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EASTERN KENTUCKY UNIVERSITY

Beyond the Veil of Ignorance: An Analysis of Global Regulations for Assisted
Suicide and the Guided Next Steps for America

Honors Thesis

Submitted

in Partial Fulfillment

of the

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By

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Beyond the Veil of Ignorance: An Analysis of Global Regulations for Assisted Suicide
and the Guided Next Steps for America

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Abstract: The concept of assistance in dying goes back to the ancient Greco-Roman world, but it is still a topic of much debate today. This paper attempts to address this debate by completing a thorough examination of the topic of assisted dying in America. It begins with a thorough examination of assisted dying through the legal lens of the United States Constitution and court decisions, moves into an analysis and rebuttal of common objections regarding assisted dying, and examines assisted dying regulations around the world in order to examine what qualities are important in developing assisted dying regulations, along with what should be avoided. Through this analysis and the legal conclusion that assisted dying is, in fact, constitutional, this paper finally structures the outline for a plan of regulations that should be included in the legalization of assisted suicide in the United States in order to make sure that the process is implemented in a way that allows for freedom, autonomy, and equality to be properly maintained. Assisted dying is much more than an impersonal debate, however. It's a human issue. The hope is that this paper would convince readers and legislators that the legalization of assistance in dying is necessary not only from a legal standpoint, but from the human standpoint of allowing those who are suffering to die a humane and peaceful death on their own terms.

Keywords and Phrases: Assisted Dying; Assisted Suicide; Death with Dignity; United States; Constitutionality; Regulations; Legislation; Analysis

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Across cultures and times, death has been looked at as a taboo topic. Turn the death into a suicide and talk will turn into whispers and sideways glances. And make that suicide into one assisted by another person and it will become an underdiscussed, hidden-in-the-shadows matter of controversy. People tend to avoid that which makes them uncomfortable, and yet these uncomfortable topics are precisely the ones that need to be talked about most. Accordingly, in order to solve the ongoing debate of whether or not a person has the right to die, or a right to assisted suicide, it must be talked about, analyzed, and put out in the open for the world to see.

The first statutorily sanctioned assisted suicide was that of Bob Dent, who lived in Australia (Fraser & Walters, 2000). Before he died, Bob Dent dictated a letter to his wife explaining his decision, and in it he described his life as an "...incontinent, pain-racked, totally dependent existence exacerbated by watching the suffering of his wife as she cared for him. He stated that he was 'immensely grateful' that he could end his life in a dignified and compassionate manner" (Fraser & Walters, 2000). This letter serves as a stark reminder that when discussing the topic of assisted suicide, it's not just a matter of law and hypothetical issues that could arise; it's a matter of real human lives and people who are truly suffering in ways that most of us couldn't even imagine.

In this paper, I aim to start an open and honest conversation to bring the very real issue of assisted suicide to light. A detailed examination of the United States Constitution, decisions by the US Supreme Court, and other legal sources will show that there is, in fact, a right for a person to end their life on their own terms. Then other common, non-constitutionally based objections to the legalization of assisted dying will be examined. Detailed comparisons of assisted suicide regulations throughout the world will show the many existing ways that other countries have handled this issue, because while the United States has not yet recognized assisted suicide as a right, there are other countries that have. Further analysis of these regulations will contribute to a discussion of inherent problems that can arise in this type of legislation, as well as proposed solutions to these problems. And finally, a culmination of this research will result in a proposition for the best next steps that the United States can take in order to ensure that its citizens can exercise this right to assisted suicide in a safe, regulated, and carefully monitored fashion that will ensure that the essential foundations of freedom, equality, and autonomy are maintained.

Assisted suicide is not the typical suicide case. While definitions may vary, assisted suicide can generally be defined as “a deliberate intervention undertaken with the express intention of ending a life, to relieve intractable suffering” (Khan & Tadros, 2013). The piece about intractable suffering is precisely what makes the debate over assisted suicide an entirely different one from any debate over the typical suicide case. An argument for assisted suicide is not an argument that citizens of the United States, or citizens of any country for that matter, possess an innate right to have assistance in ending their life for just any reason. Instead, it is an argument that addresses the right of

people who are already dying and in pain to have a humane death on their own terms.

Moving forward, this paper will examine the issue of assisted suicide purely through the lense of these types of cases.

LEGALITY

Before anything further can be said about assisted suicide in the United States, the legality of such a proposition must first be examined. The law of the land in the United States is its constitution, and the legality of anything within the country must be interpreted through this document. However, the United States Constitution does not cover every possible circumstance or issue that will ever occur, and instead provides an overarching idea of rights and freedoms guaranteed to the American people. This is why the judicial branch of the US government exists. It's entire purpose is to interpret laws and the Constitution to figure out how they could apply to the many different circumstances that arise that are not directly addressed in the Constitution. With this in mind, when examining whether or not a national legalization of assisted suicide would be legal under the Constitution, examining what the Supreme Court has said is a good first step.

The two Supreme Court cases that most directly address the legality of assisted suicide itself are *Washington v. Glucksberg* and *Vacco v. Quill*, and in both cases, the Supreme Court upheld the constitutionality of state-level statutes that prohibited assisted suicide (Keown, 1997). *Gonzalez v. Oregon* is another case that partially addresses the idea of assisted suicide, but it moreso addresses the "...technical matters of administrative rule making and statutory interpretation... [rather than] 'the profound issues of

professional ethics and personal autonomy that have animated the national debate' over physician-assisted suicide" (Mathes, 2006). Because it does not address the legality of the actual act of assisted suicide, which is what this paper is intended to focus on, this case will not be discussed.

In *Washington v. Glucksberg*, a group of doctors, seriously ill patients, and an organization counseling those who were considering physician assisted suicide challenged a state statute forbidding assisted suicide on the grounds that it violated "...the Fourteenth Amendment's Due Process Clause by infringing a liberty interest of competent, terminally-ill patients to commit [physician assisted suicide]" (Keown, 1997). In *Vacco v. Quill*, it was argued that a different state statute prohibiting assisted suicide was a violation of the Equal Protection Clause of the Fourteenth Amendment because "By allowing terminally-ill patients on life-support machines to hasten their deaths by directing their removal, but prohibiting other terminally-ill patients from having their deaths hastened by their doctors... New York law favored the former group of patients over the later" (Keown, 1997). In both cases, the Supreme Court upheld the state statutes and did not find it a violation of citizen's fourteenth amendment rights for states to have laws prohibiting assisted suicide (Keown, 1997).

