OREGON'S DEATH WITH DIGNITY LAW
AND
EUTHANASIA IN THE NETHERLANDS:
FACTUAL DISPUTES

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SECTION 1: INTRODUCTION

Unlike most reports generated by the Legislative Council, there is no statutory mandate to study the Oregon Death with Dignity law or the law on euthanasia in the Netherlands nor is there a study committee comprising members of the legislature. The study of Oregon's law was requested by letter, dated May 13, 2004, from Representative Bill Aswad with 70 additional signatories. The study of the euthanasia law was requested by letter, dated May 19, 2004, from Representatives Haas and Sheltra with 23 additional signatories.

Both letters requested the Council to investigate and report on any factual disputes pertaining to the existing laws and practices, and to attempt to substantiate and reconcile the differing allegations based on empirical evidence. The scope of this report is necessarily limited to the empirical information the Council was able to obtain through its independent research of both primary and secondary sources, attempts to catalogue the areas of dispute, and it indicates where substantiation of the opinions of the proponents and opponents of the laws was not feasible and why. It cannot be overstated that the Council takes no position on the merits or morality of Oregon's Death with Dignity Act or the Netherlands' euthanasia law. Moreover, it is not our intent, nor was it our charge, to express any opinion on whether either practice is consistent with public interest or constitutes legitimate medical care.

The Council solicited information about the areas of study from interested parties[1] in Vermont by sending a brief e-mail questionnaire.[2] We received submissions by e-mail, as well as three voluminous submissions of materials in hard copy.[3] In addition, we did independent research in order to determine the accuracy of the materials and information submitted. Our research included finding reference materials over the internet and in hard copy and interviews with public officials or national experts where feasible and necessary. We did not create or conduct statistically valid surveys of doctors, patients, or other interested parties in Oregon nor in the Netherlands. In addition, the information we were able to obtain regarding the Netherlands was largely by secondary source due to the lack of English translations of the case law and studies.[4]

SECTION 2: DEFINITIONS AND USE OF TERMINOLOGY

One area of confusion in the debate around the laws in Oregon and in the Netherlands arises because different groups include different medical situations in discussions of "euthanasia" and "assisted suicide." This section of the report reviews the definitions of these terms in two articles. In other areas of the report, we use the definition of the term contained in the specific law we are reviewing. For instance, when we use the term "assisted suicide" in relation to the Death with Dignity law, we are referring to the situations defined by the Oregon law, not what is defined as "assisted suicide" in the Netherlands, and not the general constructs we are discussing in this section.

Ezekiel J. Emanuel, MD, PhD breaks down the concept of medical decisions which result in death into six categories of activity, based on the physician's intent, the patient's ability to consent, and the physician's actions.[5] His definitions are as follows:

Term	Definition
Voluntary active euthanasia	Intentionally administering medications or other interventions to cause the patient's death at the patient's explicit request and with full informed consent
Involuntary active euthanasia	Intentionally administering medications or other interventions to cause a patient's death when the patient was competent but without the patient's explicit request and/or full informed consent (e.g. patient was not asked)
Nonvoluntary active euthanasia	Intentionally administering medications or other interventions to cause a patient's death when the patient was incompetent and mentally incapable of explicitly requesting it (e.g. patient is in a coma)
Terminating life-sustaining treatments (passive euthanasia)	Withholding or withdrawing life-sustaining medical treatments from the patient to let him or her die
Indirect euthanasia	Administering narcotics or other medications to relieve pain with incidental consequence of causing sufficient respiratory depression to result in a patient's death
Physician-assisted suicide	A physician providing medications or other interventions to a patient with understanding that the patient intends to use them to commit suicide

The Van Der Maas study breaks down the distinctions somewhat differently in an article reporting the results of a national study requested by the Dutch government.[6] Van Der Maas also uses the physician's actions, his or her intentions, and the patient's involvement in the decision as benchmarks. The three main types of decisions looked at in the study were defined as follows:

> *Non-treatment decisions (NTD)*, the withholding or withdrawal of treatment in situations where the treatment would probably have prolonged life.
>
> *Alleviation of pain and symptoms (APS)*, with opioids in such dosages that the patient's life might have been shortened.
>
> *Euthanasia and related MDEL*,[7] the prescription, supply, or administration of drugs with the explicit intention of shortening life, to include euthanasia at the patient's request, assisted suicide, and life-terminating acts without explicit and persistent request.

Van Der Maas et al., at 670.

As can be seen by this brief comparison, the terms used can be confusing and can include a range of factual situations. When examining the claims of opponents and proponents of the laws in question, it is important to understand what factual situations are included in any statistics or reports on the topic.

SECTION 3: DEATH WITH DIGNITY - OREGON

A. INTRODUCTION

This section of the report details several areas of dispute regarding the Death with Dignity law enacted in Oregon in 1997 and describes the legal developments leading to the passage of the Death with Dignity Act. In each area of factual dispute, we identify the issues, describe the allegations and opinions of both the proponents and opponents, and report any empirical evidence on the topic.

B. DESCRIPTION OF THE DEATH WITH DIGNITY ACT

The Oregon Death with Dignity Act (the Act) is narrowly drawn and encompasses a number of procedural safeguards. This section will outline some of the more significant provisions.[8] A copy of the complete Act, as amended in 1999, is contained in Appendix B.

In order to qualify for physician-assisted suicide, a person must be an Oregon resident, 18 years of age or older, must have decision-making capacity, and must be suffering from a terminal disease that will lead to death within six months. A patient must make one written and two oral requests for medication to end his or her life, the written one "substantially in the form" provided in the Act, signed, dated, witnessed by two persons in the presence of the patient who attest that the patient is "capable, acting voluntarily, and not being coerced to sign the request," and there are stringent qualifications as to who may act as a witness. The patient's decision must be an "informed" one, and the attending physician is thus obligated to provide the patient with information about the diagnosis, prognosis, potential risks, and probable consequences of taking the medication to be prescribed, and alternatives, "including but not limited to, comfort care, hospice care and pain control." Another physician must confirm the diagnosis, the patient's decisionmaking capacity, and voluntariness of the patient's decision. There are requirements for counseling if the patient is thought to be suffering from a mental disorder which may impair his or her judgment, for documentation in the patient's medical record, for a waiting period, for notification of the patient's next of kin, and for reporting to state authorities. The patient has the right to rescind the request for medication to end his or her life at any time.

Having met the above requirements, the patient is entitled to a prescription for medication to end life. The Act does not "authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia." That is, the Act authorizes physician-assisted suicide by lethal prescription but explicitly rejects active euthanasia.

In response to concerns raised that patients will be motivated by depression to seek a physician's assistance in ending their lives, the 1999 amendments to the Act added "depression causing impaired judgment" to the generic "psychiatric or psychological disorder" that the attending physician must determine the patient does not have before prescribing medications.

The amendments also added a reporting mandate, requiring that any health care provider who dispenses medications under the Act file a copy of the dispensing record with the state health division. Finally, the Act requires the state health division to issue an annual report summarizing the experience with the statute.

C. LEGAL DEVELOPMENTS

There have been a number of state and federal cases in the United States addressing the legal parameters of end-of-life decisionmaking, generally. This section will describe briefly some of those legal decisions to the extent they shed light on the legal issues that have emerged relative to Oregon's physician-assisted suicide law. It will be followed by a separate section analyzing the legal issues relating specifically to Oregon's Death with Dignity Act.

RIGHT TO WITHDRAWAL OR WITHHOLDING OF LIFE-SAVING TREATMENT

In 1976, in the case of Karen Ann Quinlan, In re Quinlan,[9] the New Jersey Supreme Court held that Quinlan's father could make the decision to turn off the respirator that was keeping his daughter alive. In that case, the patient's constitutional right of privacy, as asserted by her guardian, outweighed the state's interest in preserving the sanctity of human life and defending the best judgment of medical professionals. The court recognized that the state's interest diminished as the potential for life diminished. This was the first of several cases concerning the withdrawal of life support from persons in a persistent vegetative state.

The issue was addressed 14 years later by the United States Supreme Court in the case of Cruzan v. Director, Missouri Department of Health.[10] In that case, Nancy Cruzan sustained brain injuries resulting in a persistent vegetative state, and when it became apparent that she had virtually no chance of regaining her mental faculties, her parents asked the hospital to remove the artificial nutrition and hydration which sustained her. The hospital refused to act absent a court order.

The Cruzan Court specifically found that the right of an individual to refuse life-sustaining medical treatment derived from the common law doctrine of informed consent and has a constitutional basis:

> “Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits and assault.” Thus, under common law, a patient can consent to, or, conversely, refuse medical treatment. Since the patient can refuse treatment at any time, the patient can have treatment withdrawn even after it has been initiated.[11]

The Court held that under the Due Process Clause of the Fourteenth Amendment, a *competent* person has a constitutionally protected liberty interest in the right to refuse treatment; however, a state can restrict the ability of others to exercise that right on behalf of an *incompetent* person. Specifically, a state may require that an incompetent person’s wish to have life-support withdrawn be proven by clear and convincing evidence. Absent such evidence, a state has a legitimate interest in the protection and preservation of human life. One notable consequence of this decision was a rise in the use of advance directives as a means of meeting the required clear and convincing standard.

