PHYSICIAN-ASSISTED DEATH AND THE SLIPPERY SLOPE: CARVING OUT AN AMERICAN LEDGE

I. INTRODUCTION

As physician-assisted death (PAD[1]) increases in social acceptance and legislative approval throughout the United States, praise for ensuring end-of-life autonomy and dignity to an aging population is often met with apprehension about the so-called slippery slope. Opponents of PAD regularly invoke the Netherlands' progressive legalization of PAD and subsequent relaxation of restrictions to illustrate the slippery slope, but such arguments generally fail to account for key differences between the Dutch and American legal and healthcare systems. This paper will discuss those differences and their bioethical implications for PAD regulation, and will propose and define a practically, legally, and ethically sound standard for PAD in the United States: to be eligible for PAD, a patient must have a terminal illness.

Part II.A charts the history of PAD legalization and expansion in the Netherlands, particularly focusing on the Dutch use of "hopeless and unbearable suffering" as the standard for PAD eligibility, and concludes that the progression constitutes a true slippery slope. Part II.B

[1] Precise and neutral terminology is essential when discussing the practice of medical intervention to end life. ***See, e.g.***, Kathryn L. Tucker & Fred B. Steele, ***Patient Choice at the End of Life: Getting the Language Right***, 28 J. LEGAL MED. 305 (2007). PAD is distinct from euthanasia, which occurs when a doctor administers life-ending medication to a patient. Euthanasia is further subdivided into "voluntary," "involuntary," and "non-voluntary," see ***infra*** note 22, and all types remain illegal in all fifty U.S. states. PAD is also different from a patient's established right to refuse further life-sustaining treatment, which the U.S. Supreme Court has upheld. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261 (1990); ***see also*** Washington v. Glucksberg, 521 U.S. 702, 725 (1997) ("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."). Finally, neutrality—which necessitates avoiding emotionally fraught words like "dignity" and "suicide"—is important, both to avoid appeals to emotion rather than ethics and to honor the goodwill of advocates on both sides of the debate. Finally, neutral language is key because support for PAD among Americans rises or falls depending on how the practice is described. Lydia Saad, *U.S. Support for Euthanasia Hinges on How It's Described*, GALLUP (May 29, 2013), https://news.gallup.com/poll/162815/support-euthanasia-hinges-described.aspx (finding that 70% of Americans approve of permitting doctors to "end the [terminally ill] patient's life by some painless means" but only 51% approve of doctors helping a terminally ill patient to "commit suicide").

documents the evolving status of PAD in the United States and early attempts to relax restrictions. Part III proposes a "ledge" on the slippery slope in the form of a requirement that patients must have a terminal illness to be eligible for PAD. Part III.A analyzes the bioethical permissibility of this requirement and contends that several distinctively American considerations favor such a limitation. Part III.B argues that the nature of the current American healthcare system, which is fundamentally different from that of the Netherlands, could lead to devastating results for patients unless a terminal illness requirement for PAD is federally imposed. Finally, Part IV concludes.

II. BACKGROUND: IS THE SLOPE TRULY SLIPPERY?

"Slippery slope" arguments posit that a given action or decision, ostensibly innocuous at the time, will potentially (or probably, or even inevitably) lead to further actions or decisions which are undesirable.[2] This type of reasoning is often fallacious because it fails to prove the causal links between each event on the imagined slope, and instead simply asserts a tenuous, or even disingenuous, chain of future causation.[3] Another common failure of slippery slope arguments is assuming, without proving, that the final outcome (i.e., the "bottom" of the slope) is

[2] *See* Frederick Schauer, ***Slippery Slopes***, 99 HARV. L. REV. 361, 368–69 (1985) (identifying the components of a slippery slope argument as (1) "the ***implicit concession*** that the proposed resolution of the instant case is not itself troublesome," and (2) a ***linguistic boundary*** providing a "description of the instant case that distinguishes it from the danger case"). Acknowledging that such claims "seem[] not to be an appeal to logic," Schauer nonetheless contends that "the slippery slope argument seems to be an accurate depiction of how the real world operates," and "appears to describe a behavioral reality." ***Id.*** at 369–70.

[3] ***See, e.g.***, Mario J. Rizzo & Douglas Glen Whitman, *The Camel's Nose Is in the Tent: Rules, Theories, and* ***Slippery Slopes***, 51 ULCA L. REV. 539, 542–43 (2003) (attacking the presumed causal chain in slippery slope arguments as "rob[bing] our future selves of the ability to make reasoned decisions" and objecting that "the undesirability of the final outcome should be imputed backward to the initial decision"). ***See also*** LAURA NUMEROFF, IF YOU GIVE A MOUSE A COOKIE (Harper Collins Publishers 1985) (asserting a slippery slope argument in which a mouse, if given a cookie, will then require a glass of milk, which will in turn necessitate a straw to drink it with, launching a humorous—if perhaps unsubstantiated—chain of causation).

either desirable or undesirable.[4] On the Supreme Court, the slippery slope has frequently been both credited and rejected by judicial titans of all political persuasions.[5] In modern times, the slippery slope argument is perhaps most vehemently invoked in the bioethics arena, generally to oppose technological or ethical advances in fields such as abortion, gene editing, cloning, human enhancements, vaccines, and various forms of euthanasia or physician-assisted death.[6]

Part II of this paper will investigate the veracity of slippery slope arguments as applied to this lattermost bioethical frontier: medical intervention to end life preemptively in the face of terminal illness, "unbearable suffering," or other suggested bases. This background review will first explore the development of PAD policy in the Netherlands, and will conclude by documenting PAD policy in American jurisdictions that authorize the practice. Overall, the evidence strongly suggests that the Dutch use of "hopeless and unbearable suffering" as a basis for PAD eligibility guarantees a slippery slope; however, the desirability and inevitability of the slope are not proven from existing data, and will be further explored in Part III in the context of the United States.

A. *The Netherlands: Lessons from the World's First Nation to Legalize PAD*

[4] *See* Rizzo & Whitman, *supra* note 3, at 543 ("The slippery slope argument appears to privilege the current over the future point of view, ruling out the possibility that new values will exist at the moment of decision.").

[5] *Compare* West Va. State Bd. of Ed. v. Barnette, 319 U.S. 624, 640–41 (1943) (Jackson, J.) (decrying forced recitation of the Pledge of Allegiance as "coerc[ing] uniformity of sentiment" in the futile manner of Roman persecution of Christianity and the Spanish Inquisition, and concluding that, ultimately, "[c]ompulsory unification of opinion achieves only the unanimity of the graveyard") *with* Panhandle Oil Co. v. Mississippi, 277 U.S. 218, 223 (1928) (Holmes, J., dissenting) (refuting the majority's slippery slope assertion that "the power to tax is the power to destroy" by noting that "most of the distinctions of the law are distinctions of degree," and that the "Court, which so often has defeated the attempt to tax in certain ways, can defeat an attempt to discriminate . . . without wholly abolishing the power to tax"). *See also* Schauer, *supra* note 2, at 362 nn.5–10 (collecting Supreme Court cases that discuss the slippery slope).

[6] *See* Rizzo & Whitman, *supra* note 3, at 541 ("A shared characteristic of these arguments is that they are used to oppose some type of change in the status quo. In that sense, and only that sense, slippery slope arguments are usually employed for 'conservative' purposes.").

The Dutch Criminal Code of 1886, enacted to replace a prior Napoleonic code, explicitly criminalized both euthanasia and assisted suicide.[7] The Netherlands experienced no further development in this area for almost a century, until public sentiment began to shift in favor of PAD after the first Dutch pro-PAD interest group formed in 1973.[8] The final three decades of the twentieth century, however, witnessed a revival of interest in PAD from the Dutch medical community, which developed quickly through caselaw and culminated in recognition by the Dutch legislature.

1. *Postma* and *Wertheim*: Declining to Prosecute Physicians for Administering PAD

In 1973, a Dutch physician named Dr. Postma euthanized her 78-year-old mother upon request following a cerebral hemorrhage.[9] At Dr. Postma's trial, the court agreed that a patient's life need not "be prolonged in every possible way," and adopted a series of conditions upon which pain relief might be administered with the risk of accelerating a patient's death, including that "the suffering must be mentally or physically unbearable."[10] Significantly, the court rejected one condition proposed by the Medical Inspector at trial, "the patient is in the terminal phase of illness," citing "many cases of incurable illness or accident-caused disability, combined with

[7] Jonathan T. Smies, ***The Legalization of Euthanasia in the Netherlands***, 7 GONZ. J. INT'L L. [i], 4–5 (2003) (quoting Articles 293 and 294 of the Criminal Code [***Wetboek van Strafrecht***] of 1886, and defining both euthanasia ("tak[ing] the life of another person at that person's express and earnest request") and assisted suicide ("intentionally incit[ing] another to commit suicide, assist[ing] in the suicide of another, or procur[ing] for that other person the means to commit suicide")).