It would seem at first glance that this would be the end of the conversation; it's not a violation of the constitution for states to prohibit assisted suicide, so therefore there couldn't be a constitutional right to assisted suicide. However, while this view may seem correct, this type of conclusion is a grossly basic and misinformed view of the court system, Supreme Court rulings, and constitutional interpretation. While judges are not supposed to be political, there is no denying that rather than being completely impartial,

the Supreme Court, and any other court system, is undoubtedly a political animal.

Constitutional interpretation, whether by a regular person or by a Supreme Court Justice, is just that: interpretation. And there is more than one way to interpret a document that is left intentionally ambiguous. In fact, in this era, it is considered normal for presidents to nominate judges to the Court based on their specific views of Fourteenth Amendment issues, and “Accusations that judges engage in judicial activism- in politics rather than law- are commonplace” (Ziegler, 2018).

Other than the obvious factor of whether a judge tends to lean liberal or conservative, there are generally two theories subscribed to when it comes to constitutional interpretation. The first is originalism, which, as described by the former Justice Scalia, is a view that “... a written constitution has a fixed meaning which does not change with time and that such meaning of the text is the same as the words signified when the constitution was first adopted” (Kirby, 2000). The second is a view of the Constitution as a living document where “The meaning and content of the words take colour from the circumstances in which the words must be understood and to which they must be applied” (Kirby, 2000). Whether the Court is filled with judges who interpret the Constitution by looking to the Founder’s original intent or who interpret it as a living document that changes and advances with the world around it has a tremendous impact on how cases are decided. Many Americans know about the decision of *Brown v. Board of Education* where the Supreme Court ruled that the idea of “separate but equal” was unconstitutional. Many years earlier, the Court ruled the exact opposite, but the opinion changed once a new group of Justices examined and interpreted the Constitution. This is only one example of many in the United States where the Court, filled with a different

group of Justices with different leanings and different interpretive theories, has overturned previous Supreme Court decisions in order to establish or abolish rights that a previous version of the Court had either denied or affirmed.

Looking at the cases of *Washington v. Glucksberg* and *Vacco v. Quill*, neither has been overturned by a new decision of the Supreme Court, but that does not mean that there have not been opposing judicial decisions on these cases. In order to get to the Supreme Court, cases must first pass through several levels of state or other federal courts. These two cases came to the Supreme Court from the Federal Court of Appeals for the Ninth and Second Circuits, respectively, and both of these courts ruled that state statutes prohibiting physician assisted suicide were unconstitutional before the Supreme Court reversed their decisions (Keown, 1997).

In addition to this, the majority released opinion of the Court is not the only opinion that is relevant to examine. While neither of these two cases had dissenting opinions, both had several concurring opinions. While the majority opinion of the Supreme Court may represent the official ruling, concurring opinions are still very important in that they show how other Justices got to the same conclusion for different reasons, thus offering better insight to their thought process' and opinions. In examining the concurring opinions in both of these cases, it becomes clear that even the Supreme Court's opinion on assisted suicide is not quite as cut and dry as it would seem.

In crafting their concurring opinions on these two cases, five of the nine Supreme Court Justices suggested the possibility of supporting a right to die in the future (Fraser & Walters, 2000), some more obviously than others. For example, in her concurring opinion, Justice O'Connor said that these statute challenges were facial challenges, and

therefore didn't require her to decide if a constitutional interest existed in a person controlling the circumstances of their own death in this case, and Justice Stevens even went so far as to say that "an interest in hastening death was sometimes entitled to constitutional protection" (Keown, 1997). These decisions also did not ban states from passing laws in their own legislatures to allow for assisted suicide on a state by state basis (Fraser & Walters, 2000). Overall, while the Supreme Court unanimously held that these two particular statutes were not in violation of the Constitution, even some of the Justices who decided on this weren't adamant on a complete ban of assisted suicide, and left the possibility open for future evaluation.

With all of this in mind, more is needed to determine the potential legality of assisted suicide than previous Supreme Court decisions. The United States Constitution and its broader ideas need to be examined. It should be noted that in addition to everything else that has been said about the previously discussed Supreme Court cases, when the Court decided on the issue of *Washington v. Glucksburg*, they defined their question and constitutional analysis in terms of whether or not there was constitutional validity to a rule against receiving assistance in dying in general instead of carving out a specific population of competent, terminally ill adults to receive special and different consideration (Kaverny, 1997). Going forward in it's examination of the Constitution, this paper will look at the issue in the opposite way. As was stated earlier, this is not an attempt to argue that all United States citizens have a right to commit suicide and receive assistance in doing so. It is an argument that a certain group of people who meet certain conditions of pain and suffering have a right to assistance in dying, and the following constitutional analysis is only made in application to these types of people.

The most obvious place to look is the Fourteenth Amendment, as this is the amendment used in the arguments of both *Washington v. Glucksberg* and *Vacco v. Quill*. The part of the Fourteenth Amendment that is relevant to this discussion reads, “...nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws” (U.S. Const. amend. XIV). To simplify it, the main rights addressed in the Fourteenth Amendment are a liberty interest of the individual to have a right to choose, and a protection of equality among all people subject to the laws of the United States.

A person’s individual interest in liberty and individual autonomy is one of the most clear cases for assisted dying that can be made from the Fourteenth Amendment. The idea of individual autonomy can often be misconstrued into a much more negative idea than it is, especially when it comes to assisted dying. When the argument is made that people should have the right to assistance in dying because of individual liberty and autonomy, there isn’t a broad argument being made that people should be able to do whatever they want as long as it isn’t harming someone else in the process. When it comes to assisted, dying, the underlying principle of the autonomy argument is actually the idea that “...’every competent person has the right to make momentous personal decisions which invoke fundamental religious or philosophical convictions... Death is seen as among the most significant events of a person’s life...’ [and it] should ‘reflect our own convictions... not the convictions of others forced on us in our most vulnerable moment’” (Steinbock, 2005).