PHYSICIAN-ASSISTED SUICIDE

No American jurisdiction currently treats suicide or attempted suicide as a crime.[12] There is very little case law, however, on whether *assisting* suicide is a crime under the common law. There is no right to assisted suicide under the United States Constitution.[13] The right may exist under a specific state constitutional provision, though to date no courts have so held, and two state supreme courts have refused to strike down state laws banning assisted suicide on grounds that they violated privacy clauses in their respective state constitutions.[14]

The two most significant cases that addressed the issue of whether there was a federal constitutional right to assisted suicide arose from challenges to state laws banning physician-assisted suicide brought by terminally ill patients and their physicians: Washington v. Glucksberg[15] and Vacco v. Quill.[16]

In Glucksberg, the Court held that the asserted right to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause of the Fourteenth Amendment. The majority distinguished the facts and rationale of Cruzan:

"The decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection. Indeed, the two acts are widely and reasonably regarded as quite distinct."[17] Upon determining that a fundamental liberty interest was not at stake, the Court went on to conclude that the Washington statute being challenged was rationally related to five legitimate governmental interests: protection of life, prevention of suicide, protection of ethical integrity of the medical profession, protection of vulnerable groups, and protection against the "slippery slope" toward euthanasia.[18] The Court then noted that perhaps the individual states were more suited to resolving or at least addressing the myriad concerns raised by both proponents and opponents of physician-assisted suicide: "Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society."[19]

In Vacco, the Court ruled that New York's ban on assisting suicide does not violate the Equal Protection Clause of the U.S. Constitution. As in Glucksberg, the Court recognized a distinction between refusing lifesaving medical treatment and taking lethal medication. The Court disagreed "with the Second Circuit's submission that ending or refusing lifesaving medical treatment 'is nothing more nor less than assisted suicide.'"[20] Rather, it determined that "[t]he distinction between letting a patient die and making that patient die is important, logical, rational, and well established . . . [and] comports with fundamental legal principles of causation . . . [T]he line between the two acts may not always be clear, but certainty is not required, even were it possible."[21] Thus, New York may ban the latter without violating the Equal Protection Clause. The Court then concluded that the New York law, like Washington's, is rationally related to legitimate state interests: namely, prohibiting intentional killing and preserving life, preventing suicide, maintaining physicians' role as their patients' healers, protecting vulnerable people from indifference, prejudice, and psychological and financial pressure to end their lives, and avoiding a possible slide toward euthanasia.

Most states have addressed the issue of assisted suicide legislatively. Forty states have enacted laws which explicitly make it a crime to provide another with the means of taking his or her life.[22] Oregon is the only state presently permitting assisted suicide by statute. Vermont has no statute specific to assisted suicide. It is unclear how a Vermont court would apply the common law in an assisted suicide case.

LEGAL CHALLENGES TO THE DEATH WITH DIGNITY ACT

As mentioned, Oregon is the only state to date with a statute affirming and regulating the right to physician-assisted suicide. Oregon voters approved the Death with Dignity Act by referendum (Ballot Measure 16) in 1994. The Act immediately was challenged in federal District Court, and implementation was delayed for three years as the case made its way through the federal court system until 1997 when the United States Supreme Court declined to review the case on appeal.[23] (While the litigation was in progress, the Oregon legislature approved legislation to permit the electorate to vote to repeal the Death with Dignity Act. Repeal was defeated by a 60 – 40% margin.)[24] Shortly after the law's implementation in 1997, the compliance with the Act was again challenged, this time by the federal Department of Justice, which issued a directive calling for the prosecution of health care professionals who participated in the assisted-suicide program. The federal challenge, likewise, has proved unsuccessful to date. A more detailed description of these legal developments follows.

Lee v. Oregon

The initial challengers of the Act consisted of terminally ill patients, physicians, and residential care facilities. They argued that the Act violated their equal protection and due process rights under the Fourteenth Amendment, their free exercise of religion and freedom of association rights under the First Amendment, and their statutory rights under the Americans with Disabilities Act (ADA) of 1990, the Rehabilitation Act of 1973, and the Religious Freedom Restoration Act (RFRA) of 1993. The Oregon District Court granted summary judgment for plaintiffs on their equal protection claim and issued a permanent injunction against the Act's enforcement on August 3, 1995. The court found that the Act violated the Equal Protection Clause because it provided insufficient safeguards to prevent against an incompetent (i.e., depressed) terminally-ill adult from committing suicide, thereby irrationally depriving terminally-ill adults of safeguards against suicide provided to adults who are not terminally ill.[25]

The court did not decide plaintiffs' other claims for relief. However, a description of those claims will be reviewed here in the interest of providing a brief overview of the legal challenges to the Act. The due process claim was based on the allegation that the Act deprives persons who are disabled due to a terminal disease of protections for their right to live and, moreover, violates plaintiffs' liberty interests because it does not guarantee sufficiently that the choice to end life will be both informed and voluntary.[26] Plaintiffs' ADA claim was based on the argument that the Act unlawfully deprives persons who are disabled due to a terminal disease of protection afforded other persons under Oregon law in violation of the ADA and, to the extent the statute applies to federally funded programs, Section 504 of the Rehabilitation Act of 1973.[27] Defendants countered that the Act does not require any individual with disabilities to use assisted suicide but rather provides the option of assisted suicide as a benefit under the law; and, accordingly, no person with disabilities is deprived of legal protections against suicide.[28] Plaintiffs also argued that the Act was unconstitutionally vague particularly in regard to the definition of "terminal illness." Finally, plaintiffs argued that the Act required health care professionals to act in a manner inconsistent with their religious and moral convictions and in violation of the free exercise clause and freedom of association protections of the First Amendment and the RFRA. Again, the court did not determine the merits of these claims.

The case was appealed to the Ninth Circuit. The Ninth Circuit vacated and remanded with instructions to dismiss the case for lack of jurisdiction. The court determined that it lacked Article III jurisdiction because all of the plaintiffs lacked standing,[29] and the claim of the doctors and health care facilities, in particular, was not ripe.[30] Specifically, the patients had not displayed an "injury-in-fact" because the asserted injury—the possibility that the plaintiff would commit suicide as a result of inadequate detection of her depression—was too speculative and not actual or imminent. The doctors and health care facilities, on the other hand, failed to show both that their alleged forced participation was a "concrete and particularized" injury and that their claim was "ripe" because the Act does not penalize a health care worker or facility for not participating.[31] And, in any event, the alleged forced association with those who do follow the Act also failed to show an "injury in fact."

Federal Challenges to Death with Dignity

Soon after the Oregon Death with Dignity Act went into effect, members of the United States Congress suggested that physicians who participated under the law's guidelines would be in violation of the federal Controlled Substances Act (CSA).[32] Attorney General Janet Reno agreed to review the matter and, in June 1998, announced that the Department of Justice would not prosecute physicians who complied with the Oregon law. Attorney General Reno concluded that the CSA did not support the ban on the use of legitimate drugs for an approved medical purpose.[33]

Later that year, a congressional bill known as the Lethal Drug Abuse Prevention Act of 1998 was introduced, proposing to block the use of controlled substances in physician-assisted suicide, euthanasia, or mercy killing.[34] It failed to pass the 105th Congress. It was revised and resubmitted to the 106th Congress as the Pain Relief and Promotion Act, but it too failed to pass.[35]

In November 2001, Attorney General John Ashcroft issued an interpretive rule reversing the position of his predecessor.[36] He directed the Justice Department to pursue action under the CSA against physicians and pharmacists who prescribed, filled, or dispensed drugs under the Death with Dignity guidelines; the so-called Ashcroft Directive. The state of Oregon immediately filed suit seeking to enjoin the federal government from enforcing the Ashcroft Directive.[37] The federal district court ruled in favor of Oregon, and the Justice Department appealed to the Ninth Circuit.

On May 26, 2004, the Ninth Circuit issued an opinion affirming the lower court's ruling.[38] Specifically, the court held that Attorney General Ashcroft exceeded his authority under the CSA when he adopted the directive declaring physician-assisted suicide in violation of the CSA. Congress had intended to limit the CSA to problems associated with drug abuse and addiction, and physician-assisted suicide was not a form of drug abuse that Congress intended to cover. Rather, physician-assisted suicide is a general medical practice to be regulated by state lawmakers in the first instance. The CSA did not give Attorney General Ashcroft unmistakably clear authority to exercise control over an area of law traditionally reserved for state authority; and, furthermore, the court held the directive violates the plain language of the CSA by not reflecting the standards and requirements of the federal statute.[39] On November 9, 2004, the Justice Department appealed that decision to the United States Supreme Court.

D. UTILIZATION AND PATIENT CHARACTERISTICS

The Oregon Department of Human Services is required by the Act to issue an annual report including statistics on the usage of the Act. This section of our report includes a summary of this information and the results of studies in Oregon regarding patient views, characteristics, and utilization of the Act. The factual disputes identified in this area are the reasons a patient would choose physician-assisted suicide, whether the rates of utilization are underreported, and concerns over utilization by people with disabilities or depression.

