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Featured Article

Medical Aid in Dying: Key Variations Among U.S. State Laws

Thaddeus Mason Pope

ABSTRACT: Medical aid in dying (MAID) is legal in eleven U.S. jurisdictions representing one-fourth of the U.S. population, but despite its legality, MAID is practically available to only a subset of qualified patients in these states. MAID's eligibility requirements and procedural safeguards may impede a patient's access. In response, state legislatures have begun to craft more flexible rules as they recalibrate the balance between safety and access. There is already significant variability among U.S. MAID statutes in terms of eligibility requirements, procedural conditions, and other mandates. While the Oregon Death with Dignity Act has served as the template for all subsequent MAID statutes, the states have not copied the Oregon law exactly. Furthermore, this nonconformity grows as states continue to engage in an earnest and profound debate about the practicality of MAID.

Thaddeus Mason Pope, *Medical Aid in Dying: Key Variations Among U.S. State Laws*, J. Health and Life Sci. L., Oct. 2020, at 25.

MAID Variations Among U.S. State Laws

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INTRODUCTION

Medical Aid in Dying (MAID) is an end-of-life option that has been spreading across the United States.[1] It provides assurance that a terminally ill patient can die when she wants based on her own criteria and enjoy life for a longer period of time. Twenty years ago, MAID was available in only one state.[2] Ten years ago, it was available in only two states.[3] Today, MAID is available in eleven U.S. jurisdictions that comprise 25% of the U.S. population.[4]

The expansion of MAID is notable not only for its size but also for its pace. States have been legalizing MAID at an increasingly accelerated speed. Five of today's eleven MAID jurisdictions enacted their statutes in the past four years. Six jurisdictions enacted statutes within the past five years. Two states enacted statutes in 2019 alone,[5] and half of the remaining forty states considered MAID legislation in 2020.[6]

Because of growing public and legislative interest in MAID, it is useful to identify and assess lessons that can be drawn from the existing laws. The eleven MAID jurisdictions have taken three different legal paths to legalization: (1) legislative, (2) judicial, and (3) standard of

1 MAID is also known as "aid in dying," "physician assisted death" "death with dignity," and "voluntary assisted dying." Alan Meisel et al., The Right to Die: The Law of End-of-Life Decisionmaking § 12.04 (3rd ed. 2020). MAID is sometimes referred to as "physician assisted suicide," but that term is generally disfavored because of the strong association of suicide with mental illness. In addition, suicide is typically compulsive, not planned, and suicidal individuals are typically not terminally ill. Press Release, Am. Ass'n of Suicidology, Statement of the American Association of Suicidology: "Suicide" Is Not the Same As "Physician Aid in Dying" (Oct. 30, 2017), https://suicidology.org/wp-content/uploads/2019/07/AAS-PAD-Statement-Approved-10.30.17-ed-10-30-17.pdf.

2 In 1994, Oregon voters approved a ballot initiative enacting the Orgon Death with Dignity Act. *See* Thaddeus Pope, *Legal History of Medical Aid in Dying: Physician Assisted Death in U.S. Courts and Legislatures*, 48 N.M. L. Rev. 267 (2018), https://digitalrepository.unm.edu/nmlr/vol48/iss2/6/; Alan Meisel, *A History of the Law of Assisted Dying in the United States* 73 SMU L. Rev. 119 (2020), https://scholar.smu.edu/smulr/vol73/iss1/8/.

3 In 2008, Washington voters approved a ballot initiative enacting the Washington Death with Dignity Act. *See* Pope, *supra* note 2.

4 *See infra* notes 9, 42, and 47 (collecting citations for California, Colorado, Hawaii, Maine, Montana, New Jersey, North Carolina, Oregon, Vermont, Washington, and Washington, DC). The population of these eleven states totals 82 million. That is 25% of the U.S. population, 330 million. *QuickFacts: United States,* U.S. Census Bureau, https://www.census.gov/quickfacts/fact/map/US/PST045219 (last visited Sept. 8, 2020).

5 Maine Death with Dignity Act, Me. Stat. tit. 22, § 2140 (2020); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-1 to -20 (2020).

6 Eighteen state legislatures considered bills to legalize MAID in 2020. Ariz. H.B. 2582 (2020); S.B. 1384, 54th Leg., 2nd Sess. (Ariz. 2020); H.B. 5420, Gen. Assemb., Feb. Sess. (Conn. 2020); H.B. 140, 150th Gen. Assemb. (Del. 2020); S.B. 1800 (Fla. 2020); Ga. S.B. 291 (2020); H.B. 1020, 121st Gen. Assemb., 2nd Reg. Sess. (Ind. 2020); Iowa S.F. 2156 (2020); S.B. 2156, 88th Gen. Assemb. (Iowa 2020); H.B. 224, Reg. Sess. (Ky. 2020); Md. H.B. 643 (2020); Md. S.B. 701 (2020); H.B. 2152, 91st Leg. (Minn. 2020); S.B. 2286, 91st Leg. (Minn. 2020); N.H. H.B. 1659 (2020); A.B. 2694, Reg. Sess. (N.Y. 2019); H.B. 2033, Reg. Sess. (Pa. 2020); H.B. 7369, Gen. Assemb. (R.I. 2020); H.B. 93, Gen. Sess. (Utah 2020); H.B. 1649 (Va. 2020); A.B. 552 (Wis. 2019); S.B. 499 (Wis. 2020). Some of these bills might have been enacted but for the COVID-19 pandemic. *Legislative Sessions and the Coronavirus,* Nat'l Conference of State Legislatures (Sept. 10, 2020), https://www.ncsl.org/research/about-state-legislatures/legislative-sessions-and-the-coronavirus.aspx. Commentators expect that the next states to enact MAID statutes will be Maryland, Massachusetts, New Mexico, and New York.

care[7]—but most have taken a legislative approach.[8] Nine jurisdictions authorize and regulate MAID through a detailed statute.[9] All nine of these statutes have many common features.

Commentators incessantly emphasize this resemblance. Referencing Oregon, the first state to enact a MAID statute, commentators frequently say that all U.S. MAID laws "have similar provisions based on the Oregon model."[10] Some law professors write that the states have taken a "follow the leader approach."[11] Some write that the states mimic the Oregon "model" or "template."[12] Others write that U.S. MAID laws "closely mirror," "follow" "parrot," or "pattern" the Oregon Act.[13]

However, these commentators overstate the point with this Xerox-like language. While U.S. MAID statutes may copy the Oregon model, they do not copy it exactly. Their approach is better described as "imitation" rather than as "duplication." The nine MAID statutes are not identical. There are material variations among them.[14] This Article identifies and contrasts these differences.

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7 *See* Pope, *supra* note 2.

8 *Id.*

9 End of Life Option Act, Cal. Health & Safety Code §§ 443.1–.22 (2020); Colorado End-of-life Options Act, Colo. Rev. Stat. §§ 25-48-101 to -123 (2020); Death with Dignity Act of 2016, D.C. Code §§ 7-661.01–.16 (2020); Our Care, Our Choice Act, Haw. Rev. Stat. §§ 327L-1 to -25 (2020); Me. Stat. tit. 22, § 2140; N.J. Stat. §§ 26:16-1 to -20; Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.800–.897 (2020); Vt. Stat. Ann. tit. 18, §§ 5281–93 (2020); Washington Death with Dignity Act, Wash. Rev. Code §§ 70.245.010-.220–.904 (2020). One of the best places for tracking the history and status of MAID law is the website of the Death with Dignity National Center and Death with Dignity Political Fund: Death with Dignity, http://www.deathwithdignity.org (last visited Sept. 10, 2020).

10 Queensland Parliament, Health, Cmtys., Disability Servs. & Domestic & Family Violence Prevention Comm., Rep. No. 34, 56th Parliament, Voluntary Assisted Dying 35 (2020), https://www.parliament.qld.gov.au/Documents/TableOffice/TabledPapers/2020/5620T490.pdf [hereinafter Rep. No. 34].

11 Ben White & Lindy Willmott, *Now that VAD Is Legal in Victoria, What Is the Future of Assisted Dying Reform in Australia?*, ABC, June 24, 2019, https://www.abc.net.au/religion/the-future-of-assisted-dying-reform-in-australia/11242116.

12 *See, e.g., id;* Anita Hannig, *Assisted Dying Is Not the Easy Way Out*, The Conversation, Feb. 18, 2020; Pamela S. Kaufmann, Death with Dignity: A Medical-Legal Perspective, AHLA Long-Term Care and the Law Meeting (Feb. 22, 2017), https://theconversation.com/assisted-dying-is-not-the-easy-way-out-129424.

13 Cody Bauer, *Dignity in Choice: A Terminally Ill Patient's Right to Choose*, 44 Mitchell Hamline L. Rev. 1024, 1036 (2018), https://open.mitchellhamline.edu/cgi/viewcontent.cgi?article=1138&context=mhlr; Edward Davies, *Assisted Dying: What Happens after Vermont?*, 346 Brit. Med. J. f4041 (2013); Arthur Svenson, *Physician-Assisted Dying and the Law in the United States: A Perspective on Three Prospective Futures, in* Euthanasia and Assisted Suicide: Global Views on Choosing to End Life 13 (Michael J. Cholbi ed. 2017), https://publisher.abc-clio.com/9781440836800/14; Taimie Bryant, *Aid-in-Dying Nonprofits*, 57 San Diego L. Rev. 147, 181 n.154 (2020), https://digital.sandiego.edu/cgi/viewcontent.cgi?article=3207&context=sdlr; Mary C. Deneen, *Bioethics—"Who Do They Think They Are?": Protecting Terminally Ill Patients Against Undue Influence by Insurers in States Where Medical Aid in Dying Is Legal*, 42 W. New Eng. L. Rev. 63, 76 (2020), https://digitalcommons.law.wne.edu/cgi/viewcontent.cgi?article=1832&context=lawreview ("All nine jurisdictions with MAiD statutes provide similar provisions . . . ."). *See also* Rep. No. 34, at 35 ("Eight other states followed Oregon with similar laws....").

14 This exemplifies the role of states as "laboratories" that try novel social experiments. *See* Wash. v. Glucksberg, 521 U.S. 702, 737 (1997) (O'Connor, J., concurring) (citing New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting)).

In Section One, the author defines MAID and describes its place in end-of-life health care. Section Two describes non-statutory approaches to legalizing MAID that two states have taken. The remainder of the Article focuses on the nine statutes and describes three types of variations.

Section Three describes two variations in eligibility requirements. These differences concern which patients are qualified to receive MAID. The states vary both in how they assess the patient's state residency and in how they assess the patient's decision-making capacity. Section Four describes three variations in procedural requirements. These differences concern how patients obtain and take MAID prescriptions. The states vary in the permitted routes of drug administration and in the duration of the oral and written request waiting periods. Section Five describes five other variations. The states vary in how they permit clinicians and facilities to opt-out; how they permit telehealth; and how they collect and report data. The states also vary in whether they include a sunset clause.

Finally, in Section Six, the author identifies imminent variations in U.S. MAID laws. During the first two decades of U.S. MAID, policymakers placed heavy emphasis on safety at the expense of access. Today, more states are working to recalibrate the balance between safety and access. Consequently, over the next several years, one can expect additional variations among state MAID laws.

Two innovations are particularly likely. First, all states now require the attending and consulting clinician to be a physician; however, some states will probably extend MAID to advanced practice registered nurses (APRNs). Second, all states now require that the patient be terminally ill with a prognosis of six months or less, but some states will probably extend that to twelve months or longer.

MEDICAL AID IN DYING

Before comparing differences among MAID laws, it is important to first clarify what MAID is. Why would someone hasten their own death? How do they do that with MAID? Who is using this end-of-life option?

Why Hasten One's Death?

There are many circumstances under which a longer life is not a better life. When quality of life diminishes, some individuals would prefer to hasten death (or at least not prolong dying)

rather than endure the perils of what, at least to them, is an exceedingly poor quality of life.[15] What exactly comprises a "poor quality of life" covers a broad spectrum that varies significantly from person to person.

For some, loss of independence might diminish quality of life to the point where they would request a hastened death.[16] For others, it may be extreme physical suffering. For these and other reasons, requests to hasten death are common throughout the United States and the world. As Justice Brennan observed, "[f]or many, the thought of an ignoble end, steeped in decay, is abhorrent."[17]

Many seriously ill patients find their lives marked with extreme suffering and both physical and mental deterioration. Unfortunately, many do not have access to a medically supervised, peaceful death. Too many patients commit suicide through violent means such as shooting, hanging, or various other forms of self-deliverance.[18] Moreover, being uncertain about their future options and being worried about future loss of dignity, comfort, and control, many patients hasten their deaths prematurely.[19] Medical aid in dying (MAID) provides an alternative: the assurance that terminally ill patients can die when they want based on their own criteria and can enjoy life for a longer period of time.[20]

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15 *See* Janet L. Abrahm, *Patient and Family Requests for Hastened Death*, 2008 Hematology 475, 475 (2008), https://ashpublications.org/hematology/article/2008/1/475/95873/Patient-and-Family-Requests-for-Hastened-Death ("Patient and family requests for hastened death are not uncommon among patients with advanced malignancies."); Linda Ganzini et al., *Oregonians' Reasons for Requesting Physician Aid in Dying*, 169 Archives Internal Med. 489, 489 (2009), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/414824 ("One in 10 dying patients will, at some point, wish to hasten death."); Jean-Jacques Georges et al., *Requests to Forgo Potentially Life-Prolonging Treatment and to Hasten Death in Terminally Ill Cancer Patients: A Prospective Study*, 31 J. Pain & Symptom Mgmt. 100, 104 (2006), https://www.jpsmjournal.com/action/showPdf?pii=S0885-3924%2805%2900631-7; Joan McCarthy et al., *Irish Views on Death and Dying: A National Survey*, 36 J. Med. Ethics 454, 456 fig. 2 (2010) (finding that a majority of individuals strongly agreed with the statement, "If I were severely ill with no hope of recovery, the quality of my life would be more important than how long it lasted."); Diane E. Meier et al., *A National Survey of Physician-Assisted Suicide and Euthanasia in the United States*, 338 New Eng. J. Med. 1193, 1195 (1998), https://www.nejm.org/doi/pdf/10.1056/NEJM199804233381706?articleTools=true.

