Euthanasia and Physician-Assisted Suicide: A Comparison of EU and U.S. Law

Stephen Hoffman
SYMPOSIUM

JURISPRUDENCE AND THE BODY:
TAKING THE PULSE OF HEALTH LAW

ONLY THE HEADSTRONG SURVIVE: THE TRAGIC COURSE OF
HEAD INJURY CLAIMS UNDER THE BERT BELL/PETE ROZELLE
NFL PLAYER RETIREMENT PLAN

Elverine F. Jenkins

THE USE OF MEDICAL IMPAIRMENT, FUNCTIONAL LOSS,
AND VOCATIONAL FACTORS TO DETERMINE LOSS OF
WAGE EARNING CAPACITY UNDER THE 2012
GUIDELINES FOR PERMANENT IMPAIRMENT

Robert E. Grey

EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE:
A COMPARISON OF E.U. AND U.S. LAW

Stephen Hoffman

WHEN PRIVACY IS NOT AN OPTION: CODIFYING THE
CONTOURS OF NECESSARY THIRD PARTIES IN
EMERGENCY MEDICAL SITUATIONS

Chris Chambers Goodman

NOTES

FROM RATS TO RICHES: HOW THE ANABOLIC STEROID
CONTROL ACT OF 2004 UNJUSTLY PUNISHED THE
GYM RAT AND HOW A NEW PRESCRIPTION IS THE
ROAD TO SALVATION

Adam Herschthal

PIERCING THE VEIL OF DANGEROUSNESS IN FORCIBLE
MEDICATION: WHY PRETRIAL DETAINES ARE
DUE MORE PROCESS THAN WASHINGTON V. HARPER

Jason Feldman

Volume 63  Number 3  2013
SYMPOSIUM

JURISPRUDENCE AND THE BODY:
TAKING THE PULSE OF HEALTH LAW

ONLY THE HEADSTRONG SURVIVE: THE TRAGIC COURSE OF
HEAD INJURY CLAIMS UNDER THE BERT BELL/PETE ROZELLE
NFL PLAYER RETIREMENT PLAN

–Elverine F. Jenkins 327

THE USE OF MEDICAL IMPAIRMENT, FUNCTIONAL LOSS, AND
VOCATIONAL FACTORS TO DETERMINE LOSS OF WAGE EARNING
CAPACITY UNDER THE 2012 GUIDELINES FOR PERMANENT
IMPAIRMENT

–Robert E. Grey 353

EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE: A
COMPARISON OF E.U. AND U.S. LAW

–Stephen Hoffman 383

WHEN PRIVACY IS NOT AN OPTION: CODIFYING THE CONTOURS
OF NECESSARY THIRD PARTIES IN EMERGENCY MEDICAL
SITUATIONS

–Chris Chambers Goodman 399

NOTES

FROM RATS TO RICHES: HOW THE ANABOLIC STEROID CONTROL
ACT OF 2004 UNJUSTLY PUNISHED THE GYM RAT AND HOW A
NEW PRESCRIPTION IS THE ROAD TO SALVATION

–Adam Herschthal 437

PIERCING THE VEIL OF DANGEROUSNESS IN FORCIBLE
MEDICATION: WHY PRETRIAL DETAINEES ARE DUE MORE
PROCESS THAN WASHINGTON V. HARPER

–Jason Feldman 467
EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE:
A COMPARISON OF E.U. AND U.S. LAW

Stephen Hoffman†

CONTENTS

INTRODUCTION ........................................................................................................... 383
I. EUTHANASIA AND PAS: DEFINITIONS AND DISTINCTIONS .............. 384
   A. Subcategories of Euthanasia ......................................................................... 386
   B. Relieving Pain and Hastening Death: The Doctrine of Double Effect ................................................................. 388
II. THE COMMON LAW NECESSITY DEFENSE AND A PHYSICIAN’S
    CONFLICTING DUTIES .................................................................................. 388
III. EUROPEAN LAW .............................................................................................. 389
    A. United Kingdom .......................................................................................... 389
    B. The Netherlands ......................................................................................... 390
    C. Switzerland ................................................................................................. 391
IV. U.S. LAW ............................................................................................................ 393
    A. Oregon .......................................................................................................... 393
    B. Washington .................................................................................................. 394
    C. Montana ....................................................................................................... 394
V. PRACTICAL CONSIDERATIONS ...................................................................... 395
CONCLUSION .............................................................................................................. 396

INTRODUCTION

While much of law is uncontroversial, a few “hot button” issues tend to rile at least one side of the ideological spectrum. Some of these issues are national, cultural, or of particular historical relevance, such as the affirmative action doctrine in the United States. Other issues, however, tend to cause a stir because of religious or philosophical reasons. Particularly in the United States, there is a deep divide among citizens regarding whether it is acceptable for a person to take the life—or, in the case of a fetus, the potential life—of another. This debate includes not only the “right to life” but also a competing “right to die.”

