>: Right to refuse life-saving medical service</td>
<td>The decision allows competent adults to refuse medical treatment; states are allowed to impose procedural safeguards to protect its interests; the decision allows competent adults to refuse medical treatment, including nutrition—that is, passive euthanasia—at least for competent adults or incompetent ones who had left previous clear indications of their wishes</td>
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<tr>
<td>1990</td>
<td>US Congress passes Patient Self-Determination Act</td>
<td>Requires hospitals that receive federal funds to tell patients to have the right to refuse treatment.</td>
</tr>
<tr>
<td>1991</td>
<td>1st state referendum on PAS and euthanasia fails in Washington State polls</td>
<td>Ballot Initiative 119 (legalization of PAS and aid in dying); Vote was 54-46%</td>
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<tr>
<td>1991</td>
<td>Death With Dignity Act introduced to Oregon legislature; fails to get out of committee</td>
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<tr>
<td>1991</td>
<td>Dr. Timothy Quill, NYC physician, admits to prescribing lethal dose of medication for patient to assist in her dying</td>
<td>Dr. Quill is not indicted</td>
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<tr>
<td>1992</td>
<td>California voters defeat Proposition 161 which would've legalized PAS and euthanasia</td>
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<tr>
<td>1993</td>
<td>The Case of Sue Rodriguez goes to Canadian Supreme Court and fails</td>
<td>Rodriguez suffered from ALS and request PAS, was denied; Draws Canada's attention to the issue of PAS</td>
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<tr>
<td>1994</td>
<td><em>Compassion v. Washington</em>: Washington’s anti-suicide law overturned</td>
<td>Ban on assisted suicide violates 14th amendment</td>
</tr>
<tr>
<td>1994</td>
<td>Oregon Death with Dignity Act Passed</td>
<td>Oregon Measure 16, passes in polls (52 to 48% against); Oregon becomes first state to legalize actively assisted dying;</td>
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<td>Year</td>
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<tr>
<td>1996</td>
<td>Northern Territory of Australia implements The Rights of the Terminally Ill Act, a voluntary euthanasia law</td>
<td>9 months later it is overturned</td>
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<tr>
<td>1997</td>
<td>U.S. Supreme Court rules there is No Right To Die</td>
<td>Rulings from <em>Washington v. Glucksberg</em> and <em>Vacco v. Quill</em>; returns decisions to the states</td>
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<tr>
<td>1998</td>
<td>Michigan defeats PAS proposal (Proposal B)</td>
<td>Fails by 29% to 71% against</td>
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<td>1998</td>
<td>Michigan passes a law making PAS a felony</td>
<td>Punishable by up to 5 yrs. In prison and $10k fine</td>
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<td>1998</td>
<td>Kevorkian broadcasts assisted death of Youk on CBS 60 minutes</td>
<td>He is then charged with 1st degree murder and sentenced to prison</td>
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<td>1999</td>
<td>The House of Representatives passes the Pain Relief Promotion Act</td>
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<tr>
<td>2000</td>
<td>Main Death with Dignity Act is defeated</td>
<td>Similar to Oregon’s law, fails by 51.5 to 48.5% against</td>
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<tr>
<td>2002</td>
<td>The Netherlands legalizes voluntary euthanasia and PAS</td>
<td>It had been permitted under guidelines for the preceding 20 years</td>
</tr>
<tr>
<td>2002</td>
<td>Belgium legalizes voluntary euthanasia and PAS</td>
<td>Similar law to Dutch</td>
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<tr>
<td>2005</td>
<td>Terri Shaivo allowed to die after 10 yrs in PVS by removal of LST equipment</td>
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<tr>
<td>2006</td>
<td>The Suicide Materials Offences Act takes effect in Australia</td>
<td>This made it a felony to pass information by phone, internet, fax, or email about any form of euthanasia</td>
</tr>
<tr>
<td>2006</td>
<td>US Supreme Court approved validity of Oregon Death With Dignity Act</td>
<td>Under challenge form the federal attorney general (<em>Gonzalez v. Oregon</em>)</td>
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<tr>
<td>Year</td>
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<tr>
<td>2008</td>
<td>Luxembourg legalized PAS and euthanasia</td>
<td>Similar to Belgian law on hastened death</td>
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<td>2008</td>
<td>Washington Death with Dignity Act is Passed</td>
<td>Making Washington the second state to legalize PAS</td>
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<tr>
<td>2008</td>
<td>Montana Death with Dignity Act is Passed</td>
<td>Ruling in case of Baxter v. State of Montana allows residents the legal right to PAS, making it the 3rd state to legalize PAS</td>
</tr>
<tr>
<td>2012</td>
<td>Massachusetts Death with Dignity Ballot Measure defeated</td>
<td>Measure would have legalized PAS for terminally ill, mentally competent patients</td>
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<tr>
<td>2013</td>
<td>Vermont signs &quot;End of Life Choices&quot; bill into law</td>
<td>Vermont becomes 4th state to allow PAS</td>
</tr>
<tr>
<td>2014</td>
<td>PAS ruled legal by New Mexico judge</td>
<td>Ruling prohibits prosecution of physicians who help competent terminally ill patients end their lives</td>
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</table>