16 For years, the three most frequently reported end-of-life concerns of patients using MAID have been (1) decreasing ability to participate in activities that made life enjoyable, (2) loss of autonomy, and (3) loss of dignity. Oregon Health Auth., Public Health Div., Oregon Death with Dignity Act: 2019 Data Summary 6 (2020), https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf.

17 Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 310 (1990) (Brennan, J., dissenting).

18 Peter M. Marzuk, *Suicide and Terminal Illness*, 18 Death Stud. 497, 500 (1994); Matthew Miller et al., *Cancer and the Risk of Suicide in Older Americans*, 26 J. Clinical Oncology 4720, 4722 (2008), https://ascopubs.org/doi/pdf/10.1200/JCO.2007.14.3990.

19 Ladislav Volicer et al., *Assistance with Eating and Drinking Only When Requested Can Prevent Living with Advanced Dementia*, 20 J. Am. Med. Directors Ass'n 1353 (2019).

20 *See* Benzi M. Kluger, *Medical Aid in Living*, JAMA Neurology (Aug. 24, 2020); Stanley A. Terman, The Best Way to Say Goodbye: A Legal Peaceful Choice at the End of Life 326 (Ronald B. Miller & Michael S. Evans eds., 2007).

Certainly, life is valuable, and societal values reinforce attempting to extend life indefinitely. However, death is unavoidable. People suffering from the diseases that cause the most deaths in this country will often experience significant suffering and/or loss of independence.[21] In this situation, the preference, for some, may be to hasten death so that death can be on the individual's own terms and with some predictability, rather than risk the unknown and potential loss of comfort and dignity.[22] Advocates often remark that MAID does not result in more people dying, just in fewer people suffering.

What Is MAID?

MAID is one key last resort "exit option."[23] With MAID, a physician writes a prescription for life-ending medication for an adult patient who is terminally ill and mentally capacitated.[24] The practice has long-standing and well-defined conditions regarding patient eligibility, the role of physicians, and the role of the patient.

Indeed, since the practice is so tightly regulated, the standard of care maps onto the statutory requirements. All nine U.S. MAID statutes have nearly identical conditions and safeguards.[25] Regarding eligibility, the patient must: (1) be over 18 years of age, (2) have decision making capacity, (3) be able to take the medication, and (4) be terminally ill, meaning that they have a prognosis of six months or less.[26]

Regarding physician practice, both the treating physician and a consulting physician must: (1) confirm that the patient satisfies all the eligibility conditions; (2) inform the patient about risks, benefits, and alternatives; and (3) confirm the patient's request for the medication is a settled and voluntary decision. If either the treating or consulting physician suspects that

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21 Judith K. Schwarz, *Stopping Eating and Drinking*, 109 Am. J. Nursing 52, 53–54 (2009).

22 Hastening Death by Voluntarily Stopping Eating and Drinking: Clinical, Ethical, and Legal Dimensions (Timothy Quill et al. eds., Oxford Univ. Press, forthcoming 2021); Thaddeus Mason Pope & Lindsey E. Anderson, *Voluntarily Stopping Eating and Drinking: A Legal Treatment Option at the End of Life*, 17 Widener L. Rev. 363 (2011). Most suffering can be alleviated through palliative care. Therefore, MAID is really for the subset of cases where palliative care is insufficient. As palliative care's toolbox expands, the demand for MAID may diminish. *Cf.* Kathryn L. Tucker, *Oregon's Pioneering Effort to Enact State Law to Allow Access to Psilocybin, a New Palliative Care Tool*, Willamette L. Rev. (forthcoming 2020).

23 *See* Timothy E. Quill et al., *Palliative Options of Last Resort: A Comparison of Voluntarily Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Active Euthanasia*, *in* Giving Death a Helping Hand: Physician-Assisted Suicide and Public Policy: An International Perspective 49 (Dieter Birnbacher & Edgar Dahl eds., 2008).

24 David Orentlicher et al., *Clinical Criteria for Physician Aid in Dying*, 19 J. Palliative Med. 259, 259 (2016).

25 Thaddeus Mason Pope, *Medical Aid in Dying: When Legal Safeguards Become Burdensome Obstacles*, ASCO Post (Dec. 25, 2017); Thaddeus M. Pope, *Current Landscape: Implementation and Practice*, Nat'l Acads. of Scis., Eng'g, & Med. Health & Med. Div. (Feb. 12, 2018), https://www.youtube.com/watch?v=yI58KsPl-HM. While Montana and North Carolina have no MAID statute. But the conditions and safeguards are similar. *See infra* notes 65 to 71.

26 Alan Meisel et al., The Right to Die: The Law of End-of-Life Decisionmaking § 12.04[C] (3rd ed. 2020).

the patient's judgment is impaired, then they must refer the patient for a mental health assessment by a third clinician.[27]

Once the physician writes the prescription, the patient may obtain the medication. Traditionally, the medication has been secobarbital or pentobarbital, a barbiturate originally developed as a sleeping pill.[28] However, price increases and supply problems have led physicians to prescribe other drugs.[29] These include compounded ones like D-DMA or DDMP2.[30] Importantly, the patient must ingest the drugs herself.[31] The patient alone takes the final overt act that causes her death.[32]

Who Uses MAID?

The United States has over sixty years of experience with MAID, when one sums the experience of each state where MAID has been available.[33] Data on most of that experience has been systematically collected and reported by both state departments of health and by academic researchers.[34] They show that physicians wrote prescriptions for over 5,000 individuals. Many

27 *Id*. *But see infra* notes 75 to 78 (explaining how Hawaii requires an automatic mental health assessment for everyone).

28 April Dembosky, *Drug Company Jacks Up Cost of Aid-In-Dying Medication*, NPR (Mar. 23, 2016, 3:24 PM), https://www.npr.org/sections/health-shots/2016/03/23/471595323/drug-company-jacks-up-cost-of-aid-in-dying-medication.

29 Catherine Offord, *Accessing Drugs for Medical Aid-in-Dying*, Scientist (Aug. 16, 2017), https://www.the-scientist.com/?articles.view/articleNo/49879/title/Accessing-Drugs-for-Medical-Aid-in-Dying/.

30 D-DMA entails Digitalis 30 minutes before Diazepam, Morphine, and Amitriptyline. DDMP2 uses Propranolol but results in a longer average time to death. *See, e.g.,* Anita Hannig, *The Complicated Science of a Medically Assisted Death*, Quillette (Mar. 18, 2020), https://quillette.com/2020/03/18/the-complicated-science-of-a-medically-assisted-death/; Christopher Harty et al., Canadian Ass'n of MAiD Assessors & Providers, The Oral MAiD Option in Canada: Part 1: Medication Protocols: Review and Recommendations (2018), https://camapcanada.ca/wp-content/uploads/2019/01/OralMAiD-Med.pdf.

31 Amanda M. Thyden, *Death with Dignity and Assistance: A Critique of the Self-Administration Requirement in California's End of Life Option Act*, 20 Chapman L. Rev. 421, 421 (2017).

32 *See infra* notes 97 to 101.

33 California (2015); Colorado (2016); DC (2017); Hawaii (2018); Maine (2019); Montana (2009); North Carolina (2019); New Jersey (2019); Oregon (1997); Vermont (2017); Washington (2008). There is a longer history of "underground" physician-assisted death. *See generally* Diane E. Meier et al., *A National Survey of Physician-assisted Suicide and Euthanasia in the United States*, 338 New Eng. J. Med 1193 (1998); Ezekiel J. Emanuel et al., *Attitudes and Practices of U.S. Oncologists Regarding Euthanasia and Physician-Assisted Suicide*, 133 Annals Internal Med. 527 (2000); Damien Pearse, *Michael Caine: I Asked Doctor to Help My Father Die,* Guardian (Oct. 8, 2010, 7:56 PM), https://www.theguardian.com/film/2010/oct/09/michael-caine-father-assisted-suicide#:~:text=Sir%20Michael%20Caine%20has%20revealed,he%20agrees%20with%20voluntary%20euthanasia. Because this practice is not transparent, it is not properly described as "MAID."

34 *See infra* notes 168 to 173. *See also* Luai Al Rabadi et al., *Trends in Medical Aid in Dying in Oregon and Washington*, 2 JAMA Network Open 1/7 (2019), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2747692; Charles Blanke et al., *Characterizing 18 Years of the Death with Dignity Act in Oregon*, 3 JAMA Oncology 1403 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5824315/; Huong Q. Nguyen et al., *Characterizing Kaiser Permanente Southern California's Experience with the California End of Life Option Act in the First Year of Implementation*, 178 JAMA Internal Med. 417 (2018).

patients get MAID prescriptions for their peace of mind, to have as "insurance" just in case their condition becomes intolerable. Since that intolerability often does not happen, only 70% of patients take their prescription.[35]

Nearly 90% of these 5,000 terminally ill patients had cancer or amyotrophic lateral sclerosis (ALS).[36] Other terminally ill patients with cardiovascular, respiratory, or other illnesses have rarely used MAID. The average age has been 74, and over 90% were on hospice.[37] Most were college educated.[38] Patients receiving MAID prescriptions have been almost evenly split male and female, but they have been overwhelmingly white even in racially diverse states like California.[39]

NON–STATUTORY APPROACHES

Most states have legalized MAID through a statute enacted either through the legislature or through a ballot initiative.[40] Those nine statutes are the primary focus of this Article. For the sake of completeness, however, the reader should recognize that two other states took a non-statutory approach. Montana legalized MAID through a court decision, and North Carolina took a "standard of care" approach.[41]

Montana

Montana law has long permitted one individual to help another person hasten death with consent, so long as that assistance is not against public policy.[42] In 2009, the Montana Supreme Court held that this exception in the homicide law applies to MAID. Therefore, a physician will not be subject to prosecution for prescribing medication to bring about the peaceful death of a competent terminally ill patient.[43] Relying upon this decision, patients and physicians participate in MAID in Montana.[44]

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35 Compassion & Choices, Medical Aid in Dying: A Policy to Improve Care and Expand Options at Life's End (2020), https://compassionandchoices.org/wp-content/uploads/Medical-Aid-in-Dying-report-FINAL-2-20-19.pdf.

36 *Id.*

37 *Id.*

38 *Id.*

39 *Id.*

40 *See supra* notes 9, 42, and 47; Pope, *supra* note 2.

41 The Montana court only removed the criminal prohibition. It did not supply any standards or rules. Therefore, the practice in Montana is properly described as a standard of care approach. *Cf.* Kathryn L. Tucker, *Aid in Dying in Montana: Ten Years after State v. Baxter,* 81 Mont. L. Rev. 207 (2020); Kathryn L. Tucker, *Give Me Liberty at My Death: Expanding End-of-Life Choice in Massachusetts*, 58 N.Y. L. Sch. L. Rev. 259 (2013/14). North Carolina is different because there is no statute, regulation, or court decision authorizing MAID. North Carolina might be described as taking a "pure" standard of care approach.

42 Mont. Code. Ann. § 45-2-211 (2020).

43 Baxter v. State, 224 P.3d 1211 (Mont. 2009).

44 *Hearing on H.B. 284 Before the H. Judicial Comm.* (Mont. 2019); Eric Kress, *Thoughts from A Physician Who Prescribes Aid in Dying*, Missoulian (Apr. 7, 2013), https://missoulian.com/news/opinion/columnists/thoughts-from-a-physician-who-prescribes-aid-in-dying/article_07680d28-9e0b-11e2-84f1-001a4bcf887a.html; Kathryn L. Tucker, *Aid in Dying in Montana: Ten Years after State v. Baxter,* 81 Mont. L. Rev. 117 (2020).

The Montana Supreme Court declared the permissibility of MAID for capacitated, terminally ill adult individuals, but it otherwise provided no rules or standards. In the following eleven years, neither the legislature nor the health care licensing boards filled this gap and provided rules and standards. The notable consequence is that Montana does not formally require the procedural requirements that are present in the nine statutory states.[45] Still, since MAID, like any medical practice, is governed by the standard of care, Montana guidelines are probably similar to the rules in the statutory states.[46]

North Carolina

Montana is not the only state to take a non-statutory approach to legalizing MAID. Some commentators argue that MAID is legal in North Carolina for the same reason that it is legal in Montana.[47] While there is no state supreme court decision addressing the question in North Carolina, there is arguably no need for such a decision. In North Carolina, as in Montana, MAID is not prohibited under current law. Therefore, like most areas of medical practice, it is permitted so long as it complies with the standard of care.[48]

Given the well-known legal risk averseness of clinicians, a standard of care approach might seem quixotic. Will physicians really write lethal prescriptions without the bright line clarity and permission of black letter law? In fact, the answer may be "yes." In closely analogous areas of end-of-life medicine such as Physician's Orders for Life-Sustaining Treatment (POLST), legal experts also recommend a non-statutory, standard of care approach.[49] Such an approach has been working in states like Minnesota where clinicians both write and follow these transportable do-not-resuscitate orders.[50]

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45 *See infra* §§ III to V.