Like many legal rights, this “right to die” is not inviolable. A person does not have total control over where, when, or in what manner he dies. There are many examples of this proposition: the use of capital punishment, civil and criminal liability for attempted suicide, and

† Stephen Hoffman practices law in Minnesota. He received his J.D. from the University of Minnesota Law School and his LL.M. from the University of Arizona James E. Rogers College of Law.
placing criminals and civilly-committed individuals under “suicide watch” to prevent them from harming themselves, to name a few. However, these responses are usually reserved for punishing a guilty party or the enforcement of desirable social values, such as the pursuit of justice. Even in these situations, the government still provides substantive rights, including the right to due process, the right against cruel and unusual punishment, and this latter right’s unspoken corollary of a right to humane treatment.

Suppose that a person is not a convicted criminal or legally insane. Instead, assume that he has a debilitating and painful disease that will not improve with medicine or time. Should he receive special consideration if he decides to end his own life? At least three European countries, as well as three U.S. states, believe that not only should he be able to make this choice, but that his ability to make this choice is socially valuable and should be protected, regulated, and subject to oversight.

Furthermore, in the medical sector, other issues inhibit these choices. For example, euthanasia is one example of “medical behavior that could potentially shorten life” (“MBPSL”). Other techniques or methods that fall within MBPSL include physician-assisted suicide (“PAS”), and its more legally supported method of exercising a “Do Not Resuscitate” (“DNR”) order. PAS includes situations where the doctor simply denies care to the patient if he cannot continue to live without receiving substantial help from doctors or medicine.

In Part I of this Article, I provide workable definitions for euthanasia and PAS and explain how they relate to each other. I also describe the doctrine of double effect, in which relieving pain comes at the expense of hastening death. In Part II, I give a brief overview of the common law defense of necessity, which is practically the sole legal defense available to physicians accused of committing euthanasia or PAS. Finally, I analyze the legal doctrines of euthanasia and PAS in Part III, focusing on legislation and cases in the E.U.—primarily the United Kingdom, the Netherlands, and Switzerland—and the U.S. states of Oregon, Washington, and Montana.

I. EUTHANASIA AND PAS: DEFINITIONS AND DISTINCTIONS

Euthanasia is not only a controversial legal issue but its definition is just as controversial, in the sense that there are varying definitions and few consistent elements among them. The term “euthanasia”

1. John Griffiths et al., Euthanasia and Law in Europe 52 (2008) [hereinafter Griffiths et al., Europe].
actually derives from the Greek *euthanatos*, which translates to “easy death.”[^2] The Random House Webster’s Dictionary defines it as “the act of putting to death painlessly or allowing to die, as by withholding extreme medical measures, a person or animal suffering from an incurable, [especially] a painful, disease or condition.”[^3] Under current European laws, euthanasia typically describes when “a doctor ends the life of a person who is suffering ‘unbearably’ and ‘hopelessly’ (without prospect of improvement) at the [patient’s] explicit request.”[^4] This usually entails the administration of a lethal injection of medications.[^5]

While PAS tends to be closely associated with euthanasia, they are actually not the same.[^6] PAS occurs when the patient makes the decision to end his own life and his doctor assists in terminating his life or “hastening death” in some manner.[^7] Euthanasia, on the other hand, does not require the consent of the patient and usually involves the use of one or more medications—called euthanatica—administered by the physician to end the patient’s life.[^8] In other words, PAS occurs when

