A Comparative Analysis of Voluntariness Safeguards and Review Procedure under Oregon and the Netherlands' Physician Assisted Dying Laws

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This article provides a comparative statutory analysis of the requirements for a voluntary decision in a request for physician assisted dying under Oregon’s Death with Dignity Act and the Netherlands’ Termination of Life on Request and Assisted Suicide (Review Procedures) Act. This comparative analysis aims to provide insight into how voluntariness is determined in practice and how the review procedure is conducted, with a view to identifying strengths and limitations within a legislative framework. First, the legislative safeguards aimed at protecting a voluntary decision are discussed. This is followed by an examination of the review procedure. This article concludes by arguing that there are concerning limitations with both the statutory safeguards and review procedure under Oregon’s Death with Dignity Act.

Cet article presente une analyse legislative comparative des exigences en matière de décision volontaire lors d’une demande d’aide médicale à mourir en vertu de la Death with Dignity Act de l’Oregon et de la Termination of Life on Request and Assisted Suicide (Review Procedures) Act des Pays-Bas. Cette analyse comparative vise à donner un aperçu de la manière dont le caractère volontaire de la décision est déterminé dans la pratique et de la manière dont la procédure d’examen est menée, en vue d’identifier les forces et les faiblesses du cadre législatif. Tout d’abord, les garanties législatives visant à protéger le caractère volontaire d’une décision sont discutées. Suit une analyse de la procédure d’examen. L’article conclut en faisant valoir qu’il existe des limites à la fois aux garanties législatives et à la procédure d’examen en vertu de la Death with Dignity Act de l’Oregon.

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Introduction

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Introduction

Euthanasia and physician assisted dying are controversial practices and remain illegal throughout most of the world. However, a select handful of jurisdictions have now actively legislated to permit these practices if certain criteria are met.1

1. See for example the Oregon Death with Dignity Act, ORS, 127.800-.897 (2015); The Washington Death with Dignity Act, RCW 70.245 (2008); An Act Relating to Patient Choice and Control at End of Life, VSA 18, Ch 113 §§ 5281-5292 (2013); California’s End of Life Option Act, HSC, Pt 1.85 §§ 443-443.22, (2015). Since writing this article, the End of Life Option Act has been declared void as unconstitutional see Ahn v Hestrin (Cal Superior Crt/County of Riverside, RIC 1607135, 26 August 2016); Ahn v Hestrin (Cal Superior Crt/County of Riverside, RIC 1607135, 25 August 2018). Therefore, physicians cannot issue lethal prescriptions under the law. The Attorney-General of California has filed a motion to vacate to be heard on 29 June 2018 see Death With Dignity, California: Current Status, online: <https://www.deathwithdignity.org/states/california/>; The District Of Columbia Death with Dignity Act (2017); Colorado End of Life Options Act, C.R.S., 25-48-101 (2017); Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 2002 (Nth); The Belgian Act on Euthanasia, May 28, 2002; Law of March 16, 2009 on Euthanasia and Assisted Suicide (Lux). An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts (medical assistance in dying), SC 2016, c 3. Since writing this article, two jurisdictions – the State of Victoria, Australia and the State of Hawaii, USA – have passed assisted dying legislation. In Victoria, the legislature passed the Voluntary Assisted Dying Act 2017 (Vic), which is set to come into force on 19 June 2019. Voluntary Assisted Dying permits eligible persons to make a request for voluntary assisted dying, subject to certain legislative safeguards see Voluntary Assisted Dying Act (2017); see also Caley Otter, ‘Voluntary Assisted Dying Bill 2019’ (Research Note No 1, Parliamentary Library & Information Services, Legislative Assembly, 2017). In Hawaii, the Our Care, Our Choice Act was signed into law on 5 April 2018. The Our Care, Our Choice Act establishes a framework for terminally ill persons to request a lethal prescription from their physician to end their life, subject to statutory safeguards. The Act is set to come into force on 1 January 2019 see Our Care, Our Choice Act 2018, House Bill 2739; see also Death with Dignity, Hawaii: Current Status, online: <https://www.deathwithdignity.org/states/hawaii/>.
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On 27 October 1997, Oregon legalised physician assisted dying (PAD) by enacting the *Death With Dignity Act* (DWDA). On 1 April 2002, the Netherlands followed by inserting defences into the *Criminal Code* to permit euthanasia and physician assisted dying (E/PAD) in certain circumstances by enacting the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002* (Review Procedures Act). Thus, these statutes rendered Oregon and the Netherlands the first jurisdictions world-wide to lawfully permit some form of assisted dying.