46 David Orentlicher et al., *Clinical Criteria for Physician Aid-in-Dying*, 19 J. Palliative Med. 259 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4779271/pdf/jpm.2015.0092.pdf.

47 *See, e.g.*, John Carbone et al., *Aid in Dying in North Carolina*, 80 N.C. Med. J. 128 (2019), https://www.ncmedicaljournal.com/content/ncm/80/2/128.full.pdf; Kathryn L. Tucker, *Aid in Dying in North Carolina*, 97 N.C. L. Rev. Addendum 1 (2019); Jeffrey Segal, *Can NC Physicians Legally Prescribe Meds to Suffering Terminally Ill Patients to Precipitate a Peaceful Death?*, Med. Just. (Jan. 12, 2019), https://medicaljustice.com/can-nc-physicians-legally-prescribe-meds-to-suffering-terminally-ill-patients-to-precipitate-a-peaceful-death/. *But see* Bryant A. Murphy et al., *No Consensus on AID, But We Can Agree on Palliative Care*, 81 N.C. Med. J. 213 (2020), https://www.ncmedicaljournal.com/content/81/3/213.

48 Kathryn L. Tucker, *Vermont Patient Choice at End of Life Act: A Historic Next Generation Law Governing Aid in Dying*, 38 Vt. L. Rev. 687 (2014); Daniel Schweppenstedde et al., RAND Europe, Regulating Quality and Safety of Health and Social Care International Experiences 13 (2014), https://www.rand.org/pubs/research_reports/RR561.html. Of course, North Carolina physicians must also comply with many other rules like those from the state Board of Medicine.

49 Charles P. Sabatino & Naomi Karp, AARP Pub. Policy Inst., Improving Advanced Illness Care: The Evolution of State POLST Laws 17, 45 (2011), https://polst.org/wp-content/uploads/2016/06/POLST-Report-04-11.pdf; National POLST Paradigm, POLST Legislative Guide 24 (2014).

50 Alan Meisel et al., The Right to Die: The Law of End-of-Life Decisionmaking § 7.10A (3rd ed. 2020) [hereinafter The Right to Die].

Other Non–Statutory Approaches

While Montana and North Carolina are the only current MAID states that have taken a non-statutory approach, other states previously attempted to follow this pathway.[51] For example, before enacting a statute in 2018, Hawaii attempted to follow a standard of care approach like North Carolina.[52] Vermont nearly took the opposite approach of following a standard of care approach ***after*** enacting a statute. The Vermont Patient Choice at End of Life Act originally included a sunset clause for the procedural requirements. Had that clause not been later repealed, Vermont MAID would have been governed by the standard of care.[53] Finally more than a dozen other states tried (albeit unsuccessfully) to legalize MAID through a court decision like Montana.[54]

VARIATIONS IN ELIGIBILITY REQUIREMENTS

Montana and North Carolina are the exceptions. Nine of eleven U.S. MAID jurisdictions authorize MAID with a statute. Because all nine of these statutes are based on the Oregon "model," they are quite similar, but these nine MAID statutes are not 100% identical. They vary along three dimensions in terms of (1) eligibility requirements, (2) procedural requirements, and (3) other dimensions. Eligibility requirements are addressed in this section, and other variations are addressed in the next two sections.

To qualify for MAID a patient must satisfy several eligibility requirements. She must be (1) an adult, (2) who is terminally ill, (3) a state resident, (4) with decision-making capacity. Every MAID statute includes these four requirements, but they differ in how they measure the last two and in how they mandate assessment of the patient's residency and capacity.

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51 Kathryn L. Tucker & Christine Salmi, *Aid in Dying: Law, Geography and Standard of Care in Idaho*, Advocate, at 1-8 (2010); S.B. 1070, 61st Leg., 1st Reg. Sess. (Idaho 2011), https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2011/legislation/S1070E1.pdf.

52 Kathryn L. Tucker, *Aid in Dying: An End of Life-Option Governed by Best Practices,* 8 J. Health & Biomed. L. 9 (2012), https://cpb-us-e1.wpmucdn.com/sites.suffolk.edu/dist/e/1232/files/2016/12/Aid-in-Dying-An-End-of-Life-Option-Governed-by-Best-Practices.pdf. *See also* Morris v. Brandenburg, 356 P.3d 564, 570 (N.M. 2015); Kevin B. O'Reilly, *5 Hawaii Doctors Offer Assisted Suicide to Terminally Ill Patients*, Am. Med. News (Apr. 17, 2012), https://amednews.com/article/20120417/profession/304179996/8/. *But cf.* Jim Mendoza, *AG Denounces Aid in Dying Ad*, Haw. News Now (Sept. 24, 2013), https://www.hawaiinewsnow.com/story/23521488/ag-denounces-aid-in-dying-ad/.

53 The Right to Die, § 12.02.

54 *See* Pope, *supra* note 2. One such lawsuit is currently on appeal. Kligler v. Healey, No. 2016-03254-F (Mass. Super. Ct. Dec. 31, 2019), https://compassionandchoices.org/wp-content/uploads/Kliger-Memorandum-of-Decision-and-Order-wm.pdf.

State Residency: How to Prove It?

Every MAID statute requires that the terminally ill, adult patient be a resident of that state.[55] For example, the California End of Life Options Act (EOLOA) provides that only "qualified individuals" can access MAID and that only residents of California are qualified individuals.[56]

While every state requires residency, they vary in terms of what evidence is enough to prove it. Most states permit the following four documents to prove state residency:

1. Possession of a driver license or other state-issued identification
2. Registration to vote
3. Evidence that the person owns or leases property in the state
4. Filing of a state return for the most recent tax year[57]

Some statutes specify fewer types of evidence as sufficient to establish residency. For example, Washington permits only the first three.[58] Other states specify more than these four types of evidence, such as Maine, which permits five additional types of evidence.[59] Washington, D.C. lists twelve additional types of evidence, and requires that the patient submit at least two of them.[60]

The ease with which a patient can prove state residency is important. Because only nine jurisdictions have MAID statutes, patients regularly move from non-MAID jurisdictions to MAID jurisdictions.[61] For example, Brittany Maynard, one of the most famous people to use

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55 End of Life Option Act, Cal. Health & Safety Code §§ 443.1(o), 443.2(a)(3) (2020); Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-102(13) (2020); Death with Dignity Act of 2016, D.C. Code § 7-661.01(13) (2020); Our Care, Our Choice Act, Haw. Rev. Stat. § 327L-1 (2020); Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(2)(K), (15) (2020); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. § 26:16-3 (2020); Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.800(11), .805 (2020); Vt. Stat. Ann. tit. 18, § 5281(8) (2020); Washington Death with Dignity Act, Wash. Rev. Code §§ 70.245.010(11), .020(1) (2020).

56 Cal. Health & Safety Code §§ 443.1(o), 443.2(a)(3).

57 *Id.* § 443.2(a)(3); Colo. Rev. Stat. § 25-48-102(14); Haw. Rev. Stat. § 327L-13; N.J. Stat. § 26:16-11; Or. Rev. Stat. § 127.860. The Vermont statute does not specify what makes someone a Vermont resident, but the state Department of Health specifies these same four factors. Vt. Dep't of Health, Act 39 Frequently Asked Questions https://www.healthvermont.gov/sites/default/files/documents/pdf/Act39_faq.pdf.

58 Wash. Rev. Code § 70.245.130. While Washington lists only three documents, it also permits other "[f]actors demonstrating Washington state residency". *Id.*

59 Me. Rev. Stat. Ann. tit. 22, § 2140(15) (also including: the location of a dwelling currently occupied by the person; place where a motor vehicle is registered; address where mail is received, address shown on a hunting or fishing license, receipt of public benefits conditioned upon residency, and any other objective facts tending to indicate a person's place of residence).

60 D.C. Health, Death with Dignity: Patient Education Module (Apr. 26, 2018), https://dchealth.dc.gov/sites/default/files/dc/sites/doh/page_content/attachments/Death%20with%20Dignity%20-%20Education%20Modules.Patient.DC%20HEALTH%20Version.04.26.18.pdf (including: utility bill, telephone bill, mail from a government agency, or student loan statement).

61 *See, e.g.,* Kevin Roster, Opinion, *I'm Dying from Cancer. I Have to Move Across the Country to Die on My Own Terms*, USA Today, June 7, 2019, https://www.usatoday.com/story/opinion/2019/06/07/medical-aid-dying-face-death-own-terms-column/1365567001/.

MAID, moved to Oregon specifically for the purpose of establishing residency and thus eligibility for MAID.[62] This is a form of medical tourism.[63] Because these patients are terminally ill, they must quickly acquire the necessary documents to prove state residency.

Capacity Assessments: Two or Three?

Every MAID statute requires not only that the patient be a terminally ill adult state resident but also that the patient have decision-making capacity. This means two things: first, it means that the patient can understand the significant benefits, risks, and alternatives to MAID, and second, it means that the patient can make and communicate an informed health care decision.[64]

To confirm the patient's capacity, every statute requires at least two assessments by two different physicians.[65] Both an attending physician and a consulting physician must "[d]etermine that the individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision."[66]

If both the attending and consulting physicians are sure that the patient has capacity, then she is qualified. If either the attending or consulting physician is sure that the patient lacks capacity, then she is not qualified. However, if either the attending or consulting physician is unsure or has concerns about the patient's capacity, then they must refer the patient for a third capacity assessment.[67]

For example, the California End of Life Options Act states: "If there are indications of a mental disorder, refer the individual for a mental health specialist assessment."[68] The District of Columbia statute mandates referral when the attending or consulting physician suspects a "psychiatric or psychological disorder or depression causing impaired judgment."[69]

The clinician who performs this third capacity assessment is a mental health specialist, usually a psychiatrist, psychologist, or clinical social worker. They must determine whether

62 Nicole Weisensee Egan, *Terminally Ill Woman Brittany Maynard Has Ended Her Own Life*, People, May 9, 2017, https://people.com/celebrity/terminally-ill-woman-brittany-maynard-has-ended-her-own-life/.

63 *See* I. Glenn Cohen, Patients with Passports: Medical Tourism, Law, and Ethics ch.8 (2014).

64 End of Life Option Act, Cal. Health & Safety Code § 443.1(c) (2020).

65 Our Care, Our Choice Act, Haw. Rev. Stat. §§ 327L-4, -5 (2020).

66 Cal. Health & Safety Code §§ 443.6(c), .8(c)-(d). Some states use the terms "competent" or "capable."

67 Cal. Health & Safety Code §§ 443.5(a)(1), .6(d); Colorado End-of-life Options Act, Colo. Rev. Stat. §§ 25-48-106, -107 (2020); Death with Dignity Act of 2016, D.C. Code § 7-661.03–.04 (2020); Haw. Rev. Stat. § 327L-1; Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(6)–(7) (2020); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-6, -8 (2020); Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.815, .820, .825 (2020); Vt. Stat. Ann. tit. 18, § 5283(a)(8) (2020); Washington Death with Dignity Act, Wash. Rev. Code §§ 70.245.040, .060 (2020).

68 Cal. Health & Safety Code §§ 443.5(a)(1)(A)(ii), .6(d).

69 D.C. Code § 7-661.03–.04.

the patient "is mentally capable and making an informed decision."[70] They do this by determining whether the patient is suffering from impaired judgment due to a mental disorder.[71]

However, decades of government-collected and reported data show that physicians rarely refer patients for this third capacity assessment. Attending and consulting physicians refer only 4% of patients who receive a MAID prescription.[72] Consequently, few MAID patients receive a mental health specialist capacity assessment.[73] Some commentators suggest that this rate may be too low.[74]

But not in Hawaii, where capacity assessment works differently. In Hawaii, every MAID patient gets a third capacity assessment.[75] It is not contingent or conditional on the judgment of the attending or consulting physician. It is automatically and always required.[76] Recognizing that making a terminally ill patient obtain a third clinical assessment could be burdensome, Hawaii

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70 Colo. Rev. Stat. § 25-48-108.

71 Cal. Health & Safety Code § 443.7; Colo. Rev. Stat. § 25-48-108; D.C. Code § 7-661.01(4); Haw. Rev. Stat. § 327L-6; Me. Rev. Stat. Ann. tit. 22, § 2140(8); N.J. Stat. Ann. § 26:16-8; Or. Rev. Stat. § 127.825; Vt. Stat. Ann. tit. 18, § 5283(8); Wash. Rev. Code § 70.245.060.

72 Oregon Health Auth., Public Health Div., Oregon Death with Dignity Act: 2019 Data Summary 11 (2020), https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf; Wash. State Dep't of Health, Disease Control & Health Statistics, Ctr. for Health Statistics, DOH 422-109, 2018 Death with Dignity Act Report (2019), https://www.doh.wa.gov/YouandYourFamily/ IllnessandDisease/DeathwithDignityAct/DeathwithDignityData. Notably, Canada has a similarly low referral rate. James Downar et al., *Early Experience with Medical Assistance in Dying in Ontario, Canada: A Cohort Study,* 192 Canadian Med. Ass'n J. E173 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7043822/pdf/192e173.pdf. Not every state reports data on the rate of mental health referrals. *See infra* note 170.