---

[^3]: Id.
[^4]: GRIFFITHS ET AL., Europe, supra note 1, at 2 (referring to Dutch and Belgian law). An English translation of the Luxembourg legislation states that the patient must be competent, the request must be made voluntarily and be documented, and the patient must suffer from a constant, unbearable, and hopeless medical situation (either physically or mentally) without prospect of improvement. Sommaire: Legislation Reglementant les Soins Pliiatifs Ainsi que L’euthanasie et L’assistance au Suicide, J. OFFICIEL DU GRAND-DUCHE DE LUXEMBOURG [OFFICIAL GAZETTE OF LUXEMBOURG], Mar. 16, 2009, p. 615 (Lux.).
[^5]: GRIFFITHS ET AL., Europe, supra note 1, at 2.
[^6]: However, many commentators generally use the term “euthanasia” in reference to both “killing on request” and assisting suicide. See, e.g., id. (specifically using “euthanasia” to describe both “where the distinction is not relevant”).
[^7]: Id.
[^8]: This definition is not always used and is sometimes misused or incorrectly stated. For example, in the U.S. case of Compassion in Dying v. Washington, the Court of Appeals for the Ninth Circuit stated that, if “the patient [is] unable to self-administer the drugs . . . administration by the physician . . . may be the only way the patient may be able to receive them,” which is an issue of PAS, not euthanasia. 79 F.3d 790, 831, 831 n.119 (9th Cir. 1996), overruled by Washington v. Glucksberg, 521 U.S. 702 (1997). However, under our above definition, this would technically be euthanasia. In the UK, similarly, the House of Lords Select Committee on Medical Ethics defined euthanasia as “a deliberate intervention undertaken with the express intention of ending a life, to relieve intractable suffering.” N.M. Harris, The Euthanasia Debate, 147 J. ROYAL ARMY MED. CORPS 367 (2001) (U.K.).
In contrast, Oregon state law (which allows PAS) specifically forbids euthanasia, describing it as when “a doctor injects a patient with a lethal dosage of medication.” FAQs about the Death with Dignity Act, OREGON.GOV, http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/faqs.pdf (last visited Oct. 8, 2012) [hereinafter Oregon FAQs]. It does, however, allow “a physician [to prescribe] a lethal dose of medication to a patient, but the patient—not the doctor—administers the medication.” Id.
the doctor observes or helps the patient end his life, but does not “perform the final act.” 9 By this basic definition, euthanasia does not require that the patient voluntarily choose to end his life. In practice, however, the term “euthanasia” generally applies only to situations where the patient has chosen to die. 10 As this suggests, there are not many technical distinctions between euthanasia and assisted suicide. 11

A. Subcategories of Euthanasia

Euthanasia can also be further broken down into subcategories, 12 thereby making the distinction between euthanasia and PAS even more subtle. The two primary subcategories indicate the role the physician plays in the patient’s death. The first, “active euthanasia,” refers to when the doctor commits an overt act that causes the death of the patient. 13 For instance, a lethal injection administered by the physician constitutes active euthanasia. 14 In contrast, “passive euthanasia” occurs when the physician allows or does not prevent death by refusing to act or by withholding life-sustaining treatment. 15 This includes denying medically necessary or useful medications, artificial nutrition and hydration (“ANH”), or refusing to perform cardiopulmonary resuscitation (“CPR”). 16 These refusals may be legally required due to


10.  GRIFFITHS ET AL., EUROPE, supra note 1, at 2. Some commentators, on the other hand, focus primarily on the level of activity the patient, not the doctor, has in bringing about death. See, e.g., JOSHUA A. PERPER & STEPHEN J. CINA, WHEN DOCTORS KILL: WHY, WHY, AND HOW 165 (2010) (“The difference between assisted suicide and euthanasia is that the patient is not an active participant in euthanasia, except perhaps for expressing a wish to end his or her life.”).

11.  GRIFFITHS ET AL., NETHERLANDS, supra note 9, at 112-13. “‘Suicide’ and ‘euthanasia’ are concepts with blurred edges. It is often unclear whether a certain act counts as suicide or whether an act is an instance of euthanasia.” JEFF McMahan, THE ETHICS OF KILLING: PROBLEMS AT THE MARGINS OF LIFE 455 (2002). Some commentators, however, require that the killing or permitting the death of the person be done for the benefit of the person to die or the person responsible for the death (the so-called beneficence requirement). Euthanasia Definitions, EUTHANASIA.COM, http://www.euthanasia.com/definitions.html (last visited Oct. 8, 2012). Others may require that both the person dying and the person responsible for the death receive a benefit. McMahan, supra note 11, at 456.

12.  Richard Huxtable, a respected commentator on euthanasia law in the UK, vehemently opposes such subcategories and attempts to distinguish between different versions of euthanasia, principally on the ground that it only invites more confusion and misunderstandings about what euthanasia actually is. RICHARD HUXTABLE, EUTHANASIA, ETHICS AND THE LAW: FROM CONFLICT TO COMPROMISE xiii (2007).