[8] ***Id.*** at 7 n.19. The disinterest in PAD may have been intensified by the Netherlands' proximity to Germany, which in 1920 began promoting "dying help" from physicians to exterminate "***Lebensunwerten Lebens***" ("life unworthy of life")—which, bolstered by personal orders from Adolf Hitler in 1939, formed the foundation of the German medical community's inhumane complicity in the extermination of groups deemed racially, genetically, or socially inferior by the Nazi Party. ***See*** HENRY FRIEDLANDER, THE ORIGINS OF NAZI GENOCIDE: FROM EUTHANASIA TO THE FINAL SOLUTION (Univ. North Carolina Press 1995).

[9] Smies, ***supra*** note 7, at 9.

[10] ***Id.***

serious physical and/or mental suffering," which would render an otherwise healthy patient ineligible for PAD.[11] *Postma* was the first decision to signal judicial leniency toward physicians facing criminal liability for causing death in an effort to relieve pain.[12] In the Netherlands' next significant PAD case, *Wertheim* in 1981, the court added a few new conditions including that the patient's "suffering and the desire to die were enduring."[13]

Responding to these cases, the Dutch College of Procurators-General instructed that any case of euthanasia or assisted suicide should be referred to the College, which would apply the conditions formalized in *Postma* and *Wertheim* before deciding whether to prosecute under the Criminal Code of 1886.[14] Because Dutch prosecutors have absolute discretion about whether to prosecute any given case, the College's determination that adherence to the *Postma* and *Wertheim* standards would safeguard physicians from criminal prosecution rendered the Criminal Code of 1886's prohibition on euthanasia and assisted suicide effectively moot.[15]

In 1984, the Dutch Supreme Court upheld the defense of "necessity" offered by a doctor accused of euthanasia, establishing that physicians could defend against such charges where "the doctor found it necessary to put the welfare of the patient above the penal code which made

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[11] *Id.* at 9 n.32.

[12] *Id.* at 10. The Royal Dutch Medical Association, to support Postma at trial, submitted an open letter to the Dutch Minister of Justice signed by eighteen doctors admitting to the same act for which Postma stood accused. *Id.* at 10 n.33.

[13] *Id.* at 10–11. Other conditions added by *Wertheim* included "that the patient was well informed of his situation and alternatives, was capable of and actually did weigh the various considerations; that there were no alternative means to improve the situation; and that the person's death did not inflict any unnecessary suffering on any third party." *Id.* at 11.

[14] *Id.* at 12.

[15] *See id.* at 12–13 (discussing how the Dutch "policy of tolerance," under which "behavior that is formally illegal is tolerated" by Dutch prosecutors "if undertaken in accordance with certain standards," has been instrumental in the gradual promotion, acceptance, and eventual legalization of euthanasia and assisted suicide, as well as drugs and prostitution).

assisted suicide and euthanasia a crime."[16] The same year, the Royal Dutch Medical Society issued "the five requirements of careful practice," which a court quickly upheld, and the Dutch Minister of Justice announced that prosecutors would not act against doctors complying with the new requirements.[17]

2. PAD for Non-Somatic Suffering, Non-Voluntary PAD, and Legislative Recognition for the "Hopeless and Unbearable Suffering" Standard

In 1994, the Dutch Supreme Court took the next sizeable step in protecting PAD[18] by extending protection to physicians who administered PAD for non-somatic, non-terminal suffering. After several lower Dutch courts protected doctors who offered PAD to non-somatic and non-terminal patients, including a 25-year-old woman with *anorexia nervosa* and a 50-year-old woman with chronic depression exacerbated by drug and alcohol abuse,[19] the Dutch Supreme Court endorsed these lower courts' reasoning in the case of Dr. Boudewijn Chabot, a psychiatrist who provided life-ending medication to a patient who felt "no desire to live" after the recent

[16] Herbert Hendin, *The Slippery Slope: The Dutch Example*, 35 DUQ. L. REV. 427, 427 n.1 (1996).

[17] Smies, *supra* note 7, at 18–19. The requirements, adopted in the case of *Admiraal* by the District Court for The Hague, were: "(1) the request for euthanasia must be voluntary; (2) the request must be well-considered; (3) the patient's desire to die must be a lasting one; (4) the patient must experience his suffering as unacceptable for him; (5) the doctor concerned must consult a colleague." *Id.* at 18. In 1988, the Dutch Supreme Court endorsed the five requirements, adding that failure to meet the fifth requirement would not result in prosecution. *Id.* at 19.

[18] Another small but noteworthy step was taken the same year by the Dutch legislature after reviewing the landmark 1990 Remmelink Report. The Report documented the results of the Netherlands' current PAD regulations: Dutch doctors ended the lives of 2,300 patients who requested PAD and 1,040 patients "who did not know or consent to what was happening"—of this second group, "14% of patients were fully competent, and 72% had never given any indication that they would want their lives terminated." Walter Wright, *Historical Analogies, Slippery Slopes, and the Question of Euthanasia*, 28 J. L. MED. & ETHICS 178, 183 (2000). In response, the legislature enacted a law formalizing the requirement that doctors who administer euthanasia or assist in patient suicide must submit a written account summarizing their compliance with the judicially sanctioned standards. *See* J.K.M. Gevers, *Legislation on Euthanasia: Recent Developments in the Netherlands*, 18 J. MEDICAL ETHICS 138, 139 (1992).

[19] J.K.M. Gevers, *Physician-Assisted Suicide and the Dutch Courts*, 5 CAMBRIDGE Q. HEALTHCARE ETHICS 93, 95 (1996).

deaths of her two sons.[20] The Court rejected the prosecution's argument that the necessity defense should not apply in cases of non-terminal suffering, reasoning that, "confronted with a choice between mutually conflicting duties," i.e., protecting life and relieving suffering, the doctor "chose to perform the one of greater weight."[21]

Having jettisoned any requirement that patients seeking PAD must have a terminal disease, a somatic disease, or any disease at all, in 1995 the Dutch judiciary next permitted "non-voluntary euthanasia,"[22] i.e., PAD without an explicit request from the patient.[23] In two 1995 cases, ***Prins*** and ***Kadijk***, doctors were charged with murder for terminating the life of a three-day-old baby with "spina bifida, hydrocephalus, a spinal cord lesion and brain damage," and a newborn with trisomy 13, whose "death was to be expected at most within a year, and probably within six months."[24] Both physicians were acquitted based on the necessity defense, and both

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[20] Smies, ***supra*** note 7, at 20 & n.78. Her psychiatrist noted that "she did not suffer from a psychiatric disease like schizophrenia or a vital depression, but she was depressed in a more specific sense, in relation to a complicated mourning process." ***Id.*** at 20.

[21] ***Id.*** at 20. Commentators have noted that the Court's extension of physician immunity in this case was motivated by a desire to avoid the discriminatory implications of extending protection for some patients and denying it to others based on the subjective determination that their suffering is or is not serious enough. ***See, e.g.***, Wright, ***supra*** note 18, at 183 (noting that this type of reasoning "is the archetypal engine for a slippery slope"); Hendin, ***supra*** note 16, at 124–25 ("The rationale for such extensions has been that to deny the right to die with assistance to the chronically ill, who will have longer to suffer than the terminally ill, or to those who experience psychological pain not associated with physical disease is a form of discrimination.").

[22] "Non-voluntary euthanasia" refers to "a situation in which the will of the individual is not ascertainable or has not been made manifest"; this practice is distinguishable from "involuntary euthanasia" which occurs when "an individual is euthanized even though an express will to the contrary is known." Smies, ***supra*** note 7, at 21.

[23] A second Remmelink Report published in 1996 (compiling anonymous data on PAD from Dutch physicians) revealed that, between 1990 and 1995, requests for PAD increased from 8,900 to 9,700, and physician compliance with these requests rose from 2,300 to 3,200. Henk Jochemsen, ***Dutch Court Decision on Nonvoluntary Euthanasia Critically Reviewed***, 13 ISSUES L. & MED. 447, 450 (1998). Unlike the 1990 Report, the 1996 Report surveyed pediatricians and reported about 90 cases in which the doctor "acted with the explicit intention to shorten life," including 15 cases in which "the lives of newborns had been terminated." ***Id.*** The Report also found that "only 40% of the cases of voluntary euthanasia and assisted suicide were reported and that (in 1995) the cases of nonvoluntary euthanasia were not reported at all," leading commentators to conclude that Dutch legal authorities "ha[d] neither a clear insight into the practice of life-termination by physicians, nor effective control of it." ***Id.***

[24] ***Id.*** at 451–52. Administering PAD to newborns was already a widespread, if not widely publicized, practice in the Netherlands: "A 1987 survey conducted by the Dutch Pediatric Society found that of the eight neonatology

courts agreed that the parents' request for PAD was not necessary (their consent was merely noted, not cited as a requirement) because the doctors' independent medical judgment was sufficient and PAD cannot be administered at the request of another.[25]

In 2002, the Netherlands became the first country in the world to legalize PAD by statute, formalizing the judicially established standard of "hopeless and unbearable suffering."[26] The malleable parameters of this fundamentally subjective standard have been gradually clarified as PAD cases have expanded in both quantity and justification in subsequent decades.