While the idea of individual autonomy is a compelling one, there is a common, constitutionally based argument that even if a person does have a liberty interest in

something, that interest must be weighed against relevant state interests, and in the case of assisted suicide, the state has a relevant interest in the preservation of life (Destro, 1994). What is often ignored, however, is that the preservation of human life has changed drastically over the years. People used to die from illness or injury significantly quicker, but advances in modern medicine have lead to people lingering in life for longer and longer, the dying process often becoming "...protracted, painful, and undignified" (Fraser & Walters, 2000). This significant prolonging of life changes the factors that should be considered in examining a state's interest in the preservation of life. As one American judge has put it:

...what interest can the state possibly have in requiring the prolongation of a life that is all but ended? Surely the state's interest lessens as the potential for life diminishes... And what business is it one the state to require the continuation of agony when the result is imminent and inevitable?... The greatly reduced interest of the state in preserving life copeis [sic] the answer to these questions: 'None'. (Steinbock, 2005, p. 236)

The second part of the relevant section of the Fourteenth Amendment addresses the inherent right of United States citizens to equality under the law. At first glance, it may seem that allowing for assisted suicide is not an equality issue, because as long as it is universally recognized in one way or the other, everyone is being treated the same. A deeper look at the issue, however, shows that there are multiple inherent equality issues with not allowing for terminally ill patients to seek assistance in dying

There are two main equality issues that can be discussed in regards to assisted dying that apply to the United States, the first being class inequality. It would seem that this would not apply to assisted dying, because if it is not allowed for all, how could there be an inequality in how different classes have access to it? Reality, however, shows that “More than 20% of physicians in both the United States and Australia admit to taking deliberate action to end the lives of particular patients”, and because more privileged members of society are more likely to have a relationship of trust with a doctor willing to discreetly handle the issue, it is almost indubitable that the wealthy are the ones who benefit from this while the poorer population does not (Fraser & Walters, 2000).

The second main equality issue harkens back to the earlier discussed *Vacco v. Quill* decision: a discrimination against terminally ill patients based on what illness they have. Patients who have a terminal illness and are being kept alive with the assistance of machines are able to request that treatment be removed so that they can die, yet terminally ill patients who are just as sick but not being kept alive by machines cannot request that a treatment be added so that they can die (Fraser & Walters, 2000). One of the main reasons this argument has been rejected by those who examine it is the idea that when a person removes treatment, they are being killed by the underlying disease and not necessarily by suicide. However, as was mentioned earlier, before this argument failed in the Supreme Court, it succeeded in the Ninth Circuit Court of Appeals, and the Ninth Circuit didn't buy into this technicality. They instead presented the example of withdrawing a gastrostomy tube, in which the patient would actually die of starving themselves to death without the tube instead of the actual underlying condition (Fraser & Walters, 2000). In the end, they concluded that there was “...no ethical or

constitutionally recognizable difference between a doctor's pulling the plug on a respirator and his prescribing drugs which will permit a terminally ill patient to end his own life'" (Fraser & Walters, 2000). While this particular issue of equality may have been rejected by the Supreme Court, it can't be denied that the argument and logic behind it is extremely compelling.

One final piece of interesting evidence comes from, of all places, the legal status of the death penalty in the United States. It's an interesting thought to ponder, and brings up the complex issue of autonomy versus the power of the government. In the United States, a healthy person can have their life taken against their will so long as due process is followed, but a person who is genuinely suffering, already dying, and wants their life to end cannot receive assistance in dying. The Fourteenth Amendment says that the government may deprive a person of life so long as due process of the law is followed. If the government can follow due process in the court system to end the life of an unwilling person, why can't an individual, autonomous person follow a different type of due process, filled with safeguards, double checks, board reviews, and more, to receive assistance in dying from a doctor? If a due process procedure is developed to ensure that assisted suicide is carried out in an ethical way that is truly in line with the patient's wishes, why wouldn't assisted suicide line up with the requirements of the Fourteenth Amendment?

Overall, while different things can be said by different judges and different analysts, it is clear from looking at the Constitution, court decisions, and the general framework of legality in America that, with the right safeguards and procedures in place, a right to assistance in dying can be found in the United States Constitution. While the

right Supreme Court has not yet sat on the bench and the right case has not yet come before them to make them properly address the issue, a time is steadily approaching when assistance in dying will be recognized as a right in America.

COMMON OBJECTIONS TO ASSISTED DYING

With being such a debate-prone subject, the arguments against the legalization of assisted suicide encompass topics much broader than law and the United States Constitution. While many of these objections may not carry the weight of constitutional objections, some have still been instrumental in helping to prevent assisted dying from being legalized. As such, addressing them as well is important.

A Matter for States

As was mentioned earlier, the Supreme Court did not bar individual states from passing their own assisted dying legislation, so the argument could be made that a national legalization is not needed and assisted suicide regulations should simply be left to the individual states. On the surface, this sounds like a good idea. It allows for the legalization of assistance in dying while also not taking control away from states when it comes to regulating certain medical practices. However, it must also be recognized that leaving assisted dying policies entirely up to individual states will lead to a wide range of results, ranging from states that completely disallow it, to states that allow it with extremely strict regulations, to states that allow it with relatively loose regulations. This level of freedom in regulation could lead to many different issues with many different policies depending on how much or little an individual state chooses to regulate. This difference in policy between states could also lead to people venue shopping across states

to try to find doctors that will most easily help them die, and the number of potential abuses that could arise from this are innumerable. A national, comprehensive, strict, and monitored policy is the best way to make sure that every United States citizen is treated equally and fairly while high standards are maintained throughout.

Religion

Some of the more common objections to the legalization of assisted dying come from religion, and historically, "...laws against suicide and mercy killing have developed from religious doctrine..." (Steinbock, 2005). Any religious objections, however, are objectively irrelevant to arguments regarding the legalization of assisted dying in the United States. The very first part of the First Amendment of the United States Constitution reads, "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof..." (U.S. Const. Amend. I), guaranteeing American citizens a freedom of and from religion. While this means that those who oppose assisted dying for religious reasons do not have to use it as an option in their lives, it also means that other people cannot be denied the ability to receive assistance in dying simply because it goes against someone else's religious beliefs.

Potential for Abuse

Another big and well vocalized objection to assisted dying is concerns over the potential that abuses could occur. While it is noble to worry about and try to protect vulnerable groups that could potentially be abused by a system that allows for assisted suicide, if the same logic were applied to other laws, no legislation would ever be passed. The reality is that someone will always find a loophole or a way to exploit almost any law, so instead of refusing to legalize assisted dying over concerns with abuse, attention

should be directed towards finding the best way to prevent abuse from occurring once it has been legalized. The best way to do so is to build into any law passed several layers of required safeguards and double checks in order to help ensure that anyone receiving assistance in dying is fully competent, understands the decision, and is making the decision freely. Nationalizing the legalization of assisted dying will also help with this goal because it will ensure that everyone is following the same detailed set of regulations instead of having variances by state. The types of safeguards and checks that can be used to best achieve this goal will be discussed later in this paper in the analysis of existing assisted dying regulations around the world.