**References for Timeline**


APPENDIX C: OVERVIEW OF IMPORTANT COURSE CASES

In re Quinlan (70 N.J 10)

March 31, 1976

Summary: This case considered the request to have ventilator support removed from 21-year-old Karen Ann Quinlan in 1975. Her parents requested this action after Karen had remained on a ventilator for 5 months and her doctors determined her to be in a “persistent vegetative state,” but her doctors refused and the case subsequently came under consideration by the New Jersey Superior Court. Though her parents’ request was denied, the New Jersey Supreme Court later reversed the decision based on their determination that the removal of ventilator support is supported by Quinlan’s “right to privacy.”

Comment: The Quinlan case led to an upsurge in interest in living wills. Living wills were the first form of advance health care directives to be introduced, allowing competent adults to specify what kinds of medical treatment they would or would not want if they should become incompetent (Yount, 2000).

Six months later, California passed the Natural Death Act, providing legal merit to advanced directives.

Bouvia V. Superior Court Ex. Rel. Glenchur

Cal Repr 297 C. CT. APP.

1986

Summary: This case considered the request of an Oregon resident, Elizabeth Bouvia, to have her feeding tube removed so that she could starve herself to death. Bouvia was a 26-year-old woman of normal intelligence who was born with CP and also complained of considerable pain from arthritis. After making her request while a patient in 1983 at Riverside Hospital in California in 1983, she was admitted to psychiatry and the chief psychiatrist refused her request. Bouvia called media attention to her plight and demanded her rights as a mentally competent
adult to refuse medical treatment. Probate judge Hews found her both competent and rational, but refused her request for feeding tube removal and subsequent death citing the effect he felt that her dying would have on the hospital staff and other disabled people. She was subsequently force-fed (Yount, 2000).

Comment: A critical outcome of this case is the Appeals court's statement that "any competent adult, terminally ill or not, had a constitutional right to refuse life-sustaining medical treatment" (Yount, 2000). A similar case concerning Larry McAfee, who became a quadriplegic after a motorcycle accident, "showed that disabled people could obtain the right to kill themselves by refusing life-sustaining treatment if they persisted through the court system long enough" (Yount, 2000). Neither Bouvia nor McAfee exercised their opportunity to kill themselves once afforded the option to do so.

Cruzan v. Director, Missouri Dept. of Health

497 U.S. 261

June 25, 1990

Summary: Following an automobile accident that left her in a “persistent vegetative state,” Nancy Beth Cruzan was kept alive for several weeks via artificial feedings. The request of her parents to end life support was denied by hospital officials unless court approval could be obtained. A state trial court upheld the parents' request for cessation of artificial feeding, but this decision was reversed by the Missouri Supreme Court. The U.S. Supreme Court later upheld the ruling of the Missouri Supreme Court in a 5-4 decision. The actions of the State of Missouri to preserve human life were constitutional in the absence of "clear and convincing evidence" that Cruzan desired treatment to be withdrawn.

Comment: This decision allows competent adults to refuse medical treatment, including nutrition—that is, passive euthanasia—at least for competent adults or incompetent ones who had provided previous clear indications of their wishes. Also, many states amended their living
will laws to permit withdrawal of food and water from patients in PVS if they had signed advance directives requesting this (Yount, 2000).

Washington v. Glucksberg
521 U.S. 702
June 26, 1997

Summary: This case considers a law suit challenging the ban on physician-assisted suicide by the State of Washington. The plaintiffs in this case, Harold Glucksberg, MD, three other doctors, three seriously ill patients, and the Compassion in Dying organization, claimed that the Washington ban was unconstitutional. They argued that the liberty interest protected by the Fourteenth Amendment allows mentally competent, terminally ill adults to commit physician-assisted suicide. The District Court ruled in favor of the plaintiffs, and the Ninth Circuit upheld their decision. This was later reversed by the Supreme Court in a 9-0 decision, finding that the ban on physician-assisted suicide is not a violation of the Fourteenth Amendment.

Vacco v. Quill
526 U.S. 793
June 26, 1997

Summary: This case considered the constitutional challenge of New York state’s ban on physician-assisted suicide. The plaintiffs, Timothy Quill, MD, two other physicians and three gravely ill patients, argued that the ban violated the Equal Protection Clause of the Fourteenth Amendment. The New York law allowed patients to refuse life-sustaining treatment, but denied any right to assisted suicide. The District Court ruled in favor of the State of New York, but the Second Circuit reversed in favor of Dr. Quill. The Supreme Court, in a 9-0 ruling, upheld the constitutionality of New York's ban on physician-assisted suicide.
Comment: In Washington v. Glucksberg and Vacco v. Quill, the U.S. Supreme Court unanimously held that PAS is not a fundamental liberty interest protected by the constitution. The court implied that it might consider state legalization of PAS constitutional, which has sparked earnest debate on PAS in the dying process (Gostin, 1997).