3. Present Day: The Groningen Protocol, the "Completed Life" Pill, and Rapidly Expanding Access to PAD

In 2004, Dr. Eduard Verhagen, the medical director of pediatrics at a medical school in Groningen, the Netherlands, created a set of five requirements establishing when non-voluntary euthanasia might be performed on newborns and infants without the threat of legal prosecution.[27] Since its publication two years after the Dutch legalized PAD, the Groningen Protocol has so far protected all physicians from prosecution who follow its guidelines; however, no legislation has

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centers surveyed all allowed for the termination of newborns in some circumstances." Smies, ***supra*** note 7, at 22 n.94.

[25] Other reasons included the "short life expectancy" and the burden on third parties. Jochemsen, ***supra*** note 23, at 454–55 (positing that "[i]f a court accepts an appeal to the defense of necessity [in such cases,] it logically would have to accept that in certain circumstances there is a duty to kill").

[26] For a detailed description of the bill's political history, see Smies, ***supra*** note 7, at 35–38. For the text of the amendments and a discussion of the Act, see ***id.*** at 38–41. A variation from judicial standards included a provision that a patient's minority would not per se invalidate their request for PAD. ***Id.*** at 40. Patients ages sixteen to eighteen could receive PAD pursuant to their parents' "involve[ment] in the process," and patients ages twelve to sixteen could receive it subject to an absolute parental right to veto the request. ***Id.*** at 41.

[27] Eduard Verhagen & Pieter J.J. Sauer, ***The Groningen Protocol—Euthanasia in Severely Ill Newborns***, 352 N. ENGL. J. MED. 959 (2005). The five requirements, created by a team of physicians in consultation with legal authorities, are (1) "the diagnosis and prognosis must be certain," (2) "hopeless and unbearable suffering must be present," (3) "the diagnosis, prognosis, and unbearable suffering must be confirmed by at least one independent doctor," (4) "both parents must give informed consent," and (5) "the procedure must be performed in accordance with the accepted medical standard." ***Id.*** at 961 tbl. 2 (altered capitalization from original).

yet recognized or adopted it.[28] Dr. Verhagen identified three categories of infants eligible for PAD: those "with no chance of survival[,] who will die soon after birth," those who "have a very poor prognosis and are dependent on intensive care," and finally, those "with a hopeless prognosis who experience what parents and medical experts deem to be unbearable suffering."[29] In justifying the third category, Dr. Verhagen wrote that a majority of European neonatologists "are convinced that intensive care treatment is not a goal in itself," because the "aim is not only survival of the infant, but also an acceptable quality of life."[30] The Groningen Protocol has been the subject of fierce debate and controversy both in the Netherlands and abroad,[31] and remains the official Dutch policy on non-voluntary infant euthanasia today.

In 1991, 74-year-old former Dutch Supreme Court Judge Huibert Drion published an article titled "The Self-Chosen End for Old People," which argued that anyone over age 75 who lived alone should have the choice of seeking the means of self-termination from a doctor, free

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[28] Hilde Lindemann & Marian Verkerk, *Ending the Life of a Newborn: The Groningen Protocol*, 38 HASTINGS CTR. REPORT 42, 42 (2008).

[29] Verhagen & Sauer, *supra* note 27, at 959–60. Conditions placing an infant or newborn in the first group might include "severe underlying disease, such as lung and kidney hypoplasia," the second group could include "infants with severe brain abnormalities or extensive organ damage caused by extreme hypoxemia," who "may survive" but "expectations regarding their future condition are very grim," and the third group might include "a child with the most serious form of spina bifida [who] will have an extremely poor quality of life, even after many operations" and infants for whom, even after intensive treatment, "the quality of life will be very poor" with "no hope of improvement." *Id.*

[30] *Id.* at 960–61 (citing "[a] national survey of neonatologists in the Netherlands [showing] that each year there are 15 to 20 cases of euthanasia in newborn infants who would be categorized in the third group," and expressing suspicion that "most cases are simply not being reported"). In twenty-two cases cited by Dr. Verhagen, the following considerations were used to determine whether to euthanize a newborn: "extremely poor quality of life (suffering)" (100% of cases studied); "predicted lack of self-sufficiency" (100%); "predicted inability to communicate" (82%); "expected hospital dependency" (77%); and "long life expectancy" (59%). *Id.* at 960 tbl. 1 (altered capitalization from original).

[31] *See, e.g.*, Eric Kodish, *Paediatric Ethics: A Repudiation of the Groningen Protocol*, 371 LANCET 892, 893 (2008) (commenting that "[t]he leap of faith required to assess [unbearable] suffering in an infant with any certainty suggests a mirage of clinical accuracy that borders on hubris" and suggesting that "[t]he very notion that there is an 'accepted medical standard' for infanticide calls for resistance in the form of civil disobedience").

of charge.[32] The so-called "completed life pill" has seen rising support since Judge Drion's suggestion, "from 31% in 2001 to 33% in 2005 to 45% in 2008."[33] In 2016, Dutch Minister of Health Edith Schippers addressed the Dutch Parliament in defense of a proposed "completed life bill," arguing that the rule is needed for elderly people who cannot "continue life in a meaningful way," who struggle with "loss of independence," "reduced mobility," "a sense of loneliness," "loss of loved ones," or "who are burdened by general fatigue, deterioration and loss of personal dignity."[34] In December 2016, the Dutch government declared its intent to enact legislation protecting completed-life euthanasia for otherwise healthy patients of advanced age, "who regard their life as completed and request help in ending it," but whose suffering lacks a medical dimension.[35] After years of debate and many failed attempts to form a supportive multi-party coalition, a bill was submitted for consideration in July 2020, but was temporarily withdrawn after its proponents "found it 'inappropriate'" to submit such a bill during the ongoing COVID-19 pandemic.[36]

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[32] Tony Sheldon, ***Huibert Drion***, 328 BMJ 1204 (2004). Judge Drion's suggestion perhaps inspired a trial judge seven years later in the case of Dr. Philip Sutorius, who was acquitted for assisting a suicide based solely on the patient's "tiredness of life." Smies, ***supra*** note 7, at 24 & n.98.

[33] Els van Wijngaarden et al., ***Ready to Give Up on Life: The Lived Experience of Elderly People Who Feel Life Is Completed and No Longer Worth Living***, 138 SOCIAL SCI. & MED 257, 258 (2015).

[34] Dan Bilefsky & Christopher F. Schuetze, ***Dutch Law Would Allow Assisted Suicide for Healthy Older People***, N.Y. TIMES (Oct. 13, 2016), https://www.nytimes.com/2016/10/14/world/europe/dutch-law-would-allow-euthanasia-for-healthy-elderly-people.html.

[35] *Letter of the Government Position on "Completed Life,"* GOVERNMENT OF THE NETHERLANDS (Oct. 12, 2016), https://www.government.nl/topics/euthanasia/news/2016/10/21/government-scope-for-assisted-suicide-for-people-who-regard-their-life-as-completed.

[36] *Submission of Euthanasia at "Completed Life" Law Causing Strife Among Coalition Parties*, NL TIMES (July 17, 2020, 4:50 PM), https://nltimes.nl/2020/07/17/submission-euthanasia-completed-life-law-causing-strife-among-coalition-parties. Dutch Parliamentarian Pia Dikjstra, the bill's sponsor, stated that the bill seeks to address a growing problem that "the difference between your biological and your biographical life is increasing thanks to advancing medical conditions." ***Id.***

The almost two decades since the Netherlands' legalization of PAD have witnessed a steady rise of the procedure's reported usage. Since legalization, reported cases of euthanasia have swelled from 2,120 in 2007, to 3,136 in 2010, to 6,585 in 2017, accounting for over 4% of all deaths in the Netherlands' population of 17 million.[37] Euthanizations for purely psychiatric reasons, while still relatively uncommon, are also increasing: in 2008, only 2 psychiatric patients were euthanized; in 2016, it was 64, and in 2017, it rose to 83.[38] One Dutch professor of ethics, Theo Boer, who supported legalization of PAD and served as an ethics consultant for euthanasia for over a decade, resigned due to concern over rising euthanization for psychological suffering, cautioning that "[s]upply has created demand."[39] Embodying Professor Boer's concerns, a clinic specifically created for euthanasia has opened in The Hague, known as the famous "End of Life Clinic," whose 62 doctor-nurse teams euthanized 32 patients in 2012 and 750 in 2017, a year in which the clinic received 2,500 applications.[40] Most recently, in October 2020, the Dutch government stated that doctors would be exempt from prosecution for euthanizing patients under

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[37] Molly Jackson, ***Dutch Euthanization of Psychiatric Patients Draws Scrutiny***, GLOBAL JOURNALIST (Mar. 4, 2019), https://globaljournalist.org/2019/03/dutch-euthanization-of-psychiatric-patients-draws-scrutin/. By 2018, the procedure's ubiquity prompted one journalist to remark that "[e]veryone in the Netherlands seems to know someone who has been euthanized." Christopher de Bellaigue, ***Death on Demand: Has Euthanasia Gone Too Far?***, THE GUARDIAN (Jan. 18, 2019, 1:00 PM), https://www.theguardian.com/news/2019/jan/18/death-on-demand-has-euthanasia-gone-too-far-netherlands-assisted-dying.