13.  See, e.g., id. at 6.

14.  Id.

15.  See PERPER & CINA, supra note 10, at 166.

16.  Id.
an advance health care directive, such as a DNR order. However, this Article focuses on the situation where the patient has no advance directive, and is either unable to inform his doctor that he wishes to end his life or may be legally incompetent to make that decision.

One may wonder why this distinction between active and passive euthanasia is morally relevant since both acts create the same result: the death of the patient. However, there is a great moral divide between returning a patient to his unaided condition—such as by removing ANH or turning off a ventilator—and hastening his death by performing a positive action, e.g., by administering a euthanatica. The former situation just returns the patient to the condition he would be in but for medical intervention, and does not hasten his death compared to if he was initially untreated. The latter situation, on the other hand, puts the patient in a worse position than he would be if no outside factors came into play. Therefore, removing a positive benefit and introducing a negative benefit are quite different, morally speaking, even if the result is the same. This comports with both moral and legal theory, which often focus on the means pursued rather than the ends achieved. For example, if A fires a gun at B intending to kill him, A is not morally blameless if he fails in his attempt, even if B had no idea what had happened—instead, A is morally blameworthy because, even though the end of achieving B’s death was not realized, A’s intentions and actions in pursuing it make him blameworthy.

Additionally, euthanasia is designated “voluntary,” “involuntary,” or “nonvoluntary.” While the difference between involuntary and nonvoluntary euthanasia may not be obvious, this is an important distinction. Whereas involuntary euthanasia generally describes when the victim does not consent to or request euthanasia, the term “nonvoluntary” euthanasia describes when it is not possible for the victim to consent to or request euthanasia. A patient in a coma or a vegetative state, for instance, would be unable to consent.

17. Id.

18. Michael J. Kelleher states that, although “professional moral philosophers” who have not practiced medicine may find the distinction ridiculous, “most practising physicians find this division useful.” Michael J. Kelleher, Euthanasia and Physician Assisted Suicide, 2 Medico-Legal J. Ir. 77, 77 (1996).


20. McMAHAN, supra note 11, at 457.
B. Relieving Pain and Hastening Death: The Doctrine of Double Effect

These distinctions between relieving a patient’s suffering and hastening her death are not always mutually exclusive. For instance, a doctor treating a terminal cancer patient who is in great agony may prescribe or administer pain medication that has the incidental effect of hastening the patient’s death. This usually occurs in situations where she is in so much pain that an effective dose of pain-relieving medication exceeds what her physical condition will allow.

As a result, the pain medication has a “double effect” because it both helps relieve the patient’s suffering and hastens her death. In many situations, this is a foreseen consequence. Nonetheless, a doctor may escape moral and legal blame if he acts for the good of his patient—such as by relieving her pain—under the common law defense of necessity.\(^\text{21}\)

II. THE COMMON LAW NECESSITY DEFENSE AND A PHYSICIAN’S CONFLICTING DUTIES

Physicians assisting in patient suicides or administering euthanasia generally escape liability in common law jurisdictions by invoking the well-recognized defense of necessity.\(^\text{22}\) This justification, in the PAS and euthanasia contexts, alleges that the doctor had two conflicting duties: to relieve his patient’s unbearable suffering and to comply with the law or professional guidelines.

Ironically, the original version of the Hippocratic Oath, which delineates the duties and responsibilities of physicians, forbids both euthanasia and PAS. The “classical” version of the oath states, “I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect.”\(^\text{23}\) The “modern” version, however, makes no mention of either.\(^\text{24}\) According to the American Medical Association, this is due to a changing society with changing values, as well as an increased focus on the wants and needs of the patient rather than deference to the physician’s judgment.\(^\text{25}\) Even considering this

\(^{21}\) Huxtable, supra note 12, at 88.

\(^{22}\) However, this defense is not always successful. See Griffiths et al., Europe, supra note 1, at 35–37 (describing the Brongersma case in the Netherlands in 2000). The Brongersma case sparked much of the recent legislation allowing PAS. Id. at 37–39.


\(^{24}\) Id.

shift in values, “[k]illing patients, no matter how great the suffering, is not what attracts most people to medicine.”

