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EMBRACING THE END: A COMPARATIVE ANALYSIS OF MEDICAL AID IN DYING IN CANADA AND THE UNITED STATES

INTRODUCTION

In declaring independence from Great Britain, the Continental Congress of the thirteen colonies announced the unalienable right to life.[1] Conversely, the Continental Congress did not explicate how death influences the right to life. The issue of whether an individual has the right to die is one that has garnished significant attention and debate internationally and throughout American history.[2] While euthanasia and physician-assisted death are commonly used interchangeably, they are not the same and there is currently no universally accepted definition of the term "euthanasia."[3] Merriam-Webster's dictionary defines euthanasia as "the act or practice of killing or permitting the death of hopelessly sick or injured individuals (such as persons or domestic animals) in a relatively painless way for reasons of mercy."[4] Physician-assisted suicide (PAS), commonly referred to as physician-assisted death (PAD), is defined as "suicide by a patient facilitated by means (such as a drug prescription) or by information (such as an indication of a lethal dosage) provided by a physician aware of the patient's intent."[5] Essentially, the distinction is that euthanasia consists of a third party, often a physician, directly administering the lethal medication, while physician-assisted suicide refers to the prescription of a lethal medication to be self-administered by the patient.[6] This distinction has proven to be important as governments consider

1. The Declaration of Independence para. 2 (U.S. 1776).

2. *See* SHAI J. LAVI, THE MODERN ART OF DYING: A HISTORY OF EUTHANASIA IN THE UNITED STATES 3, 14, (Princeton Univ. Press ed. 2007).

3. *See* Basil Varkey, *Defining Euthanasia and the Need to be Circumspect in the Usage of the Term*, MED. PRINCIPLES & PRAC. (July 9, 2020). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7511678/pdf/mpp-0029-0499.pdf.

4. *Euthanasia*, MERRIAM-WEBSTER, https://www.merriam-webster.com/dictionary/euthanasia (last visited Sept. 17, 2022).

5. *Physician-assisted suicide*, MERRIAM-WEBSTER, https://www.merriam-webster.com/dictionary/physician-assisted%20suicide (last visited Sept. 17, 2022).

6. *See supra* notes 4-5.

the legalization of such activities.[7] Commonly, the term Aid In Dying (AID) is used when referring to PAD or PAS, and will be used accordingly throughout this Note.[8]

Today, ten US states and the District of Columbia allow some form of AID, including one state, Montana, which permits the practice of AID through a state Supreme Court ruling.[9] The practice is prohibited on the federal level and has been explicitly prohibited by state law or common law in thirty-six states.[10] Current AID law in the United States (US) consists of funding and administration requirements that can cause inequitable opportunities for certain individuals to utilize AID.[11] The United States' neighbor to the north, Canada, has grappled with this same issue and has made significant changes to its laws in the area over the past decade.[12] The evolution of Canada's Medical Assistance in Dying (MAID) law has resulted in the federal legalization of the practice and expansion of eligibility criteria as recently as 2021.[13] Providing a comprehensive and consistent legal framework for AID and euthanasia is essential for successful and equitable administration of these services. The United

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7. *Frequently Asked Questions: Oregon's Death With Dignity Act (DWDA)*, OR. HEALTH AUTH., https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/faqs.aspx - allow (explaining the distinction between PAD and euthanasia, noting that euthanasia refers to the administration of a lethal dose by a physician, while PAD refers to the prescription of a lethal dose to be administered by the patient. Oregon's DWDA allows only for PAD).; *see generally* D. Harris, B. Richard & P. Khanna, *Assisted dying: the ongoing debate*, NAT'L LIBR. OF MED. (Aug. 2006), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2585714/.

8. *Glossary of Terms*, COMPASSION & CHOICES, https://compassionandchoices.org/end-of-life-planning/learn/glossary-of-terms/#:~:text=Euthanasia%20%2D%20Also%20known%20as%20%E2%80%9Cmercy,act%20in%20the%20United%20States. (last visited July 26, 2022).

9. *In Your State*, DEATH WITH DIGNITY, https://deathwithdignity.org/states/ (last visited July 26, 2022); *Montana*, DEATH WITH DIGNITY, https://deathwithdignity.org/states/montana/ (last visited Jul. 26, 2022).

10. *States with Legal Physician-Assisted Suicide*, PROCON.ORG (July 7, 2022), https://euthanasia.procon.org/states-with-legal-physician-assisted-suicide/#illegal_states.

11. *Polling on Medical Aid in Dying*, COMPASSION & CHOICES, https://compassionandchoices.org/resource/polling-medical-aid-dying/ (last visited Sept. 17, 2022).

12. *Infra* note 80.

13. Bill C-7, *An Act to amend the Criminal Code (medical assistance in dying)*, 2nd Sess, 43rd Parl, 2021, (assented to 17th March 2021).

States has an opportunity to borrow elements from Canadian MAID law to achieve a more balanced and structured statutory framework for AID within its own borders.

Part I of this Note will review background information on euthanasia and AID in the US and Canada. This section will explore the state regulated system in the US and will explain how Canada's MAID law works in current practice considering recent modifications to the law in 2021. Part II will discuss the ethical considerations of AID and the primary arguments made by proponents and opponents of its legalization. Part III will compare a few fundamental elements of the AID regulatory framework in the US to those of the Canadian framework. Part IV will then argue that the United States should borrow certain elements of the Canadian approach to AID. This section will focus on three elements specifically: federally implemented regulation, federal funding for AID, and the ability for a physician to administer the lethal dose to a patient directly as opposed to requiring the patient to administer it themselves.

I. Background Information on Euthanasia and Assisted Death in the United States and Canada

This section will discuss statutory and common law mechanisms governing AID in the US and Canada. It will provide a brief historical look at the evolution of AID in both countries, including updates to Canada's MAID law in 2021, and a review of current procedural and eligibility criteria.

A. Euthanasia and Assisted Death in the United States

There has been an ongoing debate in the United States surrounding euthanasia and assisted death since at least the late eighteenth century.[14] The first American statute outlawing assisted suicide was enacted in New York in 1828.[15] By 1868, many states had followed New York's lead and it was considered a crime in most states to assist a suicide.[16] By 1950, organizations advocating for the use of euthanasia in certain medical scenarios

14. *See Historical Timeline - History of Euthanasia and Physician-Assisted Suicide*, ProCon.org (Mar. 29, 2022), https://euthanasia.procon.org/historical-timeline/.

15. Washington v. Glucksberg, 521 U.S. 702, 715 (1997) (stating "Every person deliberately assisting another in the commission of self-murder, shall be deemed guilty of manslaughter").

16. *Id.*

were formed in the US, including the Euthanasia Society of America (ESA)[17] and The Committee of 1776 Physicians for Legalizing Voluntary Euthanasia.[18] Nevertheless, the concepts of euthanasia and assisted suicide continued to receive condemnation in America and throughout the world.[19] In 1976, the landmark case of *In the Matter of Karen Quinlan, An Alleged Incompetent* marked a shift in the approach toward autonomy in death when it was decided by the Supreme Court of New Jersey.[20] In that case, the father of a twenty-one-year-old woman, Karen Quinlan, who was in a persistent vegetative state, sought to discontinue the procedures that were being used to keep his daughter alive, specifically through the removal of a mechanical respiratory device.[21] The court held that:

> Should the responsible attending physicians conclude that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state and that the life-support apparatus now being administered to Karen should be discontinued, they shall consult with the hospital 'Ethics Committee' or like body of the institution in which Karen is then hospitalized. If that consultative body agrees that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state, the present life-support system may be withdrawn and said action shall be without any civil or criminal liability therefor on the part of any participant, whether guardian, physician, hospital, or others. [22]

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17. *Euthanasia*, BRITANNICA, https://www.britannica.com/topic/euthanasia (last visited Sept. 17, 2022). The ESA was formed in 1938 as the National Society for the Legalization of Euthanasia with the corporate purposes "to disseminate information to the public by all lawful means of the nature, purpose, and need of euthanasia, and to foster its general adoption." *Assisted Suicide & Death with Dignity: Past, Present & Future – Part I*, PATIENTS RTS. COUNCIL, https://www.patientsrightscouncil.org/site/rpt2005-part1/#6 (last visited Sept. 17, 2022). The organization changed its name to the ESA the year that it was founded, underwent several subsequent name changes, and eventually merged with a like-minded organization to form Partnership for Caring. *See id.* Partnership for Caring ended operation in 2004. *Id.*

18. PROCON.ORG, *supra* note 14.

19. *Id.*

20. *See* Matter of Quinlan, 355 A.2d 647, 671 (1976).