[38] Jackson, ***supra*** note 37. One such patient was Eelco de Gooijer, a physically healthy 38-year-old "diagnosed with multiple disorders" including lifelong depression, who allowed his story—including interviews with himself and his family, as well as his ultimate euthanization—to be recorded by a film crew in a controversial 2018 documentary. ***Id.***; ***see also*** A DIGNIFIED DEATH (FilmMoment 2018).

[39] Harriet Sherwood, *A Woman's Final Facebook Message Before Euthanasia: "I'm Ready for My Trip Now…,"* THE OBSERVER (Mar. 17, 2018, 5:00 PM), https://www.theguardian.com/society/2018/mar/17/assisted-dying-euthanasia-netherlands. Professor Boer elaborated on his fears about psychiatric euthanasia: "We're getting used to euthanasia, that is exactly what should not happen. We're no longer speaking about the exceptional situations that the law was created for, but a gradual process towards organized death." ***Id.***

[40] ***Id.*** In 2017, 9% of the patients euthanized by the End of Life Clinic (***Levenseindekliniek***) had psychiatric illnesses, and another 10% had dementia. ***Id.***

the age of twelve (which is currently illegal under the 2002 Act), so long as they obtain parental consent, two other doctors concur, and the child faces "hopeless and unbearable suffering."[41]

The rise in PAD cases has been accompanied by the expansion of conditions deemed eligible for PAD under the burgeoning definition of "hopeless and unbearable suffering." In 2016, a Dutch man obtained euthanasia "because he could no longer carry on living as an alcoholic" after twenty-one stints in rehab.[42] The same year, a woman in her 20s who suffered from severe post-traumatic stress disorder as a result of childhood sexual abuse was permitted to undergo euthanasia.[43] In 2017, a Dutch woman whose husband had been approved for euthanasia after a stroke was herself approved for euthanasia because his death might've left her "completely disoriented, ending up in a nursing home."[44] In 2018, a 29-year-old suffering from "severe anxiety, depression, eating disorders and psychosis" was approved for euthanasia amid "huge support on social media," accompanied by a documentary about her euthanasia experience and a final post announcing her euthanasia on Facebook four hours before her death.[45] A friend

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[41] Daniel Boffey, *Dutch Euthanasia Rules Changed After Acquittal in Sedative Case*, THE GUARDIAN (Nov. 20, 2020, 8:53 PM), https://www.theguardian.com/world/2020/nov/20/dutch-euthanasia-rules-changed-after-acquittal-in-sedative-case.

[42] Tom Embury-Dennis, *Man in the Netherlands Euthanised Due to His Alcohol Addiction*, INDEPENDENT (Nov. 29, 2016), https://www.independent.co.uk/news/world/europe/man-holland-netherlands-dutch-euthanised-alcohol-addiction-alcoholic-netherlands-a7446256.html.

[43] Matt Payton, *Sex Abuse Victim in Her 20s Allowed by Doctors to Choose Euthanasia Due to "Incurable" PTSD*, INDEPENDENT (May 11, 2016), https://www.independent.co.uk/news/world/europe/sex-abuse-victim-her-20s-allowed-dutch-doctors-undergo-euthanasia-due-severe-ptsd-a7023666.html.

[44] Richard Wheatstone, *"They Kissed and Passed Away Holding Hands,"* THE IRISH SUN (Aug. 14, 2017, 12:49 PM), https://www.thesun.ie/news/1396085/loving-couple-91-pass-away-in-rare-double-euthanasia-after-65-years-marriage-because-dying-together-was-their-deepest-wish/.

[45] Sherwood, *supra* note 39.

who lay beside her during her the procedure stated that "she wanted other psychiatric patients to know that they also have a choice."[46]

In 2019, a doctor was acquitted after surreptitiously sedating her Alzheimer's patient's coffee before euthanizing her without her consent, due to the patient's written declaration four years prior that she would rather be euthanized than put in a care home.[47] When the patient stirred from her sleep and stood up, interrupting the lethal injection, the woman's family held her down while the doctor euthanized her.[48] Responding to concerns arising from this verdict, in April 2020 the Dutch Supreme Court sanctioned euthanasia for patients even where "the patient no longer expresses an explicit wish to die," and affirmed that "a doctor need not take a literal interpretation of an advance directive if the circumstances do not match the eventual scenario."[49] Further, the Dutch euthanasia review committee revised its guidelines to permit "[d]octors euthanizing a patient with severe dementia [to] slip a sedative into their food or drink" if the doctor is worried that the patient might become "disturbed, agitated or aggressive" at the impending euthanization.[50]

4. Is It A Slippery Slope?

The Netherlands' policy on PAD has steadily evolved over the past fifty years, with each step forward seeming to necessitate the next for the sake of logical, ethical, or legal consistency.

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[46] ***Id.*** This prompted Professor Boer to express concern that the woman's "death is being portrayed as a brave solution to severe suffering," because "[i]f it becomes a societal norm that a person who has a psychiatric condition can opt to die, that is a problem." ***Id.***

[47] Daniel Boffey, ***Dutch Doctor Acquitted in Landmark Euthanasia Case***, THE GUARDIAN (Sept. 11, 2019, 11:00 AM), https://www.theguardian.com/world/2019/sep/11/dutch-court-clears-doctor-in-landmark-euthanasia-trial.

[48] ***Id.***

[49] ***Dutch Court Approves Euthanasia in Cases of Advanced Dementia***, THE GUARDIAN (Apr. 21, 2020, 11:23 AM), https://www.theguardian.com/world/2020/apr/21/dutch-court-approves-euthanasia-in-cases-of-advanced-dementia; Boffey, ***supra*** note 41.

[50] Boffey, ***supra*** note 41.

After the Dutch judiciary ceased prosecution for PAD in the 1970s and approved the necessity defense for PAD in the 1980s for physicians who deemed their patients' suffering so severe it outweighed the duty to preserve life, the subjective "hopeless and unbearable suffering" standard became the norm. By the 1990s it seemed necessary to extend protection to physicians who administered PAD to psychiatric patients as well, because psychological and mental suffering could also be "hopeless and unbearable." The objective of relieving suffering in turn compelled the courts to permit non-voluntary euthanasia on newborns and infants, even those with non-terminal symptoms. After the Dutch legislature formally recognized what the judiciary had been building for decades amid mounting popular support, the Dutch system of suffering-based PAD has culminated in the Groningen Protocol, impending legalization of the "completed life pill," and swiftly expanding access to PAD for a variety of non-somatic, non-terminal, and even non-medical conditions deemed to entail "hopeless and unbearable suffering."

To avoid fallacious reasoning, slippery slope arguments must provide evidence of causation, which is clear in the case of the Netherlands' suffering-based PAD policy. Each step in the progression not only enabled the next step; it formed the bioethical impetus that ***compelled*** the subsequent development.[51] Once PAD is permitted on the basis of hopeless and unbearable suffering for somatic patients, how can doctors refuse to credit the suffering of psychiatric patients as meeting the standard? Once doctors' subjective judgment becomes the guide, how can anyone refute their determination that an infant's suffering qualifies it for PAD? What about the suffering of an alcoholic, a survivor of sexual abuse, or an elderly wife dreading the

[51] The slippery slope of Dutch suffering-based PAD is demonstrably a logical, or conceptual, slope (i.e., "we are logically committed to accept B once we have accepted A"), and may very well also represent an empirical, (or psychological or causal) slope (i.e., "the effect of accepting A will be that, as a result of psychological and social processes, we sooner or later will accept B"). Wibren van der Burg, ***Slippery Slope Arguments*** 7 (Aug. 7, 2009), available at https://ssrn.com/abstract=1445308.

approaching euthanasia of her husband? The evolution of PAD in the Netherlands demonstrates a causal chain indicative of a true slippery slope. In considering the unfolding PAD experiment in the United States, it is crucial to note that the Dutch slippery slope is not due to any unique quality of the Netherlands' culture or government; rather, the slippery slope arises due to bioethical presuppositions inherent in the nature of suffering-based PAD itself, and it will thus begin to emerge in any system that accepts suffering as a basis for PAD.[52]

B. *United States Jurisdictions: Inching Toward the Edge*

In 1997, the United States Supreme Court ruled that neither the Due Process Clause nor the Equal Protection Clause of the Fourteenth Amendment guarantees a constitutional right to obtain PAD.[53] In doing so, the Court overruled a Ninth Circuit decision finding a constitutional "right to die" and expressly relegated the "extensive and serious evaluation of physician-assisted suicide" to the "laboratory of the States."[54] Since this experiment commenced, the rate at which