73 *See generally* Lois A. Weithorn, *Psychological Distress, Mental Disorder, and Assessment of Decisionmaking Capacity Under U.S. Medical Aid in Dying Statutes*, 71 Hastings L.J. 637 (2020), http://www.hastingslawjournal.org/wp-content/uploads/Weithorn_Psychological-Distress-Mental-Disorder-and-Assessment-of-Decisionmaking-Capacity-Under-U.S.-Medical-Aid-in-Dying-Statutes.pdf; Brian D. Carpenter & C. Caroline Merz, *Assessment of Capacity in Medical Aid in Dying, in* Assessing Capacities of Older Adults: A Casebook to Guide Difficult Decisions 243 (Jennifer Moye ed., 2020).

74 *See, e.g.,* Linda Ganzini, *Legalised Physician-Assisted Death in Oregon*, 16 QUT L. Rev. 76 (2016), https://www.deathwithdignity.org/wp-content/uploads/2015/11/623-2243-1-PB-1.pdf; Linda Ganzini & Anthony L. Back, *The Challenge of New Legislation on Physician-Assisted Death*, 176 JAMA Intern Med. 427 (2016); Council on Psychiatry and Law, APA Resource Document on Physician Assisted Death 11-12, 16 (2017).

75 While not legally required in any state except Hawaii, some institutions in other states automatically require a third capacity assessment in their own policies. For example, while California law does not automatically require a third capacity assessment, individual facilities like UCSF do. *See, e.g.,* Barbara Koenig, *Reflections on Preparing for And Responding to Legalization in California, in* Physician-Assisted Death: Scanning the Landscape: Proceedings of a Workshop 89–98 (2018); James A. Bourgeois et al., *Physician-Assisted Death Psychiatric Assessment: A Standardized Protocol to Conform to the California End of Life Option Act*, 59 Psychosomatics 441 (2018), https://escholarship.org/uc/item/7xj942bb.

76 Haw. Rev. Stat. §§ 327L-4(a)(5), -4, -6.

permits it to be performed not only by a physician but also by a psychologist or clinical social worker.[77] Hawaii also permits this third capacity assessment to be performed through telehealth.[78]

VARIATIONS IN PROCEDURAL REQUIREMENTS

MAID statutes vary not only in their eligibility requirements (like residency and capacity) but also in their procedural requirements that dictate how qualified patients may access MAID. Every state requires that the patient: (1) make two oral requests, (2) make one written request, and (3) take the prescription drug themselves. However, the states differ on the details. They vary on the duration of mandated waiting periods between oral requests, the duration of mandated waiting period after the written request, and on the routes by which the drug may be administered.

Oral Request Waiting Period: 0, 15, or 20 Days?

Every MAID statute requires that the patient make two oral requests for MAID. Every statute further requires that those two requests be separated by at least fifteen days.[79] For example, California mandates that "[a]n individual seeking to obtain a prescription for an aid-in-dying drug . . . shall submit two oral requests, a minimum of 15 days apart. . . ."[80] This is designed to assure that the request reflects a considered and voluntary choice by the patient.[81]

While 15 days is the most common duration, some states have longer waiting periods, and some have potentially shorter waiting periods. For example, the Hawaii Our Care, Our Choice

77 *Id*. § 327L-1. Some propose extending this to also include psychiatric mental health nurse practitioners. *Testimony Before the S. Comm. on Commerce, Consumer Protection, and Health* (Haw. 2020), https://www.capitol.hawaii.gov/Session2020/Testimony/SB2582_TESTIMONY_CPH_02-04-20_.PDF.

78 Haw. Rev. Stat. § 327L-1.

79 End of Life Option Act, Cal. Health & Safety Code § 443.3(a) (2020); Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-104(1) (2020); Death with Dignity Act of 2016, D.C. Code § 7-661.02(a)(1) (2020); Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(11)–(13) (2020); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-10 (2020); Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.840, .850 (2020); Vt. Stat. Ann. tit. 18, § 5283(a)(2) (2020); Washington Death with Dignity Act, Wash. Rev. Code §§ 70.245.090, .110(1) (2020).

80 Cal. Health & Safety Code § 443.3(a). Some clinicians have taken the patient's request on the fifteenth day after the first request, but the plain language of every statute requires that the patient make the second request on the sixteenth day or later. Colo. Rev. Stat. § 25-48-104(1) ("separated by at least fifteen days"); D.C. Code § 7-661.02(a)(1) ("separated by at least 15 days"); N.J. Stat. Ann. §§ 26:16-10 ("at least 15 days shall elapse"); Or. Rev. Stat. §§ 127.840, .850 ("no less than 15 days after"); Vt. Stat. Ann. tit. 18, § 5283(a)(2) ("[n]o fewer than 15 days"); Wash. Rev. Code §§ 70.245.090, .110(1) ("at least fifteen days after").

81 State laws often require waiting periods for major life-impacting decisions like abortion, sterilization, marriage, divorce, and adoption. *See* Paul Stam, *Woman's Right to Know Act: A Legislative History*, 28 Issues L. & Med. 3, 66 (2012).

Act requires that the patient's oral requests be separated by at least twenty days, instead of just fifteen days.[82] Hawaii has the longest required waiting period in the United States.[83]

Oregon took the opposite approach, shortening rather than lengthening its waiting period. Between 1994 and 2019, the Oregon Death with Dignity Act required a 15-day waiting period, and this was the model followed by every other state except Hawaii. Effective January 1, 2020, however, Oregon amended its statute to permit waiver of the entire 15 days when the patient will not survive that long.[84]

> [I]f the qualified patient's attending physician has medically confirmed that the qualified patient will, within reasonable medical judgment, die within 15 days after making the initial oral request under this section, the qualified patient may reiterate the oral request to his or her attending physician ***at any time*** after making the initial oral request.[85]

Consequently, an imminently dying patient in Oregon could make both her first and second oral requests on the same day (with no waiting period).

Other states are looking to follow Oregon's lead.[86] They are apparently motivated by significant evidence demonstrating that the 15-day waiting period impedes patient access to

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82 Haw. Rev. Stat. §§ 327L-2, -9 & -11.

83 Mara Buchbinder & Thaddeus M. Pope, *Medical Aid in Dying in Hawaii: Appropriate Safeguards or Unmanageable Obstacles?*, Health Aff. Blog (Aug. 13, 2018) [hereinafter Buchbinder & Pope]. In fact, it often takes Hawaii patients 34 days to navigate the process. *See, e.g., Testimony in SUPPORT of HB 2451 RELATING TO HEALTH* Before the H. Comm. on Health (Haw. 2020) (statement of the State of Hawaii Department of Health), https://www.capitol.hawaii.gov/session2020/testimony/HB2451_TESTIMONY_HLT_01-31-20_.PDF [hereinafter *Testimony in SUPPORT of HB 2451 RELATING TO HEALTH*]; *Testimony in SUPPORT of SB 2582 RELATING TO HEALTH Before the S. Comm. on Commerce, Consumer Protection, & Health* (Haw. 2020) (statement of the State of Hawaii Department of Health), https://www.capitol.hawaii.gov/session2020/testimony/SB2582_TESTIMONY_CPH_02-04-20_.PDF [hereinafter *Testimony in SUPPORT of SB 2582 RELATING TO HEALTH*]. A significant number of patients die before the end of the 20-day waiting period. *Id.* (statement of Charles F Miller, Director, Kaiser Hawaii Medical Aid in Dying Program).

84 S.B. 579, 80th Leg. Assemb., Reg. Sess., 2019 Laws Ch. 624, https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/SB579/Enrolled.

85 Or. Rev. Stat. § 127.840(2) (emphasis added); see also *id.* § 127.850(2).

86 *See, e.g.,* H.B. 2739 (Haw. 2020), https://www.capitol.hawaii.gov/session2018/bills/HB2739_HD1_.pdf; Dep't of Health Office of Planning, Policy, & Program Dev., Report to the Thirtieth Legislature State of Hawaii 2020: Pursuant to Act 2 Session Laws of Hawaii 2019 (HB2739 H.D. 1) (2019), https://health.hawaii.gov/opppd/files/2020/01/OPPPD-Our-Care-Our-Choice-Act-Annual-Report-2019-3.pdf; H.B. 2419, 66th Leg., Reg. Sess. (Wash. 2020), http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/House%20Passed%20Legislature/2419-S.PL.pdf?q=20200913182845; H.B. 171, 53rd Leg., 1st Sess. (N.M. 2017), https://www.nmlegis.gov/Sessions/17%20Regular/bills/house/HB0171.pdf; S.B. 252, 53rd Leg., 1st Sess. (N.M. 2017), https://www.nmlegis.gov/Sessions/17%20Regular/bills/senate/SB0252.pdf, https://www.nmlegis.gov/Sessions/17%20Regular/bills/senate/SB0252.pdf. *See also* Voluntary Assisted Dying Act 2019 § 48(2)(b) (W. Austl. 2019), https://www.legislation.wa.gov.au/legislation/prod/filestore.nsf/FileURL/mrdoc_42491.pdf/$FILE/Voluntary%20Assisted%20Dying%20Act%202019%20-%20%5B00-00-00%5D.pdf?OpenElement.

MAID.[87] Many terminally ill patients do not begin exploring the option until late in their illness trajectory. By that point, they have little remaining time and cannot survive 15 days.[88] For example, one California study shows that one-fourth of patients died or lost capacity during the waiting period.[89] Similarly, in Canada, which has only a 10-day waiting period, more than one-fourth of patients cannot wait even that long.[90]

Written Request Waiting Period: 0 or 48 Hours?

Every MAID statute requires not only that the patient make two oral requests but also that they make a written request.[91] Patients must make this written request on a specified form.[92] Furthermore, just as there is a waiting period between the two oral requests, some states require a 48-hour waiting period between the written request and the writing of the prescription.[93] For example, the New Jersey statute provides: "[A]t least 48 hours shall elapse between the attending physician's receipt of the patient's written request and the writing of a prescription . . . ."[94]

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87 *See, e.g., Testimony in SUPPORT of HB 2451 RELATING TO HEALTH*; *Testimony in SUPPORT of SB 2582 RELATING TO HEALTH*.

88 Buchbinder & Pope, *supra* note 83.

89 Huong Q. Nguyen et al., *Characterizing Kaiser Permanente Southern California's Experience with the California End of Life Option Act in the First Year of Implementation*, 178 JAMA Internal Med. 417 (2018).

90 James Downar et al., *Early Experience with Medical Assistance in Dying in Ontario, Canada: A Cohort Study,* 192 Canadian Med. Ass'n J. E173 (2020). *See also* Debbie Selby et al., *Medical Assistance in Dying (MAiD): A Descriptive Study from a Canadian Tertiary Care Hospital*, 37 Am. J. Hospice & Palliative Med. 58 (2020) (10 days reduced 39% of the time). Lori Seller et al., *Situating Requests for Medical Aid in Dying Within the Broader Context of End-of-Life Care: Ethical Considerations*, 45 J. Med. Ethics 106 (2019); Health Canada, First Annual Report on Medical Assistance in Dying in Canada: 2019, at 6 (2020), https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying-annual-report-2019/maid-annual-report-eng.pdf (26.5% did not result in a MAID death, because the patients died before receiving MAID). Canadian law permits a waiver of the waiting period if the patient will die or lose capacity before that. S.C. 2016, C-14 (Can.), https://laws-lois.justice.gc.ca/PDF/2016_3.pdf.

91 End of Life Option Act, Cal. Health & Safety Code § 443.3(b) (2020); Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-104 (2020); Death with Dignity Act of 2016, D.C. Code § 7-661.02 (2020); Our Care, Our Choice Act, Haw. Rev. Stat. §§ 327L-2, -9 (2020); Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(4)–(5), (24) (2020); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-4 (2020); Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.810 (2020); Vt. Stat. Ann. tit. 18, § 5283(a)(4) (2020); Washington Death with Dignity Act, Wash. Rev. Code §§ 70.245.030, .090 (2020).

92 Cal. Health & Safety Code § 443.11; Colo. Rev. Stat. § 25-48-112; D.C. Code § 7-661.02(b)–(c); Haw. Rev. Stat. §§ 327L-2, -23; Me. Rev. Stat. Ann. tit. 22, § 2140; N.J. Stat. Ann. §§ 26:16-5, -20; Or. Rev. Stat. §§ 127.810, .897; Wash. Rev. Code § 70.245.220. The Vermont statute does not specify a form, but the state Department of Health has designed forms. https://www.healthvermont.gov/systems/end-of-life-decisions/patient-choice-and-control-end-life. There is variability regarding who may serve as a witness.

93 D.C. Code § 7-661.02(a)(2); Haw. Rev. Stat. § 327L-11; Me. Rev. Stat. Ann. tit. 22, § 2140(13); N.J. Stat. Ann. § 26:16-10; Or. Rev. Stat. § 127.850(1); Wash. Rev. Code § 70.245.110(2). California and Colorado do not require a 48-hour waiting period after the written request. Oregon's waiver of the oral request waiting period also permits waiver of the written request waiting period. Or. Rev. Stat. §§ 127.840(2), .850(2).