REQUESTS AND UTILIZATION

One survey of Oregon physicians in 1999 reports that 5% of practicing physicians received at least one request by a patient for a lethal prescription under the Death with Dignity law.[40] The total number of requests received was 221, several of which appeared to be duplicate requests by patients.[41] Of the 165 patients for which physicians included outcomes in the questionnaire, 29 received prescriptions. Of the 29 patients with prescriptions, 17 (59%) took the prescription, 11 (38%) died from other causes, and one was still alive at the time of the survey.[42] Of the 136 patients who did not receive prescriptions, 27 (20%) died prior to the time the provisions of the law were met, 21 (15%) did not meet the legal criteria, and 21 (15%) changed their minds.[43] In 30 (22%) of the cases, the physician was not willing to provide the prescription, and the physician was not willing to provide a prescription in any circumstance in 40 (29%) of the cases.[44]

The Oregon Department of Human Services is required under the law to collect information on the utilization of and compliance with the Death with Dignity law. Although the law allows the Department to review a sample, due to the low utilization rates, the Department reviewed all the mandated physician and pharmacy reports.[45] Below is a table showing the utilization rates in Oregon since the law went into effect:[46]

	1998	**1999**	**2000**	**2001**	**2002**	**2003**
Number of Prescriptions written	24	33	29	44	58	67
Number of those with prescriptions who used medication	16	27	27	21	38	42
Number of deaths pursuant to DWD law/per 10,000 total deaths in Oregon	5.5	9.2	9.1	7	12.2	14

One concern raised by opponents of the law is whether the statistics accurately reflect any violations or utilization of the law because the information is self-reported by physicians.[47] One argument presented is that physicians do not have first-hand knowledge of what occurred during the patient's death because the medication is self-administered, and there may be unreported clinical problems or violations of the law.[48] The Oregon Department of Human Services reported that in the year 2000, physicians were present at 14 of 27 deaths.[49] There is no empirical evidence specifically on underreporting, although studies done on the Oregon law have surveyed hospice nurses and hospice social workers, in addition to physicians, and have found similar utilization statistics among these provider groups who are often at the death of a patient.[50] Although there is no study specifically on underreporting, one recent study of family members of deceased Oregonians did not identify any unreported cases of assisted suicide.[51]

There is also a criticism of the statistics gathered by the Department of Human Services because the data is based only on reported cases. The criticism is that there may be underreporting by physicians and that, because of patient confidentiality, there is insufficient information about physician-assisted suicide. There is no way for this office to determine if physicians in Oregon are or are not underreporting patient deaths under the Death with Dignity Act. The law does require that the death be reported, and failure to do so is a legal violation. Although the law does not state a specific penalty for failure to report, the general penalties apply.[52] The physician could be prosecuted under Oregon law or be reported to the professional conduct board if a case is not reported, as he or she would not have met the statutory requirements for legally assisting in a suicide.[53] It is also important to note that academic studies interviewing physicians, hospice nurses, and hospice social workers come to similar conclusions as the state studies.[54] Of course, it can be argued that a physician who was unwilling to report the death to the Department of Human Services may also not report the death in an academic study. Underreporting has been documented by studies in the Netherlands; it is difficult to determine if the incidence of underreporting in another country is comparable to the situation in Oregon due to cultural differences and the difference in how the law in the Netherlands arose. See generally Section 4 of this report on the Netherlands.

A concern raised by the proponents of the law is that the opponents often use the percentage increase in deaths, in lieu of the actual number of deaths, in Oregon.[55] The percentage change of deaths by lethal medication between 1998 and 2003 is dramatic, approximately 275%; this percentage represents a shift from 16 to 42 deaths.[56] The number of deaths in 2003 (42) is approximately 1/7 of 1% of all deaths in Oregon, still a small number of total deaths in that state.[57]

PATIENTS' REASONS AND VIEWS

The characteristics and views of patients and their families who use Oregon's Death With Dignity law have been studied by questionnaires and interviews with physicians, nurses, social workers, psychiatrists, and psychologists working with this population.

Overall, the patients choosing assisted suicide are described as independent, determined, and inflexible.[58] Fifty-seven percent of patients requesting a lethal prescription cited a loss of independence as an important reason in the patient's decision, 55% cited poor quality of life (current or future concern of), 54% cited a readiness to die, and 53% cited a desire to control the circumstances of death.[59] In a study of hospice nurses, it was reported that among patients who had received prescriptions for lethal medications from a physician, the most important reasons cited for wanting assistance with suicide were a "desire to control the circumstances of death, a desire to die at home, the belief that continuing to live was pointless and being ready to die." Ganzini et al., "Experiences of Oregon Nurses and Social Workers with Hospice Patients who Requested Assistance with Suicide," N Engl J Med 347, No. 8, (2002): 584. The Department of Human Services in Oregon found similar results with losing autonomy, less able to engage in activities making life enjoyable, and loss of dignity cited as the primary end of life concerns.[60] In addition, a study of those patients who died in 1999 in which family members were interviewed found similar reasons, including concern about loss of control of bodily functions (68%), loss of autonomy (65%), physical suffering (53%), an inability to participate in activities that make life enjoyable (47%), and concern about being a burden on others (47%).[61]

One area of concern is that patients may be requesting a lethal prescription because of financial or family pressures. One study found that 11% of patients requesting a lethal prescription cited a perception of a financial burden as a reason for the request and 6% of these patients said they lacked social support.[62] Nearly one-third (38%) of patients cited a concern about burdening others as a reason, but only three of these patients actually received a prescription.[63] This study looked at patient *requests*, not only at those patients who actually received or used the medication, which is a smaller number of patients. Also, a study of hospice nurses and social workers found that lack of social support and concern about finances were relatively unimportant to the patients who actually had *received* a lethal prescription.[64]

The study also reported information on the health insurance status of those requesting the prescription for lethal medication. The results are as follows:

Health Insurance by Type	**No. (%)** **Total responses received: 143**
Medicare	63 (44)
Health maintenance organization	23 (16)
Other managed care	20 (14)
Fee for service	17 (12)
Oregon Health Plan (Medicaid)	11 (8)
Military coverage	4 (3)
None	3 (2)
Unknown	18 (13)

Ganzini et al., "Physicians' Experiences with the Oregon Death with Dignity Act", N Engl J Med 342, No. 8 (2000): 561.

The study determined that the demographic characteristics of the patients who requested the lethal prescription were "nearly identical to those of members of the general population of Oregon who died." Id. at 562. In addition, the type of health insurance was not correlated with whether the patient received a lethal prescription nor with whether another type of intervention, such as a referral to hospice, was made by the physician.[65]

A recent study of family members of deceased patients with a terminal illness found that "dying Oregonians were approximately 100 times more likely to consider [assisted suicide] than to follow through with obtaining a lethal prescription."[66] The study also determined that those with a high school education were as likely to personally consider assisted suicide as those with post-baccalaureate education, but those with post-baccalaureate education were significantly more likely to get a lethal prescription.[67]

CHARACTERISTICS OF PATIENTS REQUESTING A LETHAL PRESCRIPTION

The mean age of the patients who requested lethal prescriptions from physicians was 68 years; 52% were men and 97% were white.[68] Forty-six percent of those who requested lethal medications were married or living as married.[69] Ninety-three percent of these patients were competent, and 20% had symptoms of depression.[70] Thirty-two percent of the patients were currently enrolled in a hospice program at the time of the request.[71] Seventy-six percent had an estimated life expectancy of less than six months and in 41% of the cases, the request followed an acute deterioration in the person's medical condition.[72] It is important to note that not all the patients who requested the lethal medications received the prescription from the physician. In addition, not all patients who received the prescription filled it or used it.[73]

DEPRESSION

Depression in patients is a concern often cited in regard to the law, because physicians who are not psychiatrists under-diagnose depression, and because the number of patients who *received* a lethal prescription in Oregon in 2003 and were referred for psychiatric evaluation was about 5%.[74] Under Oregon law, a psychological evaluation is required when the attending or consulting physician believes that the patient may suffer from a "psychiatric or psychological disorder or depression causing impaired judgment."[75] The legal purpose of this safeguard is to ensure that the patient is competent to make an informed choice.

In 70% of all suicides over the age of 60, medical illness is an important factor.[76] One study determined that the incidence of depression in those patients *requesting* assistance with suicide[77] in Oregon is 20% and reported the incidence of depression among dying cancer patients to be between 59-100% based on other studies.[78] In addition, 11% of the patients who requested a lethal prescription in Oregon who had symptoms of depression changed their mind about their request after receiving a trial of medication for depression or anxiety or after evaluation by a mental health expert.[79] Patients who received comprehensive palliative-care services through a hospice program, whether depressed or not, were more likely to change their minds about assisted suicide than those who did not receive these services.[80] A study of patients with amyotrophic lateral sclerosis (ALS) found that depression was not linked to a desire to participate in assisted suicide, but that a feeling of hopelessness was.[81] Patients with depression often have feelings of hopelessness, but patients may be hopeless without being depressed.[82]

There is not much clinical research on depression in dying patients nor on the effectiveness of treatment of depression in dying patients.[83] One study of patients in four inpatient palliative care units in England given common medications to treat depression found that 75% of patients died within two weeks, prior to the time the medication was effective.[84] Another study of 24 hospice inpatients found that if patients were given a specific, quick acting drug, 46% improved.[85] Only 7% of the patients improved, however, if they were within the last six weeks of death.[86]

Depression in patients facing death as the result of a terminal illness is a complicated issue. Competence can be a shifting state,[87] and determinations of decision-making capacity are based on a professional judgment that a patient's decision is rational or reasoned, not on an objective standard.[88] Also, even serious mental disorders may not effect decision-making capacity.[89]

PEOPLE WITH DISABILITIES

Another often cited concern is that people with disabilities will be pressured to use the law or will use the law more often than people without disabilities. We were able to gather the type of illnesses patients using a lethal prescription had and some evidence on the predictors of interest in assisted suicide among patients with amyotrophic lateral sclerosis (ALS). Otherwise, we were unable to find empirical evidence on the underlying causes of the decisions of people with disabilities in regard to physician-assisted suicide.