[52] Currently, PAD has been nationally legalized in the Netherlands (2002), Belgium (2002), Luxembourg (2009), Colombia (2014), Canada (2016), Spain (effective June 25, 2021), and New Zealand (effective November 2021), and is partially or restrictively permitted by dozens of other nations, including Germany, Switzerland, and Australia. Belgium, with the most developed PAD system outside the Netherlands, shows signs of slippage as well: initial legalization permitted PAD on the basis of non-terminal physical or mental suffering, and the legislature extended it to minors in 2014. Toni C. Saad, ***Euthanasia in Belgium: Legal, Historical and Political Review***, 32 ISSUES L. MED. 183 (2017). In 2018, more than six Belgian patients were euthanized per day, and doctors were acquitted for administering PAD to a woman "suffering from the stress of a broken relationship" and untreated autism. ***Belgium Euthanasia: Three Doctors Cleared in Landmark Trial***, BBC NEWS (Jan. 31, 2020), https://www.bbc.com/news/world-europe-51322781. In March 2021, Canada amended its Criminal Code to remove the "terminal illness" requirement for PAD, and substituted a requirement of "a grievous and irremediable condition." ***An Act to Amend the Criminal Code (Medical Assistance in Dying)***, S.C. 2021, c 7 (Can.). The amendment extended PAD to patients suffering with dementia, and permits doctors to comply with their advance directives for PAD at a prearranged time, even if the patient later expresses a desire to continue living after losing their capacity to consent. Jocelyn Downie & Stefanie Green, ***For People with Dementia, Changes in MAiD Law Offer New Hope***, POLICY OPTIONS (Apr. 21, 2021), https://policyoptions.irpp.org/magazines/april-2021/for-people-with-dementia-changes-in-maid-law-offer-new-hope/.

[53] Washington v. Glucksberg, 521 U.S. 702 (1997) (reversing the Ninth Circuit's finding that Washington's 1979 Natural Death Act, which prohibited PAD, violated the Due Process Clause); Vacco v. Quill, 521 U.S. 793 (1997) (finding that a New York law banning PAD did not violate the Equal Protection Clause, and distinguishing between a patient's protected right to refuse treatment and the purported right to authorize a doctor to end one's life).

[54] *Glucksberg*, 521 U.S. at 737 (O'Connor, J., concurring).

state legislatures are legalizing PAD has been accelerating exponentially, and calls to relax the requirements necessary to obtain PAD have already arisen in several states post-legalization.

In 1994, Oregon became the first state to legalize PAD via a ballot initiative.[55] The Oregon Death With Dignity Act (DWDA) was not implemented until 1998 due to legal challenges at the state level, after which it survived a federal challenge all the way to the U.S. Supreme Court in 2006.[56] The DWDA promulgated four key requirements for PAD eligibility in Oregon: (1) the patient must be over eighteen and a resident of Oregon; (2) the patient must be capable of self-administering the medication; (3) two physicians must confirm that the patient is suffering from a terminal illness, i.e., "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months"; and (4) the patient must voluntarily communicate a wish for PAD both orally and in writing.[57] As soon as the protracted litigation surrounding the DWDA subsided in 2006, the Act became a template for other states, resulting in nearly identical requirements for PAD in every state to legalize the practice by statute.[58]

In 2008, Washington legalized PAD following a ballot initiative.[59] In 2009, the Montana Supreme Court found protection for PAD in the Rights of the Terminally Ill Act, which

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[55] *See* NEIL M. GORSUCH, THE FUTURE OF ASSISTED SUICIDE AND EUTHANASIA 115–25 (Princeton Univ. Press 2006) (charting the contentious history of Oregon's initial implementation of its PAD statute).

[56] OR. REV. STAT. 127.885 § 4 (1994); Gonzalez v. Oregon, 546 U.S. 243 (2006) (rejecting Oregon's attempt to block PAD legalization using the federal Controlled Substances Act).

[57] *Id.* at 127.805 § 201(1); 127.800 § 1.01(12). Oregon physicians wrote 198 prescriptions for PAD in the first five years after the DWDA, and the number increased by 76% in the three years after that. GORSUCH, *supra* note 55, at 119.

[58] *See* Alyssa Thurston, *Physician-Assisted Death: A Selected Annotated Bibliography*, 111 L. LIBR. J. 31, 43 (2019) (describing the DWDA as "provid[ing] a model for other state [PAD] laws").

[59] WASH. REV. CODE § 70.245 (2008).

guarantees terminal patients the right to "autonomous[] end-of-life decisions."[60] In 2013, the Vermont state legislature became the first in the nation to legalize PAD by statute, rather than ballot initiative or court decision.[61] PAD legalization began accelerating more rapidly in the late 2010s: California[62] and Colorado legalized it in 2016, Washington, D.C. followed in 2017, Hawaii in 2018, New Jersey and Maine in 2019, and, most recently, New Mexico in 2021.[63]

Currently, PAD has been legalized by statute in nine states and the District of Colombia, and found legal by judicial decision in one state, Montana.[64] PAD is prohibited by law in thirty-three states, prohibited by common law in three others, and the remaining four have no clear law regarding PAD.[65] The pace of legalization shows no sign of slowing, with PAD bills continuing to saturate state legislatures across the nation every year: between January 1994 and February 2020, over 280 PAD bills were proposed in forty-three states and Washington, D.C.[66]

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[60] Baxter v. Montana, 224 P.3d 1211, 1217 (Mont. 2009).

[61] VT. STAT. ANN. Tit. 18, § 113 (2013); *see also* Kathryn L. Tucker, *Vermont's Patient Choice at End of Life Act: A Historic "Next Generation" Law Governing Aid in Dying*, 38 VT. L. REV. 687 (2014).

[62] End of Life Option Act, CAL. HEALTH & SAFETY CODE § 443 (West 2016). The California legalization movement was catalyzed by the nationally publicized death of 29-year-old Brittany Maynard in 2014, who lobbied for PAD in California after being diagnosed with incurable brain cancer, and ultimately moved to Oregon to access the DWDA. *See History of the End-of-Life Choice Movement*, COMPASSION & CHOICES, https://compassionandchoices.org/resource/history-end-life-choice-movement/ (last visited Apr. 13, 2021).

[63] COLO. REV. STAT. § 25-48-101 (2016); D.C. CODE § 21-182 (2017); HAW. REV. STAT. § 327L (2019); N.J. STAT. ANN. § 26:16 (2019); ME. REV. STAT. ANN. tit. 22, § 418 (2019); H.B. 47, 2021 Leg., Reg. Sess. (N.M. 2021) (going into effect June 18, 2021).

[64] *See Resources*, DEATH WITH DIGNITY (last visited Apr. 13, 2021), https://www.deathwithdignity.org/learn/.

[65] *See States with Legal Physician-Assisted Suicide*, PROCON.ORG, https://euthanasia.procon.org/view.resource.php?resourceID=000132 (last updated July 25, 2019) (listing each state law prohibiting PAD in thirty-four states (erroneously including New Mexico's recently overruled prohibition), listing common law bans in Alabama, Massachusetts, and West Virginia, and stating that Nevada, North Carolina, Utah, and Wyoming lack any clear law about PAD).

[66] *Attempts to Legalize Euthanasia/Assisted-Suicide in the United States*, PATIENTS RIGHTS COUNCIL, http://www.patientsrightscouncil.org/site/failed-attempts-usa/ (last visited Apr. 13, 2021).

All state statutes legalizing PAD presently adhere to Oregon's requirements; however, in the absence of any federal guidance or regulation regarding PAD, the states are free to set whatever regulations they choose, including, potentially, the Dutch suffering-based model. No state has yet suggested or approved such a model, but several have proposed legislation to broaden PAD access. In 2015, Oregon introduced a bill to redefine "terminal disease" in the DWDA to refer to illness that will "result in death within one year" instead of the original "six months."[67] The national PAD advocacy group Death with Dignity, the powerhouse behind many successful state legalization attempts, opposed this expansion because the "effort could jeopardize attempts to introduce [PAD] to other states" and raised "the risk of the slippery-slope argument."[68] A 2019 Oregon bill succeeded in eliminating a mandatory 15-day reflection period for certain patients likely to die within that window.[69]

In Washington, a bill currently before the state Senate after its House approval seeks to increase access to PAD by allowing certain nurse practitioners and physician assistants to act as "a physician" under the Washington DWDA's language, reducing the mandatory 15-day reflection period to 72 hours, and permitting the life-ending medication to be mailed to the patient.[70] In California, a bill currently before the state Senate seeks to reduce the 15-day reflection period to forty-eight hours and eliminate a "final attestation" requirement, which obligates PAD patients to affirm their desire to die a fourth and final time after receiving the

[67] H.B. 3337, 78th Or. Leg. Assembly, Reg. Sess. (2015).

[68] Molly Harbarger, *Legislator's Promise to a Dying Friend: Death with Dignity Amendment to Help ALS, Alzheimer's Patients Fails*, THE OREGONIAN (updated Jan. 9, 2019), https://www.oregonlive.com/politics/2015/04/legislators_promise_to_a_dying.html.

[69] S.B. 579, 80th Or. Leg. Assembly, Reg. Sess. (2019).