94 N.J. Stat. Ann. §§ 26:16-10(a)(6).

Unlike the oral request waiting period, this 48-hour requirement typically does not delay patient access, because this waiting period can run concurrent to the oral request waiting period. For example, the patient could make both her first oral request and her written request on January 1.[95] She could make her second oral request on January 16 and receive a prescription that same day. In this example, the patient satisfies ***both*** the oral and written request waiting period requirements in just 15 days.

However, this is not possible in Vermont. There, the written request waiting period runs consecutively to, not concurrently with, the oral request waiting period. The Vermont Patient Choice at End of Life Act requires that the physician not write the prescription until at least 48 hours "after the last to occur" whether that is the patient's written request or the patient's second oral request.[96] Therefore, the minimum total waiting period in Vermont is 17 days. This is the second longest mandatory waiting period after Hawaii's 20 days.

Route of Drug Administration: GI or IV?

MAID statutes vary not only on the duration of oral and written request waiting periods but also in exactly how the patient can take the prescription drug. Every MAID statute requires that the patient herself take the lethal medication. The patient must take the final overt act causing her death. Accordingly, the California End of Life Options Act requires that the patient "has the physical and mental ability to self-administer the aid-in-dying drug."[97] After all, nobody else may administer it to her or for her.[98]

If the physician or another individual administered the lethal medication to the patient, that would be euthanasia.[99] That is not permitted in any U.S. jurisdiction. Legalizing euthanasia has not even been proposed in any U.S. jurisdiction for over thirty years.[100] Self-administration is a consistent centerpiece of U.S. MAID laws.[101]

But while the MAID statutes uniformly require patient self-administration, they use different verbs to describe how the patient may take the drug. Five statutes use the word

95 There is some variability regarding when the patient may make her written request. Most states permit it after both physicians have confirmed eligibility. New Jersey permits it at the time of the first oral request. *Id.* §§ 26:16-10(a)(3). The District of Columbia permits it between the first and second oral requests. D.C. Code § 7-661.02(a)(2).

96 Vt. Stat. Ann. tit. 18, § 5283(a)(12).

97 Cal. Health & Safety Code § 443.2(a)(5).

98 Confusingly, the term "MAID" in Canada refers to both patient self-administration and to clinician administration (euthanasia). *See* S.C. 2016, C-14 (Can.), https://laws-lois.justice.gc.ca/PDF/2016_3.pdf.

99 Compassion in Dying v. Wash., 79 F.3d 790, 840 (9th Cir. 1996) (Beezer, J., dissenting) ("Euthanasia occurs when the physician actually administers the agent which causes death.").

100 Pope, *supra* note 2.

101 In contrast, Belgium, Canada, and the Netherlands also permit clinician administration. Australian jurisdictions permit clinician administration only when self-administration is not possible. *See Legislative Background: Medical Assistance in Dying (Bill C-14, as Assented to on June 17, 2016)*, Can. Dep't of Justice, https://www.justice.gc.ca/eng/rp-pr/other-autre/adra-amsr/toc-tdm.html (last modified Jan. 23, 2017).

"ingest."[102] California, for example, requires that the individual "self-administer" the drug which means the "individual's affirmative, conscious, and physical act of administering and ***ingesting*** the aid-in-dying drug to bring about his or her own death."[103] Indeed, the California's End of Life Option Act (EOLOA) uses the term "ingest" fifteen times to refer to the manner by which the patient must take the drug.[104]

This language is legally and practically significant. The term "ingest" indicates that the route of administration is gastrointestinal.[105] This usually means the patient will drink the medication from a cup or straw.[106] But some patients cannot consume the medication orally. Fortunately, for them, there are two other ways to "ingest" drugs. Patients dependent upon clinically assisted nutrition and hydration can press a plunger on a feeding tube.[107] Other patients can press the plunger on a rectal tube.[108]

With any of these three modes of ingestion, clinicians or family members can assist the patient (for example, by opening the medication, by mixing it in a cup, or by inserting a tube), but the patient herself must make the drug enter her body. The California End of Life Options Act emphasizes the distinction between preparing the drug and ingesting the drug. "A person who is present may, without civil or criminal liability, ***assist*** the qualified individual by ***preparing*** the aid-in-dying drug so long as the person does not assist the qualified person in ingesting the aid-in-dying drug."[109] Without this language, preparing the drugs would probably constitute felony assisted suicide.[110]

The remaining four states do not use the word "ingest." Instead, they use broader language like "take"[111] "administer"[112] or "self-administer."[113] Again, this language is legally and practically

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102 End of Life Option Act, Cal. Health & Safety Code § 443.1(p); Death with Dignity Act of 2016, D.C. Code §§ 7-661.05(f) & (h)–(i), .09(b), .12, .13(b) (2020); Oregon Death with Dignity Act, Or. Rev. Stat. § 127.875 (2020); Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(2)(L) (2020); Washington Death with Dignity Act, Wash. Rev. Code § 70.245.010(12) (2020).

103 Cal. Health & Safety Code § 443.1(p) (emphasis added).

104 *Id. passim.*

105 United States v. Ten Cartons, 888 F. Supp. 381, 393–94 (E.D.N.Y. 1995), *aff'd*, 72 F.3d 285 (2d Cir. 1995).

106 This is usually a powder mixed with liquid. David Orentlicher et al., *Clinical Criteria for Physician Aid in Dying*, 19 J. Palliative Med. 259 (2016); McGehee v. Hutchinson, No. 4:17-cv-00179, ¶ 310 (E.D. Ark. May 31, 2020).

107 *Id.* ¶ 309.

108 Email from Kimberly Kirchmeyer, Executive Director of the Medical Board of California, to Gary Johanson, MD (Sept. 6, 2016); Thalia DeWolf, *Rectal Administration of Aid-in-Dying Medications*, Am. Clinicians Acad. on Med. Aid in Dying, https://www.acamaid.org/rectal-administration-of-aid-in-dying-medications/ (last visited Sept. 14, 2020).

109 Cal. Health & Safety Code § 443.14(a) (emphasis added).

110 *See* Cal. Penal Code § 401 (2020) ("Any person who deliberately aids . . . another to commit suicide is guilty of a felony.").

111 Our Care, Our Choice Act, Haw. Rev. Stat. § 327L-1 (2020) (defining "self-administer" to means an "individual performing an affirmative, conscious, voluntary act to ***take into the individual's body*** prescription medication to end the individual's life") (emphasis added).

112 Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-3 (2020).

113 Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-102(7), (15) (2020); Vt. Stat. Ann. tit. 18, § 5284 (2020).

significant. These verbs permit routes of administration other than gastrointestinal.[114] Most notably, these other statutes permit intravenous administration. So, rather than having to administer the medication through the gut, the patient can inject it with a needle into a vein.[115]

This is important for two reasons. First, some patients cannot effectively take the drugs through a gastrointestinal route.[116] They may have a bowel obstruction, poor absorption, or uncontrolled vomiting. While ingestion may be possible it is not as effective as intravenous administration, especially for these patients.[117] Second, intravenous administration is safer and faster. The rate of complications (like regurgitation) from ingestion is significant in "ingest only" states like Oregon.[118] These complications could be substantially reduced with intravenous administration.[119]

Furthermore, IV administration is workable. Patients self-administer antibiotics and other medications through IV at home.[120] Evidence on this practice shows that home IV therapy is

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114 *See, e.g.,* Texas Controlled Substances Act, Tex. Health & Safety Code § 481.002 (2020) (defining 'administer" to include "injection, inhalation, ingestion, or other means").

115 Bettie Lilley Nosek & Deborah Trendel-Leader, IV Therapy For Dummies (2012). Note that intravenously administered medication would not be the same medication as that which patients orally ingest. Indeed, U.S. clinicians have not yet worked out protocols and procedures for IV self-administration.

116 *Hearing on H.B. 2217 Before the S. Comm. on Judiciary* (Ore. 2019), https://olis.leg.state.or.us/liz/2019R1/Downloads/CommitteeMeetingDocument/198434 (statement of Charles Blanke); Jody B. Gabel, *Release from Terminal Suffering? The Impact of AIDS on Medically Assisted Suicide Legislation*, 22 Fla. St. U. L. Rev. 369, 426 (1994).

117 H.B. 2217, 80th Leg. Assemb., Reg. Sess. (Or. 2019), https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/HB2217/A-Engrossed (hearing on May 19, 2019). *See also* Queensland Parliament, Health, Cmtys., Disability Servs. & Domestic & Family Violence Prevention Comm., Rep. No. 34, 56th Parliament, Voluntary Assisted Dying 43 (2020) (noting that 9 of 52 people to receive MAID in Victoria needed clinician administration because self-administration was not possible).

118 Oregon Health Auth., Public Health Div., Oregon Death with Dignity Act: 2019 Data Summary 11 (2020), https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf; Washington State Department of Health, 2018 Death with Dignity Act Report 13 (July 2019), https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2018.pdf. These problems were anticipated from the beginning. *See, e.g.,* Timothy Egan, *Suicide Law Placing Oregon on Several Uncharted Paths*, N.Y. Times (Nov. 25, 1994), at A1. They even threatened to cause the repeal of the Oregon Death with Dignity Act in 1997. *See, e.g.,* H.B. 2954 (Or. 1997); *Basics on Ballot Measure 51*, Or. Legis. Pol'y & Res. Off. (1997), https://digital.osl.state.or.us/islandora/object/osl%3A4732/datastream/OBJ/view.

119 Notably, in jurisdictions where both MAID and euthanasia are available, almost no patients use MAID. Health Can., Fourth Interim Report on Medical Assistance in Dying in Canada (2019), https://www.canada.ca/content/dam/hc-sc/documents/services/publications/health-system-services/medical-assistance-dying-interim-report-april-2019/medical-assistance-dying-interim-report-april-2019-eng.pdf. In those rare cases when ingestion is used, Canadian clinicians are prepared to offer "IV rescue" as a backup in case oral self-administration is unsuccessful. Christopher Harty et al., Canadian Ass'n of MAiD Assessors & Providers, The Oral MAiD Option in Canada: Part 1: Medication Protocols: Review and Recommendations (2018).

120 *See generally* Antonella Tonna et al., *Home Self-Administration of Intravenous Antibiotics As Part of an Outpatient Parenteral Antibiotic Therapy Service: A Qualitative Study of the Perspectives of Patients Who Do Not Self-Administer*, 9 BMJ Open 1 (2019), https://bmjopen.bmj.com/content/bmjopen/9/1/e027475.full.pdf; Deepak Agrawal et al., *Patients Welcome IV Self-Care; Physicians Hesitate*, NEJM Catalyst (Dec. 6, 2017); Elizabeth D. Mitchell et al., *Clinical and Cost-Effectiveness, Safety and Acceptability of Community Intravenous Antibiotic Service Models: CIVAS Systematic Review*, 7 BMJ Open 1 (2017), https://bmjopen.bmj.com/content/bmjopen/7/4/e013560.full.pdf.

safe and cost-effective. Consequently, hospitals are increasingly discharging patients with prescriptions for home IV medications.[121] Still, many physicians are uncomfortable with allowing patients to self-administer IV medications. So, the practice is not yet widespread.[122]

Even with MAID specifically there are precedents for patient intravenous self-administration. Physician advocates Jack Kevorkian and Phillip Nitschke created mechanical devices and used them with patients.[123] Note that while Kevorkian set up the IV line for his first patient, "Mrs. Adkins was the one who pushed the button, which began the flow of pain killer and potassium chloride into her system."[124]

Some object that intravenous administration is prohibited even in states that use broad language to define the permissible routes of drug administration.[125] They point to the following language in every MAID statute: "Nothing in this part may be construed to authorize a physician or any other person to end an individual's life by lethal injection, mercy killing, or active euthanasia."[126]

However, this prohibition does not apply on its face. It does not prohibit lethal injection ***by the patient***.[127] The prohibitory language proscribes only lethal injection by "a physician or any

121 *Discharge Instructions: Administering IV Antibiotics,* Fairview, https://www.fairview.org/patient-education/86488 (last visited Sept. 15, 2020).

122 Kavita P. Bhavan et al., *Achieving the Triple Aim Through Disruptive Innovations in Self-Care* 316 JAMA 2081 (2016).

123 Nicole Goodkind, *Meet the Elon Musk of Assisted Suicide, Whose Machine Lets You Kill Yourself Anywhere*, Newsweek (Dec. 1, 2017 8:00 AM), https://www.newsweek.com/elon-musk-assisted-suicide-machine-727874; George J. Annas, *Physician Assisted Suicide: Michigan's Temporary Solution*, 328 New Eng. J. Med. 1573 (1993). Gary Schnabel, a pharmacist with the Oregon Board of Pharmacy, also developed a device. Mark O'Keefe & Tom Bates, *Hearings Reveal Confusion about Committing Suicide*, Oregonian (Mar. 15, 1997).

124 Jennifer Zima, *Assisted Suicide: Society's Response to a Plea for Relief or a Simple Solution to the Cries of the Needs*, 23 Rutgers L.J. 387, 387 n.4 (1992). *See also* Susan Clevenger, Dying to Die - The Janet Adkins Story: A True Story of Dying with the Assistance of Doctor Jack Kevorkian (2019).

125 Personal communications to author after NCCMAID. Lethal injection was proposed and rejected in early MAID bills and ballot initiatives. Pope, *supra* note 2. However, that was lethal injection by the clinician, not by the patient. *See, e.g.,* Washington Physician-Assisted Death, Initiative 119 (1991).