III. EUROPEAN LAW

Euthanasia law—and the law governing PAS generally—has become more established in Europe over the last few decades, with some countries legalizing it and others prohibiting it.

A. United Kingdom

In the United Kingdom, the Medical Treatment (Prevention of Euthanasia) Bill was presented in the House of Commons on December 15, 1999. The bill prohibited anyone responsible for the care of a patient from withdrawing or withholding medical treatment or sustenance if one purpose is to hasten or cause the death of the patient. The definitions included in the bill similarly make it unlawful to withdraw ANH if one purpose is to hasten death, unlike the laws of some other European countries. Even with this legislation, some medical ethicists and legal experts disputed the bill’s clarity and usefulness in proscribing euthanasia. Ultimately, the bill unceremoniously died in Parliament. While there were many other attempts to officially legalize assisted suicide in the aftermath, none were successful.

In February of 2010, however, the Crown Prosecution Service published a new policy on prosecuting assisted-suicide cases—namely, whether to prosecute at all. In a press release, the Director of Public...
Syracuse Law Review

Prosecutions Keir Starmer stated that the new policy “is now more focused on the motivation of the suspect rather than the characteristics of the victim.”34 Still, many characteristics of the victim are important in determining liability, such as whether the victim was legally competent to decide to end his life. The policy lists sixteen “public interest factors” that, if present, tend to favor prosecution.35 Even so, prosecutions are rare.36

B. The Netherlands

Euthanasia—at least active euthanasia—was “technically illegal” under Dutch law before 2002.37 However, doctors practiced it openly and were rarely, if ever, held criminally liable.38 In 1984, the Dutch Supreme Court effectively legalized euthanasia in the Schoonheim case39 based on the necessity defense, subject to a requirement of due care.40 Under Dutch law, the necessity defense is available when an actor has “made a justifiable choice between two conflicting duties.”41 In Schoonheim, the Court found that the physician’s two duties—to respect life according to the Dutch Penal Code and to relieve suffering—justified euthanasia.42 In addition, Dutch courts are more lenient in punishing acts which hasten death. For example, unlike in the UK, Dutch courts allow the withdrawal of life-sustaining but futile treatment as long as there is some benefit.43

<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>UK Assisted Suicide Policy, supra note 33 (section titled “Public interest factors tending in favour of prosecution”).</td>
</tr>
<tr>
<td>For instance, between April 1, 2009 and October 1, 2012, UK police have referred sixty-six cases to the Crown Prosecution Service. Assisted Suicide, CROWN PROSECUTION SERVICE, <a href="http://www.cps.gov.uk/publications/prosecution/assisted_suicide.html">http://www.cps.gov.uk/publications/prosecution/assisted_suicide.html</a> (last visited Oct. 29, 2012). Although twelve cases currently remain outstanding, none of the other fifty-four cases have resulted in prosecution. Id.</td>
</tr>
<tr>
<td>Id.</td>
</tr>
<tr>
<td>Id., supra note 1, at 77.</td>
</tr>
<tr>
<td>Id. The necessity defense is codified in Article 40 of the Dutch Penal Code. Id.</td>
</tr>
<tr>
<td>Id.</td>
</tr>
<tr>
<td>Id. at 77 n.103. The precise wording of the conflicting duties used by Dutch courts since Schoonheim has taken on different forms. For example, in Chabot, the Dutch Supreme Court described a doctor’s duty as one to relieve “unbearable suffering with no prospect of improvement.” Id.</td>
</tr>
<tr>
<td>Griffiths et al., Europe, supra note 1, at 66-67.</td>
</tr>
</tbody>
</table>
In 2002, the Termination of Life on Request and Assisted Suicide (Review Procedures) Act went into force. With this legislation, the Netherlands enacted substantive and procedural law regarding euthanasia. Specifically, it created a mechanism that would allow the Dutch government to review euthanasia cases by using “Regional Review Committees” to ensure that several requirements, including the duty of due care, have been satisfied. In addition, doctors are required to report to the municipal pathologist that the deceased did not suffer a “natural death.” If a committee finds that the doctor did not act with due care, or if the doctor did not report his act but is later determined to have assisted in the patient’s death, then the committee refers the case to the Dutch prosecution authorities. Although the law generally acts to protect doctors from liability, they may lose its protection by failing to comply with its requirements.