The Department of Human Services has reported on the underlying illness of those who died by using a lethal medication prescribed pursuant to the law.[90] In 2003, 83% (35 of 42) of patients had a malignant neoplasm (cancer), 7% (3/42) had amyotrophic lateral sclerosis (ALS), 5% (2/42) had HIV/AIDS, 2% (1/42) had chronic lower respiratory disease. Between 1998-2002, 78% (100/129) of patients had malignant neoplasms, 8% (10/129) had ALS, 1% (1/129) had HIV/AIDS, 6% (8/129) had chronic lower respiratory disease, and 8% (10/129) had one of the following: aortic stenosis, congestive heart failure, diabetes mellitus with renal complications, gastrointestinal stromal tumor, myelodysplastic syndrome, pulmonary disease with fibrosis, scleroerma, and Shy-Drager syndrome.[91]

In Oregon in 1999, 5% of patients with ALS chose assisted suicide, as opposed to 0.4% of cancer patients who died that year.[92] In patients with ALS who discussed wanting physician-assisted suicide in the month before their death, family members reported "more frequent and severe insomnia, more frequent pain, more severe discomfort other than pain and greater distress at being a burden in comparison to ALS patients who did not discuss wanting assisted suicide." Ganzini et al., "Predictors and Correlates of Interest in Assisted Suicide in the Final Month of Life Among ALS Patients in Oregon and Washington," J Pain Symptom Manage 24 (2002): 314. Predictors of interest in assisted suicide included the patient's indication that she or he would consider assisted suicide and high feelings of hopelessness.[93] Depression was not an indicator.[94] Another study of attitudes of patients with ALS found that patients with strong religious beliefs and frequent religious practices were "much less likely to consider assisted suicide an option than those who were less religious." Ganzini et al., "Attitudes of Patients with Amyotrophic Lateral Sclerosis and Their Care Givers Towards Assisted Suicide," N Engl J Med 339 (1998): 971. A majority of the patients with ALS surveyed indicated they would consider assisted suicide.[95] In this study, no correlation was found between the caregiver's perception of the patient's suffering, level of social support, emotional distress and economic burden, and the patient's attitude toward assisted suicide.[96]

TIME BETWEEN PRESCRIPTION AND DEATH

Another concern raised is that there are patients who received the medication, but were not in the last six months of life.[97] It is accurate that there have been patients who received the medication and who lived longer than six months.[98] The explanation presented by physicians is that a physician cannot predict death with exactitude, and this is necessarily a profession opinion, which is not always accurate. There are also many patients that die prior to completing the requirements of the law and that do not receive lethal prescriptions.[99]

E. IMPACT ON END-OF-LIFE CARE

GENERAL BACKGROUND

In November 1992, the Robert Wood Johnson foundation issued a report entitled Means to a Better End: A Report on Dying in America Today. As stated in that report

"Experts - and the public - generally agree that the best end-of-life care treats the whole person - body, mind and spirit. This is called palliative care. Palliative care works aggressively to relieve pain and other physical symptoms; it also offers emotional and spiritual support to the patient and family, while respective their culture and traditions. Care for people near the end of life is largely financed and delivered through Medicare and Medicaid - programs that were not designed to provide comprehensive palliative care."

Palliative care is provided in hospitals, nursing homes, other long-term care facilities, hospices, and in the home of the patient. The availability and quality of service varies from state to state. The Robert Wood Johnson Foundation established Last Acts which is a national coalition of health care providers and others, to promote end-of-life care throughout the country. In the Means to a Better End report, Last Acts rates each of the 50 states and the District of Columbia on the basis of eight criteria measuring end-of-life care. An unfortunate finding of this report is that "Despite many recent improvements in end-of-life care and greater public awareness about it, this report shows that Americans at best have no better than a fair chance of finding good care for their loved ones or for themselves when facing a life-threatening illness. In most states, too few patients are accessing hospice and palliative care services, there are too few professionals trained in pain management and palliative care, and there are too many patients dying in hospitals and nursing homes-in pain-rather than at home with their families." Although the state-by-state analysis of service is discouraging, the report describes "how state coalitions composed of diverse professional and consumer groups have recognized the serious problems with care of the dying in their states and are working actively to try to fix them. Already some of their efforts have resulted in substantial progress. . . ."

PALLIATIVE CARE SERVICES IN OREGON

The issue raised around palliative care is whether this type of care was improved by the enactment of the Death with Dignity law. In order to determine the factual basis, this office interviewed Ann Jackson, Executive Director, Oregon Hospice Association (OHA), and a member of the Task Force to Improve the Care of Terminally Ill Oregonians. Ms.

Jackson was asked to evaluate the impact the Oregon Death with Dignity Act (the Act) has had on palliative care services in that state.

Ms. Jackson found that after the law was passed, hospice nurses reported that physicians in Oregon were doing better at managing pain. More physicians attended continuing education classes in palliative care after passage of the Act than before. These classes were offered by Oregon Health and Science University (OHSU) which trains medical students, interns, and residents in end-of-life care. Ms. Jackson also determined that prior to 1994, hospice organizations which sponsored pain programs for physicians in 2001 in eastern Oregon were not well attended by area doctors.

Oregon has a strong history of palliative care. OHSU's inpatient palliative care team was developed around 1994. In Oregon, the law allows hospice organizations to provide palliative care as well as hospice care. The Oregon law allowing advanced directives was passed in 1977. Oregon was the first state to combine advance directives and health care powers of attorney and remains among the least restrictive. Utilization of advance directives in Oregon is believed to be the highest in the nation. A 1997 study revealed that two-thirds of Oregonians had an advance directive at death, and 85% of families believed the deceased's wishes were respected. Oregon developed physician orders for life sustaining treatment beginning in 1992. When the Physician Orders for Life Sustaining Treatment (POLST) is in use, respect for wishes increases to virtually 100%. Recent studies indicate that advance directives elsewhere in the country are not a factor in the kind of care a patient receives.

Ms. Jackson also indicated that the rate of assisted suicide has been roughly 1/10th of 1%. It is Ms. Jackson's opinion that assisted suicide "is not disproportionately used by minorities, people in rural areas, the poor, the uneducated, or the uninsured. There are no places in Oregon where care is not accessible. The educated appear to have better access to information. There is no evidence to suggest that anyone has been coerced into using it. People who are depressed do not use it, probably because depression makes it difficult to carry out many actions. High hospice utilization also means that mental health is constantly monitored by hospice social workers. There have been no botched cases. There have been no calls to 911 related to the use of medication. There has not been a migration to Oregon. Opponents often state that it would be essential to have the kind of infrastructure that Oregon had when such a law is considered. I think the law has been a catalyst in many respects in Oregon, even though we already had good palliative care here."

HOSPICE CARE IN OREGON

Hospice provides pain and symptom management and a range of psychosocial services and spiritual support to patients and their families through the duration of life-limiting illness. Hospice provides information on care options and carries out those decisions with respect for wishes of the people involved and the laws of the state.

In an interview with this office, Linda Ganzini, M.D., Associate Professor of Psychiatry at Oregon Health and Science University (OHSU), states that an extensive network of hospice care services was essential before the Death with Dignity law was in place. She further states that hospice services are provided extensively and at a high level of competence in Oregon.

We also interviewed Joan Teno, M.D. who is a practicing physician in Rhode Island. Her practice involves end-of-life care for patients. Dr. Teno is also a researcher at Brown University and the current Chair of the American Geriatric Society Ethics Committee. She believes that 50 – 60% of end-of-life patients in each state should have hospice care available. She stated that the Oregon law has been well implemented in Oregon, and that hospice is an important component of the end-of-life care.

Ann Jackson, Executive Director of OHA, was also asked to evaluate the availability and quality of hospice care in Oregon during the period the Act has been in effect. She found that:

"Hospice and/or palliative/comfort care was available to all Oregonians when [the Act] was passed. Both were required as part of the basic health package for the Oregon Health Plan.[100] One county did not have hospice care in 1994. . . ." The last county had a hospice program certified by Medicare in October 2002. Ms. Jackson indicates that "hospice services are available even in the most remote and rural areas of Oregon at this time. One county with a population of 7,000 and 10,000 square miles was Medicare-certified in 1992. Analysis of Medicare data (over 65) throughout the U.S. confirms that Oregon's physical access to hospice care is greater than any other state." Oregon has ranked highly in terms of the use of hospice since at least 1992 according to Ms. Jackson.

Ms. Jackson has found that "awareness of end-of-life care options is probably greater in Oregon, especially among health care professionals. Every Oregonian who has used [the Act] has been offered hospice care. . . . Nearly 89% [of patients] over the six years were in hospice care at the time they ingested medication, 93% in 2003. Most significantly, I think, is the long length of stay in hospice these individuals have. Oregon's median length of stay is approximately 16 days. . . . Not having been referred or admitted earlier is always the number-1 complaint regarding hospice care. In 1999, the median length of stay for individuals using [the Act] was 49 days. Individuals are eligible for hospice when they have a life expectancy of 6 months or less, similar to [the Act]."

DYING IN THE HOME—HAS THE OREGON DEATH WITH DIGNITY ACT HAD AN IMPACT?

Research indicates that 70% of Americans would prefer to die in their homes as opposed to in a hospital, nursing home, or other facility. Ann Jackson was asked about the percentage of people dying in their homes and what, if any, impact the Act has had on these numbers. Her response follows:

"Oregon has had a very high rate of home deaths and a very low rate of hospital deaths. In 1961, Oregon's hospital utilization in length of stay (LOS) was shortest in the nation. A high rate of hospital deaths is directly correlated with the number of beds available. Oregon has deliberately kept the number of beds low and has developed alternative care settings such as foster homes and assisted living facilities. Oregon has also not had many inpatient hospices. Fewer than 2% of hospice deaths occur in an inpatient setting. This does not include individuals whose residence is a facility, but it does include individuals who are in an inpatient setting for general acute inpatient care or respite care. The death rate at home has continued to increase over the years, slowing somewhat recently."

PAIN MANAGEMENT—HAS IT BEEN AFFECTED BY THE OREGON DEATH WITH DIGNITY ACT?

Pain management is a critical factor in end-of-life experiences throughout the country. Various researchers, including Linda Ganzini and Joan Teno report that the range of pain management solutions varies from state to state. Ann Jackson, again, provided assistance:

"The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT) studies of the late 80s and early 90s revealed that the lowest rate of pain in five major medical centers in the country was above 50%. A 1997 study in Oregon revealed a rate of moderate to severe pain at approximately 35-38% across all settings, which is, of course, horrific. There was an increase of pain in the hospital setting in November-December 1997, nearly doubling." As Ms. Jackson explained, this increase may have been the result of efforts to repeal the Act, ongoing at that time, as well as threats of prosecution under federal law.