Understandably, the possibility that someone could abuse the system even with plenty of safeguards in place is a disturbing thought, but comfort can be taken in the knowledge that studies have shown that abuses of the assisted dying system are actually fairly rare to begin with. In a study examining the risk to vulnerable groups in the Netherlands and Oregon, two places where assisted dying is legal, it was found that the only group with a heightened risk was people with AIDS (Battin et al., 2007). In other categories that may be traditionally considered to vulnerable, such as women, people of color, the elderly, the poor, and the poorly educated, there was no evidence found that they had a heightened risk of being disproportionately impacted by assisted suicide (Battin et al, 2007). Other, more widespread, studies that included the United States, Canada, and European countries also found no evidence that vulnerable groups were receiving aid in dying more frequently than the general population (Emmanuel et al., 2016).

Lack of Access to Palliative Care

Another argument raised against the legalization of assisted dying is problems with the palliative care system, with some arguing that assisted dying should only be allowed once quality palliative care is equally accessible to everyone (Barutta & Vollman, 2015). The main point of this argument is that if proper palliative care is not available to all, it is possible that people who could otherwise benefit from palliative care would instead chose assisted dying, which could lead to equality issues because typically it's the economically disadvantaged who cannot afford palliative care (Barutta & Vollman, 2015). This argument, however, is flawed in its justification. To begin with, this argument is based on a concern that the economically disadvantaged will be disproportionately affected by assisted suicide, but as was mentioned earlier, studies have shown that vulnerable groups like the economically disadvantaged have not been disparately impacted by assistance in dying. And besides this, the reality is that assisted dying is more common among the affluent than the poor (Barutta & Vollman, 2015), so concerns that there will be a disproportionately high rate of assisted dying among the poor are simply unfounded.

However, even if these claims were well founded, there would still be a disturbing flaw in this argument. It is argued that because access to palliative care is not universal, legalizing assisted dying would lead to inequality in how people are able to manage pain and suffering, but not legalizing it would actually lead to greater inequality. If it so happened that the rich sought out relief from suffering through palliative care and the poor sought it out through assisted dying, at least both groups would still have access to some type of relief. But when assisted dying is not legal, the rich still have access to

palliative care, but the poor are left with no options for relief. Overall, to deny access to assistance in dying for this reason would be unnecessarily cruel, and while access to palliative care does need to improve, people shouldn't be denied assistance in dying until that happens (Barutta & Vollman, 2015).

The Hippocratic Oath

A final common objection given to the legalization of assisted dying is an appeal to the Hippocratic Oath taken by doctors that says to 'do no harm', however, an examination of the wording and origin of this oath shows that this type of appeal is a mistaken sentiment. To begin with, the roles and viewpoints of physicians at the time of the oath's origin should be examined. In classical culture, the sanctity of human life that many espouse today actually was subservient to a belief that the free man had an inherent right to dispose of his life as he saw fit (Amundsen, 1978). In fact, many different philosophers and schools of thought allowed for and justified suicide, some even calling it "...an honorable alternative to hopeless illness" (Amundsen, 1978). Overall, assisting in suicide was actually fairly common among Greco-Roman physicians, and those who opposed it were in the minority (Amundsen, 1978). Drawing justification for the prohibition of assisted dying from a document coming from this time period is flawed.

In spite of the culture surrounding the Hippocratic Oath showing a classical acceptance of assistance in dying, the oath itself is still worth examining to see if an argument against assisted dying does, in fact, exist within it. The part of the oath that seems to most explicitly forbid assistance in dying is a passage that reads "I will not give a drug that is deadly to anyone if asked for it" (Van Hooff, 2004). On a surface level, this is clearly a promise by physicians to not assist patients in committing suicide, but it must

be remembered that the oath was not originally written in English, and translations can muddle meanings. The form of the words used in the original Greek show that in this statement, the person requesting the drug and the one who would receive it are not necessarily the same person, meaning that rather than an oath against assisting patients in dying, this is actually an oath to not murder a patient by secretly poisoning them at the request of a third party (Van Hoof, 2004).

Along the same vein, many would bring up the concept of “do no harm” from the Hippocratic Oath and say that a doctor assisting in dying is clearly a violation of this sentiment (Steinbock, 2005), but there is an inherent flaw in this argument. The concept of what constitutes a harm is extremely subjective. While one person could say that dying is inherently harmful, another could just as easily say that forcing a person to continue to live in a constant state of suffering is harmful. With this in mind, “The case against legalizing [physician assisted suicide] should not rest on the implausible assumption that death is never a benefit to the dying person” (Steinbock, 2005).

Though the Hippocratic Oath may have not proved a case against assisted suicide, its examination does raise an important question about doctors: What about doctors who are morally opposed to assisted dying? It can be generally agreed that the assisted dying process, by virtue of being a medical issue, would need to involve a doctor, so legalization of assisted dying would bring into conflict the actual practice of it and the doctors responsible for assisting who may view it as ethically wrong (Bosshard et al., 2008). While a person’s personal conviction against assisted dying should in no way hinder another person from their right to assisted dying, it cannot be denied that it would be extremely emotionally taxing for a doctor who opposed assisted dying to have to bear

the responsibility of having helped end a life, and this type of trauma would be unacceptable. Fortunately, there is a solution to this problem. In a 2014 survey of physicians, it was found that 54% of US Physicians agreed that physician assisted suicide should be allowed (Emmanuel et al, 2016). With this in mind, it would be more than reasonable to only have doctors who agree with assisted suicide be responsible for assisting patients in dying, and patients could keep factors like this in mind when choosing physicians.

INTERNATIONAL EXAMINATION AND ANALYSIS

Having found constitutional justification for a right to assisted dying and having addressed many concerns associated with the practice, the next question that must be posed is how to move forward from here. The prospect of making a plan for the United States to move forward in legalization can seem daunting, but fortunately, there are other countries in the world that have already recognized this right and created legislation. While it is important that any plan for implementation in the United States is unique to the country and its specific set of rights and freedoms, looking to what other countries have done before can provide several ideas for possible safeguards and regulations, as well as an opportunity to look at any areas that leave room for abuse so that they can be gotten ahead of and avoided.

In looking at international policies for assisted dying, it is important to understand the difference between voluntary euthanasia and assisted suicide because as will be seen, some countries allow for only one or the other. Voluntary euthanasia is an act where "...a medical professional directly administers a substance that causes the death of the

patient...”, whereas in assisted suicide, “...a medical professional prescribes to a person a substance they can self-administer to cause death...” (Carter et al., 2018).