**C. Switzerland**

Assisted suicide is also legal in Switzerland. In fact, Switzerland’s assisted suicide laws have allowed it to become very prominent in recent years due to what has affectionately been termed “death tourism,” led by the company Dignitas. The company helps terminally-ill foreign nationals travel to Zurich. Once there, an individual is physically examined to confirm his terminal diagnosis and is further evaluated to ensure he is legally competent to decide to end his life. This does not mean that patients with mental disorders are unable to receive assistance in committing suicide—patients with diseases such as incurable bipolar disorder or schizophrenia may use the company’s services as well. In its brochure, Dignitas uses broad language to define who may avail themselves of their assistance.

---

44. *Id.* at 82.
45. *Id.* These requirements include, *inter alia,* that: the patient’s decision was informed, voluntary, and carefully considered; similar to the Court’s holding in *Chabot,* the patient’s suffering was “unbearable” and “there was no prospect of improvement”; the doctor and patient agree there is no reasonable alternative to suicide in light of the patient’s condition; and the physician consulted an independent doctor to ensure that these other requirements are met. *Id.* at 82.
46. *Id.* at 83.
47. *GRIFFITHS ET AL., EUROPE,* supra note 1, at 82 n.134.
49. *Id.* at 164-65.
50. *Id.*
51. *Id.* at 165.
52. *Id.*
However, just because these services are available does not mean that people use (or abuse) them often. According to a study released by Dignitas, approximately 70% of people that visited its Zurich facilities for a consultation never advanced beyond that step. Of those that did advance, only 13.3% of those patients that received a prescription for the lethal dosage (called a “recipe”) actually had the prescription filled.

On May 15, 2011, Swiss voters voted on two proposed cantonal referenda regarding assisted suicide. The first proposed to ban the practice completely, the second, in contrast, sought to restrict it to only Zurich residents, in effect prohibiting non-citizens from seeking suicide assistance in Switzerland. Voters, reinforcing a belief in a universal “right to die,” soundly rejected both measures by sizeable margins. However, the Swiss have expressed a desire for clearer legal standards for assisted suicide and the government plans to revise its laws in the near future.

broschuere-dignitas-e.pdf (last visited Oct. 8, 2012). (“Anyone suffering from an illness which will lead inevitably to death, or anyone with an unendurable disability, who wants voluntarily to put an end to their life and suffering can, as a member of Dignitas, request the association to help them with accompanied suicide.”).


57. Id. (Volksinitiative: “Nein zum Sterbetourismus im Kanton Zürich!” [Popular Initiative: “No to Death Tourism in the Canton of Zurich!”]).

58. Of the nearly 279,000 votes cast, over 84% of voters rejected the total ban on assisted suicide and over 78% rejected restricting it to only Zurich residents. Resultate im Kanton, STATISTISCHES AMT: KANTON ZÜRICH, http://www.statistik.zh.ch/internet/justiz_inneres/statistik/de/wahlen_abstimmungen/abstimmungen_2011/abstimmungen_15052011/resultate/kanton.html (last visited Oct. 11, 2012).

In the United States, the legal issues underlying euthanasia and PAS have become much more prominent in the last two decades. PAS, for example, rose to national prominence when the U.S. Supreme Court reviewed the constitutionality of restricting it in the 1997 case of Washington v. Glucksberg. In Glucksberg, the Court granted certiorari to hear a number of cases relating to the possible existence of a constitutional “right to die.” At issue in the case was a set of Washington statutes banning assisted suicide. While Glucksberg primarily dealt with PAS, the Court often analogized it to euthanasia. In addition, the Court determined that if a constitutional right exists in which people truly enjoy a “right to die,” it would necessitate a related right to receive assistance in dying. In its decision, then Chief Justice William H. Rehnquist wrote for the Court in holding that no such rights existed, leading to the conclusion that the Constitution does not protect PAS.

Although no state permits active euthanasia, some U.S. states now allow PAS.