[70] H.B. 1141, 2021 Reg. Sess. (Wash. 2021).

medication.[71] California's latest bill does not address statewide calls to extend the law to patients suffering with Alzheimer's, dementia, and chronic pain, but such demands to relax or remove the "terminal" requirement are loud and growing.[72]

III. Analysis: Proposing a Uniquely American Ledge on the Slippery Slope

There is a general consensus among state governments, advocacy groups, and healthcare workers that the current state "laboratories" testing out legalized PAD are, so far, conducting their experiments safely and by the books.[73] But the United States should take heed of the Netherlands' experience with the slippery slope of suffering-based PAD. With six states legalizing PAD in the past five years and many others sure to follow, and given the inevitable calls for loosening requirements and creating exceptions to state PAD regulations, the federal government should preemptively carve out a ledge on the slippery slope of PAD in the United States. If any state abandons its residency requirement and adopts the Netherlands' standard of "hopeless and unbearable suffering" as a basis for PAD, not only will that state begin its descent down the slippery slope as logic demands increasingly broad categories of eligibility, but all other state PAD restrictions will be rendered moot as patients simply travel to the less restrictive

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[71] S.B. 380, 2021 Reg. Sess. (Ca. 2021). This bill's purpose is to permanently renew the original California PAD legalization statute, which was enacted with a ten-year sunset clause.

[72] *See, e.g.*, Nicholas Goldberg, *California's Aid-in-Dying Law Is Working. Let's Expand it to Alzheimer's Patients*, Los Angeles Times (July 15, 2020), https://www.latimes.com/opinion/story/2020-07-15/california-aid-in-dying-law-assisted-suicide-alzheimers-dementia ("[W]e should make more people eligible to participate in what's come to be known as "aid in dying," if they choose to. Alzheimer's patients and others facing dementia seem like an obvious place to start, although policymakers also could consider people with certain degenerative disease or those living in chronic pain, even if they aren't within six months of death."); Ralph Shaffer, *My Friend Has Dementia and Wants to End Her Life. California's Assisted-Suicide Law Excludes Her*, Los Angeles Times (Feb. 23, 2020), https://www.latimes.com/opinion/story/2020-02-23/dementia-assisted-suicide-law-california-exclusion ("[T]he requirement that a person need be within six months of death before qualifying for a prescription should be abandoned for dementia patients.").

[73] *See, e.g.*, *For Healthcare Providers*, Death with Dignity (last visited Apr. 29, 2021), https://deathwithdignity.org/learn/healthcare-providers/ ("Oregon's law went into effect in 1997 and Washington's in 2009, and throughout the laws' history, there has never been a documented case of coercion or undue influence related to the Death with Dignity Act. Not one.").

areas of the country.[74] The high potential for domestic "suicide tourism"[75] necessitates federal government intervention to establish a bedrock PAD qualification—terminal illness—that will neutralize the threat of the PAD slippery slope once and for all.

A. *A "Terminal Illness" Requirement* Is Bioethically Acceptable, though not Necessary, as a Standard for Prescribing PAD

The bioethical dilemma at the heart of PAD arises from what the American Medical Association (AMA) has described as the "irreducible moral tension" between the twin duties of every physician administering end-of-life care: preserving life and relieving suffering.[76] As recently as 2019, the AMA has confirmed its position that preserving life trumps relieving suffering when it comes to end-of-life care, describing PAD as "fundamentally inconsistent with the physician's professional role."[77] Reasonable and heartfelt arguments exist for prioritizing

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[74] Although New Mexico's bill legalizing PAD in 2021 includes a residency requirement, a proposed version of the bill in 2019 was strongly criticized for omitting the residency requirement, thus enabling, or perhaps inviting, suicide tourism in the state. H.B. 90, 54th Leg., First Sess. (N.M. 2019).

[75] Suicide tourism occurs when non-residents travel to a jurisdiction with legalized PAD for the sole purpose of utilizing the procedure, which they are unable to obtain in their native jurisdiction. *See* Saskia Gauthier et al., ***Suicide Tourism: A Pilot Study on the Swiss Phenomenon***, 41 J. MED. ETHICS 611 (2015). The practice is banned in every U.S. state and the Netherlands, but is notoriously common in Switzerland due to vague, but very permissive, PAD laws. *See id.*; Hannah Roberts, ***Italian Woman, 85, Ends Her Life at Swiss Euthanasia Clinic Because She Was Upset about Losing Her Looks***, PATIENTS RIGHTS ACTION FUND (Feb. 20, 2014, 12:24 PM), https://patientsrightsaction.org/italian-woman-85-ends-her-life-at-swiss-euthanasia-clinic-because-she-was-upset-about-losing-her-looks/ (describing a woman's successful trip to Switzerland to obtain PAD "because she was 'unhappy about losing her looks'").

[76] ***Physician-Assisted Suicide***, AM. MED. ASSOC. (last visited Apr. 30, 2021), https://www.ama-assn.org/delivering-care/ethics/physician-assisted-suicide; *see, e.g.*, Susana Nuccetelli & Gary Seay, ***Relieving Pain and Foreseeing Death: A Paradox About Accountability and Blame***, 28 J.L. MED. & ETHICS 19, 22 (2000) (arguing that "doctors have certain duties just because they are doctors," and that "foremost among these . . . are the duties to conserve and extend life whenever possible, and to relieve physical suffering").

[77] Council on Ethical and Judicial Affairs, ***Physician Assisted Suicide H-140.952***, AM. MED. ASSOC. (2019), https://policysearch.ama-assn.org/policyfinder/detail/assisted%20suicide?uri=%2FAMADoc%2FHOD.xml-0-483.xml. The AMA further instructs that "[r]equests for [PAD] should be a signal to the physician that the patient's needs are unmet and further evaluation to identify the elements contributing to the patient's suffering is necessary." *Id.* In *Washington v. Glucksberg*, the Supreme Court agreed with the AMA that "physician-assisted suicide is fundamentally incompatible with the physician's role as healer." 521 U.S. 702, 731 (1997).

either goal, but the current method of every American state is to prioritize preserving life over relieving suffering,[78] and this choice is bioethically defensible.

Medical advances are escalating this tension as lifespans lengthen faster than cures and treatments are being developed. From 1960 to 2015, the average American life expectancy leapt up ten years, from about 69 to about 79.[79] From 2016 to 2060, this figure is predicted to increase at least another six, to an unprecedented 85.6 years.[80] As the aging American population continues to outpace the advance of medical technology, physicians' powers to relieve suffering while preserving life will become more and more constrained. How should the American medical community prepare to face the challenge posed by a population increasingly made up of those who may feel, to borrow a phrase from Dutch Parliamentarian Pia Dikjstra's defense of the Completed Life Bill, as though their "biographical" lives have exceeded their "biological" lives?[81] A sure protection for the medical community against the inevitable surge in end-of-life moral dilemmas is to carve out an unequivocal ledge on the slippery slope by requiring terminal illness for PAD eligibility.

European nations like the Netherlands have prioritized relieving suffering over preserving life in their standards of medical care,[82] reflecting the European legal culture's strong emphasis

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[78] The prioritization of preserving life over relieving suffering is evidenced by the requirement in all nine states with legalized PAD that a patent's illness be terminal before they become eligible for PAD. In the other forty states where PAD remains illegal (as well as Montana, where the state legislature has not formalized the state supreme court decision recognizing PAD), the prioritization is evident because no amount of suffering will excuse a physician's choice to terminate the patient's life.

[79] Lauren Medina et al., ***Living Longer: Historical and Projected Life Expectancy in the United States, 1960 to 2060***, UNITED STATES CENSUS BUREAU 3, fig. 1 (Feb. 2020), https://www.census.gov/content/dam/Census/library/publications/2020/demo/p25-1145.pdf.

[80] ***Id.***

[81] ***See supra*** note 36.

[82] Hilde Buiting et al., ***Reporting of Euthanasia and Physician-Assisted Suicide in the Netherlands: Descriptive Study***, BMC MED. ETHICS 1, 2 (2009) ("[F]or the Dutch, Belgian and Luxembourg Acts, addressing the patient's

on "dignity" as an "inviolable" human right.[83] Legislative and judicial support for the "right to dignity" in the United States, however, has been slow to develop. Justice Anthony Kennedy famously championed the right in a string of landmark civil rights cases culminating in *Obergefell v. Hodges*,[84] but many scholars have cautioned that the right is too poorly defined in American jurisprudence to effectively safeguard fundamental rights.[85] For example, although the Supreme Court invoked dignitary interests to support its ruling in *Brown v. Board of Education*, it did so largely to repair the unspeakable wounds it unleashed by brusquely dismissing dignitary concerns in *Plessy v. Ferguson*.[86] The malleability of a dignitary standard is also illustrated by its broad modern applications by the Court, from defending a ban on late-term abortion to protecting private gun ownership.[87] Further illustrating the uncertainty of dignity as an anchor for rights, the Court has never opined on the proper response to the easily foreseeable situation involving diametrically opposed dignitary rights, such as the competing dignity claims

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suffering is the most important principle underlying the Act. The Oregon and Washington Acts, on the other hand, put emphasis on patients' rights and on helping patients to maintain control and independence.").