The Netherlands

In 2002, the Netherlands became the first European country to formally decriminalize assisted dying (Bosshard et al., 2008). In this country, doctors cannot be prosecuted for helping a patient die or ending a patient’s life by request as long as statutory due care is exercised, meaning that “...the request is voluntary; the patient’s physical or mental suffering is unbearable with no prospect of improvement; the patient is fully informed about the prognosis; and doctor and patient have jointly concluded that no other reasonable solution exists” (Dyer et al., 2015). Unlike some other countries that will be seen, the Netherlands does allow for patients who are not terminally ill to receive assistance in dying so long as doctors determine that the suffering of living is great enough to warrant it (Bosshard et al., 2008), and it also allows for minors to be assisted in dying so long as those aged 12-15 have parental consent and those aged 16-17 have a parent involved in the decision (Dyer et al., 2015).

With allowing for the assistance of dying, the Netherlands has several safeguards in place in order to help prevent abuses from occurring. In order for a doctor to assist a patient in dying, they must first consult at least one other doctor who can state in writing that due care was followed in the process, and the Royal Dutch Medical Association has a network of independent medical assessors specifically for this purpose (Dyer et al., 2015). In addition to this, in order to assist a patient in dying, there must be a close doctor-patient relationship, and the death must be reported by the doctor to the proper regional euthanasia review committee (Dyer et al., 2015).

Belgium

Similar to the Netherlands, Belgium made strides forward in legalizing assisted dying in 2002 by legalizing voluntary euthanasia (Dyer et al., 2015). Also similarly to the Netherlands, help with assisted dying in Belgium is restricted to doctors, and a certain criteria of due care must be met in order to carry out the assisted death (Bosshard et al., 2008). Euthanasia by lethal injection can be carried out in patients “...who are mentally competent and have an incurable condition, including mental illness, that causes them constant and unbearable physical or mental suffering” (Dyer et al., 2015). The country’s legislation allows for legal voluntary euthanasia for children as well as adults, but euthanizing a child requires parental consent in addition to all other criteria (Dyer et al., 2015).

The legal obligations that doctors must follow in Belgium are fairly similar to those in the Netherlands (Dyer et al., 2015), however there are some additional rules in place as well. If a patient requesting euthanasia is not in the final stages of their illness, “...the doctor must consult a second independent medical specialist, and at least a month must elapse between the patient’s written request and the act of euthanasia” (Dyer et al., 2015).

Luxembourg

Luxembourg is another European nation that moved to legalize assistance in dying in the late 2000’s by legalizing euthanasia and assisted suicide in 2009 (Dyer et al., 2015). Unlike the Netherlands and Belgium, Luxembourg’s legislation only allows for adults to make the decision to receive help in ending their lives (Dyer et al., 2015). In order to be eligible for assistance in dying, patients must be “mentally competent adults

with a severe and incurable terminal condition, causing constant and unbearable physical or psychological suffering without prospects of improvement” (Dyer et al., 2015).

Doctors who assist in the dying also must meet statutory due care requirements by consulting various groups and people in the process, including another independent medical specialist, the medical team of the patient, and a person who the patient has designated as a “person of trust”, and once the death has occurred, they must report it to the National Commission for Control and Assessment (Dyer et al., 2015).

Canada

In 2016, Canada implemented a law known as MAID (Medical Assistance in Dying) that allowed for both voluntary euthanasia and physician-assisted suicide (Carter et al., 2018). In order to receive assistance in dying, an adult person who is capable of making their own decisions and who has made a voluntary request must “...have a serious and incurable illness, [be] in an advanced state of irreversible decline in capacity or physical/psychological suffering intolerable to them.... and their death [must be] reasonably foreseeable...” (Carter et al., 2018). There were also several safeguards intentionally set up for this process, including a requirement that two separate, independent medical professionals must write out opinions confirming that the patient meets the requirements to receive assistance in death, and a requirement that there be at least a ten day period between the initial request for MAID and the second medical review (Carter et al., 2018).

Columbia

Columbia is the only country in South America to have decriminalized assisted dying. In 1997, the Columbian Constitutional Court decriminalized mercy homicide, but

no specifications were given by the Ministry of Health in terms of how these killings could occur legally until 2015 (Dyer et al., 2015). With regulations now in place, voluntary euthanasia is allowed in Columbia to “...adult patients with a terminal disease that produces severe pain and suffering that cannot be relieved” (Dyer et al., 2015). In addition to a patient consciously requesting to have assistance in dying, the process of receiving euthanasia must be supervised by not only a medical specialist, but also a lawyer and a psychiatrist or clinical psychologist (Dyer et al., 2015).

It is estimated that about 20 illegal cases of voluntary euthanasia occurred in Columbia while legalization was still in limbo between the court decision and the actual passage of legislation (Dyer et al., 2015), pointing to the importance of actually legislating the legalization of assisted dying rather than waiting for a court decision. Once everything was official, however, Ovidio González became the first to use it, and prior to his death he shared the haunting sentiment that ““I want to die while I’m alive and not once I’m dead”” (Dyer et al., 2015).

Switzerland

Switzerland is a different case to other countries that allow for assistance in dying because there isn’t much regulation in terms of requirements for an assisted suicide to occur. Rather than having a lot of detailed legislation, Switzerland simply made it so that assisted suicide, but not euthanasia, is not illegal as long as the assistance is given without any selfish motives (Bosshard et al., 2008). Unlike many other countries, there is no requirement that the one assisting has to be a doctor, or that a doctor even has to be involved at all, leading to the formation of Swiss right-to-die groups (Bosshard et al.,

2008), and there is no requirement that the person receiving assistance have a terminal illness or be a Swiss citizen (Dyer et al., 2015).

Because of the lack of legislation and restrictions on assisted suicide in Switzerland, a new phenomenon has arisen in the country known as suicide tourism. Suicide tourism occurs when people from other countries come to Switzerland for the sole purpose of being able to commit suicide (Gauthier et al., 2015). While right-to-die-organizations do work with willing doctors so that they can prescribe the lethal medication to the person requesting assistance in dying, there is no physician-patient relationship required for this to occur, making it easier for outsiders to use services in Switzerland to die (Steck et al., 2013). Each right-to-die-organization has its own set of rules and procedures, but four out of the six in Switzerland allow foreign people to use their services (Dyer et al., 2015), and this type of access has led to an increase in rates of suicide tourism and the number of countries from which people are coming to Switzerland in order to die (Gauthier et al., 2015).