A. Oregon

Oregon legalized PAS through the enactment of its Death with Dignity Act in 1997, making it the first U.S. state to do so. The Act “allows terminally-ill Oregonians to end their lives through the voluntary self-administration of lethal medications, expressly prescribed by a physician for that purpose.” However, the law does not allow just anyone to utilize these services—a potential patient needs to be an adult Oregon resident, capable of making medical decisions, who has less than six months to live due to a terminal illness. The treatment generally consists of the oral administration of barbiturates that the
patient must administer himself; the physician is forbidden from doing it.\textsuperscript{71} Oregon’s Death with Dignity Act also protects doctors from criminal liability for providing lethal medication to patients, assuming that the patient satisfies the requirements mentioned above.\textsuperscript{72} Interestingly, it also mandates that a patient’s decision to end his own life cannot affect life, health, or accident insurance benefits, since it is no longer considered suicide at that point.\textsuperscript{73}

\subsection*{B. Washington}

In 2008, Washington voters supported its own Death with Dignity Act, otherwise known as I-1000 or Initiative 1000.\textsuperscript{74} This initiative was based in large part on Oregon’s Act, officially known as Measure 16. The first reported death under the new law occurred on May 21, 2009, when sixty-six year-old Linda Fleming self-administered a lethal injection.\textsuperscript{75} Ms. Fleming had received a diagnosis of Stage Four pancreatic cancer just a month before.\textsuperscript{76} As of February 29, 2012, a total of 157 terminal patients are known to have died by ingesting medications pursuant to the Act.\textsuperscript{77}

\subsection*{C. Montana}

The decision in \textit{Baxter v. Montana}, handed down on December 31, 2009, established that competent yet terminally-ill patients may seek lethal medication in order to end their lives.\textsuperscript{78} In \textit{Baxter}, the Montana Supreme Court held that, although there is no constitutional right to PAS in Montana, there is no legislation or case law to the contrary.\textsuperscript{79}

\begin{itemize}
\item \textsuperscript{71} See, e.g., \textsc{Miriam Boleyn-Fitzgerald}, \textsc{Contemporary Issues in Science: Ending and Extending Life} 86 (2010).
\item \textsuperscript{72} \textsc{Or. Rev. Stat.} 127.885 \textsection{} 4.01(1).
\item \textsuperscript{73} “Oregon statute specifies that participation under the [Death with Dignity] Act is not suicide, so should not affect insurance benefits by that definition.” \textsc{Oregon FAQs}, supra note 8 (referring to \textsc{Or. Rev. Stat.} 127.875 \textsection{} 3.13).
\item \textsuperscript{74} The vote passed by a 58.68\% to 41.32\% margin. \textsc{Death with Dignity Nat’l Ctr.}, \textit{Washington Voters Pass Death with Dignity Act, Living with Dying Blog} (Nov. 4, 2008), \url{http://www.deathwithdignity.org/2008/11/04/washington-voters-approve-death-dignity-act}.
\item \textsuperscript{75} William Yardley, \textit{First Death for Washington Assisted-Suicide Law}, \textsc{N.Y. Times}, May 23, 2009, at A10.
\item \textsuperscript{76} See id.
\item \textsuperscript{77} See \textsc{Death with Dignity Act}, \textsc{Wash. St. Dep’t of Health}, \url{http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct.aspx} (last visited Oct. 30, 2012). During this period, a total of 253 patients received the lethal medication. \textit{Id.}
\item \textsuperscript{78} 224 P.3d 1211, 1222 (Mont. 2009).
\item \textsuperscript{79} \textit{Id.} at 1217, 1222.
\end{itemize}
Physician-Assisted Suicide

However, in making this narrow ruling, the Court avoided the direct question presented in the case: whether PAS is actually a right guaranteed under the Montana state constitution.\textsuperscript{80} Since this right was not created through legislation, Montana’s protection of physician-assisted suicide is much more tenuous than the protection offered under Oregon and Washington law.\textsuperscript{81}

V. PRACTICAL CONSIDERATIONS

Although euthanasia and PAS are illegal in many jurisdictions, this may not have much of an effect on physicians or their criminal liability. According to Drs. Joshua Perper and Stephen J. Cina, even though committing euthanasia in the United States could earn a doctor a murder charge and conviction, “[c]ourts have been lenient with most physicians accused of voluntary euthanasia.”\textsuperscript{82} In fact, they argue, “[I]less than two dozen doctors have been prosecuted in the United States and the convicted doctors have usually received light sentences.”\textsuperscript{83} Similarly, Dr. Richard Huxtable notes the same result in the United Kingdom: even if a doctor commits euthanasia, and although “the law makes no concession to the allegedly merciful circumstances of the crime, he] will almost certainly walk free from the courtroom.”\textsuperscript{84} This is most likely due to the philosophical idea of “social harm” that permeates criminal law. Pursuant to this concept, if the act of terminating a patient’s life is done at his request or even with his explicit consent, and is done in order to relieve his debilitating and hopeless pain and suffering, a moral wrong might not exist. Other countries have also