21. *Id.* at 651.

22. *Id.* at 671.

While this ruling was not an affirmation of euthanasia or assisted suicide, it was historic in that it was the first time any US court held that the right of privacy included the right to remove a life-sustaining device from a patient.[23] A few months later, California passed the California Natural Death Act, becoming the "first state in the nation to grant terminally ill persons the right to authorize the withdrawal of life-sustaining procedures when death is believed imminent."[24]

In 1990, the Supreme Court of the United States confronted the issue of whether a person has the right to refuse lifesaving medical treatment in *Cruzan v. Director, Missouri Department of Health*.[25] While the issue in *Cruzan* was the removal of life-sustaining treatment in regard to an individual who was incompetent, its importance was in the Court's holding that "a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment."[26] Later that year, Congress passed the Patient Self-Determination Act, which requires "hospitals that receive federal funds to tell patients that they have a right to demand or refuse treatment."[27]

In 1994, after two failed attempts in the early 1990s by Washington State and California to allow physicians to assist with the death of patients, the Death with Dignity Act was successfully passed in Oregon, becoming the first law in American history allowing for physician-assisted suicide.[28] Oregon's Death with Dignity Act (DWDA) went into effect in 1997 and the US Supreme Court upheld the law in its 2006 ruling in *Gonzales v. Oregon*.[29] Shortly after Oregon passed its DWDA, President Clinton delivered a blow to the program by signing the Federal Assisted Suicide Funding Restriction Act of 1997, which prohibited the use of federal funds in support of physician-assisted suicide.[30] The law is codified in 42 U.S.C.A. § 14401 and its

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23. David P. Falck, *In Re Quinlan: One Court'S Answer To The Problem Of Death With Dignity*, 34 WASH. & LEE L. REV. 285, 294 (1977).

24. Les Ledbetter, *California Grants Terminally Ill Right to Put an End to Treatment*, N.Y. TIMES (Oct. 2, 1976), https://www.nytimes.com/1976/10/02/archives/california-grants-teminally-ill-right-to-put-an-end-to-treatment.html.

25. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 269 (1990).

26. *Id.* at 278.

27. PROCON.ORG, *supra* note 14.

28. *See* PROCON.ORG, *supra* note 14; *Oregon*, DEATH WITH DIGNITY, https://deathwithdignity.org/states/oregon/ (last visited Jul. 26, 2022).

29. *See* Gonzales v. Oregon, 546 U.S. 243, 275 (2006).

30. *Glucksberg*, 521 U.S. at 718.

principle purpose is to prohibit the use of federal funds to "pay for items and services (including assistance) the purpose of which is to cause (or assist in causing) the suicide, euthanasia, or mercy killing of any individual."[31] 42 U.S.C.A. § 14401 is still in effect today and while it identifies that "assisted suicide, euthanasia, and mercy killing have been criminal offenses throughout the United States and, under current law, it would be unlawful to provide services in support of such illegal activities[,]" it also recognizes that the states are able to individually "furnish services in support of such activities."[32]

Today, nine states and the District of Columbia have passed legislation allowing AID for patients who meet certain statutorily defined eligibility requirements.[33] One other state, Montana, currently permits the practice through a state Supreme Court ruling, which will be discussed in further detail in Part B of this section.[34] The most recent state to legalize AID is New Mexico, which signed its End-of-Life Options Act into law on April 8, 2021.[35] With the federal government allowing the states to legalize AID individually, individual state law on the matter has been created at different times and through different mechanisms.[36] Although enacted separately, certain eligibility requirements are similar between the states.[37] Overlapping requirements include: (1) the requesting individual's mental competence, (2) diagnosis of a terminal illness that will lead to death within six months, and (3) the capability to administer or ingest medication without assistance.[38] This last requirement reflects the position of US jurisdictions to prohibit euthanasia.[39] The impact of

31. 42 U.S.C.A. § 14401(b).

32. *Id.* §§ 2-3.

33. DEATH WITH DIGNITY, *supra* note 9.

34. *Id.*

35. *New Mexico*, COMPASSION & CHOICES, https://compassionandchoices.org/in-your-state/new-mexico#:~:text=On%20April%208%2C%202021%2C%20Governor,effect%20on%20June%2018%2C%202021 (last visited July 27, 2022).

36. *See generally 'Death With Dignity' Laws by State*, FINDLAW (May 24, 2018), https://www.findlaw.com/healthcare/patient-rights/death-with-dignity-laws-by-state.html (noting that state law on AID had been legalized by the legislature, ballot initiatives, and in Montana, through a Supreme Court ruling).

37. *See Frequently Asked Questions*, DEATH WITH DIGNITY, https://deathwithdignity.org/resources/faqs/ (last visited July 26, 2022).

38. *Id.*

39. *Id.*

prohibiting a physician or physician equivalent from directly administering a lethal medication is that those individuals with degenerative illnesses or neurological issues that may suffer from impaired functionality of their arms and legs are in effect excluded from participating in assisted dying programs.[40]

B. The Common Law Approach in Montana

Due to the unique nature of physician-assisted suicide in Montana and to contribute to the analysis in Part IV of this Note, it is useful to understand how the state has approached the issue. Montana's Rights of the Terminally Ill Act, codified in the Montana Code § 50-9-103, declares that "[a]n individual of sound mind and 18 years of age or older may execute at any time a declaration governing the withholding or withdrawal of life-sustaining treatment."[41] The Act provides information on how to request such withholding or withdrawal and stipulates procedural and eligibility requirements.[42]

The Supreme Court of Montana considered the constitutionality of the Rights of the Terminally Ill Act in *Baxter v. State*.[43] Robert Baxter was a "retired truck driver . . . who was terminally ill with lymphocytic leukemia with diffuse lymphadenopathy."[44] In 2008, Baxter was being treated with multiple rounds of chemotherapy and as a result, he suffered from a number of debilitating symptoms.[45] It was eventually determined that "[t]here was

40. *See* Anita Hannig, *How Our Assisted Dying Laws Work Against Some People Who Suffer The Most*, WBUR (Feb. 04, 2020), https://www.wbur.org/cognoscenti/2020/02/04/marieke-vervoort-medically-assisted-dying-anita-hannig; Carol Parrot & Robert Wood, *Medical Aid in Dying in Washington State: A primer for participating physicians and pharmacists*, (Feb. 19, 2022), https://endoflifewa.org/wp-content/uploads/2022/03/PRIMER-updated-2.28.22.pdf.

41. Mont. Code Ann. § 50-9-103 (West).

42. *Id.*

43. Baxter v. State, 354 Mont. 234, 237 (2009).

44. *Id*. Lymphocytic leukemia is "a type of cancer that starts in cells that become certain white blood cells (called lymphocytes) in the bone marrow." *What Is Chronic Lymphocytic Leukemia?*, AM. CANCER SOC'Y (May 10, 2018), https://www.cancer.org/cancer/chronic-lymphocytic-leukemia/about/what-is-cll.html. Lymphadenopathy is the enlargement of lymph nodes, usually caused by some underlying disorder. James D. Douketis, *Lymphadenopathy*, MERCK MANUAL PRO. VERSION (June 2022), https://www.merckmanuals.com/professional/cardiovascular-disorders/lymphatic-disorders/lymphadenopathy.