It is important to note that there is no right to request an assisted death in either Oregon or the Netherlands. Rather, the statutes establish a regulatory framework for physicians to follow if confronted with a request for assisted dying. Failure to comply with the legislative criteria can result in criminal prosecution in the Netherlands. The position concerning criminal prosecution is not as clear in Oregon, however, failure to comply with the legislative requirements can result in professional disciplinary action.

Strict requirements must be satisfied before a person can receive assistance to die. Voluntariness and the absence of external pressure, or a similar behaviour that operates to undermine voluntariness, form part of

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2. See ORS, 127.800-897 (2015), *ibid*, hereafter referred to as the DWDA. The DWDA prohibits euthanasia and only authorises a physician to prescribe lethal medication for the person to self-administer. Additionally, the term physician assisted dying, as opposed to physician assisted suicide, is preferred here as actions taken under the DWDA are not deemed to be suicide. See the DWDA, § 3.14.

3. See, *Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 2002* (Nth). The Netherlands have adopted a broader approach to assisted dying and permit both acts of euthanasia and physician assisted dying. Thus, in the Netherlands, the physician can either actively administer a lethal injection to eligible patients (euthanasia) or provide them with medication to self-administer (PAD).

4. The Northern Territory, Australia, was the first jurisdiction globally to legalize euthanasia and physician assisted suicide by enacting *The Rights of the Terminally Ill Act, 1995* (NT). However, the legislation was subsequently invalidated by the Federal Government enacting the *Euthanasia Laws Act, 1997* (Cth), which curtailed the scope of the Territories legislative power on euthanasia and physician assisted suicide.

5. However, in the Netherlands, concerns have been raised over the ostensible increase in reported cases of E/PAD over the past few years. Theo Boer poignantly criticises the Dutch model arguing that ‘Euthanasia is fast becoming the preferred, if not the only acceptable, mode of dying for cancer patients. Whereas the law treats assisted dying as an exception, public opinion is shifting towards interpreting it as a right’ see Theo Boer, “Why Dutch and Belgian Experiences on Assisted Dying Should Concern Other Countries” (2016) 131 Zadok Perspectives at 5-6.

6. ORS § 4.01(1). It is important to highlight at the outset of this discussion that there have been no adverse findings against physicians for failing to properly consider voluntariness or to assess for external pressure in a request for E/PAD. In Oregon under the DWDA there have been cases where provisions aimed at safeguarding voluntariness were contravened and these cases were sent to the Oregon Medical Board for determination. However, in all referred cases, the Oregon Medical Board did not sanction physicians for non-compliance with the law. For further discussion see pages 34-36 and Part III.
the key safeguards and are fundamental elements of a valid request in both Oregon and the Netherlands.

This article will critically examine the safeguards aimed at protecting the voluntariness of decisions and the review procedure under Oregon’s Death with Dignity Act and the Netherlands Review Procedure Act. The purpose for limiting this critical analysis to Oregon and the Netherlands is that together they have accumulated a vast amount of empirical evidence and scholarly discussion when compared to other jurisdictions with similar laws. Additionally, providing a comparative analysis of two distinctly different approaches to regulating assisted dying will provide key insight into any strengths and limitations inherent in a particular model to protecting the voluntariness of decisions.