126 End of Life Option Act, Cal. Health & Safety Code § 443.18 (2020); Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-121 (2020); Death with Dignity Act of 2016, D.C. Code § 7-661.15(a) (2020); Our Care, Our Choice Act, Haw. Rev. Stat. §§ 327L-18(a) (2020); Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(20); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-15(a) (2020); Oregon Death with Dignity Act, Or. Rev. Stat. § 127.880 (2020); Vt. Stat. Ann. tit. 18, § 5292 (2020); Washington Death with Dignity Act, Wash. Rev. Code § 70.245.180(1) (2020).

127 Pamela S. Kaufmann, Death with Dignity: A Medical-Legal Perspective, AHLA Long-Term Care and the Law Meeting (Feb. 22, 2017); Council on Psychiatry and Law, APA Resource Document on Physician Assisted Death 8 (2017) (interpreting the "other" as a third person). The language of the prohibition may also not extend to intravenous "infusion" into the blood which is distinct from "injection" which may be intermuscular or subcutaneous.

other person." It references "the individual" as the subject of the injection but not as the agent of the injection.[128] Therefore, this prohibitory language is irrelevant to self-administered MAID.

Legislative history confirms this reading. This "lethal injection" language originated with the 1994 Oregon Death with Dignity Act. The voter pamphlet for the ballot initiative included this language indented under a bold heading that stated: "Under Measure 16, only the dying person may self-administer the medication."[129] This clarifies that "lethal injection" was focused on the agent of administration and not the manner of administration.

An even broader look at the legislative history confirms this. Before 1994, bills and ballot initiatives aimed to legalize both MAID and euthanasia.[130] Those efforts failed because having the physician be the final agent was comparatively more controversial. Therefore, reform efforts since 1994 have focused only on MAID.[131] In short, the point of the prohibition was to authorize MAID yet prohibit euthanasia.[132]

Self-administered IV MAID is consistent with this requirement. It changes only the route of administration, not the agent of administration. The patient ***herself*** pushes the lethal medication. The patient herself causes the "lethal injection." With self-administered IV MAID, the physician only establishes the intravenous line. This is analogous to a third person preparing the medication that the patient then drinks herself.[133] As a recent government report describes it, "the person who provides the assistance, such as a relative or doctor, does not perform the final act that causes the death. The death is caused by the person themselves."[134]

This has already been judicially tested. In December 1990, a Michigan court dismissed criminal charges against Jack Kevorkian for assisting in the death of Janet Adkins. While

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128 Contrast a new law in Victoria, Australia that permits physician administration when the patient cannot self-administer. That changes not only the *route* of administration but also *who* administers the lethal medication. Ben P. White et al., *Does the Voluntary Assisted Dying Act 2017 (Vic) Reflect Its Stated Policy Goals?*, 43 UNSW L.J. 417 (2020), http://www.unswlawjournal.unsw.edu.au/wp-content/uploads/2020/06/02-WHITE-ET-AL.pdf.

129 State of Or. Sec'y of State, Voter's Pamphlet 127 (1994) (although the booklet also says the Measure does not allow "suicide machines").

130 *See, e.g.,* Initiative 119 (Wash. 1991); S.B. 1141 (Or. 1991); Proposition 161 (Cal. 1992); Allan Parachini, *Bringing Euthanasia Issue to the Ballot Box: Group Sponsors State Initiative to Legalize 'Physician-Assisted Suicide'* , L.A. Times (Apr. 10, 1987), https://www.latimes.com/archives/la-xpm-1987-04-10-vw-165-story.html.

131 Timothy E. Quill et al., *Sounding Board: Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician Assisted Suicide*, 327 New Eng. J. Med. 1380 (1992).

132 Several authors of the Oregon Death with Dignity Act opined that it did not prohibit self-administered IV MAID. *See, e.g.,* Mark O'Keefe & Tom Bates, *Hearings Reveal Confusion about Committing Suicide*, Oregonian (Mar. 15, 1997) ("Peter Goodwin . . . a co-author of Measure 16, said, 'My own belief is that medication would cover intravenous medication.'"); Mark O'Keefe, *House Takes Up Assisted Suicide*, Oregonian (May 13, 1997) ("Cheryl Smith, who helped write Measure 16 . . . said, `I believe that Measure 16 allows a machine like Kevorkian's.'"). There were later extensive hearings about routes of administration. H.B. 2954 (Or. 1997).

133 *Cf.* Baxter v. State, 224 P.3d 1211, 1217 (Mont. 2009) ("[A] physician who aids a terminally ill patient in dying is not directly involved in the final decision or the final act. He or she only provides a means by which a terminally ill patient *himself* can give effect to his life-ending decision").

134 Queensland Parliament, Health, Cmtys., Disability Servs. & Domestic & Family Violence Prevention Comm., Rep. No. 34, 56th Parliament, Voluntary Assisted Dying 12 (2020).

Michigan has not affirmatively authorized MAID, it had not yet prohibited it. The court explained that "Mrs. Adkins was the proximate cause of her own death."[135] For the same reason, other Michigan courts dismissed charges against Kevorkian in the deaths of Shery Miller and Marjorie Wantz.[136]

The prohibition on lethal injection is written to require self-administration and thereby prohibit euthanasia. It does not address the route of administration.[137] MAID statutes are silent as to the specific means of self-administration. Consequently, commentators have concluded that despite the prohibition on "lethal injection," "self-administered lethal intravenous infusion . . . may not be prohibited."[138] It is permissible if the patient "pushes a switch to trigger a fatal injection after the doctor has inserted an IV needle."[139]

Furthermore, we can look to Swiss law for guidance. Like U.S. MAID laws, Swiss law requires self-administration. "The final action in the process leading to death must always be performed by the patient."[140] Swiss providers have reconciled this self-administration requirement with IV administration. They openly and regularly have patients administer MAID through IV drips.[141] Some have even developed an "easy to handle remote control" that the patient can "activate through a small movement (e.g. a finger, toe, or jaw) to start the

135 George J. Annas, *Physician Assisted Suicide -- Michigan's Temporary Solution*, 20 Ohio N.U. L. Rev. 561 (1993-1994); People v. Kevorkian, No. CR-92-115190 (Mich. Cir. Ct. Oakland Cnty. July 21, 1992).

136 *Michigan v. Kevorkian*, 9 Issues L. & Med. 189, 200 (1993) ("Ms. Miller pulled the screwdriver which caused the flow of carbon monoxide to commence . . . Ms. Miller took her own life."). *Cf.* Sanders v. State, 112 S.W. 68, 70 (Tex. Crim. App. 1908) (distinguishing furnishing poison from "placing it in the mouth or other portions of the body"), *overruled on other grounds*, 277 S.W. 1080 (Tex. Crim. App. 1925).

137 *But see Hearing on H.B. 2217 Before the S. Judiciary Comm.*, Reg. Sess. (Or. 2019), https://olis.leg.state.or.us/liz/2019R1/Downloads/CommitteeMeetingDocument/198274 (statement of Geoff Sugerman, Death with Dignity National Center).

138 Raphael Cohen-Almagor & Monica G. Hartman, *The Oregon Death with Dignity Act: Review and Proposals for Improvement*, 27 J. Legis. 269, 287 (2001), http://www.ethesis.net/cohen/Oregon.pdf.

139 Lynn D. Wardle, *A Death in the Family: How Assisted Suicide Harms Families and Society*, 15 Ave Maria L. Rev. 43, 47 n.11 (2016-2017).

140 Swiss Acad. of Med. Scis., *Medical-Ethical Guidelines: Management of Dying and Death*, 148 Swiss Med. Weekly w14664 § 6.2.1 (2018), https://smw.ch/article/doi/smw.2018.14664.

141 *See, e.g., Swiss Law & Requirements*, Pegasos Swiss Ass'n, https://pegasos-association.com/requirements/ ("Pegasos offers VAD using intravenous transfusion, and even though it is a doctor who will insert the cannula into the person's arm, it is the person, themselves, who must activate the drip delivering the drug."); Dignitas, Dignitas Brochure 7 (15th ed. 2019), http://www.dignitas.ch/images/stories/pdf/informations-broschuere-dignitas-e.pdf ("In every case, for legal reasons, the patient must be able to undertake the last act . . . to open the valve of the intravenous access tube") [hereinafter Dignitas]. *See also* Luke Harding, *A Little Sightseeing, a Glass of Schnapps, then a Peaceful Death in a Suburban Flat*, Guardian (Dec. 4, 2004), https://www.theguardian.com/society/2004/dec/04/health.medicineandhealth1 (interview with Ludwig Minelli, founder of Dignitas Clinic); Susan Stefan, Rational Suicide, Irrational Laws: Examining Current Approaches to Suicide in Policy and Law (American Psychology-Law Society Series 190 (1st ed. 2016); Daniel Sperling, Suicide Tourism: Understanding the Legal, Philosophical, and Socio-political Dimensions 33 (2019); Queensland Parliament, Health, Cmtys., Disability Servs. & Domestic & Family Violence Prevention Comm., Rep. No. 34, 56th Parliament, Voluntary Assisted Dying 34 & n.182 (2020).

attached pump."[142] They even videotape the procedure to document that the patient opened the valve all by herself.[143] There is no legal obstacle to administering MAID the same way in Colorado, Hawaii, New Jersey, and Vermont.

OTHER VARIATIONS AMONG U.S. MAID STATUTES

We have examined five ways in which U.S. MAID statutes vary. Two concern patient eligibility requirements: (1) how to assess the patient's state residency, and (2) how to assess the patient's decision-making capacity. Three differences concern the manner of accessing MAID: (3) the duration of the oral request waiting period, (4) the duration of the written request waiting period, and (5) the permitted route of drug administration.

But the nine MAID statutes vary not only in terms of eligibility and procedural requirements but also along five other dimensions.[144] These include: (a) how clinicians can assert conscience-based objections, (b) how facilities can assert conscience-based objections, (c) whether assessment and counseling can be done through telehealth, (d) how death certificates are completed, (e) how states collect and report data, and (f) whether the statute includes a sunset clause.

Conscience–Based Objections by Clinicians

Every MAID statute makes participation voluntary not only by patients but also by clinicians and facilities.[145] Individual clinicians may assert a conscience-based or personal objection and they cannot be punished for refusing to participate.[146] This means that clinicians can refuse to discuss or educate the patient on eligibility or process. They can refuse to conduct eligibility

142 Dignitas, How Dignitas Works 16 (May 2014), http://www.dignitas.ch/images/stories/pdf/so-funktioniert-dignitas-e.pdf.

143 George Mills, *What You Need to Know About Assisted Suicide in Switzerland*, Local (May 10, 2018), https://www.thelocal.ch/20180503/what-you-need-to-know-about-assisted-death-in-switzerland.

144 There are also other variations. For example, will state Medicaid (or other insurance) pay for MAID consultations and prescriptions? Must facilities post their policies on MAID? How should patients and families dispose of unused drugs? Yet, many of these rights and obligations come from other sources of law, not from the MAID statutes themselves. *See, e.g.,* H.B. 2326, 66th Leg., Reg. Sess. (Wash. 2019), http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/House%20Bills/2326-S.pdf?q=20200915125826. *But cf.* S.B. 3047, 30th Leg. (Haw. 2020), https://www.capitol.hawaii.gov/session2020/bills/SB3047_.pdf.

145 End of Life Option Act, Cal. Health & Safety Code § 443.14(e) (2020); Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-117 (2020); Death with Dignity Act of 2016, D.C. Code § 7-661.10(a) (2020); Our Care, Our Choice Act, Haw. Rev. Stat. §§ 327L-19(a)(2) (2020); Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(21) (2020); Oregon Death with Dignity Act, Or. Rev. Stat. § 127.885(2), (4) (2020); Vt. Stat. Ann. tit. 18, § 5285 (2020); Washington Death with Dignity Act, Wash. Rev. Code § 70.245.190(1)(b), (d) (2020).

146 While physicians play a central role, MAID also involves pharmacists, non-physician mental health specialists like social workers and psychologists. Cal. Health & Safety Code § 443.1(l); Colo. Rev. Stat. § 25-48-102(6); Me. Rev. Stat. Ann. tit. 22, § 2140(2)(E) (also including clinical social workers and clinical professional counselors); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-3 (2020) (including clinical social worker).

assessments, write prescriptions, or fill prescriptions for MAID. They can even refuse to make or assist referrals to participating providers.

But the right to refuse is not unlimited. When the patient finds a new physician who is willing to participate, the original objecting physician must transfer the patient's medical records and must do that even if they think it makes them complicit in what they judge to be an immoral act.[147]

The scope of permitted refusal is narrower in Vermont. Most MAID statutes permit objecting physicians not to inform a patient regarding his or her rights and not to refer the patient to a physician who participates.[148] But Vermont has a separate end-of-life informed consent rights statute.[149] A federal court interpreted this statute to require that objecting physicians must either inform patients about their MAID rights or refer them somewhere they can learn their options.[150]

Conscience–Based Objections by Facilities

Not only individual clinicians but also health care entities assert conscience-based objections—many facilities have opted-out. For example, few religiously affiliated institutions participate with MAID.[151] But what about non-objecting individual clinicians that work for such entities (as either employees or independent contractors)? May they participate when their hospital or health care system has opted out?