45. *Baxter*, *supra* note 43, at 237. Baxter's symptoms included "infections, chronic fatigue and weakness, anemia, night sweats, nausea, massively

no cure for Mr. Baxter's disease and no prospect of recovery."[46] Baxter wanted his physician to prescribe him a lethal dose of medication that he could self-administer at a time of his choosing.[47] Unfortunately, there were concerns about whether the prescription of a lethal dose would constitute Deliberate Homicide under Montana's criminal code.[48] Deliberate Homicide in Montana is defined as "purposely or knowingly caus[ing] the death of another human being" and a conviction of Deliberate Homicide is punishable by death.[49] The Montana Code allows for consent to be a defense to Deliberate Homicide unless one of four exceptions apply.[50] The fourth exception is if it would be against public policy to allow for the killing and this exception is the basis upon which Baxter, four physicians, and Compassion & Choices[51] brought suit against the state of Montana.[52] The District Court held that "a patient may use the assistance of his physician to obtain a prescription for a lethal dose of medication" and that this "includes protection of the patient's physician from prosecution under the State's homicide statutes."[53] The Supreme Court of Montana affirmed this holding, thereby permitting physician-assisted dying under the circumstances of *Baxter*.[54]

Since the decision in *Baxter*, the Montana state legislature has made numerous attempts both to criminalize and legalize physician-assisted suicide.[55] The most recent attempt to criminalize the practice was through bill SB 290, which stalled on March 1,

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swollen glands, significant ongoing digestive problems and generalized pain and discomfort." *Id.*

46. *Id.* at 238.

47. *Id.*

48. *Id.* at 239.

49. Mont. Code Ann. § 45-5-102 (West).

50. *Baxter*, *supra* note 43, at 240.

51. "Compassion & Choices is the nation's oldest, largest and most active nonprofit working to improve care, expand options and empower everyone to chart their end-of-life journey." *Our Mission. Our Work.*, COMPASSION & CHOICES (Jan. 15, 2021), https://www.compassionandchoices.org/docs/default-source/fact-sheets/fs-our-mission-our-work-about-cc-final-1.15.21.pdf?sfvrsn=76415293_1.

52. *Id.*

53. *Id.* at 238.

54. *Montana*, DEATH WITH DIGNITY, https://deathwithdignity.org/states/montana/ (last visited Nov. 26, 2021).

55. *See* Katheryn Houghton, *Getting a Prescription to Die Remains Tricky Even As Aid-in-Dying Bills Gain Momentum Across the U.S.*, TIME (Mar. 29, 2021, 9:00 AM), https://time.com/5950396/aid-in-dying-2021/.

2021, after a split vote.[56] Without a clear statutory framework, there is confusion from both physicians and patients about how to navigate what is allowed under the *Baxter* ruling.[57] Generally, the Montana Supreme Court's decision in *Baxter* is interpreted to allow for a physician to use a patient's consent as a defense against a charge of Deliberate Homicide when that charge arises from prescribing a lethal dose of a drug to a patient if the patient was mentally competent and terminally ill, and the request was in writing.[58] Unfortunately, the lack of a statutory framework makes it somewhat risky for physicians to engage in the practice, and some may choose to avoid the practice entirely in order to avoid the chance of criminal liability.[59]

C. Euthanasia and Assisted Death in Canada

The path toward legalization of euthanasia and physician-assisted death in Canada started in 1972 when the country decriminalized suicide.[60] Although suicide was decriminalized, assisted suicide remained a criminal offense.[61] Until 2016, Section 241 of Canada's Criminal Code imposed criminal liability on anyone who counseled, aided, or abetted another to commit suicide.[62] This criminal liability could, in certain circumstances, lead to imprisonment for up to fourteen years.[63] Furthermore, Section 14 of Canada's criminal code expanded this application even where the individual had consented to their own death.[64] Together, these two sections of the criminal code prohibited physician-assisted death.[65]

In 2011, the British Columbia Civil Liberties Association filed a lawsuit challenging the constitutionality of these two sections.[66] The challenge arose out of a claim on behalf of the

56. *Id.*; *Montana*, PATIENTS RTS. COUNCIL, https://www.patientsrightscouncil.org/site/montana/ (last visited July 27, 2022).

57. *See* Houghton, *supra* note 55.

58. *Baxter*, *supra* note 40; FINDLAW, *supra* note 36.

59. *See* Houghton, *supra* note 55.

60. Florence Kellner & Tabitha de Bruin, *Suicide in Canada*, THE CAN. ENCYC. (Feb. 24, 2022), https://www.thecanadianencyclopedia.ca/en/article/suicide.

61. *See id.*

62. Criminal Code, R.S.C. 1985, c. C-46 § 241 (Can. 2016).

63. *Id*.

64. *Id.* § 14.

65. *See supra* text accompanying notes 62-64.

66. Kellner & de Bruin, *supra* note 60.

families of Kay Carter and Gloria Taylor, who suffered from degenerative spinal stenosis and ALS respectively.[67] In 2014, after a series of rulings and appeals, *Carter v. Canada* was brought before the Supreme Court of Canada, which held that Sections 14 and 241(b) infringed on the rights delineated in Section 7 of the Canadian Charter of Rights and Freedoms and are unconstitutional:

> to the extent that they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.[68]

As a result of the Supreme Court ruling, the Canadian government was given twelve months to create new law modifying parts of the criminal code that prohibited medical assistance in dying.[69]

In June 2016, about sixteen months after the Supreme Court handed down its decision in *Carter v. Canada,* the Canadian legislature responded by passing Bill C-14.[70] Bill C-14 formally legalized assisted dying in Canada by creating a MAID regime and establishing the procedural safeguards and eligibility criteria for medically assisted death.[71] Furthermore, Bill C-14 modified the criminal code to exempt medical practitioners and nurse practitioners from a charge of culpable homicide for providing a person with MAID.[72] The bill also extended this exemption to people who assisted medical practitioners and nurse practitioners.[73] Among other aspects, one of the eligibility requirements was

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67. *Id.*

68. Carter v. Canada (Attorney General), 2015 SCC 5, [2015] 1 SCR 331, para. 147 (Can.).

69. *Medical assistance in dying*, GOV'T OF CAN., https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html (July 26, 2022).

70. Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, 1st Sess., 42nd Parl., 2016 (assented to 17th June 2016).

71. Kellner & de Bruin, *supra* note 60.

72. Bill C-14, *supra* note 70.

73. *Id.*

that a "natural death has become reasonably foreseeable."[74] This restriction was the subject of *Jean Truchon and Nicole Gladu v. Attorney General of Canada and Attorney General of Quebec*, a future challenge brought to the Superior Court of Quebec in 2019.[75] Jean Truchon was a fifty-one-year-old man who "suffered from spastic cerebral palsy with triparesis since birth," and Nicole Gladu was a seventy-three-year-old woman who suffered from Polio since she was four and developed other degenerative diseases throughout her life.[76] While both were able to live relatively full lives, their deteriorating illnesses caused them to consider ending their lives.[77] Despite their worsening conditions, each leading to paralysis and loss of autonomy, they were ineligible to receive MAID under the reasonably foreseeable death standard because they would be able to live in their degenerative states for many more years.[78] The court agreed with the challengers, holding that the "reasonably foreseeable" provision was unconstitutional under the Canadian Charter of Rights and Freedoms.[79] In response, the Canadian government introduced further amendments to MAID legislation and on March 17, 2021, those amendments, including the removal of the "reasonably foreseeable" death eligibility requirement, were implemented when Bill C-7 received Royal Assent.[80]

D. Canada's MAID Law Today

Canada's MAID law is statutorily defined in § 241 of Canada's Criminal Code.[81] The country's MAID Law has undergone significant modifications in the past decade, [82] and it is important to understand how it works today in order to see how the United States may be able to leverage its framework. Currently, § 241.1 of Canada's Criminal Code allows two methods of MAID: "[T]he administering by a medical practitioner or nurse practitioner of

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74. *Legislative Background: Medical Assistance in Dying (Bill C-14, as Assented to on June 17, 2016)*, GOV'T OF CAN. (June 2016), https://www.justice.gc.ca/eng/rp-pr/other-autre/adra-amsr/adra-amsr.pdf.