Australia

Unlike most other countries that have legalized assistance in dying, Australia has only legalized assisted dying in certain parts of the country instead of having a uniform policy throughout the country as a whole. Currently, assisted dying is allowed in the state of Victoria, and it was allowed for a brief time in the Northern Territory before being overturned by the Commonwealth Parliament (Duckett, 2017)

Though the assisted dying legislation in the Northern Territory has been overturned, it's specific criteria and procedures can still be analyzed in a useful manner. In order to receive aid in dying under this legislation, a patient had to have a condition

causing severe pain or suffering that could not be cured by a measure acceptable to the patient and that would cause death (although no time frame was specified) (Duckett, 2017). The patient must have been at least 18 and sound of mind so as to make the decision freely and voluntarily, not have suffered from treatable clinical depression at the time of the request, and have waited a seven day notice after their initial request for aid in dying, plus another 48 hour delay (Duckett, 2017). In order to ensure these measures were met, three medical professionals had to certify the decision, including a psychiatrist and an expert in the patient's illness (Duckett, 2017).

Victoria's Voluntary Assisted Dying Act involved a lot more planning and detail. It was passed after 30 years of research in 2017, and was implemented in 2019 (Duckett, 2017). In order to receive assistance in dying, patients in Victoria must have a terminal condition that is expected to cause death in six months or less (or in the case of neurodegenerative conditions, twelve months or less), be suffering in a way that cannot be relieved and made tolerable, be 18 or older, make the request voluntarily, and go through a two stage request process where the second stage is at least nine days after the first request (Duckett, 2017). In order to certify this process, two or three medical practitioners must be involved in order to determine whether the patient's condition meets the required criteria and to make sure the patient has the decision-making capacity to make such a decision (Duckett, 2017). This legislation also has additional safeguards in place, including penalties for pressuring someone to decide on assisted dying, and a prohibition on doctors initiating a conversation about assisted dying with their patients (Duckett, 2017).

The United States

While assisted suicide may not yet be legal in the entirety of the United States, it is similar to Australia in that certain states have legalized the practice. Oregon was the first state to legalize assisted dying, with the Oregon Death with Dignity Act going into effect in 1997 (Dyer et al., 2015). In Oregon, a mentally sound adult resident of that state can be prescribed life-ending drugs for the purpose of assisted suicide if they have a terminal disease with a life expectancy of six months or less (Dyer et al., 2015). A second, consulting physician must confirm the diagnosis and that the patient meets the criteria, and if either doctor determines that a psychiatric disease like depression is playing a role in the patient's decision, the patient is referred to counselling and the decision is put on hold (Dyer et al., 2015). Even if all criteria for assisted suicide are met, a patient must still go through a fifteen day waiting period before drugs can be prescribed (Ziegler & Bosshard, 2007). In addition to this 15 day waiting period between oral requests, patients must also submit a written request at least 48 hours prior to receiving their prescription that is witnessed by two people who can attest that the patient is mentally capable, making the request voluntarily, and not being coerced, one of which may not be a relative or heir of the patient or an employee of the medical facility where the patient is receiving care (Oregon Death With Dignity Act, 1994). During the process, the physician must document everything to show that regulations are being followed and submit this for review, and the state department reviewing said reports will release an annual statistical report with this information (Oregon Death with Dignity Act, 1994).

Once this legislation was passed in Oregon, it's implementation actually ended up being somewhat similar to in Switzerland, except in a more regulated way. Since no

doctor or hospital is forced to partake in the assisted suicide process, most assisted suicides are facilitated through right-to-die groups that help to inform patients of end of life decisions and give them information on how to navigate the process and find doctors willing to help them (Ziegler & Bosshard, 2007). This is not an Oregon-specific process, however, as right-to-die groups such as Compassion and Choices are nationwide and provide services to most states, helping patients navigate either assisted dying or other end of life care options depending on what their state allows for (Ziegler & Bosshard, 2007).

Washington became the second state to legalize assisted suicide in 2009 with the implementation of the Washington Death with Dignity Act, and the requirements in this act are essentially the same as Oregon's (Washington Death with Dignity Act, 2008). Vermont followed Washington with the Patient Choice and Control at the End of Life Act in 2013 which was, again, very similar to the Oregon legislation. However, there is a difference in that the two witnesses to the written request by a patient must both be non-interested parties instead of just one of them (Patient Choice and Control at the End of Life Act, 2013).

In 2015, two US States legalized assistance in dying. Colorado enacted the Colorado End-of-Life Options Act which is essentially the same as Oregon's legislation, except it does not require state review or an annual statistical report (Colorado End-of-Life Options Act, 2015). California also legalized assisted suicide with the End of Life Option Act which is very similar to the Oregon legislation. Unlike Oregon, though, California requires that the patient fill out and execute one final form of attestation within

the 48 hours prior to self-administering the prescribed aid-in-dying drug (End of Life Option Act, 2015).

The next to legalize assisted suicide was the District of Columbia in 2016 with the Death with Dignity Act of 2016. It is essentially the same as the legislation in Oregon, just with a few more regulation for pharmacists regarding who the medication can be released to and a requirement to inform the attending physician when the drug is picked up (Death with Dignity Act of 2016, 2016). After the District of Columbia was Hawaii in 2018 with the Our Care, Our Choice Act, and this act has a few more key differentiators than many of the prior listed acts. Instead of a 15 day waiting period, Hawaii requires a 20 day waiting period, and instead of only requiring counseling if the attending or consulting physician deems it necessary, Hawaii requires that all patients receive counseling from a psychiatrist, psychologist, or clinical social worker in order determine that the patient is not suffering from depression or any other illness that may impact his or her decision (Our Care, Our Choice Act, 2018).

The two most recent states to legalize assisted suicide have been Maine and New Jersey in 2019. Like some other acts mentioned, the Maine Death with Dignity Act contains essentially the same requirements as the Oregon Legislation (Maine Death with Dignity Act, 2019). New Jersey's Medical Aid in Dying for the Terminally Ill Act is also essentially the same as Oregon's legislation in terms of requirements (Medical Aid in Dying for the Terminally Ill Act, 2019).

While assisted suicide is technically legal in Montana, it is a unique case. In 2009, the Montana Supreme Court ruled in the case of *Baxter v. Montana* that a terminally ill patient's consent would be a valid defense to any murder charges brought against a

doctor for assisting a patient in dying, so a physician prescribing lethal medication to a patient that wants to die would not be in violation of state homicide laws (Lathum, 2015). Unlike other states, however, Montana has no legislation regulating the assisted suicide practice because even though it has been legalized through the courts, the state legislature has continually stalled any and all bills attempting to regulate it since the decision was made (Lathum, 2015).