Ms. Jackson also indicates that proponents of assisted suicide often mislead their audiences by arguing that the only alternative to pain is death. However, Ms. Jackson indicates "pain has not been a significant reason for individuals to use [the Act]. Fear of pain appears to be a greater factor than actual pain." Palliative care provides adequate pain relief as an option.

William Lamers, M.D. is a medical consultant to the Hospice Foundation of America and a practicing physician in Malibu, California. He has had over 30 years of experience with end-of-life care. It is his position that Oregon is at the forefront of end-of-life care and that the Oregon law has not diminished that care but rather, has enhanced it. His remarks were not intended as an endorsement of assisted suicide but a factual representation of its consequences. He additionally stated that he considers Ann Jackson and the work of her office to be of the highest quality and credibility.

In conclusion, it is quiet apparent from credible sources in and out of Oregon that the Death with Dignity Act has not had an adverse impact on end-of-life care and in all probability has enhanced the other options. There is agreement among the professionals we interviewed that the Oregon experience does not necessarily translate into an equivalent experience in other states adopting a similar death with dignity law.

F. SELECTION OF HEALTH CARE PROVIDER & PROVIDER VIEWS

One criticism made by opponents of the Death with Dignity Act is that patients who are refused a lethal prescription from one physician are able to go to another physician to request the prescription. A study of patients reported to the Oregon Department of Human Services found that in 1999, 31% (8 of 26) of patients *received* a prescription by the first physician approached.[101] In another study, the researchers found that 35% (57 of 161) of patients who requested a lethal prescription had requested a prescription from another physician.[102] A study of patients reported to the Oregon Department of Human Services found that in 1998, the first year the law was in effect, 40% of patients were "unable to initiate the prescription process with the first physician they approached and had to request a prescription from a second or third physician." Chin et al., "Legalized Physician-Assisted Suicide in Oregon – the First Year's Experience," N Engl J Med 340 (1999): 582. This study attributed the patient's inability to get a prescription to physician opposition to Death with Dignity and hospital systems choosing not to participate in physician-assisted suicide based on official hospital policies in place at that time and a 1995 survey of physician attitudes.[103]

Not surprisingly, health care professionals express a broad range of views on the Death with Dignity Act. In 1994, the Oregon Medical Society chose to remain neutral with respect to Ballot Measure 16 and neither supported nor opposed the concept of physician-assisted suicide.[104] In 1997, when the Legislature referred to the voters the issue of whether to repeal the Act, the Oregon Medical Society came out in favor of repeal on grounds that the law was flawed with regard to several unclear issues related to physicians' statutory duties and prerogatives. Since then, the Legislature addressed those flaws by amending certain provisions of the Act, and the Medical Society's original 1994 position of neutrality remains in place.[105]

According to a 1995 survey of physicians thought to be eligible to prescribe a lethal dose of medication under the Act if the law was upheld, 60% of the respondents thought physician-assisted suicide should be legal in some cases, and nearly half (46%) said they might be willing to prescribe a lethal does of medication if it were legal to do so; 31% responded that they would be unwilling to do so on moral grounds.[106] According to a 1999 survey of 4,053 physicians eligible to prescribe under the Act, 65% participated in the survey (2,649) and indicated that physicians grant about one in six requests for a prescription for lethal medication and one in 10 requests actually results in suicide.[107] The 1999 study contained some problems reported by physicians who assisted suicide under the Act, including unwanted publicity (3 physicians), difficulty obtaining the lethal medication or a second opinion (3), difficulty understanding the requirements of the law (3), difficulties with hospice providers (1), not knowing the patient (1), or the absence of someone to discuss the situation with (1).[108] With respect to the law's requirement that physicians confidentially report lethal medication to the Oregon Department of Human Services, some physicians were concerned about reporting because they feared that the patient's privacy (in 16 cases), their own privacy (in 18), or the privacy of the patient's family (in 15) would be violated or that retroactive sanctions would be imposed by the Drug Enforcement Agency (in 7).[109] Four physicians expressed ambivalence about having provided assistance with suicide, though two of the four noted that they had become less ambivalent over time; one deciding not to provide such assistance again.[110]

In 2000, 35 physicians were interviewed about the impact requests for assisted suicide had on them, focusing on emotional reactions, factors influencing their decisions, and sources of support.[111] The interviews revealed that requests for assisted suicide had a powerful impact on physicians and their practices. Physicians often felt unprepared and experienced apprehension and discomfort before and after receiving requests. Sources of discomfort included concerns about adequately managing symptoms and suffering, not wanting to abandon patients, and incomplete understanding of patients' preferences, especially when physicians did not know patients well. Participation in assisted suicide required a large investment of time and was emotionally intense. Regardless of whether they prescribed or not, physicians did not express major regrets about their decision. Requests often facilitated discussion of important issues, and many physicians felt that the process increased their confidence and assertiveness in discussing end-of-life issues with other patients. Physicians rarely sought support from colleagues; instead they tended to discuss emotional aspects of their experiences with their spouses.

In 1997, a national survey was taken of forensic psychiatrists asked to evaluate the process, thresholds, and standards they believe mental health professionals should use in assessing a terminally ill patient's capacity to consent to assisted suicide.[112] Of the 456 who were sent a questionnaire, 290 (64%) responded. Two of the conclusions reached were: First, that the ethical views of psychiatrists may influence their clinical opinions regarding patient competence to consent to assisted suicide; and second, that the extensive evaluation recommended by forensic psychiatrists likely would minimize this bias and assure that only competent patients have access to assisted suicide, but the process itself might burden terminally ill patients.[113]

In a 1996 random sample of 625 Oregon psychologists, of which 423 were included in the final sample, a majority of the respondents felt that, for a competent individual, both suicide and assisted suicide were acceptable under some circumstances, or the decision should be left to the individual involved.[114] Seventy-eight percent of the respondents favored the enactment of the Death with Dignity Act. Twenty percent felt that psychologists' participation in the assisted suicide process would constitute a threat to the profession, for reasons such as tarnishing psychology's public image (36%), politicization of professional issues (23%), and role conflicts (20%).[115] One-third of the respondents indicated that performing an evaluation under the Act would be outside their practice area.[116] When asked about the level of confidence in performing an assessment to determine whether a psychiatric disorder was impairing a patient's judgment, responses varied with the nature of the evaluation. For example, in the context of a single evaluation, one-half the respondents replied that they were "not at all confident," with only seven reporting they were "very confident." In the context of a long-term relationship with the patient, only three felt "not at all confident," whereas 64 reported they would feel "very confident." When asked if they felt a request for assisted suicide from a terminally ill patient was prima facie evidence of a mental disorder, 13 of the respondents (3%) agreed or strongly agreed with this assertion, whereas 21% disagreed and 76% strongly disagreed.[117]

All of the studies show that a significant number of patients go to more than one physician before receiving a prescription for a lethal medication. All the surveys also indicate that physician-assisted suicide has been and continues to be a very controversial issue within the medical profession.

G. MONITORING OREGON'S DEATH WITH DIGNITY ACT

The Oregon Death with Dignity Act requires that a comprehensive medical file be established for each person requesting a physician-assisted suicide.[118] This requirement reads as follows:

> The following shall be documented or filed in the patient's medical record:
>
> (1) All oral requests by a patient for medication to end his or her life in a humane and dignified manner;
>
> (2) All written requests by a patient for medication to end his or her life in a humane and dignified manner;
>
> (3) The attending physician's diagnosis and prognosis, determination that the patient is capable, acting voluntarily and has made an informed decision;
>
> (4) The consulting physician's diagnosis and prognosis, and verification that the patient is capable, acting voluntarily and has made an informed decision;
>
> (5) A report of the outcome and determinations made during counseling, if performed;
>
> (6) The attending physician's offer to the patient to rescind his or her request at the time of the patient's second oral request pursuant to ORS 127.840; and
>
> (7) A note by the attending physician indicating that all requirements under ORS 127.800 to 127.897 have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed.

In addition to the above, the Act requires a psychiatric/psychological consultant's compliance form and a pharmacy dispensing record.[119] And finally, a chronology and death certificate extract form is placed in the patient's file. See Appendix C for the forms required.[120]

The Oregon Death with Dignity Act requires the Oregon Department of Human Services (DHS) to monitor compliance with the law. Each year since inception of the act, the department has analyzed the required information for each patient requesting physician-assisted suicide. This information is compiled in an annual report.[121]

The sole responsibility for monitoring the Oregon law is vested in the DHS, and a review of the process indicates that a thoroughly comprehensive examination takes place in the case of each patient. Darcy Neimeyer, Executive Assistant at the Oregon Department of Human Services for the Office of Disease Prevention and Epidemiology, reports that since inception of the act, referrals have been made by the DHS to the Oregon Board of Medical Examiners approximately four to six times. The referrals involved irregularities found in the patient request forms required by ORS 127.855 s. 3.09(2). There is a requirement that two witnesses sign the form in the presence of the requesting patient. In the few cases mentioned, the date of the signatures revealed that the witnesses did not sign in the presence of the patient. In each case, the Medical Practice Board determined that the Death with Dignity Act was not violated.