[83] *See, e.g.*, *Article 1—Human Dignity*, EU CHARTER OF FUNDAMENTAL RIGHTS (2007) ("The dignity of the human person is not only a fundamental right in itself but constitutes the real basis of fundamental rights.").

[84] *See* Note, *Equal Dignity—Heeding Its Call*, 132 HARV. L. REV. 1323, 1323 (2019) ("[D]espite Justice Kennedy's seeming contradictions, one constant emerged: a robust belief in the Court's power to enforce what he believes are the promises of the Constitution[, including] that of equal dignity.").

[85] *See, e.g.*, Leslie Meltzer Henry, *The Jurisprudence of Dignity*, 160 U. PENN. L. REV. 169, 229 (2011) (examining conceptions of dignity including institutional status, equality, liberty, personal integrity, and collective virtue, and concluding that "dignity's conceptions and functions are dynamic and context-driven").

[86] Brown v. Bd. of Ed. of Topeka, 347 U.S. 483, 494 (1954) ("To separate [Blacks] from others of similar age and qualifications solely because of their race generates a feeling of inferiority as to their status in the community that may affect their hearts and minds in a way unlikely ever to be undone."); Plessy v. Ferguson, 163 U.S. 537, 551 (1896) (describing as a "fallacy" the argument that "the enforced separation of the two races stamps the colored race with a badge of inferiority" because such feelings arise not from the law itself, "but solely because the colored race chooses to put that construction upon it").

[87] Gonzales v. Carhart, 550 U.S. 124, 157 (2007) ("The [Partial Birth Abortion Ban] Act expresses respect for the dignity of human life."); McDonald v. Chicago, 561 U.S. 742 (2010) (Scalia, J., concurring) (citing a dignitary interest in gun ownership, which "pertains to the plaintiff's ability to independently define his identity . . . or some aspect of his self-determination, bodily integrity, . . . dignity or respect" (internal quotation marks omitted)).

where a religious wedding photographer refuses to serve same-sex couples, or a conscientious healthcare provider refuses to offer PAD to a qualified patient.[88] The European focus on human dignity is laudable and bioethically sound as a basis for medical decisionmaking, but it is certainly not the only permissible approach, and as a currently underdeveloped doctrine in the American legal tradition, dignity should not form the basis of PAD jurisprudence in the United States.

Carving an absolute ledge in the PAD slippery slope with a "terminal illness" standard is also advisable for America because it will preclude the ethically required acquiescence to PAD requests from a broad array of psychiatric patients, as experienced in the Netherlands, and this is critical against the backdrop of the unfolding American mental health crisis. The 2010s witnessed a heartbreaking decline in the mental health of American teenagers: rates of depression rose by 50% or more, and suicide attempts and suicidal ideation more than doubled.[89] Mental illness was growing more prevalent in America even before the onset of the COVID-19 pandemic, with a steady and sizeable proportion of youth and adults suffering without treatment.[90] In 2020, as the pandemic ravaged the nation, nearly 10.3 million U.S. adults

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[88] *See* Jeffrey Rosen, *The Dangers of a Constitutional "Right to Dignity,"* THE ATLANTIC (Apr. 29, 2015), https://www.theatlantic.com/politics/archive/2015/04/the-dangerous-doctrine-of-dignity/391796/ (questioning the wisdom of "empowering judges to decide whose dignity trumps when the interests of citizens with very different conceptions of dignity clash").

[89] Jean M. Twenge et al., *Age, Period, and Cohort Trends in Mood Disorder Indicators and Suicide-Related Outcomes in a Nationally Representative Dataset, 2005–2007*, 128 J. ABNORMAL PSYCH. 185 (2019) (noting that depression rose by over 60% in teens ages fourteen to seventeen from 2009 to 2017, and by 47% in teens ages twelve to thirteen over the same period); Brett Burstein et al., *Suicidal Attempts and Ideation among Children and Adolescents in US Emergency Departments, 2007–2015*, 173 JAMA PEDIATRICS 598 (2019) (citing the doubling in teenage suicide attempts and suicidal ideation between 2007 and 2015).

[90] Maddy Reinert et al., *The State of Mental Health in America 2020*, MENTAL HEALTH AM. (2019), https://www.mhanational.org/issues/state-mental-health-america ("In 2017–2018, 19% of [U.S.] adults experienced a mental illness, an increase of 1.5 million people over last year's dataset."). Lack of treatment was a significant problem pre-COVID: in 2017 and 2018, "60% of youth with major depression did not receive any mental health treatment" and "23.6% of adults with a mental illness reported an unmet need for treatment." *Id.*

reported serious suicidal thoughts—an increase of almost half a million from 2019—and CDC data revealed that symptoms of anxiety and depressive disorders rose substantially in 2020 compared to 2019.[91]

If states follow the Dutch model and legalize PAD for non-somatic suffering, the implications could be disastrous. Many victims of the rising mental health crisis would opt for PAD rather than seeking treatment (as evidenced by the skyrocketing rates of suicide and suicidal ideation), and research into treatments for disorders like depression and anxiety might diminish as patients eligible for treatment choose PAD instead. State mental health agencies spent a total of $29.4 billion to combat suicide in 2005;[92] would—and ***should***—this spending decrease as states endorse PAD as an acceptable treatment for psychiatric conditions? Requiring terminal illness for PAD will protect those grappling with mental health, because conditions such as depression and anxiety may respond favorably to medical treatment despite their tendency to temporarily increase suicidal ideation.[93] Offering PAD to patients experiencing psychological suffering may be ethically defensible, but until the American medical community is able to seriously engage with the nation's mounting mental health crisis in the wake of the pandemic, this option could ultimately cause significant harm to current and future American mental health patients.

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[91] ***Adults with Serious Thoughts of Suicide 2020***, MENTAL HEALTH AM. (2020), https://www.mhanational.org/issues/2020/mental-health-america-prevalence-data; Mark Czeisler et al., ***Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic***, CTRS. DISEASE CONTROL & PREVENTION (Aug. 14, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm#.

[92] Justin M. Ross et al., ***Does State Spending on Mental Health Lower Suicide Rates?***, 41 J. SOCIO-ECONOMICS 408, 408 (2012).

[93] ***See, e.g.***, ***Facts & Statistics***, ANXIETY & DEPRESSION ASS'N OF AM. (last visited Apr. 30, 2021), https://adaa.org/understanding-anxiety/facts-statistics; ***Stories of Triumph***, ANXIETY & DEPRESSION ASS'N OF AM. (last visited Apr. 30, 2021), https://adaa.org/educational-resources/from-our-community/stories-of-triumph.

Finally, requiring a terminal illness to receive PAD is a bioethically valid position because, as many moral and philosophical traditions throughout human history have recognized, suffering is an unpleasant but critical engine for human growth and innovation, uniquely enabling introspection and inner strength, and, according to some, giving meaning to life itself.[94] Religious texts of prominent global belief systems resoundingly endorse suffering as a means to spiritual growth and self-actualization.[95] Prominent secular philosophers have also unreservedly praised suffering as a vital means to test and improve humanity.[96] Some degree of suffering is inevitable in every human life, and it is ethically permissible to create a culture that seeks to gain from suffering rather than to eradicate it at all costs. Prioritizing preserving life over relieving suffering affirms the insurmountable power of the human spirit to persevere even against brutal and debilitating hardship, and attests to the intrinsic value of human life even in the midst of pain.

B. *America's Healthcare System Necessitates a Different Approach from the Netherlands*

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[94] ***See, e.g.***, VIKTOR FRANKL, MAN'S SEARCH FOR MEANING (Austria, 1946). Frankl, a neuroscientist and Holocaust survivor, reflected on the unspeakable suffering he witnessed and attested to its unique ability to impart meaning to human life: "If there is a meaning in life at all, then there must be a meaning in suffering. Suffering is an ineradicable part of life, even as fate and death. . . . The way in which a man accepts his fate and all the suffering it entails . . . gives him ample opportunity—even under the most difficult circumstances—to add a deeper meaning to his life." ***Id.*** at 67.

[95] ***See, e.g.***, ***Job*** 36:15–16 (Complete Jewish Bible) ("God, with his affliction, delivers the afflicted; and he gets their attention by pressing on them. Indeed, he is drawing you away from distress to an untroubled open place."); ***James*** 1:2–3 (English Standard Version) ("Count it all joy, my brothers, when you meet trials of various kinds, for you know that the testing of your faith produces steadfastness."); ***Quran*** 2:155–157 ("And We will surely test you with something of fear and hunger and a loss of wealth and lives and fruits, but give good tidings to the patient . . . . Those are the ones upon whom are blessings from their Lord and mercy.").

[96] ***See, e.g.***, FRIEDRICH NIETZSCHE, BEYOND GOOD AND EVIL (Liepzig, 1886) ("[W]hatever depth, mystery, disguise, spirit, artifice, or greatness has been bestowed upon the soul—has it not been bestowed through suffering?"); BERTRAND RUSSELL, IN PRAISE OF IDLENESS AND OTHER ESSAYS (George Allen & Unwin, 1935) ("The attempt to escape from pain drives men to triviality, to self-deception, to the invention of vast collective myths. . . . Both private and public misfortune can only be mastered by a process in which will and intelligence interact.").