MAID statutes in every state permit health care facilities to prohibit their employees and staff from participating with MAID while on the premises or while acting within the purview of the entity.[152] The general understanding has been that such clinicians may participate in MAID on their own time. In Colorado, however, a large Catholic system is litigating a claim

147 Cal. Health & Safety Code § 443.14(e)(3); Colo. Rev. Stat. §§ 25-48-113(2), -117; D.C. Code § 7-661.10(b); Haw. Rev. Stat. § 327L-19(a)(4); Me. Rev. Stat. Ann. tit. 22, § 2140(21); N.J. Stat. Ann. § 26:16-17(c); Or. Rev. Stat. § 127.885(4); Wash. Rev. Code § 70.245.190(1)(d).

148 *See, e.g.,* Cal. Health & Safety Code § 443.14(e)(2).

149 Vt. Stat. Ann. tit. 18, § 5282.

150 Vt. All. for Ethical Health Care v. Hoser, 274 F. Supp. 3d 227 (D. Vt. Apr. 5, 2017) (citing Vt. Stat. Ann. tit. 18, § 1871 and Vt. Stat. Ann. tit. 12, § 1909(d)). *Cf.* Mara Buchbinder, *Aid in Dying Laws and the Physician's Duty to Inform,* 43 J. Med. Ethics 666 (2017).

151 Cindy L. Cain et al., *Hospital Responses to the End of Life Option Act: Implementation of Aid in Dying in California*, 179 JAMA Internal Med. 985 (2019). With mergers and consolidation, fewer health systems may participate in the future. *See* Ian D. Wolfe & Thaddeus M. Pope, *Hospital Mergers and Conscience-Based Objections — Growing Threats to Access and Quality of Care,* 382 New Eng. J. Med. 1388 (2020); Harris Meyer, *Proposed Virginia Mason-CHI Franciscan Merger Increases Worry about Catholic Limits on Health Care in Washington State*, Seattle Times (Aug. 3, 2020, 8:24 AM), https://www.seattletimes.com/seattle-news/health/proposed-virginia-mason-chi-franciscan-merger-increases-worry-about-catholic-limits-on-health-care-in-washington-state/.

152 Cal. Health & Safety Code §§ 443.15–.16; Colo. Rev. Stat. § 25-48-118; D.C. Code § 7-661.10(c)-(e); Haw. Rev. Stat. § 327L-19(b)–(e); Me. Rev. Stat. Ann. tit. 22, § 2140(22); Or. Rev. Stat. § 127.885(5); Vt. Stat. Ann. tit. 18, § 5286; Wash. Rev. Code § 70.245.190(2). The New Jersey statute does not contain this language.

that it can prohibit its physicians from participating in MAID even when they act outside the purview of their employment.[153]

Telehealth Assessment and Counseling

Particularly since the COVID-19 pandemic, there has been an increased interest in and use of telehealth.[154] This includes MAID.[155] Indeed, a new professional society, the American Clinicians Academy on Medical Aid in Dying (ACAMAID) released guidance on how to provide MAID through telehealth.[156]

The Hawaii MAID statute addresses telehealth explicitly in the context of the mental health counseling. This is the third clinical assessment for determining that the patient is capable and does not appear to be suffering from undertreatment or nontreatment of depression or other conditions which may interfere with her ability to make an informed decision.[157] The Hawaii law states that these mental health consultations with a psychiatrist, psychologist, or clinical social worker "may be provided through telehealth."

But what about the attending and consulting physician who assess terminal illness and capacity?[158] No U.S. MAID statute specifically says that may be done by telehealth, and none specifically prohibits it. Consequently, one might conclude that clinicians may provide MAID through telehealth to the same extent as they can provide other health care services through telehealth.

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153 Morris v. Centura Health Corp., No. 2019-CV-31980 (Arapahoe Cnty. Dist. Ct., Colo., Dec. 20, 2019). Relatedly, the U.S. Supreme Court is hearing a case that questions the thirty-year old rule that government can enforce laws that burden religious beliefs or practices as long as the laws are "neutral" or "generally applicable." Fulton v. City of Phila., Pa., No. 19-123 (U.S. Nov. 4, 2020) (oral argument). Federal regulations may permit an even broader scope of conscience-based refusal. Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed. Reg. 23,170 (May 21, 2019) (to be codified at 45 C.F.R. pt. 88). These regulations have been enjoined and those injunctions are on appeal. New York v. U.S. Dept. Health & Human Servs., No. 19-4254 (2d Cir. 2020); City and County of San Francisco v. Azar, No. 20-35044 (9th Cir. 2020).

154 Cathleen Calhoun, *Strategic Perspectives: Telehealth Has Taken a Giant Step Forward, But Will the Momentum Continue?*, Wolters Kluwer Health L. Daily (May 20, 2020).

155 *See* Konstantin Tretyakov, *Medical Aid in Dying by Telehealth*, 30 Health Matrix 325 (2020), https://scholarlycommons.law.case.edu/cgi/viewcontent.cgi?article=1650&context=healthmatrix.

156 Comm. to Evaluate Telemedicine for Aid-in-Dying Requests in the Context of the Coronavirus Epidemic, *Telemedicine Policy Recommendations*, Am. Clinicians Acad. on Med. Aid in Dying (Mar. 25, 2020), https://cpsns.ns.ca/wp-content/uploads/2020/09/Medical-Assistance-in-Dying-Standard-Temporary-Amendment-Mar-27-2020-Sept-18-2020.pdf. Medical licensing boards in other jurisdictions have also issued telehealth guidance during the COVID-19 pandemic. *See, e.g.,* Coll. of Physicians & Surgeons of N.S., Temporary Amendments to the College's MAiD Standard (2020), https://cpsns.ns.ca/wp-content/uploads/2020/09/Medical-Assistance-in-Dying-Standard-Temporary-Amendment-Mar-27-2020-Sept-18-2020.pdf; College of Physicians and Surgeons of British Columbia, *Practice Standard: Medical Assistance in Dying* (Mar. 26, 2020).

157 Haw. Rev. Stat. § 327L-1.

158 *Cf.* S.B. 3047, 30th Leg. (Haw. 2020), https://www.capitol.hawaii.gov/session2020/bills/SB3047_.pdf (allowing telehealth for all clinicians when the patient is unable to leave her residence).

On this analysis, telehealth for MAID is not equally available in every state. For example, in Vermont, telehealth can only be provided in the context of a "[b]ona fide physician-patient relationship."[159] That requires not only assessment of the patient's medical history and current medical condition but also a "personal physical examination."[160] So, both the attending and consulting physician must have visited with the patient in person before or concurrent with providing MAID.

Other constraints may also be manageable. For example, California requires that the physician "[c]onfirm that the qualified individual's request does not arise from coercion or undue influence by another person by discussing with the qualified individual, ***outside of the presence*** of any other persons."[161] While it may be more difficult to know that the patient is alone when meeting through a phone or computer camera, the physician can confirm this by asking the patient to move the camera around the room.[162]

Death Certificate Completion

While most provisions in MAID statutes focus on how patients may obtain MAID, some provisions address what happens ***after*** MAID. One perennially controversial issue concerns whether the patient's death certificate identifies MAID as the cause of death. Here, the states take three different approaches.[163]

Four MAID statutes prohibit MAID from being listed as the cause of death on the patient's death certificate. Instead, the death certificate must list the underlying terminal illness.[164] In four other states the statute is silent, but state agency guidance directs listing the underlying terminal illness.[165] For example, the California Department of Public Health states:

159 Vt. Stat. Ann. tit. 18, § 5281(1) (2020).

160 *Id.*

161 End of Life Option Act, Cal. Health & Safety Code § 443.5(a)(4) (2020).

162 Konstantin Tretyakov, *Medical Aid in Dying by Telehealth*, 30 Health Matrix 325, 343 (2020).

163 Canadian provinces also vary in whether they require or prohibit MAID from being listed as the cause of death. Janine Brown et al., *Completion of Medical Certificates of Death After an Assisted Death: An Environmental Scan of Practices*, 14 Healthcare Pol'y 59 (2018).

164 Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-109(2) (2020); D.C. Code § 7-661.05(h); Our Care, Our Choice Act, Haw. Rev. Stat. §§ 327L-4(b) (2020); Washington Death with Dignity Act, Wash. Rev. Code §§ 70.245.040(2) (2020). Many bills in prospective MAID states also require listing the terminal illness. *See, e.g.*, A.B. 2694 § 2899-p, Reg. Sess. (N.Y. 2019), https://nyassembly.gov/leg/?default_fld=&leg_video=&bn=A02694&term=2019&Summary=Y&Text=Y.

165 New Jersey Medical Aid in Dying for the Terminally Ill Act Frequently Asked Questions 3–4 (July 31, 2019), https://www.state.nj.us/health/advancedirective/documents/maid/MAID_FAQ.pdf ("NJDOH Office of Vital Statistics and Registry recommends that providers record the underlying terminal disease as the cause of death and mark the manner of death as 'natural'."); Or. Health Auth., *Frequently Asked Questions: Oregon's Death with Dignity Act (DWDA)*, Oregon.gov, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/faqs.aspx#deathcert (last visited Sept. 14, 2020) (same); Vt. Dep't of Health, Report to the Vermont Legislature: Report Concerning Patient Choice at the End of Life 4 (2018), https://legislature.vermont.gov/assets/Legislative-Reports/2018-Patient-Choice-Legislative-Report-12-14-17.pdf ("100% of the death certificates listed the appropriate cause (the underlying disease) and manner of death (natural), per Act 39 requirements.").

"Certifiers . . . report the underlying terminal disease as the cause of death on the death certificates. This approach complies with applicable law . . . and effectuates the California Legislature's intent to maintain the confidentiality of individuals' participation in the Act."[166] Only Maine offers no guidance on whether to list MAID on the patient's death certificate.[167]

Data Collection and Reporting

Conscience-based objection and telehealth affect how patients access MAID, but the states also vary in how they collect and report data. Every MAID statute requires that state agencies publish annual reports on usage.[168] The data reports from the first two states (Oregon and Washington) demonstrate a strong safety record that paved the way for enactment of legislation in the subsequent seven states.[169]

But the states vary in terms of what information they collect and report.[170] Oregon and Washington collect and report the broadest range of data. California does less.[171] Colorado, Vermont, and Washington, DC collect and report the least.[172] This variability is unfortunate, because reform is more difficult when one knows less about how the law is working.[173]

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166 Cal. Dep't of Public Health, California End of Life Option Act 2019 Data Report 5 (2020), https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CDPHEndofLifeOptionActReport2019%20_Final%20ADA.pdf. *But see Document #3459: The California End of Life Option Act* ¶ 26, CMA Legal Counsel (2016), https://www.uclahealth.org/workfiles/eol/cma-guidance-end-of-life-option-act-on-call.pdf (directing physicians to list the cause "they feel is the most accurate").

167 Maine legislation originally followed the approach taken in Colorado, DC, Hawaii, and Washington, but as in California and Vermont, that was amended in later versions of the bill.

168 End of Life Option Act, Cal. Health & Safety Code §§ 443.9, .19 (2020); Colo. Rev. Stat. § 25-48-111(2); D.C. Code § 7-661.07; Haw. Rev. Stat. §§ 327L-14, -25; Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(17) (2020); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. § 26:16-13 (2020); Oregon Death with Dignity Act, Or. Rev. Stat. § 127.865 (2020); Wash. Rev. Code § 70.245.150.

169 N.J. Stat. Ann. § 26:16-2(b). Oregon and Washington data were also important to reform in jurisdictions around the world. *See, e.g.,* Carter v. Canada (Attorney General), 2013 BCCA 435, https://www.canlii.org/en/bc/bcca/doc/2013/2013bcca435/2013bcca435.html.

170 Jean T. Abbott et al., *Accepting Professional Accountability: A Call for Uniform National Data Collection on Medical Aid-In-Dying*, Health Aff. Blog (Nov. 20, 2017), https://www.healthaffairs.org/do/10.1377/hblog20171109.33370/full/ [hereinafter Abbott et al.]. This study was published before Maine and new Jersey enacted their statutes, but that would not change the analysis, although the state agencies could promulgate regulations that promote the collection ad reporting of broader data. *See* Me. Rev. Stat. Ann. tit. 22, § 2140(17); N.J. Stat. Ann. § 26:16-13.

171 But in addition to the annual DOH reports, the California Assembly holds periodic hearings on the implementation of the EOLOA. *See, e.g.,* Cal. State Assembly, Assembly Select Committee on End of Life Health Care, Tuesday, February 25th, 2020, https://www.assembly.ca.gov/media/assembly-select-committee-end-life-health-care-20200225/video.

172 Abbott et al.

173 *See* Thaddeus M. Pope, *Extrajudicial Resolution of Medical Futility Disputes: Key Factors in Establishing and Dismantling the Texas Advance Directives Act*, *in* International Perspectives on End of Life Reform: Politics, Persuasion, and Persistence (Ben White & Lindy Wilmott eds., forthcoming 2021); Health Canada, First Annual Report on Medical Assistance in Dying in Canada, 2019 9 (2020), https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying-annual-report-2019/maid-annual-report-eng.pdf ("Nearly all countries that permit some form of medically assisted dying consider public reporting to be a critical component to support transparency and foster public trust in the application of the law.").