In addition to the monitoring requirement outlined above, there are penalties for noncompliance.[122]

SECTION 4: EUTHANASIA - THE NETHERLANDS

A. INTRODUCTION

This section of the report describes the law on euthanasia and physician-assisted suicide in the Netherlands and reviews the primary areas of dispute around the law. Generally speaking, the concept of euthanasia has broad public and social acceptance in the Netherlands.[123] Unlike in Oregon, the law on euthanasia was developed through the courts, not through the legislative process. It was not until the 2000-2001 legislative session that the common law which had developed in the courts became codified, and somewhat expanded, in the Termination of Life on Request and Assisted Suicide (Review Procedures) Act.[124] Because the criteria initially were created by the courts on a case-by-case basis, some of the disputes pertain to differing interpretations of the court cases[125] or to situations which have not been resolved through the court process. In addition, there are two national studies of the end of life medical practices, which include some practices which are arguably illegal under current Dutch law. In the debates, sometimes no distinction is made between a practice that is legally defensible and a practice that is not. We have done our best to summarize the issues presented by the opponents and proponents of the law and to provide empirical data where possible.

B. LEGAL DEVELOPMENTS AND CRITERIA

The practice of euthanasia and physician-assisted suicide is still illegal - a criminal offense - in the Netherlands.[126] The common law and now the legislation, however, have created an exemption from criminal liability for doctors who meet certain criteria. It is worth noting at the outset that the Dutch court system is very different from that of the United States. The Dutch system is not based on an adversarial process where each party presents its side of the story and the judge resolves factual disputes. Moreover, the concepts of individual rights based on a Constitutional document and of consumer/patient protections are foreign in the Dutch legal system, and malpractice suits are rare.[127] Instead, the Dutch system relies on a balancing of issues, looking for the societal good, and there is a recognition of a professional's ethical responsibilities as a valid defense to statutorily defined criminal activity.[128]

Prior to the 2001 legislation, there were two sections of the Dutch Criminal Code which were implicated by the practices of euthanasia and assisted suicide. Section 293 of the Dutch Criminal Code prohibits the killing of someone at his or her request, and section 294 prohibits assisting someone in committing suicide, including furnishing the means for the suicide.[129] Also in the Dutch criminal code[130] is a provision allowing an individual accused of a crime to raise a defense of necessity where the person is confronted with conflicting duties.[131] The necessity defense was first accepted by the Dutch Supreme Court in a euthanasia case in 1984, when a doctor argued that the patient's wish to die created a conflict of duties - the duty to preserve life and the duty to relieve the patient's suffering.[132] Prior to that time, there were at least two cases where doctors raised the necessity defense in euthanasia situations.[133] The courts in these cases, however, rejected the necessity defense and found the doctors guilty.[134] The courts did not impose harsh sentences on the doctors, which then sparked a public debate about euthanasia.[135]

In the 1984 case, the court set forth several criteria[136] which doctors must meet in order to raise a successful necessity defense in a euthanasia situation. These criteria are (1) the patient must request euthanasia repeatedly and knowingly, (2) the patient must be experiencing suffering that cannot be relieved by any means except death, and (3) the doctor must consult with a second doctor.[137] These criteria were adopted by the Royal Dutch Medical Association (RDMA) in 1984. This is legally significant because the local prosecutors and courts look to the professional ethical standards when reviewing the necessity defense.[138] Many of the factual disputes about euthanasia in the Netherlands are due to differing interpretations of each of these criteria.

In 1991, the RDMA established guidelines for reporting euthanasia and physician-assisted suicide.[139] In 1994, the RDMA proposal was codified by the legislature.[140] The notification procedure requires a doctor performing euthanasia to inform the local medical examiner through the use of an extensive questionnaire, the medical examiner reports the information to the public prosecutor, and the prosecutor investigates to determine if prosecution is warranted. The 1994 laws did not change the Dutch Criminal Code or legalized euthanasia.[141]

The criteria developed by the Dutch courts became codified in 2001 with the Termination of Life on Request and Assisted Suicide (Review Procedures) Act.[142] This act amends sections 293 and 294 of the Dutch criminal code to allow euthanasia or assisted suicide where a doctor meets the due care criteria and informs the local medical examiner of his or her actions.[143] The due care criteria are:

> The doctor must have been convinced that the patient's request was sincere and voluntary;
>
> The doctor must have been convinced that the patient's suffering was both hopeless and unbearable;
>
> The doctor must have consulted with the patient about his or her situation and his or her prospects;
>
> The doctor and the patient together must have come to the conclusion that no alternative is realistically available;
>
> The patient must have been seen by at least one impartial doctor, who must have given his or her opinion, in writing, about the first four criteria; and
>
> The doctor must have carried out the euthanasia or assisted suicide with due care. de Vries et al., at 377.

In addition, the statute sets up ethics committees to assess the doctor's conduct based on the information provided to the local coroner.[144]

C. UTILIZATION

Utilization rates of euthanasia and reporting by physicians are two related areas where there is much dispute. There have been two studies requested by the Dutch government on the use of euthanasia and other medical decisions at the end of life. This section reviews the findings of these studies, including statistics on utilization rates, statistics on reporting rates by physicians, and any related findings explaining the incidence. At the core of the dispute is the issue of what acts by physicians should be included in the statistics on "euthanasia." We have broken down the statistics into the most specific details. Another dispute arises in this area around underreporting by physicians. There is one study on reporting by physicians, which we include in this section. Another disputed issue is whether there has been a "slippery slope" effect in the Netherlands. We include a brief discussion of this issue; however, it is at its core an interpretation of facts, which goes beyond the scope of this report.

The first national Dutch study on euthanasia and other medical decisions concerning the end of life was done in 1990 and published in 1991. The study included three methods of collecting information - interviews with physicians (Study I), analysis of death certificates with a follow up questionnaire to the physician (Study II), and a different questionnaire sent to physicians regarding current patients (Study III) – and, thus, three distinct samples.[145] Because of this, the statistics can be analyzed at least four different ways. Each of the three sample sets resulted in an estimate of incidence of euthanasia, plus a best estimate was developed by the researchers by comparing the three samples. The table below includes the complete set of statistics on the incidence of euthanasia as a percentage of all deaths in the Netherlands.[146]

Euthanasia and related MDEL [147]	Study 1	Study II	Study III	Best Estimate
Euthanasia	1.9% (1.6-2.2)	1.7% (1.4-2.1)	2.6% (2.0-3.5)	1.8%
Assisted Suicide	0.3% (0.2-0.4)	0.2% (0.1-0.3)	0.4% (0.2-0.9)	0.3%
Life-terminating acts without explicit and persistent request	Unavailable	0.8% (0.6-1.1)	1.6% (1.1-2.2)	0.8%
Totals		2.7% (2.3-3.1)	4.7% (3.5-5.8)	2.9%

Van Der Maas et al. at 670.

In 1995, a follow up study was commissioned to look at the incidence of euthanasia and related end-of-life decisions, describe the patients, physicians and circumstances involved, and evaluate changes in these practices between 1990 and 1995. The methodology was nearly identical to that of the first study, but did not include a questionnaire about current patients, and was completed by some of the same researchers.[148]

It is important to note that one of the legal changes that occurred in this time was new law on the reporting of euthanasia and related practices by the medical profession.

The 1995 study found the estimated incidence of medical decisions related to the end of life as a percentage of total number of deaths in the Netherlands:[149]

Type of decision	Interview study	Death-certificate study
Euthanasia	2.3% (1.9-2.7)	2.4% (2.1-2.6)
Physician-assisted suicide	0.4% (0.2-0.5)	0.2% (0.1-0.3)
Life-terminating acts without patient's explicit request	0.7% (0.5-0.8)	0.7% (0.5-0.9)

Van Der Maas, (1995) at 1701. The study determined that there had been a total increase in physician-assisted death, which includes the use of pain medication at the end of life and withdrawal of treatment, of 5% between 1990 and 1995.[150] The incidence of euthanasia compared to the total population increased by between 0.4 to 0.7%.[151] The increase in euthanasia deaths is approximately 1,000 patients.[152] The study also finds that 36-38% of the explicit patient requests for euthanasia or assisted-suicide were agreed to and acted on by physicians in 1995, as compared to 27-32% of requests in 1990.[153]

One issue in the debate around euthanasia is whether there is a "slippery slope," meaning that as euthanasia is accepted in the country, the incidence will rise and the types of allowable physician involvement will also rise. There is no way for this office to determine conclusively if there has or has not been a "significant" increase in the rates, because what amount of increase is significant is subjective. For instance, one commentator feels that an increase of deaths from euthanasia from 671 patients to 1,064 in a five-year period is significant and a sign that the practice is becoming increasingly accepted.[154] The 1995 study, however, concluded that the data did not support or refute the slippery slope argument.[155] The statistics can be interpreted to support or deny the slippery slope argument, depending on how they are broken down and presented.

D. REPORTING REQUIREMENTS

In 1991, the RDMA established a reporting guideline asking physicians to report deaths as a result of euthanasia and physician-assisted suicide to the county coroner. This guideline did not have the force of law. The procedure involves the coroner who notifies the public prosecutor who initiates an investigation. In 1994, this notification procedure was codified in statute and became a civil law as part of the Burial and Cremation Act 1994. It was not until 2001, however, that the reporting requirement became part of the legal test for the necessity defense. In 2001, the reporting procedure was also changed to require the reports to go to regional ethics committees, who then decided if referral to the prosecutor was appropriate. In other words, a physician's failure to report prior to 2001 did not support criminal prosecution, although it was a civil violation. It is also important to note that the necessity defense only applies to euthanasia and physician-assisted suicide. For instance, a life-terminating act without patient request remains illegal in the Netherlands.