Critical Analysis

The first ever assistance in dying legislation was passed by the Northern Territory of Australia in 1995, and though, as has been mentioned, it was overturned by a bill in the Commonwealth Parliament in 1997 (Duckett, 2017), it's legacy still lives on. The framework of the legislation passed in the Northern Territory created a precedent that can be seen in much of the legislation that has been passed in other countries since, including a terminal criterion (the patient will die from their condition), a suffering criterion (unbearable suffering and/or no means of alleviation), an autonomy criterion (mentally competent, adult, without pressure, etc), a clarity criterion (a clear and explicit request was made, potentially with a waiting period), and an independent verification criterion (the patient's eligibility is verified by independent medical practitioners) (Duckett, 2017). It is through its effectiveness in addressing these criteria that other legislation can be most effectively analyzed.

The Unique Case of Switzerland

Before discussing the aforementioned criteria, the unique case of Switzerland's decriminalization of assisted suicide must first be discussed. Unlike the rest of the countries and locations examined, Switzerland has failed to regulate the practice of

assisted suicide within its borders other than making it so that the practice is legal so long as the one giving assistance does not have selfish motives (Bosshard et al., 2008). While individual right-to-die groups have developed their own sets of policies and procedures, and many of them are fairly comprehensive, this overall lack of monitoring and guidelines for acceptable practice leaves the practice of assisted dying in Switzerland open to a nearly infinite number of possible abuses. This possibility for abuse is very important to keep in mind, and serves as a stark warning that a failure to create detailed and comprehensive legislation when regulating assisted dying could lead to a slew of problems in a country.

This warning should and will be kept in mind going forward in this paper, but the lack of regulation for assisted dying in Switzerland means that beyond the acknowledgement of the potential for abuse, there's not much more that can be done in terms of policy analysis. Because of this, Switzerland will not be further discussed in the following analysis sections that aim primarily to discuss holes and successes in different countries' established criterion for the practice of assisted dying.

The Terminal Criterion

Of the countries and locations discussed, there are two besides Switzerland that do not contain a requirement that the patient seeking assistance in dying have a terminal condition: the Netherlands and Belgium. This, for the first time, raises the question of whether or not a terminal condition should be a necessary criterion in creating legislation for assisted suicide. Should a physical illness have to be terminal in order for a patient to receive assistance in dying? Or, going a step further like Belgium explicitly has, should mental illness be a valid illness to receive assistance in dying?

Much of the earlier discussed legal argument for the legalization of assisted dying hinges on the idea that the government should have no legitimate interest in prolonging a life that is going to end shortly, and in cases like that, a person who is dying anyway should have the right to make that death be in a dignified way on their own terms. Further, when certain Supreme Court Justices implied the possibility of allowing for a right to assisted suicide in the future, the implication was geared towards exceptional cases involving a specific class of people with features such as incredible pain, loss of dignity, and/or a terminal illness (Kaverny, 1997). If assistance in dying is not restricted to those with terminal illnesses, the legislation is significantly less likely to find constitutional support. So to answer these two questions simply: allowing someone without a terminal illness to receive assistance in dying would unravel the argument for legalization too much to allow it to happen in the creation of legislation for America.

The Suffering Criterion

The suffering criterion for the allowance of assisted suicide is fairly uncontested no matter which country or locality is being discussed. While wording does differ a bit by legislation, it can be said that, generally, in order for a person to receive assistance in dying, they must be suffering to a degree that is unbearable and has no options for relief or improvement that are acceptable to the patient. The only significant question raised in examining the suffering criterion is whether or not psychological suffering should be taken into account in addition to physical suffering, because some legislation explicitly mentions it and some does not. Allowing for a patient to receive assistance in dying purely based on psychological suffering would veer far too close to the idea of allowing for assistance in dying due to mental illness, an idea that has already been discussed and

rejected as an option for America. In spite of this, though, the weight of psychological suffering when it comes to dealing with a terminal illness cannot be discounted from the total suffering experience. Because of this, psychological suffering should be allowed to be included in the suffering criterion of legislation as long as it is taken into account in combination with physical suffering as a part of a holistic approach to examining suffering.

The Autonomy Criterion

The autonomy criterion is one of the most important to examine in creating legislation for assistance in dying because it is the criterion that aims to ensure that a patient choosing to receive assistance in dying is mentally competent and is doing so without outside pressure. While much of ensuring competency and lack of outside pressure is addressed more in the process of independent verification, reading through existing legislation raises two particularly interesting questions under the autonomy criterion: Should minors be able to receive assistance in dying, and should euthanasia, assisted suicide, or both be permitted?

As is seen above, there are only two places in the world that allow for minors to receive assistance in dying: the Netherlands and Belgium. Both of these places require a parent to be involved in the decision of assisted dying for minors, and this stipulation that minors cannot make the decision on their own contributes to the question of whether minors are capable of making truly autonomous decisions when it comes to assisted dying. Belgium actually did not allow for minors to receive assistance in dying when it first legalized the practice of euthanasia, and it wasn't until ten years later that the stipulation was added via an amendment to the original act (Saad, 2017). It is posited that

part of the reason for this was a fear that including such a measure would be so controversial that it would prevent the act from passing altogether (Saad, 2017).

It would seem that even in countries where assisted dying is legal for minors, the demand is minimal, which raises the question of how necessary it is to include minors in this type of legislation, especially considering how polarizing the topic can be (Saad, 2017). If the end goal is legalizing assisted dying, it must be asked whether or not it's worth risking the entire legislation over something so controversial when it isn't even in high demand. In the end, since this would be America's first ever nationalized legislation for assisted dying, it is a safe bet to follow the lead of Belgium and start out with a more restrictive law that only allows for adults to receive assistance in dying. Then once that baseline has been established and the first step has been made, legislation can be modified at a later time if observation and analysis deem it necessary.

Moving on to the second question, the query of whether assisted suicide, euthanasia, or both should be included in legalization is also an autonomy issue. Because euthanasia involves the lethal drug being administered to a patient while assisted suicide involves a patient administering the lethal drug to themselves, assisted suicide provides one final moment for the patient to truly make their own decision regarding whether they want to go through with the assisted dying process or not. Assisted suicide allows for an extra safeguard to ensure that a patient's decision is autonomous, and this addition makes it the better choice for legislation in comparison to euthanasia.