75. *Truchon and Gladu v. Att'y Gen. (Canada) and Att'y Gen. (Quebec)*, 2019 CanLII 3792, (Can. Q.C.C.S.).

76. *Id.* at paras. 17; 51.

77. *Id.* at paras. 48; 61.

78. *Id.* at paras. 35; 63.

79. *Id.* at para. 12.

80. Bill C-7, *supra* note 13.

81. Criminal Code, R.S.C. 1985, c C-46 s 241.

82. *See supra* notes 60-80 and accompanying text.

a substance to a person, at their request, that causes death," or "the prescribing or providing by a medical practitioner . . . or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death."[83] Put simply, the two types of MAID are provider-administered, commonly referred to as euthanasia, or self-administered, commonly referred to as physician-assisted death.[84] Eligible providers include medical practitioners, defined as individuals who are "entitled to practise medicine under the laws of a province" and nurse practitioners, defined as individuals who are "registered nurse[s] who, under the laws of a province, [are] entitled to practise as a nurse practitioner — or under an equivalent designation — and to autonomously make diagnoses, order and interpret diagnostic tests, prescribe substances and treat patients."[85] The remainder of this section will discuss the eligibility requirements, the procedural safeguards, and the review process.

E. Eligibility Requirements of Canada's MAID Law

Criminal Code Section 241.2(1) outlines the eligibility requirements for a person to receive MAID.[86] In order to be eligible for MAID, an individual must:

> [(1)]be eligible . . . for health services funded by a government in Canada; . . . [(2) be] at least 18 years of age and capable of making decisions with respect to their health; . . . [(3)] have a grievous and irremediable medical condition; . . . [(4)] have made a voluntary request for medical assistance in dying that . . . was not made as a result of external pressure; and . . . [(5)] give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.[87]

An individual must meet all five of the eligibility requirements above to utilize medical assistance in their death.[88] § 241.1(2) defines a "grievous and irremediable medical condition" and Bill C-7 required removal of subsection 241.2(2)(d), which contained

83. *Id.* § 241.1.
84. *See* MERRIAM-WEBSTER, *supra* notes 4-5.
85. Criminal Code, *supra* note 81.
86. *Id.* § 241.2(1).
87. *Id.*
88. *Id.*

the "reasonably foreseeable" element previously required to constitute a grievous an irremediable medical condition.[89] There is an exclusion stating that "mental illness is not considered to be an illness, disease or disability"[90] but importantly, those with mental illnesses can still be eligible for MAID if they meet the physical eligibility requirements.[91]

F. Procedural Safeguards of Canada's MAID Law

Bill C-7 resulted in the creation of two tracks to providing MAID, each with their own set of procedural safeguards.[92] The first track is for those situations in which a natural death is reasonably foreseeable, and the second track is for situations in which a natural death is not reasonably foreseeable.[93] There is no set temporal requirement for a reasonably foreseeable death, rather whether there is a sufficient temporal proximity to death is assessed on a case-by-case basis.[94] In addition to sharing the eligibility requirements noted in subsection 241.2(1), shared procedural safeguards between the two tracks include: (1) two medical or nurse practitioners must be of the opinion that the individual satisfies the eligibility requirement, with the second practitioner providing a written opinion of confirmation; (2) the person requesting MAID must have signed and dated their request before an independent witness who must also sign and date the document; (3) the requesting person must be informed that they can withdraw their request at any time; and (4) "immediately before providing the medical assistance in dying, give the person an opportunity to withdraw their request and ensure that the person gives express consent to receive medical assistance in dying."[95]

There are additional procedural safeguards that are specifically required for track two, applying to individuals whose

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89. Bill C-7, *supra* note 13.

90. Criminal Code, *supra* note 81, § 241.2(2.1).

91. *Medical Assistance in Dying (MAiD) and Mental Illness – FAQs*, CAMH (July 2022), https://www.camh.ca/en/camh-news-and-stories/maid-and-mental-illness-faqs - :~:text=Can people with mental illness,meet all the legal criteria.

92. *See* Bill C-7, *supra* note 13.

93. *Id.*

94. GOV'T OF CAN., *supra* note 74.

95. Criminal Code, *supra* note 81, § 241.2(3)(h).

natural death is not reasonably foreseeable.[96] In certain situations, the medical or nurse practitioners will need to consult with experts on the specific condition causing the individual's suffering and ensure that the requesting "person has been informed of the means available to relieve their suffering, including, where appropriate, counselling services, mental health and disability support services, community services and palliative care."[97] Stemming from those discussions, there must also be an agreement between the medical or nurse practitioner that the person has given serious consideration to other means available, and there must be "at least 90 clear days between the day on which the first assessment" is made and when MAID is provided.[98]

Applying only to track one individuals, there is the option for a Final Consent Waiver that allows for a medical or nurse practitioner to administer a substance to a person to cause their death if that person loses the capacity to consent at some point during the process.[99] The waiver must be signed prior to the person losing the capacity to consent and otherwise requires many of the same eligibility requirements.[100] For tracks one and two, there is a permissible advanced request called Advance Consent.[101] This exception was created for situations in which the self-administration of a lethal substance has failed, and the person subsequently lost their ability to consent.[102] Individuals who suffer from a mental illness have their MAID requests subject to independent and Parliamentary Review.[103]

II. ARGUMENTS FOR AND AGAINST AID

The ongoing debate around AID centers primarily on ethical and legal frameworks.[104] In understanding how the law can best approach this complicated issue, it is important to understand

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96. *Id.* § 241.2(3.1).
97. *Id.*
98. *Id.*
99. *Id.*
100. *Id.*
101. *Id.*
102. Criminal Code, *supra* note 81, § 241.2(3.5).
103. Bill C-7, *supra* note 13.
104. Mara Buchbinder, *Access to Aid-in-Dying in the United States: Shifting the Debate From Rights to Justice*, AM. J. OF PUB. HEALTH (June 2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5944872/#.

the arguments for and against AID. The three primary arguments by proponents of AID are patient autonomy, relief of suffering, and safe medical practice.[105] Primary arguments against AID include the Suicide Contagion theory and the Slippery Slope theory that allowance of AID may cause.[106] This section will discuss these arguments in more detail.

A. Arguments in Favor of AID

The argument for patient autonomy centers around the concept of "governance over one's own actions."[107] As mentioned in Part I of this Note, since the 1990s, patients in the US have enjoyed the autonomy in exercising their right to refuse lifesaving medical treatment.[108] Fundamental American values such as freedom of religion, freedom of speech, and political freedom also rest on individual autonomy.[109] Furthermore, a core principle throughout international law is the right to self-determination, referring to an individual's right to "decide their own destiny."[110] Proponents of patient autonomy argue that "patients accustomed to making their own health care decisions throughout life should also be permitted to control the circumstances of their deaths."[111] Providing individuals with autonomy in their own death "provides important psychological benefits" by allowing these individuals more "autonomy, control, and choice."[112] One study of patients who chose physician-assisted suicide under Oregon's Death with Dignity Act found that the "most frequently reported reason[] for choosing PAS under the DWDA [was] 'loss of autonomy' (87%)."[113]

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105. Lydia Dugdale et al., *Pros and Cons of Physician Aid in Dying*, 92 YALE J. OF BIOLOGY AND MED. 747, 748 (Dec. 2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6913818/.