In 1995, the Dutch minister of health and justice requested an evaluation of the notification procedure then in place.[156] The study determined that 41% of all cases of euthanasia and physician-assisted suicide were reported in 1995,[157] an increase from 18% in 1990.[158] Included in the study was a review of the reasons cited for reporting by physicians. The reasons physicians reported were:

physician reports all cases (75%)

reporting is required (17%)

reporting is the official policy of the physician's institution (13%)

reporting gives an account to society (13%).[159]

Thirty-seven percent (37%) of the physicians thought the reporting requirements were time-consuming, 30% found it burdensome, 11% felt incriminated by the process, 5% found it to be a breach of privacy, 30% were neutral on the process, 19% felt supported, 13% had general positive views, and 7% felt relieved by the process. [160]

Of the 49 physicians who said they had not reported cases of euthanasia or assisted suicide, the reasons given for failing to report were a wish to avoid the fuss of a judicial inquiry (25 doctors), a wish to protect the patient's relatives from a judicial inquiry (12), a request from the patient's relatives to be protected from a judicial inquiry (10), failure to fulfill the legal requirements (8), and the belief that this is a confidential matter between doctors and patients (6).

One fact which is often cited in relation to the issue of underreporting is that in 11% of the cases where a doctor did not report the death, he or she consulted with another physician as required by the Dutch medical society guidelines for prudent practice.[161] The study also shows that in 58% of these same cases, the physicians discussed the case with colleagues.[162] It is unclear from the literature what the difference between a consultation and a discussion with colleagues is.

E. VOLUNTARINESS REQUIREMENT

One disputed issue is whether the requirement in the necessity defense of a repeated and persistent patient request is met when a physician suggests euthanasia as an option to the patient prior to the time the patient asks about euthanasia. One side of the debate argues that a physician should, as with all medical procedures, provide the patient with the options, and that it is not fatal to the legal requirement for the physician to include euthanasia as an option. The other side argues that the voluntariness of the process is compromised by a physician offering the suggestion to the patient. In the 1991 study, the researchers determined that physicians initiated the discussion of euthanasia or physician-assisted suicide 12% of the time.[163] The 1995 study found a 15% incidence.[164] The legality of the issue is currently undecided by the courts and is not addressed in the 2001 statute. At the heart of this issue is whether one believes that the physician-patient relationship is coercive or advisory in nature. This is not an issue that lends itself to empiric data and we are therefore unable to resolve this dispute.

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[1] The list of interested parties was generated from the witness lists of the public and committee hearings held in the last legislative session, from personal knowledge by members of the Council as to which groups had expressed interest in the study, and by a request in the e-mail that the questionnaire be forwarded broadly to anyone else who might be interested.

[2]

[3] See Appendix A.

[4] These materials are available for public inspection by contacting the Council.

The Council, in fact, contacted the Dutch Embassy in an effort to obtain primary source materials in English, but was unable to do so. The case law is only available in Dutch. We did not have a budget to provide translation of the materials, and so were unable to read the original materials and had to rely on reports or secondary materials in English.

[5] Emanuel, Ezekiel, "Euthanasia: Historical, Ethical, and Empiric Perspectives," Arch Intern Med (9/12/94): 154.

[6] Van Der Maas, van Delden, Pijnenborg, Looman, "Euthanasia and other medical decisions concerning the end of life," The Lancet 338 (9/14/91): 669.

[7] MDEL means medical decisions concerning end of life. Id. at 669.

[8] In large part this section reflects the analysis of the law contained in the following treatise: Alan Meisel et al., The Right to Die: The Law of End-of-Life Decisionmaking, § 12.06[A], (3rd ed. 2004).

[9] 355 A.2d 647 (N.J. 1976), cert. denied, 429 U.S. 922 (1976).

[10] 497 U.S. 261 (1990).

[11] Id. At 269 (quoting Shloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914)).

[12] Meisel et al., The Right to Die: The Law of End-of-Life Decisionmaking, § 12.02[A], (3rd ed. 2004).

[13] Washington v. Glucksberg, 521 U.S. 702 (1997); Vacco v. Quill, 521 U.S. 793 (1997).

[14] Krischer v. McIver, 697 So. 2d 97 (Fla. 1997); Sampson v. State, 31 P.3d 88 (Alaska 2001).

[15] 521 U.S. 702 (1997).

[16] 521 U.S. 793 (1997).

[17] Glucksberg at 724.

[18] Id. at 730-733.

[19] Id. at 735.

[20] Vacco at 798 (quoting 80 F.3d 716, 729).

[21] Id. at 793-794, 808.

[22] Meisel, § 12.09, Table 12-1.

[23] Lee v. Oregon, 891 F. Supp. 1429 (D. Or. 1995) (implementation enjoined), vacated and remanded, 107 F.3d 1382 (9th Cir.) (lack of federal jurisdiction), cert. denied, 522 U.S. 927 (1997).

[24] Meisel, § 12.06[A] (citing Gail Kinsey Hill, Suicide Law Stands, Oregonian, Nov. 5, 1997, at 1).

[25] 891 F. Supp. at 1438.

[26] 869 F. Supp. at 1498-1499.

[27] Id. at 1499.

[28] Id. As mentioned, the court did not decide whether the Act provides an option or a benefit under the law. A related and more recent ADA claim was considered by Oregon Deputy Attorney General David Schuman in a letter to Oregon Senator Neil Bryant dated March 15, 1999. Deputy A.G. Schuman indicated that, because the Death with Dignity Act does not allow individuals who because of a disability are unable to self-medicate to avail themselves of the "benefit" of a "death with dignity," it may unlawfully discriminate against such persons and, moreover, raises the issue of whether the state should provide "reasonable accommodation" for such disabled individuals. As Deputy A.G. Schuman acknowledged, however, this claim presents a novel legal issue, and it is by no means clear the challenge would succeed in a court of law. (To date, no such claim has been made in court.)

[29] The standing requirement has three elements: (1) the plaintiff must have suffered an "injury in fact," an invasion of a legally protected interest which is (a) concrete and particularized, and (b) actual or imminent, not conjectural or hypothetical; (2) there must be a causal connection between the injury and the conduct complained of—the injury must be traceable to the challenged action of the defendant and not the result of the independent action of some third party not before the court; and (3) it must be likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision. 107 F.3d at 1387.

[30] Ripeness concerns timing, and its basic rationale is to prevent the courts, through avoidance of premature adjudication, from entangling themselves in abstract disagreements. Whether a claim is ripe depends on the fitness of the issues for judicial decision and the hardship to the parties of withholding court consideration. 107 F.3d at 1387-1388.

[31] In fact, the Oregon Act explicitly provides that no health care provider is required to participate in the Act even if such participation may seem to be mandated by contract or statute. Or Rev State § 127.885(4) (2001).

[32] 21 U.S.C.A. §§ 801-971.

[33] Meisel, § 12.06[B].

[34] H.R. 4006, 105th Cong. (1998).

[35] H.R. 2260, 106th Cong., 1st Sess. (1999); S. 1272, 106th Cong., 1st Sess. (1999).

[36] 66 Fed. Reg. 56,607.

[37] Oregon v. Ashcroft, 102 F. Supp. 2d 1077 (D. Or. 2002).

[38] Oregon v. Ashcroft, 368 F.3d 1118, C.A. 9 (Or. 2004).

[39] Id. at 1125.

[40] Ganzini et al., "Physicians' Experiences with the Oregon Death with Dignity Act", N Engl J Med 342, No. 8, (2000): 558.

[41] Id. at 558.

[42] Id. at 561.

[43] Id. at 561.

[44] Id. at 561.

[45] See generally, Annual Reports on www.dhs.state.or.us/publichealth/chs/pas/pas.cfm

[46] Sixth Annual Report on Oregon's Death with Dignity Act, Department of Human Services, Oregon. Available at www.dhs.state.or.us/publichealth/chs/pas/pas.cfm

[47] Foley & Hendin, "The Oregon Report Don't Ask, Don't Tell," Hastings Center Report, 37 (May-June 1999); Letter by National Legal Center for the Medically Dependent & Disabled, Inc. (4/13/99), Appendix X.

[48] Submissions by Dr. Orr and the Roman Catholic Diocese of Burlington.

[49] Sullivan et al., Correspondence, N Engl J Med 344, (2001): 605.

[50] See studies by Ganzini et al., Chin et al., & Sullivan et al.

[51] Tolle, et al., "Characteristics and Proportion of Dying Oregonians Who Personally Consider Physician-Assisted Suicide," J Clinical Ethics 15, No. 2 (2004): 115.

[52] Oregon Revised Statutes 127.890 s.4.02(4).

[53] Id.

[54] Compare studies by Ganzini et al. with Chin et al. and Sullivan, et al.

[55] Submission by Death with Dignity Vermont & End-of-Life Choices Vermont.

[56] Sixth Annual Report, Dept. of HS.

[57] Id.

[58] Ganzini et al., "Oregon Physicians' Perceptions of Patients Who Request Assisted Suicide and Their Families", Journal of Palliative Medicine 6, No. 3 (2003): 381.

[59] Ganzini et al., "Physicians' Experiences with the Oregon Death with Dignity Act", N Engl J Med 342, No. 8 (2000): 559. See also Chin et al., "Legalized Physician-Assisted Suicide in Oregon – the First Year's Experience," N Engl J Med 340 (1999): 582; Sullivan et al., "Legalized Physician-Assisted Suicide in Oregon – The Second Year," N Engl J Med 342 (2000): 599.

[60] Sixth Annual Report, Table 4, Department of Human Services, Oregon. Available at www.dhs.state.or.us/publichealth/chs/pas/pas.cfm

[61] Sullivan et al., "Legalized Physician-Assisted Suicide in Oregon – The Second Year," N Engl J Med 342 (2000): 601. Four of the ten patients who expressed concern about suffering were not perceived to be suffering by their family members at the time of the request. Id.

[62] Ganzini et al., "Physicians' Experiences with the Oregon Death with Dignity Act", N Engl J Med 342, No. 8, (2000): 559. See also Chin et al., "Legalized Physician-Assisted Suicide in Oregon – the First Year's Experience," N Engl J Med 340 (1999): 582, which had similar findings.