The Clarity Criterion

The clarity criterion seeks to ensure that a patient's request for assisted suicide is one that is made clearly and explicitly. In looking at steps that can be taken in order to

ensure that such a decision is made with full understanding and clarity, the idea of waiting periods between an initial request for assisted dying and the actual death must be examined. Most countries do require some specific waiting period, but a few exceptions to this rule do beg the question of whether this is necessary or not. Fortunately, like the assisted suicide versus euthanasia question, this one can be very quickly resolved by simply asking which answer will lead to the most safeguards being in place. With this in mind, having a designated waiting period quickly becomes the better option as opposed to not having one because it gives patients built in time to really reflect on their decision to ensure that that it is what they really want.

The Independent Verification Criterion

Examining the independent verification criterion in other countries is especially important because the independent verification process is where many of the safeguards and double checks come in that help to prevent abuses from occurring. Every country or locality that has legalized or regulated assisted dying has a requirement for independent verification by at least one other medical practitioner in order to verify the patient's eligibility for assistance in dying. However, beyond this basic similarity, there are many differences between countries in regards to the independent verification criterion.

Unlike other countries, the Netherlands and Luxembourg require that all instances of assisted dying be reported to a national review board once the death has occurred (Dyer et al., 2015). This raises the question of whether a review board like this would be good for the United States. The answer, once again, is easily found by determining which option would provide for more safeguards to be in place. Having a national review board

will be an extra layer of protection to help increase chances than any issues or instances of corruption are caught early and stopped before they become bigger problems.

Another key point that separates countries is who is involved in the independent verification process. Beyond the verification by a second, independent medical practitioner, some countries require independent verification from additional sources, including psychiatrists, an expert in the field of the patient's illness, or even a lawyer. In looking at the types of people who could be involved in independent verification, the one that stands out as absolutely necessary is the psychiatrist. It has been shown that "Depression is strongly associated with a desire for hastened death in terminally ill people..." (Price, 2015), so in order to ensure that the decision to receive assistance in dying is truly autonomous, it must be ensured that depression or some other mental illness isn't clouding the patient's judgement.

Another interesting point that can be made on the topic of independent verification is the possibility of involving judges in the process. Judges could play an important role in assisted dying by making the final decision of whether a person may receive assistance in dying after hearing the case of everyone involved, including the doctors and psychiatrists involved in independent verification process and the patient themselves, and deciding whether all requirements for assisted dying have been met from a legal perspective (Castelló, 2009). This, once again, serves as an extra layer of protection to ensure that regulations are being followed and abuses are not occurring.

A PLAN FOR THE LEGALIZATION OF ASSISTED SUICIDE IN THE UNITED STATES

With all of this analysis done, the information gathered can now be applied into a plan for the creation of national assisted suicide legislation in the United States. Herein are the aspects that I deemed to be necessary in order to create the best possible plan for implementation of assisted dying in America.

To begin with the very basics, the United States should only allow for physician assisted suicide and not euthanasia, and the option of medically assisted suicide should only be available to mentally competent adults who have made the decision of their own free will. In order to be eligible for assisted suicide, a patient must have a terminal illness and, based on numbers from other existing legislation, their prognosis should put their life expectation at six months or less. In addition to having a terminal illness, the patient must be experiencing, due to that illness, physical and psychological suffering to an unbearable degree with no acceptable prospects of relief or improvement.

In addition to these eligibility criteria for patients to receive assistance in dying, any legislation passed should be passed with several required safeguards included in order to ensure that all standards are met and abuses aren't occurring. To begin with, there should be a required waiting period between any patient's initial request for assistance in dying and the day that they are officially prescribed the lethal medication. While the exact length of time for this waiting period can be adjusted and hammered out more precisely once legislation is being drafted, my recommendation is that this waiting period be no less than one week. Whether or not all of the criteria for assistance in dying have been met by a patient, including that they're mentally competent, fully understand

what they are doing, and are doing it of their own free will, should be independently verified by both a second, independent medical practitioner and a psychiatrist. The patient's meeting with these independent verifiers should be one-on-one in order to ensure there is no undue influence on the evaluation. Once the patient's doctor, the independent medical practitioner, and the psychiatrist have all determined that the patient meets all eligibility requirements for receiving assistance in dying, the case should be presented before a judge, who will make the final determination of whether all eligibility requirements have been met from a legal standpoint. Finally, once the patient has died due to assisted suicide, their physician should report the death to a national review committee for review.

When creating legislation for the legalization of assisted dying, it is important that these many levels of safeguards are not brushed over or watered down. The entire purpose of having safeguards in place for such legislation is to "...attempt to restrict physician aid-in-dying to those it would genuinely benefit and to protect vulnerable persons for whom it might otherwise pose a risk of harm" (Gunderson & Mayo, 2000). The necessary aspects for legalization that have been identified in this plan serve this purpose to a tee. The recommended regulations and safeguards ensure that only a limited and deserving community will be able to receive assistance in dying instead of making it widely legal for everyone, and they ensure that several layers of protections are in place in order to help prevent and catch cases of abuse and possible corruption. The whole plan is based on a system similar to that of checks and balances, with different people from different backgrounds working together to ensure that no one person can abuse the system.

CONCLUSION

In 2002, Diane Pretty was facing a terminal illness in the United Kingdom and wanted to receive assistance in dying because more than anything, she said that she wanted to have “... a quick death without suffering, at home surrounded by my family so that I can say goodbye to them” (Steinbock, 2005). Instead, she developed fatal breathing difficulties, spent her final weeks experiencing pain and discomfort in spite of the use of palliative care, and finally slipped into a coma-like state, dying in the hospital in the way she feared and dreaded most (Steinbock, 2005). The United Kingdom, like the United States, does not allow for assistance in dying, and heartbreaking stories like Pretty’s exist across countries, seas, and cultures. The stories of those who long to die peacefully and are instead left to suffer for weeks on end until their inevitable deaths come are numerous, tragic, and highlight the need for change to happen.

The possibility of assisted dying being legalized for the entirety of the United States is not quite as foreign and far off of a concept as one might believe. Though it would be easy to push this type of change off, the sooner this process begins, the better. The legalization of assisted suicide is much more than an argument on paper full of hypotheticals, small nit-picks, and inflated personal moral values. There are very real people who are suffering in very real ways who would immensely benefit from the legalization of assisted suicide, yet instead of taking steps to help them, America has brushed the problem under the rug for years. This paper has compiled a massive amount of important information about assisted suicide together, and it is the hope that this information will be used by legislators to make logically formed decisions about the

future of assisted dying in the United States so that this country can finally move beyond the veil of ignorance.

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