106. *Id.*

107. *Id.*

108. *See* Cruzan, *supra* note 25, at 278.

109. *See The Bill of Rights: A Brief History*, ACLU, https://www.aclu.org/other/bill-rights-brief-history (last visited Oct. 21, 2022).

110. *Self determination (international law)*, LII, https://www.law.cornell.edu/wex/self_determination_(international_law) (last visited Sept. 18, 2022).

111. Dugdale et al., *supra* note 105.

112. Buchbinder, *supra* note 104.

113. E. Dahl & N. Levy, *The case for physician assisted suicide: how can it possibly be proven?*, 32 J. OF MED. ETHICS 335, 335 (June 2006), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2563370/.

Relief of suffering is the second argument that is frequently exercised by people in support of AID.[114] This argument centers around the fundamental reason for healthcare in the first place, which is that the goal of medical treatment is to relieve patients from the suffering of illness and disease.[115] Proponents suggest that if a patient is suffering as they near the end of their life, ending that suffering through ingestion of lethal medication at the request of the suffering individual is humane and compassionate.[116] Opponents of this argument emphasize that the primary goal of healthcare is to promote human life, not end it.[117] This argument focuses on increasing the length of a person's life but often turns a blind eye to the quality of that extended life.

Finally, "safe medical practice" refers to the idea that an individual may choose to end his or her life regardless of whether a physician will be allowed to assist them in their efforts.[118] Suicide is no longer illegal in the United States.[119] In 2020, there were an estimated 1.2 million suicide attempts and 45,979 successful suicides.[120] While suicide is no longer illegal in the US, proponents argue that patients who are suffering from a medical illness and are seeking help through AID deserve to have professional assistance rather than being forced to seek life-ending means for themselves.[121]

B. Arguments Against AID

Two main arguments against AID are the Suicide Contagion theory and the Slippery Slope theory.[122] Suicide Contagion is a theory observing that exposure to suicide or suicidal behaviors can result in an overall societal increase in suicide or suicidal behaviors.[123] This can include direct exposure, such as suicide or

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114. *See* Dugdale, *supra* note 105, at 748.

115. *Id.*

116. *Id.*

117. *Id.*

118. *Id.* at 748-49.

119. Peter Rogatz, *Physician Aid in Dying: Pros and Cons*, THE HUMANIST (Nov.-Dec. 2001), http://endoflifechoicesny.org/wp-content/uploads/2015/08/Physician-Aid-in-Dying-Pros-and-Cons.pdf.

120. *Suicide Statistics*, AM. FOUND. FOR SUICIDE PREVENTION (2020), https://afsp.org/suicide-statistics/ (last visited Sept. 18, 2022).

121. Rogatz, *supra* note 119.

122. Dugdale et al., *supra* note 105.

123. *What does "suicide contagion" mean, and what can be done to prevent it?*, U.S. DEP'T OF HEALTH & HUM. SERV., https://www.hhs.gov/answers/mental-

suicidal behavior within one's family or peer group, or indirect exposure, such as suicide or suicidal behavior observed through the media.[124] Proponents of this argument could point to studies of Oregon's DWDA, which showed an increase in the number of lethal prescriptions written between 1998 to 2014, after the DWDA was enacted.[125] While these statistics are valid, it is important to note that the mere existence and continuation of a mechanism by which individuals can receive legal AID may be a contributing factor to the increase in prescriptions, rather than some form of Suicide Contagion. Furthermore, there is evidence that the way the media reports certain suicides, especially high-profile suicides, can be a factor increasing suicide contagion.[126] Responsible reporting by the media such as providing accurate information, offering suicide help information, and being particularly cautious when reporting high-profile suicides can decrease the risk of suicide contagion.[127]

The Slippery Slope argument refers to the objection that once AID is permitted, "we will find ourselves on a slippery slope leading to coercion and involuntary euthanasia of vulnerable patients."[128] Included in this theory is the idea that once the doors are open to AID, the criteria for eligibility will be continuously and dangerously expanded.[129] This argument purports that the only way to prevent the slippery slope is to prohibit any form of AID.[130] This framework is notably broad and ignores the ability of well-designed procedural safeguards in AID law to protect individuals from the slippery slope.[131] Furthermore, this broad

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health-and-substance-abuse/what-does-suicide-contagion-mean/index.html (last visited Sept. 18, 2022).

124. *Id.*

125. Dugdale et al., *supra* note 105, at 749.

126. *See generally* WORLD HEALTH ORG., PREVENTING SUICIDE: A RESOURCE FOR MEDIA PROFESSIONALS, 2017 UPDATE (2017), https://apps.who.int/iris/bitstream/handle/10665/258814/WHO-MSD-MER-17.5eng.pdf?sequence=1&isAllowed=y.

127. *See id.* at 4-7.

128. Rogatz, *supra* note 119.

129. *See* Dugdale, *supra* note 105, at 749.

130. *See* Rogatz, *supra* note 119 ("[T]he objection is raised that once we open the door to physician-aid-in-dying we will find ourselves on a slippery slope. . . We do not deal with those slippery slopes by prohibition, but rather by adopting reasonable ground rules and setting appropriate limits.").

131. *See id.*

prohibition discounts the legitimate interest of a person seeking AID in favor of a theoretical future harm that could occur.[132]

C. Specific Opposition: Concerns about Equitability

Some opponents of AID predicted that the people most likely to seek PAD in Oregon would be the "poor, the ill-educated, and the uninsured."[133] There is a logical reasoning behind this prediction, which is that those who are poor or uninsured are more likely to be conscious of the financial burden that health care can place on their loved ones. Data coming out of Oregon does not support this prediction.[134] The Oregon Death with Dignity Act "requires the Oregon Health Authority to collect information about the patients and physicians who participate in the Act and to publish an annual statistical report."[135] Information for the 2021 calendar year, published in February 2022, contains the most recent full year of information as well as data for the program since 1998.[136] The report provides statistics for the individual years of 2020 and 2021, aggregate information for 1998–2019, and the total patient population who have died from ingesting a lethal dose of medication between 1998–2021, which was 2,159 patients by the end of 2021.[137] While household income is not reported, education level and insurance status is.[138] In 2021, 71.9 percent of patients had at least some college education and only 3.4 percent had not graduated high school or received their GED.[139] Over the span of the program from 1998–-2021, these numbers were 73 percent and 5.1 percent respectively.[140] Furthermore, 19.8 percent of all patients had a master's degree or higher and 43.9 percent had a bachelor's degree

132. *Id.* "[T]heoretical future harm can be mitigated by establishing appropriate criteria that would have to be met before a patient could receive assistance." *Id.*

133. Dahl & Levy, *supra* note 113.

134. *See generally* OR. HEALTH AUTH. PUB. HEALTH DIV., OREGON DEATH WITH DIGNITY ACT 2021 DATA SUMMARY (2022), https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year24.pdf.

135. *Id.* at 4.

136. Data includes required reporting forms and death certificates received by OHA as of January 21, 2022. *Id.*

137. *Id.* at 5.

138. *Id.* at 10-11.

139. *Id.* at 10.