\textsuperscript{81} While these three states were the first to offer protection for physician-assisted suicide, it should be noted that they are not the only states who have considered such legislation or will consider it. For instance, Massachusetts put this precise issue of PAS to voters as a ballot initiative on November 6, 2012. Question 2: Prescribing Medication to End Life, \textsc{Mass. Secretary of State}, http://www.sec.state.ma.us/ele/ele12/ballot_questions_12/question2.htm (last visited Oct. 30, 2012). The measure—allowing PAS—lost by approximately 60,000 votes, out of nearly 3 million cast. Return of Votes for Massachusetts State Election, \textsc{Mass. Secretary of State}, http://www.sec.state.ma.us/ele/elepdf/rov12.pdf (last visited Jan. 1, 2013).

\textsuperscript{82} PERPER & CINA, supra note 10, at 166.

\textsuperscript{83} Id.

\textsuperscript{84} HUXTABLE, supra note 12, at 52. Though Dr. Huxtable was referring to mercy killers in this context, his use of “mercy killing” and “euthanasia” in his book differ only slightly. The primary distinction between these terms, according to Dr. Huxtable, is that “mercy killing” is typically committed by someone who is not a doctor. Id. at 34 (“The legal officials insist that euthanasia—or ‘mercy killing’ as it tends to be dubbed when members of the public are involved—is murder . . . ”).
used this theory in selectively prosecuting PAS and euthanasia cases.\textsuperscript{85}

Additionally, neither civil nor criminal liability may exist in the context of withdrawing or withholding treatment in order to hasten death. According to Dr. Norman Frost, who heads the Program in Medical Ethics at the University of Wisconsin, “despite widespread belief to the contrary, there are no reported cases of doctors in the United States being found liable, civilly or criminally, for withholding or withdrawing life-sustaining treatment from any patient of any age for any reason.”\textsuperscript{86} Because of this, it would seem that U.S. law is much more accepting of passive euthanasia than active euthanasia, even where it has not been legalized.

It is important to note that, while distinctions between euthanasia and PAS are not always consistent or obvious, a single misstep by a physician can subject him to criminal and civil liability.\textsuperscript{87} For example, Dr. Jack Kevorkian went to prison for eight years not because he assisted in over 100 suicides,\textsuperscript{88} but because, during the course of assisting his last patient’s suicide, he pressed the syringe plunger that delivered the fatal drug.\textsuperscript{89} When he pressed it, he crossed the philosophical divide between then-allowed PAS and illegal euthanasia.

CONCLUSION

Euthanasia and PAS both have checkered and controversial legal histories. While there are significant distinctions between them, both confront what many have termed a fundamental right: the right to die. Several countries and U.S. states are now fielding lawsuits and legislative lobbying efforts brought in order to establish this right. Many of these laws are in their infancy and courts must elaborate and refine them before their impacts will be clear. Even in those jurisdictions deeming PAS or euthanasia illegal, prosecution authorities

\textsuperscript{85} See, e.g., John Keown, \textit{Physician-Assisted Suicide and the Dutch Supreme Court}, 111 L.Q. REV. 394, 395 (1995) (“[E]ven in the rare cases in which Dutch doctors are prosecuted and convicted, they may, even so, escape punishment.”).

\textsuperscript{86} \textit{Boleyn-Fitzgerald, supra} note 71, at 87.

\textsuperscript{87} According to Drs. Joshua Perper and Stephen Cina, “[c]ourts have been lenient with most physicians accused of voluntary euthanasia.” \textit{Perper & Cina, supra} note 10, at 166. They argue that Kevorkian’s sentence was unusually severe because he publicly flouted the law in assisting patient suicides. \textit{Id.}

\textsuperscript{88} Keith Schneider, \textit{Dr. Jack Kevorkian Dies at 83; A Doctor Who Helped End Lives}, N.Y. TIMES, June 4, 2011, at A1 (stating that Kevorkian assisted the deaths of “about 130 ailing patients”).

\textsuperscript{89} Kevorkian was actually sentenced to ten to twenty-five years in prison but released early due to his failing health. \textit{Statement from Judge to Kevorkian}, N.Y. TIMES, Apr. 14, 1999, at 23.
and families rarely punish doctors either civilly or criminally as long as one primary goal was to relieve patient suffering. It will be particularly interesting to see how American and European laws ultimately compare, but the differences will not be borne out for some time.