Sunset Clauses

The future of most MAID statutes has been threatened by litigation or legislation.[174] But as enacted, those laws were intended to be permanent options. None was enacted on a trial or pilot basis.[175]

In contrast, when California enacted its End of Life Option Act during an extraordinary legislative session in October 2015, it included a sunset clause.[176] "This part shall remain in effect only until January 1, 2026, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2026, deletes or extends that date."[177] Unlike other MAID statutes, the EOLOA expires.[178] Therefore, unless reauthorized, MAID will cease to be a legal practice in California.[179]

FORTHCOMING VARIATIONS

The previous sections described current differences among U.S. MAID laws, but the variability will likely continue to grow as states continue studying "barriers to access."[180] Many are already seeking to recalibrate the balance between safety and access.[181]

Two aspects of MAID laws are especially primed for change: scope of practice and terminal illness. The states are currently uniform in permitting only physicians to provide

174 *See, e.g.,* Ahn v. Hestrin, No. RIC-1607135 (Riverside Cnty. Sup. Ct., Cal.), https://compassionandchoices.org/legal-advocacy/recent-cases/ahn-v-hestrin/; Glassman v. Grewal, No. MER-C-53-19 (Mercer Cnty. Sup. Ct., NJ), https://compassionandchoices.org/legal-advocacy/recent-cases/glassman-v-grewal/.

175 While the Vermont statute's legalization of MAID was permanent, the procedural safeguards were initially designed to sunset. *See* Alan Meisel et al., The Right to Die: The Law of End-of-Life Decisionmaking § 12.05 (3rd ed. 2020).

176 A.B. 15 (Cal. 2015), codified at End of Life Option Act, Cal. Health & Safety Code §§ 443 to 443.22 (2020). The law went into effect on June 9, 2016.

177 Cal. Health & Safety Code § 443.215.

178 *Id.*

179 Without the EOLOA, MAID would be a felony in California. Cal. Penal Code § 401(a) (2020) (Any person who deliberately aids, or advises, or encourages another to commit suicide, is guilty of a felony.").

180 H.B. 2419, Reg. Sess. (Wash. 2020), http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/House%20Passed%20Legislature/2419-S.PL.pdf?q=20200915155130 (passed both chambers but vetoed on April 3, 2020 because of COVID-19); Cal. State Assembly, Assembly Select Committee on End of Life Health Care, Tuesday, February 25th, 2020, https://www.assembly.ca.gov/media/assembly-select-committee-end-life-health-care-20200225/video. *See also* Ben P. White et al., *Does the Voluntary Assisted Dying Act 2017 (Vic) Reflect Its Stated Policy Goals?*, 43 UNSW L.J. 417, 442–43 (2020) (noting that many patients "find the process overwhelming and too difficult to navigate" and that "few medical practitioners will agree to be involved"); Rosalind McDougall & Bridget Pratt, *Too Much Safety? Safeguards and Equal Access in the Context of Voluntary Assisted Dying Legislation*, 21 BMC Med. Ethics 1 (2020), https://bmcmedethics.biomedcentral.com/track/pdf/10.1186/s12910-020-00483-5 (arguing that aiming to maximize safety has negative implications for access).

181 Not every new bill seeks to expand access. For example, one of the newer MAID statutes, in Hawaii, added or increased several procedural requirements. Buchbinder & Pope, *supra* note 83. More recently, a Maryland bill would have significantly constrained access. Md. S.B. 311 / H.B. 399 (2019). On the other hand, states can also expand access through non-legal means like public education and provider outreach.

MAID. However, some states are likely to allow APRNs to provide MAID. The states are also currently uniform in how they define terminal illness, but some states are likely to define terminal illness more broadly than a six-month prognosis. The states may also diverge along several other dimensions.

Scope of Practice: MD or APRN?

Every U.S. MAID statute now requires that both the attending and the consulting clinician (who assesses eligibility, provides counseling, and writes the prescription) be a physician. While most statutes are more flexible about who can perform the mental health assessment (*e.g.* clinical social worker or psychologist), none permit a non-physician to otherwise determine eligibility or write the prescription.

But limiting MAID to physicians constrains access to MAID, especially in rural areas where there is a shortage of physicians. In response, some states have proposed legislation that would allow APRNs to perform these tasks.[182] Already, 6% of MAID in Canada is performed by APRNs,[183] and this makes sense. Across the United States, many states have already expanded scope of practice to permit APRNs to assess capacity and write POLST orders regarding life-sustaining treatment.[184]

Terminal Illness: Six Months or Longer

Every U.S. statute now requires that the patient have a terminal illness. This is typically defined as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months."[185] Both the attending and consulting physician must certify a prognosis that the patient has a terminal disease that will cause her death within six months.

At first glance, the six-month prognosis seems reasonable. It aligns with the eligibility for hospice under Medicare.[186] Hospice, a program of care and support for people who are

182 S.B. 2582, 30th Leg. (Haw. 2020), https://www.capitol.hawaii.gov/session2020/bills/SB2582_SD1_.pdf; S.B. 3047, 30th Leg. (Haw. 2020), https://www.capitol.hawaii.gov/session2020/bills/SB3047_.pdf; H.B. 171, Reg. Sess. (N.M. 2017), https://www.nmlegis.gov/Sessions/17%20Regular/bills/house/HB0171.pdf (also extending to physician assistants); S.B. 252, 53rd Leg., 1st Sess. (N.M. 2017), https://www.nmlegis.gov/Sessions/17%20Regular/bills/senate/SB0252JUS.pdf (same); A.B. 10059 (N.Y. 2016), https://nyassembly.gov/leg/?default_fld=&leg_video=&bn=A10059&term=2015&Summary=Y&Text=Y. MN. *See also* Western Australia Voluntary Assisted Dying Act of 2019 § 54(1)(a), http://www.austlii.edu.au/cgi-bin/viewdb/au/legis/wa/consol_act/vada2019302/. *See also Testimony in SUPPORT of HB 2451 RELATING TO HEALTH* Before the H. Comm. on Health (Haw. 2020); *Testimony in SUPPORT of SB 2582 RELATING TO HEALTH Before the S. Comm. on Commerce, Consumer Protection, & Health* (Haw. 2020).

183 James Downar et al., *Early Experience with Medical Assistance in Dying in Ontario, Canada: A Cohort Study,* 192 Canadian Med. Ass'n J. E173 (2020).

184 Alan Meisel et al., The Right to Die: The Law of End-of-Life Decisionmaking § 7.10A (3rd ed. 2020).

185 Our Care, Our Choice Act, Haw. Rev. Stat. § 327L-1 (2020).

186 42 C.F.R. §§ 418.3, .20 (2020).

terminally ill, focuses on comfort (palliative care) rather than curing illness. Because there are over 4000 hospices used by more one million patients each year, this six-month terminal illness requirement is familiar and salient.[187]

But the six-month requirement has been a big limit on MAID access.[188] Among other things, it wrongly assumes that life expectancy can always be accurately predicted.[189] The arbitrary time scale has meant that patients with cancer are the primary users of MAID. While cancer deaths comprise just 20% of total deaths, cancer accounts for 80% of MAID. Canadian studies have found that an even more flexible standard substantially limits access.[190]

In response, current MAID states have sought to amend their statutes to relax the temporal limit.[191] For example, Oregon has considered bills to extend the terminal illness requirement from six months to ***twelve months***.[192] Bills in other states go even further, eliminating the temporal requirement altogether. For example, a New Mexico bill defines terminal illness as a "disease or condition that . . . will result in death ***within a reasonable time***."[193] Such a standard has proven workable in Canada for years.[194]

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187 *National Center for Health Statistics*: *Hospice Care,* CDC, https://www.cdc.gov/nchs/fastats/hospice-care.htm (last visited Sept. 15, 2020).

188 Queensland Parliament, Health, Cmtys., Disability Servs. & Domestic & Family Violence Prevention Comm., Rep. No. 34, 56th Parliament, Voluntary Assisted Dying 120 (2020); Ben P. White et al., *Does the Voluntary Assisted Dying Act 2017 (Vic) Reflect Its Stated Policy Goals?*, 43 UNSW L.J. 417 (2020).

189 *See* All-Party Parliamentary Grp. for Terminal Illness, Six Months to Live?: Report of the All-Party Parliamentary Group for Terminal Illness Inquiry into the Legal Definition of Terminal Illness (2019), https://www.mariecurie.org.uk/globalassets/media/documents/policy/appg/all-party-parliamentary-group-for-terminal-illness-report-2019.pdf.

190 Truchon v. Procureur Général du Canada, 2019 QCCS 3792, https://www.canlii.org/fr/qc/qccs/doc/2019/2019qccs3792/2019qccs3792.html [hereinafter Truchon].

191 H.B. 2419, Reg. Sess. (Wash. 2020), http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/House%20Passed%20Legislature/2419-S.PL.pdf?q=20200915162544 (commissioning a study on barriers to access).

192 H.B. 2232, 80th Leg. Assemb., Reg. Sess. (Or. 2019), https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/HB2232/Introduced [hereinafter Or. H.B. 2232].

193 H.B. 171 § 2(F), 53rd Leg., 1st Sess. (N.M. 2017) (emphasis added).

194 *Truchon*, *supra* note 190. Even though this is a comparatively flexible standard compared to the U.S. terminal illness requirement, the Quebec court held it unconstitutional, since it is more restrictive than the Supreme Court of Canada judgment that declared a right to MAID.

Other Future Variations

Variability along other dimensions is not as likely as variability in terms of scope of practice and terminal illness. However, there are ongoing academic and policy debates concerning whether MAID should be available: (1) to mature minors,[195] (2) through advance requests,[196] and (3) through third party administration.[197]

CONCLUSION

Medical aid in dying is a legal end-of-life option for one in four Americans. It is, however, one of the most heavily regulated health care services. The scope and manner of that regulation already varies materially across the eleven U.S. MAID jurisdictions. As more states enact MAID statutes and as current states amend their existing statutes, variability is likely to increase. Innovation and non-conformity are positive developments. States considering reform are now less likely to blindly copy and paste older statutes and more likely to engage in "critical review."[198]

In 1997, the U.S. Supreme Court observed: "Americans are engaged in an earnest and profound debate about the morality, legality and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society."[199] More than two decades later, the debate is continuing. Innovation is continuing in the "laboratory of the states."[200] Over the next five years, we will see more states legalize MAID.[201] We will also see more differences among MAID states as some move to recalibrate the balance between access and safety.

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195 Council of Canadian Acads., The State of Knowledge on Medical Assistance in Dying for Mature Minors: The Expert Panel Working Group on MAID for Mature Minors (2018), https://cca-reports.ca/wp-content/uploads/2018/12/The-State-of-Knowledge-on-Medical-Assistance-in-Dying-for-Mature-Minors.pdf .

196 S.B. 893, 79th Leg. Assemb., Reg. Sess. (Or. 2017), https://olis.leg.state.or.us/liz/2017R1/Downloads/MeasureDocument/SB893/Introduced [hereinafter Or. S.B. 893]; S.B. 3047, 30th Leg. (Haw. 2020), https://www.capitol.hawaii.gov/session2020/bills/SB3047_.pdf. *See also* Council of Canadian Acads., The State of Knowledge on Advance Requests for Medical Assistance in Dying: The Expert Panel Working Group on Advance Requests for MAID (2018), https://cca-reports.ca/wp-content/uploads/2019/02/The-State-of-Knowledge-on-Advance-Requests-for-Medical-Assistance-in-Dying.pdf. *Cf.* Nicholas Goldberg, *California's Aid in Dying Law is Working: Let's Expand It to Alzheimer's Patients*, LA Times (July 15, 2020); Elie Isenberg-Grzeda et al., *Legal Assistance in Dying for People with Brain Tumors,* Annals Palliative Med. 1, 4 (2020), http://apm.amegroups.com/article/view/48382/pdf ("Patients with neurologic disease . . . sought MAID earlier in their illness trajectory than if the law allowed for an advanced directive to choose MAID.").

197 *See, e.g.,* Or. S.B. 893 (2017) (allowing request by agent); Or. H.B. 2232 (2019) (changing definition of "self-administration").

198 Ben P. White et al., *Does the Voluntary Assisted Dying Act 2017 (Vic) Reflect Its Stated Policy Goals?*, 43 UNSW L.J. 417 (2020); Taimie Bryant, *Aid-in-Dying Nonprofits*, 57 San Diego L. Rev. 147, 185, 217 (2020). *Cf.* Ed Longlois, *Efforts to Expand Assisted Suicide Underway,* Catholic Sentinel (Oct. 9, 2020).

199 Wash. v. Glucksberg, 521 U.S. 702, 735 (1997).

200 *Id.* at 737 (O'Connor, J., concurring).

201 These states will probably include Maryland, Massachusetts, New Mexico, and New York.

SUMMARY OF VARIATIONS AMONG MAID LAWS									
	CA	CO	DC	HI	ME	NJ	OR	VT	WA
Indicia of residency	4	4	16	4	9	4	4	4	3
Minimum capacity assessments	2	2	2	3	2	2	2	2	2
Minimum total waiting period (days)	15	15	15	20	15	15	0	17	15
Route of administration	GI	Any	GI	GI	Any	Any	GI	Any	GI
Conscience based objection by clinicians	B	B	B	B	B	B	B	N	B
Conscience based objection by institutions	B	XB	B	B	B	B	B	B	B
Death certificate	TI	TI	TI	TI	MAID	TI	TI	TI	TI
Data collection & reporting	B	N	N	M	TBD	TBD	B	N	B
Sunset clause	Yes	No	No	No	No	No	No	No	No

B (broad), GI (gastrointestinal), M (medium), N (narrow), X (extra)

Author Profile

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