The different bioethical standards for PAD access in the United States ("terminal illness") and the Netherlands ("hopeless and unbearable suffering") are justified by the vastly different healthcare systems in these two countries. The United States' private healthcare system is, in short, widely mistrusted and demonstrably ineffective, leaving many citizens without coverage.[97] In stark contrast, the Netherlands' system of universal healthcare is considered trustworthy and effective by Dutch citizens and covers nearly everyone in the country.[98] The United States' far more cautious approach to PAD is necessary until American healthcare, like the Dutch system, sees a long overdue increase in accountability, access, and, most importantly for PAD, trust.[99]

In 2018, the U.S. Census Bureau reported that 27.5 million Americans, or 8.5% of the population, lacked health insurance.[100] In 2019, the CDC found that this figure was 32.8 million—nearly double the entire population of the Netherlands.[101] Meanwhile, as of 2016, less

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[97] ***See, e.g.***, Irene Papanicolas et al., ***Health Care Spending in the United States and Other High-Income Countries***, 319 JAMA 1024 (2018) (reporting that healthcare in the United States covers a lower proportion of the population than healthcare systems in the next ten highest-income countries, and costs approximately double what these countries spend on healthcare despite being no more effective by most standards).

[98] ***See, e.g.***, Madelon Kroneman et al., ***Netherlands: Health System Review***, 18 HEALTH SYST. TRANSIT. 1, 192–202 (2016) (reporting that Dutch citizens rate their universal public healthcare system highly amid rising life expectancy, decreasing wait times, and broad accessibility); Claus Wendt, ***Social Health Insurance in Europe: Basic Concepts and New Principles***, 44 J. HEALTH POL'Y L. 665 (2019) (comparing five European models of social health insurance and finding that they do not lead to higher costs than private models and have not caused a "trust crisis" among the public).

[99] ***See, e.g.***, van der Burg, ***supra*** note 51 ("The Dutch [PAD] practice heavily leans on trusting physicians . . . . Physicians trust fellow physicians, patients trust physicians, and the legal system entrusts physicians with these decisions. If someone with a basic attitude of distrust looks at this situation, he will see an extreme danger of abuse."); R.J.M. Dillman, ***Euthanasia in the Netherlands: The Role of the Dutch Medical Profession***, 5 CAMBRIDGE Q. HEALTHCARE ETHICS 100, 100 (1996) (arguing that the Dutch PAD standard is acceptable when "viewed within the context of Dutch society, the Dutch system of healthcare, and the socio-cultural approach to moral questions in the Netherlands," including "respect for human dignity, accountability, and scrupulousness").

[100] Edward R. Berchick et al., ***Health Insurance Coverage in the United States: 2018***, UNITED STATES CENSUS BUREAU 2 (Nov. 2019), https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf. Additionally, many Americans rely on employer health plans (about 55% in 2018), which may provide inadequate coverage or impose cost-related barriers to necessary access. ***Id.***

[101] ***Health Insurance Coverage***, CTRS. DISEASE CONTROL & PREVENTION (last visited Apr. 30, 2021), https://www.cdc.gov/nchs/fastats/health-insurance.htm.

than 0.2% of the Dutch population, or about 23,000 people, remain uninsured.[102] In addition, while the Dutch system includes mental healthcare as a standard benefit, about 11% of the American population suffering from mental illness, totaling 5.1 million people, remain uninsured.[103]

The abhorrent prospect of a patient opting for PAD because they lack health insurance and cannot afford treatment for their underlying condition, while virtually nonexistent in the Netherlands,[104] could become the reality for millions of American patients if suffering-based PAD were legalized.[105] This scenario would frustrate the goal of PAD, which aims to maximize patient dignity and autonomy while minimizing suffering, because uninsured or inadequately covered patients would be strongly incentivized to end their lives for financial reasons. The threat of this inhumane choice looms large for the massive population of uninsured Americans and weighs heavily in favor of requiring terminal illness for PAD, which would avoid tainting the end-of-life autonomy enabled by PAD with the cruel pressure to avoid expensive treatment by ending life preemptively.

The American healthcare system poses another threat to Americans living in states with legalized PAD because no laws currently prevent insurance companies from covering PAD while refusing to cover treatment for the patient's underlying condition. Under this regime, even

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[102] Roosa Tikkanen et al., *International Health Care System Profiles: Netherlands*, COMMONWEALTH FUND (June 5, 2020), https://www.commonwealthfund.org/international-health-policy-center/countries/netherlands.

[103] *Id.*; Reinert et al., *supra* note 90, at 10.

[104] *See* Sherwood, *supra* note 39 (noting that the famous Dutch *Levenseindekliniek*, or "End of Life Clinic," which operates solely to offer PAD, is fully funded by the Dutch health insurance system).

[105] *See* Shaffer, *supra* note 72 (describing a dementia patient who "doesn't want to live through losing her mind, and [who] wants the savings she and her late husband accumulated to go to her children rather than to the extremely high cost of caring for Alzheimer's patients").

insured American patients will be put to the brutal choice of opting for PAD to save money, rather than to end life with dignity. Examples already exist of insurance companies creating this inhumane dilemma for patients: in California, a woman's private insurance company declined to cover her chemotherapy treatment while offering to pay for PAD;[106] patients in Montana, Vermont, and Washington have qualified for PAD while being deemed ineligible for hospice "either because they are too healthy or still want treatment for their terminal condition";[107] and in Oregon, the state's Medicaid program extends coverage to palliative care, which includes PAD, but not to many critical treatments and drugs for diseases like cancer, prompting one doctor to wonder, "[W]hat sort of a choice is it when life is expensive but death is free?"[108] In states with legalized PAD, most private health insurance companies cover the costs of the procedure,[109] but as long as they are not required to also cover treatments for the patient's underlying condition, Americans should hesitate to legalize PAD in their state and open this Pandora's Box.

The American healthcare system seems to sidestep the dilemma of preserving life versus relieving suffering, instead asserting a new primary principle to drive PAD policy: maximizing profits. Until this system is restructured to prioritize patients over profit, PAD policies in the United States must embrace skepticism and protect patients accordingly. Requiring a terminal illness for PAD cements every PAD prescription in an objective, verifiable standard, and

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[106] Bradford Richardson, *Assisted-Suicide Law Prompts Insurance Company to Deny Coverage to Terminally Ill California Woman*, WASHINGTON TIMES (Oct. 20, 2016), https://www.washingtontimes.com/news/2016/oct/20/assisted-suicide-law-prompts-insurance-company-den/.

[107] Ira Byock, *Doctor-Assisted Suicide Is Unethical and Dangerous*, N.Y. TIMES (Sept. 4, 2015, 2:25 PM), https://www.nytimes.com/roomfordebate/2014/10/06/expanding-the-right-to-die/doctor-assisted-suicide-is-unethical-and-dangerous.

[108] William L. Toffler, *A Doctor-Assisted Disaster for Medicine*, WALL ST. J. (Aug. 17, 2015, 7:11 PM), https://www.wsj.com/articles/a-doctor-assisted-disaster-for-medicine-1439853118.

[109] David Grube & Ashley Cardenas, *Insurance Coverage and Aid-in-Dying Medication Costs*, 3 JAMA ONCOLOGY 1137 (2017).

decreases the incentive for insurance companies to simply urge PAD on patients who require expensive treatment. Permitting any subjectivity in American PAD standards, such as the Dutch "hopeless and unbearable suffering" standard, creates a strong motivation for insurance companies to promote the comparatively cheap option of PAD over more expensive, life-preserving alternatives. Ultimately, a subjective standard will remain unworkable in the United States until healthcare coverage is nearly universal, insurance companies are required to cover treatment for underlying conditions when they cover PAD, and, most importantly, patient trust is earned and maintained through transparency, consistency, and compassion.

IV. Conclusion

As states continue to legalize PAD and calibrate their requirements for obtaining it, and as the aging American population grapples with a profit-centered healthcare system that often wields the powers of life and death, federal intervention is necessary to ensure accountability in PAD administration. The United States can and should carve a ledge in the slippery slope of PAD legalization by requiring prospective PAD recipients to have a terminal illness. Such a ledge would preclude the Dutch suffering-based model with its inevitable expansion to psychiatric suffering and beyond, and would protect millions of uninsured American patients from pressure to choose PAD on the basis of financial savings rather than dignity and autonomy.

Perhaps the American healthcare system will one day earn the trust of its patients and suffering-based PAD will become viable in the United States. Compassionate and careful standards could guarantee all patients the end-of-life freedoms afforded in the Netherlands while managing the slippery slope through documentation, transparency, and rigorous bioethical inquiry. However, given the widespread mistrust in the United States' current healthcare system, requiring terminal illness for PAD eligibility is the best way to protect patients while maximizing

their autonomy to the greatest extent practicable. It is an imperfect solution fit for our imperfect system, and should be enacted with the hope that future advances in accountability and empathy in American healthcare will give rise to better end-of-life options and greater patient autonomy.