140. *Id.*

or higher.[141] The information from Oregon indicates that ill-education is not the cause of individuals seeking AID.[142]

As for insurance status, as of 2021, 42.3 percent of all patients throughout the life of the program had private insurance, and 56.7 percent had some form of government provided insurance.[143] Only 0.6 percent were uninsured in 2021 and zero patients were uninsured in 2020.[144] Furthermore, a mere 5 percent of all patients since 1998 reported "[f]inancial implications of treatment" as a reason for participating in the program, a number that has increased slightly in recent years.[145]

III. COMPARISON BETWEEN THE APPROACH IN CANADA AND THE UNITED STATES

The approach of the United States to AID differs from the approach in Canada in a few notable ways. First, through 42 U.S.C.A. § 14401, the US leaves the decision of whether to permit AID to the states.[146] The statute provides that physician-assisted death is illegal unless the states choose otherwise.[147] The lack of a uniform federal regulation in this space means that those states that are interested in legalizing AID must design and pass their own laws and regulations, including eligibility requirements and procedural safeguards.[148] This approach produces a disjointed regulatory system where the law may vary from state to state.[149]

This disjointed regulatory system also means that it is up to the states to determine how to monitor data requirements from such a program, if implemented in the state.[150] Conversely, Canada has enacted MAID law on a federal level.[151] The federal regulation establishes the baseline eligibility criteria and

141. 20.3% reported having some college education and 8.8% reported having an Associate Degree. *Id.*

142. *Supra* notes 139-41 and accompanying text.

143. OR. HEALTH AUTH. PUB. HEALTH DIV., *supra* note 134, at 11.

144. *Id.*

145. Categories for this question were not mutually exclusive. *Id.* In 2021, 8.4% cited "Financial implications of treatment" as a reason for participating in the program. This number is up from 6.6% in 2020. *Id.* at 13.

146. *Supra* note 32.

147. *Id.*

148. *Supra* note 37.

149. *Id.*

150. *Id.*

151. GOV'T OF CAN., s*upra* note 69.

procedural safeguards but tasks the provinces with the delivery and implementation of MAID services in accordance with the Criminal Code.[152] Provincial regulatory bodies can then develop guidelines for clinicians and create review committees to ensure that MAID is being delivered in accordance with federal law.[153] Furthermore, in 2018, the Canadian federal government added Regulations for the Monitoring of Medical Assistance in Dying (SOR/2018-166), which provides a detailed structure for uniform data collection and reporting requirements of physicians and nurse practitioners.[154] This regulation requires specific data points to be collected by all provinces in a consistent manner and "provides a comprehensive picture of the administration of Medical Assistance in Dying (MAID) across the country."[155] These reporting regulations will allow Canada to continuously refine and improve its MAID law while preventing abuse of the system.[156]

Second, 42 U.S.C.A. §14401 explicitly conditions that federal funds cannot be used to support the activities of "assisted suicide, euthanasia, and mercy killing."[157] This means that Medicare will not cover the cost of AID, even in the US jurisdictions where AID is legal.[158] Through the use of the uniform reporting

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152. *Third Annual Report on Medical Assistance in Dying in Canada 2021*, GOV'T OF CAN. (July 2022), https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying/annual-report-2021/annual-report-2021.pdf.

153. *Id.* § 1.2.

154. *Regulations for the Monitoring of Medical Assistance in Dying*, SOR/2018-166 (Can.).

155. GOV'T OF CAN., *supra* note 152, Minister's Message.

156. *See Project Title: Public Reporting as a Quality Improvement Strategy: A systematic review of the multiple pathways public reporting may influence quality of health care*, AGENCY FOR HEALTHCARE RSCH. & QUALITY (Aug. 17, 2011), https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/public-reporting-quality-improvement_research-protocol.pdf ("According to economic theory, public reporting corrects asymmetries in information. Public reporting accomplishes this by making previously unobservable quality of health care more transparent so everyone involved can use the information. . . Public reporting in this context can provide data that translate to goals or targets for practice change and quality improvement and to incentives to improve." *Id.*

157. *Supra* note 31.

158. Buchbinder, *supra* note 104; Medicare is the federal health insurance program that covers individuals over the age of 65 and certain people below 65 with disabilities. *What's Medicare?*, MEDICARE.GOV, https://www.medicare.gov/what-medicare-covers/your-medicare-coverage-choices/whats-medicare (last visited Sept. 18, 2022).

requirements, Canada released data showing that 83.3 percent of MAID cases occurred in people age sixty-five and older.[159] The obvious implication of restricting the use of federal funds for AID is that people who rely on federal or state health insurance may not be given an equitable opportunity to participate in AID, even if they are otherwise eligible.[160] One state, California, budgeted for Seconal (a barbiturate sometimes used in AID) to be covered by the state's Medicaid program, however, not all states have implemented similar measures.[161] About 17.8 percent of people in the US were covered by Medicaid in 2020.[162]

Third, every US jurisdiction that has enacted an AID statute requires that a patient have an irreversible disease that will result in death in six months or less.[163] Conversely, the approach in Canada does not include a strict temporal requirement.[164] As mentioned above, there are two tracks of eligibility for MAID in Canada: one for those whose death is reasonably foreseeable and the other for those whose death is not reasonably foreseeable.[165] Neither of these tracks outline a strict time-based threshold in determining the foreseeability of death.[166]

Fourth, no jurisdiction in the US allows for euthanasia.[167] As a reminder, this refers to the physician or physician equivalent directly administering a lethal dose to a patient. Rather, AID law in the US requires that the patient be able to self-administer the lethal prescription drug.[168] Importantly, the self-

159. GOV'T OF CAN., *supra* note 152, § 4.2.

160. *Supra* note 158; *infra* notes 185-86.

161. Buchbinder, *supra* note 104.

162. Jenny Yang, *Percentage of people covered by medicaid in the United States from 1990 to 2021*, STATISTA (June 20, 2022), https://www.statista.com/statistics/200960/percentage-of-americans-covered-by-medicaid/.

163. End of Life Option Act, CAL. HEALTH & SAFETY CODE § 443.1 (West); Colorado End-of-life Options Act, COLO. REV. STAT. ANN. § 25-48-102 (West); Our Care, Our Choice Act, HAW. REV. STAT. ANN. § 327L-1 (West); Maine Death with Dignity Act, ME. REV. STAT. tit. 22, § 2140 (West); Medical Aid in Dying for the Terminally Ill Act, N.J. STAT. ANN. § 26:16-3 (West); End-of-Life Options Act, N.M. STAT. ANN. § 24-7C-2 (West); Oregon Death with Dignity Act, OR. REV. STAT. ANN. § 127.800 (West); Patient Choice at End of Life, VT. STAT. ANN. Tit. 18, § 5281 (West); The Washington Death with Dignity Act, WASH. REV. CODE ANN. § 70.245.010 (West).

164. GOV'T OF CAN., *supra* note 94.

165. *See* Bill C-7, *supra* note 13.

166. *Id.*

167. *Supra* note 39.

168. Buchbinder, *supra* note 104.

administration requirements in Oregon and Vermont have been interpreted to "permit caregivers to put medication into the patient's g-tube to be ingested, as long as the patient commits the last act of ingesting the medication."[169] However, even this interpretation requires that a patient be able to push the medication through the tube and into their body or swallow medication to facilitate death.[170] For many individuals who would be utilizing AID, this is not an option as these individuals may have lost functionality of their arms or be too weak to push.[171] Conversely, in Canada, a lethal dose or injection may be provided by a physician directly to a patient.[172]

IV. AID LAW REFORM IN AMERICA BASED ON THE CANADIAN MODEL

Although there are some similarities between AID law in the US and MAID in Canada, the US could greatly benefit from incorporating elements of the Canadian model into its own. This section discusses several specific elements the US should consider incorporating as it examines its approach to AID law in the future.