[63] Id. at 562.

[64] Ganzini et al., "Experiences of Oregon Nurses and Social Workers with Hospice Patients who Requested Assistance

with Suicide," N Engl J Med 347 (2002): 584.

[65] Id. at 562.

[66] Tolle, et al., "Characteristics and Proportion of Dying Oregonians Who Personally Consider Physician-Assisted Suicide," J Clinical Ethics 15, No. 2 (2004): 115.

[67] Id. at 116.

[68] Ganzini et al., "Physicians' Experiences with the Oregon Death with Dignity Act", N Engl J Med 342, No. 8 (2000): 559.

[69] Id. at 559.

[70] Id. at 559.

[71] Id. at 559.

[72] Id. at 558.

[73] See generally, Ganzini et al., "Physicians' Experiences with the Oregon Death with Dignity Act", N Engl J Med 342, No. 8 (2000): 559.

[74] Correspondence, N Engl J Med 343, No. 2 (2000): 150-152; Submission by the Roman Catholic Diocese of Burlington: Foley & Hendin, "The Oregon Report Don't Ask, Don't Tell," Hastings Center Report (May-June 1999): 39.

[75] Oregon Rev. Stat. Sections 127.800-897 (1994).

[76] Foley & Hendin, "The Oregon Report Don't Ask, Don't Tell," Hastings Center Report (May-June 1999): 37.

[77] Not all of the patients who requested a lethal prescription received one.

[78] Ganzini et al., "Physicians' Experiences with the Oregon Death with Dignity Act", N Engl J Med 342, No. 8 (2000): 562.

[79] Id.

[80] Correspondence, N Engl J Med 343, No. 2 (2000): 150-152.

[81] Ganzini et al., "Attitudes of Patients with Amyotrophic Lateral Sclerosis and Their Care Givers toward Assisted Suicide," N Engl J Med 339 (1998): 971-972. This study was performed prior to the time the Death with Dignity Act was implemented.

[82] Id. at 972.

[83] Id.

[84] Id.

[85] Id.

[86] Id.

[87] Sullivan et al., "Should Psychiatrists Serve as Gatekeepers for Physician-Assisted Suicide?", Hastings Center Report (July-August 1998): 26.

[88] Ganzini, "Commentary: Assessment of Clinical Depression in Patients Who Request Physician-Assisted Death", Ethics Rounds 19 (2000): 476.

[89] Sullivan at 27.

[90] Sixth Annual Report on Oregon's Death with Dignity Act, Department of Human Services. Available at www.dhs.state.or.us/publichealth/chs/pas/pas.cfm

[91] Id.

[92] Ganzini, "Physician-Assisted Death – A Last Resort", N Engl J Med 346 (2002): 1663; Ganzini et al., "Predictors and Correlates of Interest in Assisted Suicide in the Final Month of Life Among ALS Patients in Oregon and Washington," J Pain Symptom Manage 24 (2002): 313.

[93] Ganzini et al., "Predictors and Correlates of Interest in Assisted Suicide in the Final Month of Life Among ALS Patients in Oregon and Washington," J Pain Symptom Manage 24 (2002): 314.

[94] Id.

[95] Id.

[96] Ganzini et al., "Attitudes of Patients with Amyotrophic Lateral Sclerosis and Their Care Givers Toward Assisted Suicide," N Engl J Med 339 (1998): 972.

[97] Submission by the Roman Catholic Diocese of Burlington.

[98] Sixth Annual Report, Dep. of HS.

[99] Ganzini et al., "Oregon Physicians' Perceptions of Patients Who Request Assisted Suicide and Their Families", Journal of Palliative Medicine 6, No. 3 (2003): 381; Ganzini et al., "Physicians' Experiences with the Oregon Death with Dignity Act", N Engl J Med 342, No. 8 (2000): 559; Sixth Annual Report, Dept. of Human Services.

[100] The Oregon Health Plan legislation was passed in 1987, per Ms. Jackson.

[101] Sullivan et al., at 601.

[102] Ganzini et al., "Physicians' Experiences with the Oregon Death with Dignity Act", N Engl J Med 342, No. 8 (2000): 559.

[103] Chin et al., "Legalized Physician-Assisted Suicide in Oregon – the First Year's Experience," N Engl J Med 340 (1999): 582.

[104] Statement from Jim Kronenberg, CAE, Associate Executive Director, Oregon Medical Association, dated September 30, 2003.

[105] Id.

[106] Lee, Melinda A. et al., "Legalizing Assisted Suicide – Views of Physicians in Oregon," N Engl J Med 334 (1996): 310-315.

[107] Ganzini et al., "Physicians' Experiences with the Oregon Death with Dignity Act", N Engl J Med 342, No. 8 (2000): 557-563.

[108] Id. at 562.

[109] Id.

[110] Id.

[111] Dobscha et al., "Oregon Physicians' Responses to Requests for Assisted Suicide: A Qualitative Study," Journal of Palliative Medicine 7, No. 3 (2004): 451-471.

[112] Ganzini et al., "Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists," Am Jrnl Psychiatry 157 (April 2000): 4.

[113] Id.

[114] Fenn et al., "Attitudes of Oregon Psychologists Toward Physician-Assisted Suicide and the Oregon Death with Dignity Act," Am Psychological Assoc Jrnl 30, No. 3 (1999): 235-244.

[115] Id.

[116] Id.

[117] Id.

[118] ORS 127.855, s. 3.09.

[119] ORS 127.800 – ORS 127.897.

[120] The information required by subsection (7) of ORS 127.885 s. 3.09 may also be obtained through an interview if requested by the physician.

[121] Appendix D is a description of the reporting system and data analysis as published in the Sixth Annual Report of DHS.)

[122] ORS 127.890 s. 4.02.

[123] Emanuel, EJ "Euthanasia: Historical, Ethical & Empiric Perspectives." Archives of Internal Medicine 154 (1994): 1895. See also deVries, Ubaldus, A Dutch Perspective, The Limits of Lawful Euthanasia, 13 Annals Health L (2004): 392 fr. 1. Hendin, Herbert, The Dutch Experience at 98. Foley (eds.), Chapter 5 in The Case Against Assisted Suicide and for the Right to End of Life Care, Johns Hopkins Univ. Press (2002). See also Meisel and Cerminara, The Right to Die: The Law of End-of-Life Decisionmaking 3rd, Section 12.07 (2004).

[124] The Act is available in English on the Dutch government website: www.mimbuza.ul. See also Appendix E.

[125] Unfortunately, the court cases are only reported in Dutch, so the Council is unable to access the original case law to give an independent interpretation and must rely on secondary sources.

[126] WVS §§ 293, 294 [Dutch Criminal Code].

[127] de Vries et al., at 366-367; Schwatz, Robert "Euthanasia and Assisted Suicide in the Netherlands, Cambridge Quarterly of Health Care Ethics 4 (1995): 111-112, translation of Legemaate Johan, Legal Aspects of Euthanasia and Assisted Suicide in the Netherlands, 73-94.

[128] Id.; de Vries et al., at 366-368.

[129] WVS §§ 293, 294 (Dutch Criminal Code).

[130] WVS § 40 (Dutch Criminal Code).

[131] See de Vries et al., at 370-376.

[132] de Vries et al., at 371.

[133] de Vries et al., at 370-371.

[134] Id.

[135] de Vries et al., at 370-371.

[136] The criteria are broken down in different ways, so are sometimes described as 2, 3, or 5 different criteria. This is a semantic difference, not a legally significant difference.

[137] Welie, Jos. The Medical Exception: Physicians, Euthanasia & the Dutch Criminal Law, Journal of Medicine & Philosophy 17 (1992): 436.

[138] Schwartz, at 114.

[139] Schwartz, at 116-117.

[140] Schwartz, at 115-116.

[141] Schwartz, at 115.

[142] de Vries et al., at 376.

[143] Id. at 376-377.

[144] Id. at 377.

[145] Van Der Maas at 670. Van Der Maas, van Delden, Pijnenborg, Looman, "Euthanasia and other medical decisions concerning the end of life." The Lancet 338 (9/14/91): 660.

[146] Total deaths in the Netherlands was 128,786 in 1990. Van Der Maas et al. at 670.

[147] The definition of "euthanasia and related MDEL" is the prescription, supply, or administration of drugs with the explicit intention of shortening life to include euthanasia at the patient's request, assisted suicide, and life-terminating acts without explicit and persistent request. Id. at 670.

[148] Van Der Maas et al., “Euthanasia, Physician-Assisted Suicide, and other Medical Practices Involving the End of Life In the Netherlands, 1990-1995” N Engl J Med 335 No. 22 (1995): 1699-1711.

[149] The total number of deaths in the Netherlands in 1995 was 135,546.

[150] Van Der Maas (1995) at 1704.

[151] Because there were two studies, the exact percentage varies depending on which study you examine.

[152] Glick, Shimon. Letter, N Engl J Med 336, No. 19 (5/8/97): 1385.

[153] Van Der Maas (1995) response to letters at 1386.

[154] Hendin, Rutenfrans & Zylicz, “Physician-Assisted Suicide and Euthanasia in the Netherlands”, JAMA, vol. 277, No. 21 (6/4/97): 1721.

[155] Van Der Maas (1995) at 1705.

[156] Van Der Wal et al., “Evaluation of the Notification Procedure for Physician-Assisted Death in the Netherlands,” N Engl J Med 335, No. 22 (11/28/96): 1706-1711.

[157] Id. at 1706.

[158] Id. at 1707.

[159] Id. at 1707.

[160] Id. at 1707.

[161] Id. at 1709.

[162] Id. at 1709

[163] Van Der Maas (1995) response to letters at 1386

[164] Id.