A. Federal Legalization of AID

The easiest and most effective change that the United States could make in its AID law would be to follow Canada's lead and legalize the practice at the federal level. This sweeping change would be impactful in a few ways. First, it would eliminate much of the ambiguity surrounding AID law by providing for a more structured and consistent framework for determining eligibility and administration of AID.[173] The current system in Montana is an example of why this type of change is valuable.[174] Although the current system in Montana is unique, it is not impossible that another state could find itself in a similar "grey zone."[175] Unfortunately, because there is no statutory framework in Montana, physicians who provide AID services to their patients can still be sued or prosecuted and there is no guarantee that their

169. *Id.*
170. *Supra* note 40.
171. *Id.*
172. Criminal Code, *supra* note 81, § 241.1(a)-(b).
173. *Supra* note 36.
174. *Supra* notes 41-59 and accompanying text.
175. *See* Houghton, *supra* note 55.

defense will be successful.[176] This ambiguity makes it risky for physicians to honor the requests of their patients in this area and compels physicians to deny requests from their patients for prescription of lethal medication.[177] Furthermore, the lack of a statutory framework means there is very little procedural structure and a lack of standard reporting requirements, arguably opening the door for abuse of the system.[178] Not only the existence of a statutory framework but also a common framework federally will increase control and standardization across the system.[179]

Second, federal legalization would help to create a standardized reporting mechanism that would be consistent across all states.[180] Opponents of legalizing AID cite concerns over a slippery slope.[181] One way to combat this potential harm is through robust and well-designed reporting procedures, which would be easier to implement and more uniform under centralized federal guidance.[182] The United States should borrow its framework from Canada's Regulations for the Monitoring of Medical Assistance in Dying.[183] The Canadian regulations require data to be collected "on all assessments following a person's request for MAID."[184] All assessments includes requests for MAID, tracking eligibility or ineligibility, withdrawal of a request, administration of the lethal drug or prescription of the drug, whether or not a patient has consumed their prescribed dose, and information about the resulting death if applicable.[185] The Regulations require publication of a monitoring report at least once per year on the Government of Canada website.[186]

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176. *Id.*

177. *Id.*

178. *Supra* note 150.

179. *Supra* note 152-56.

180. *Supra* note 154-55.

181. *See* Dugdale, *supra* note 105, at 749.

182. *Supra* note 152-56.

183. *See generally* GOV'T OF CAN., *supra* notes 152-56.

184. *Medical Assistance in Dying (MAID)*, EHEALTH SASK., https://www.ehealthsask.ca/services/resources/Pages/MAID.aspx (last visited Sept. 18, 2022). "This includes any requests that have not been put in writing or any preliminary assessments that may be undertaken by other health professionals—such as other types of nurses—in the care team or through a care coordination service." *Id.*

185. *Id.*

186. *Regulations for the Monitoring of Medical Assistance in Dying*, *supra* note 154, § 13(1).

Third, federal legalization would promote accessibility of AID across the US.[187] This is one of the more controversial benefits of federal legalization since opponents of AID would prefer to restrict the practice.[188] Equitable accessibility to AID services would help to provide all US residents with even-handed opportunities, regardless of where they reside. Like Canada, legalization of the practice in the United States should consider providers' beliefs and morals and should not obligate any individual to provide AID.[189] The states, like the Canadian provinces, would determine how and where AID services are provided and would be unable to permit actions that would be illegal under the federal criminal code.[190] Despite the outspoken view of opponents, studies show that AID has garnished significant favorability in the US over the past decade.[191] In one such study from 2018, 73 percent of respondents answered "Yes" to the question "When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life by some painless means if the patient and his or her family request it?"[192] Furthermore, majority support for personally wanting the option of AID was bipartisan and nearly equal amongst men and women.[193] Similarly, a 2020 Medscape poll found that 55 percent of the five thousand doctors surveyed said that physician assisted dying should be made legal for terminally ill patients.[194]

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187. *See supra* note 10 (observing that thirty-six states prohibit AID).

188. *See* Brandi McKinnon & Menfil Orellana-Barrios, *Ethics in physician-assisted dying and euthanasia*, THE SW. RESPIRATORY AND CRITICAL CARE CHRONICLES (2019), https://pulmonarychronicles.com/index.php/pulmonarychronicles/article/view/561/1236.

189. GOV'T OF CAN., *supra* note 69.

190. *Id.*

191. COMPASSION & CHOICES, *supra* note 11.

192. Jeff Jones & Lydia Saad, *Gallup Poll and Social Series: Values and Beliefs*, GALLUP NEWS SERV. (May 1-13, 2018), https://news.gallup.com/poll/235178/americans-views-euthanasia-doctor-assisted-suicide-trends.aspx. Results are based on telephone interviews conducted May 1-10, 2018 with a random sample of –1,024—adults, ages 18+, living in all 50 U.S. states and the District of Columbia. *Id.*

193. COMPASSION & CHOICES, *supra* note 9. 65% of Men answered "yes" and 68% of women answered "yes." *Id.* The same was true for 68% of self-identified republicans and 70% of self-identified democrats. *Id.*

194. Shelly Reese, *Medscape Oncology Ethics Report 2020*, MEDSCAPE (Jan. 29, 2021), https://www.medscape.com/slideshow/2020-ethics-rpt-oncology-6013582#5/. Respondents were asked, "should physician assisted dying be

Other national and state specific polls showed similar support for AID.[195]

Finally, federal legalization of AID could provide an easier route to reversing the Federal Assisted Suicide Funding Restriction Act of 1997 and subsequently allow federal funding to be used for AID.[196] This option is discussed further in the section below.

B. Lifting the restriction on government funding for AID

If federal legalization of AID is unachievable, the US government should consider repealing the Federal Assisted Suicide Funding Restriction Act of 1997 thereby allowing for federal funds to be used for AID in states where it is legal.[197] The 1997 Act in effect does not allow for Medicare or Medicaid to be used to pay for AID, even in states where the practice is legal.[198] This is especially important because the vast majority of individuals utilizing AID are above the age of sixty-five and subsequently rely on Medicare.[199] Canada now has five years of MAID data since the practice was officially legalized in 2016,[200] and data from the country's most recent report, the Third Annual Report on Medical Assistance in Dying in Canada 2021, shows that 31,664 patients have died through MAID since mid-2016 with 10,064 deaths reported in 2021.[201] In 2021, the average age at the time of death for these patients was 76.3 years old, slightly higher than in 2019 and 2020.[202] Moreover, 83.3 percent of MAID deaths occurred in individuals over the age of sixty-five.[203]

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made legal for terminally ill patients?" 55% responded "yes," 34% responded "no," and 12% responded "it depends." *Id.*

195. COMPASSION & CHOICES, *supra* note 11.

196. *Infra* notes 30-32.

197. *Supra* notes 31; 158.

198. *Id.*

199. GOV'T OF CAN, *supra* note 159; *infra* notes 203-04.

200. GOV'T OF CAN., *supra* note 152, at § 3.1.

201. *Id.* § 3.0.

202. *Id.* § 4.2. The average age at the time of MAID being provided was 75.2 in 2019 and 75.3 in 2020. *Id.*

203. "The greatest proportion of persons receiving MAID in 2021 were in the 76-80 age group (16.3%), followed by the 71-75 (15.8%) age group and 65-70 (14.7%) age group. This is a slight change from 2020, where the majority of MAID recipients were in the 71-75 (16.2%) age group. Similar to previous years, in 2021 the majority of MAID recipients (95.1%) were age 56 and up,

Data from Oregon paints a similar picture, showing that 80.6 percent of the 238 patients who died through DWDA in 2021 were aged sixty-five years or older.[204] The median age at the time of death was seventy-five.[205] Moreover, roughly 63.8 million people in the United States were enrolled in Medicare in 2020 and about 55.5 million of these people (~86 percent) were beneficiaries due to their age.[206] Due to the Federal Assisted Suicide Funding Restriction Act of 1997, if any of these people were to use AID, their public insurance would not cover the cost.[207] Furthermore, the current US population is aging.[208] "In 2020, about 16.9 percent of the American population was 65 years old or over; a figure which is expected to reach 22 percent by 2050."[209] The aging population means that over the next thirty years significantly more people are likely be covered under federal or state funded health insurance.[210] Continuing to prohibit federal funds from being used in AID, in conjunction with the trend toward legalization of the practice, will exacerbate the already evident inequitable access to the service.

One assumption of expanding federal funding is that there will be an increased cost to the federal government, and subsequently taxpayers, however, this is not necessarily the case.[211]

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with 83.3% who were age 65 and older. Only 4.9% of recipients were between the ages of 18 and 55." *Id.*

204. OR. HEALTH AUTH. PUB. HEALTH DIV., *supra* note 134, at 10.

205. *Id*.

206. *Enrollment in the Medicare program from 1966 to 2021, by type of beneficiary*, STATISTA (June 2022), https://www.statista.com/statistics/237045/us-medicare-enrollment-figures/.

207. *See* 42 U.S.C.A. § 14401(b).

208. *Demographic Changes and Aging Population*, RURAL HEALTH INFO. HUB, https://www.ruralhealthinfo.org/toolkits/aging/1/demographics#:~:text=The%20U.S.%20population%20is%20aging,grow%20to%20almost%2090%20million.&text=This%20means%20by%202030%2C%201,65%20years%20old%20and%20over (last visited Sept. 18, 2022). "Today, there are more than 46 million older adults age 65 and older living in the U.S.; by 2050, that number is expected to grow to almost 90 million." *Id*.

209. *Demographic Changes and Aging Population*, STATISTA (Oct. 28, 2021), https://www.statista.com/statistics/457822/share-of-old-age-population-in-the-total-us-population/.

210. *Supra* note 162.

211. *See What options would increase federal revenues?*, TPC, https://www.taxpolicycenter.org/briefing-book/what-options-would-increase-federal-revenues (last visited Oct. 21, 2022) (explaining that tax revenues can be increased by increasing tax rates). Additional funding required from the

In fact, access to AID may reduce health care costs in the aggregate.[212] In 2020, the Parliamentary Budget Officer (PBO) released a report in response to a request from a Senator to estimate the financial cost of Bill C-7.[213] In doing so, the PBO found that under the then current MAID legislation of Bill C-14, the total net reduction in health care costs for 2021 would be $86.9 million.[214] By expanding MAID eligibility under Bill C-7, the total net reduction in health care costs in 2021 is estimated to be $149 million CAD.[215] The PBO notes one reason for this cost reduction: "Many studies have shown that health care costs in the last year of life (and especially in the last month of life) are disproportionately high, representing between 10% and 20% of total health care costs despite these patients representing about 1% of the population."[216] There is no suggestion here that AID should be expanded to reduce health care costs. In fact, the $149 million CAD "only represents 0.08% of total provincial health care budgets for 2021."[217] Rather the data is provided to show that there would not necessarily be an added cost to taxpayers if federal funding of AID were allowed.

C. Legalizing Euthanasia

The final recommendation for the US is to consider following Canada by allowing for a physician to administer a lethal medication directly to a patient, specifically in situations in which the

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budget may require tax rates to be increased in order to bring in that additional revenue. *Id.*

212. *Infra* notes 214-16.

213. *See* Govindadeva Bernier, *Cost Estimate for Bill C-7 "Medical Assistance in Dying"*, THE PARLIAMENTARY BUDGET OFFICER (Oct. 20, 2020), https://www.pbo-dpb.gc.ca/web/default/files/Documents/Reports/RP-2021-025-M/RP-2021-025-M_en.pdf. "The Parliamentary Budget Officer (PBO) supports Parliament by providing economic and financial analysis for the purposes of raising the quality of parliamentary debate and promoting greater budget transparency and accountability." *Id.*

214. *Id*. These figures are in Canadian Dollars (CAD). One CAD equals $0.78 USD as of November 28, 2021, meaning that 86.9 million CAD would be roughly 68 million USD. https://www.google.com/intl/en/googlefinance/disclaimer/.

215. Bernier*, supra* note 213.

216. *Id*. When looking at end of life costs, the PBO assumed, based on previous years MAID data, that 14% of MAID patients will see their life shortened by 2 weeks, 25% by one month, 45% by three months, 13% by six months and 3% by a year. *Id*.

217. *Id*.

patient cannot do so themselves.[218] One noteworthy element of current AID law in America is that it requires the patient to ingest the medication on their own.[219] For patients with deteriorating neurological conditions, such as ALS, the task of swallowing may be difficult or impossible.[220] Furthermore, patients with neurological issues may also be unable to push the medication through their g-tube due to severe motor issues or full paralysis.[221] Neurological conditions accounted for 12.4 percent of MAID deaths in Canada in 2021, up from 10.2 percent in 2020.[222] Data from Oregon's 2021 report show that neurological disease accounted for 14.7 percent of DWDA deaths, up from 8.1 percent in 2020.[223] The reality is that degenerative neurological illnesses can prevent people from self-administering a lethal dose—even when creative processes of self-administration are available—thus preventing these individuals from having access to the same medical choices as others.[224] Expanding this option has the potential to be very impactful to a subset of individuals seeking AID, however, it also has a potential for abuse and any legal framework will require careful preparation and scrutiny.

CONCLUSION

Proponents of AID in the United States certainly have an uphill battle ahead if they wish to expand the availability of the

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218. "(a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death." Criminal Code, *supra* note 81, § 241.1(a)-(b).

219. *Supra* notes 39-40.

220. *Amyotrophic Lateral Sclerosis (ALS) Fact Sheet*, NIH (May 26, 2021), https://www.ninds.nih.gov/Disorders/Patient-Caregiver-Education/Fact-Sheets/Amyotrophic-Lateral-Sclerosis-ALS-Fact-Sheet.

221. *See* Parrot & Wood, *supra* note 40. Washington State requires patients to self-administer the life-ending medication. *Id.* "Some patients develop progressive weakness (e.g., those with neuromuscular diseases) or obstruction (e.g., from esophageal cancer) making them unable to swallow a half-cup of medicine." *Id.*

222. GOV'T OF CAN., *supra* note 153, § 4.1.

223. OR. HEALTH AUTH. PUB. HEALTH DIV., *supra* note 134, at 12.

224. Parrot & Wood, *supra* note 40. For patients who have been eating through a feeding tube, the medication must be self-administered into the feeding tube by the patient or a rectal tube can also be used. *Id.* "For tube self-ingestion, the patient must either push the plunger on 1-2 syringe(s) containing the suspended medicine for ingestion, or open a clamp or valve to allow the medicine to flow from a gravity bag into the feeding tube or rectal catheter." *Id*.

practice. In fact, in 2017, the federal government attempted to block Washington, D.C.'s Death with Dignity Act, but ultimately failed.[225] While most states have laws prohibiting AID,[226] the trend towards legalization of the practice seems unavoidable.[227] Support for the practice is increasing and this year alone, at least fourteen states are considering legislative action related to AID.[228] It is crucial that the US establish comprehensive eligibility and procedural criteria to guarantee that individuals who qualify for AID receive it, while also preventing abuse of the system by both patients and providers. The US has an opportunity to save itself time and resources by learning from Canada and borrowing elements of Canadian MAID law when structuring its own federal approach.

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225. *What is the Future of 'Death with Dignity' Laws in Trump Era?*, HEALTHLINE (Oct. 2018), https://www.healthline.com/health-news/death-with-dignity-laws-in-trump-era#Secular-vs.-sectarian.

226. PROCON.ORG, *supra* note 10.

227. *Supra* notes 191-95; *infra* note 228.

228. *Bills We Are Tracking*, DEATH WITH DIGNITY, https://deathwithdignity.org/in-your-state/_(last visited Aug. 2, 2022). Both supportive and restrictive legislative action. *Id.*

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To those who may be struggling with a medical condition mentioned herein or are considering ending their lives for other reasons, please understand that this Note is not meant to encourage or suggest that you should pursue such actions. Instead, it is meant to provide information and policy arguments for why individuals should have the right to make their own decisions about their end-of-life experience, including the option to consider assisted death if they choose. Please remember that there are resources available to help you cope with difficult situations and make informed decisions about your care. I would be honored if this Note helped to promote future policy initiatives aimed at expanding Aid in Dying services in the United States.