Critical examination of Oregon and the Netherlands’ assisted dying laws has generated ample discussion and research in the existing scholarly literature. For instance, Hendin and Foley, who have written extensively on Oregon’s model of physician assisted dying, argue that the legislative safeguards in Oregon’s Death with Dignity Act are frequently being circumvented. Additionally, speaking of the role of the Oregon Health Authority, they argue that the review procedure fails to collect important information and so fails to effectively monitor the law. On a similar note, Miller and Kim undertook a detailed review of reported cases of euthanasia and physician assisted suicide between 2012 and 2015 in the Netherlands where the due care criteria had not been met. They concluded that during this period, 32 cases failed to meet the due care criteria with the majority (22) failing to adhere to procedural or technical criteria, while the remainder concerned the substantive aspects of the law including voluntariness. Miller and Kim argued that in the cases where the substantive criteria were not met, the oversight committee was not concerned with “whether the physician made the correct judgment, but whether the physician followed a thorough process.” Similarly, Lewis and Black conducted a comprehensive investigation on the adherence to the legislative criteria in the Netherlands and Oregon, concluding that, amongst other things, “the legal criteria that apply to an individual’s request for assisted dying

9. Ibid at 3-8.
10. Ibid at 9 (emphasis in original).
Voluntariness Safeguards and Review Procedure under Oregon and the Netherlands’ Physician Assisted Dying Laws are well respected.” While voluntariness was considered in each of these articles, the discussion was necessarily brief, and voluntariness as a safeguard was not subject to comprehensive evaluation. Therefore, the sole focus of this article is the requirement that a request for assisted dying was voluntarily made, or in other words a true representation of a freely made decision. There is a paucity of comprehensive research, providing comparative analysis of the law in Oregon and the Netherlands concerning this, with a view to identify any strengths or limitations within a particular model. This article aims to remedy this gap in the literature.

This article will be divided into three parts. Part I will provide a descriptive overview of the statutory requirements for a valid request for PAD in Oregon and E/PAD in the Netherlands. Here an overview of legislative criteria and safeguards will be provided. However, this part will primarily focus on provisions that aim to protect the voluntariness of decisions and safeguard against external pressure. Where appropriate, evidence released by the respective oversight authorities will be considered. Part II will provide a descriptive examination of the review procedure and role of the oversight authorities who are responsible for determining compliance with the legislative criteria. Finally, Part III of this article will provide a critical comparative analysis of the voluntary safeguards and review procedure in Oregon and the Netherlands. It is at this stage where the strengths and limitations within each particular model will be drawn out and discussed. It is hoped that this comparative statutory analysis will provide key insight into an integral aspect of assisted dying regulation and prove useful for jurisdictions still considering legalisation.

I. The Legislative Safeguards
Under Oregon’s DWDA and the Netherlands’ Review Procedures Act, there are considerable steps to satisfy before a person can be deemed eligible for assistance. The process established under the DWDA is quite methodical in comparison to the requirements of the Review Procedures Act. Moreover, as will be discussed, the criteria to access PAD or E/PAD differs considerably between the two jurisdictions. The key requirements under the DWDA and the Review Procedures Act will be discussed. For ease of reference the integral differences have been tabulated. Table 1

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provides an overview of the key differences concerning the legislative criteria, whilst Table 2 provides a comparative overview of the key safeguards that aim to protect a voluntary decision.

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Terminal Illness</th>
<th>Life Expectancy</th>
<th>Decisionally Competent</th>
<th>Advance Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon Death with Dignity Act (Oregon Death with Dignity Act, 2015)</td>
<td>Yes – Person must be diagnosed with terminal illness, defined as an incurable and irreversible disease.</td>
<td>Yes – Person must produce death within six months.</td>
<td>Yes – As the time of making the request must be decide decisionally competent.</td>
<td>No</td>
</tr>
</tbody>
</table>
| The Netherlands (Determination of Life on Request Suicide (Review Procedures) Act 2002) | No – Person must be suffering from an incurable, progressive, or severe mental illness as a sole underlying cause of the request. | No | Yes – At the time of making the request, the person must be decisionally competent. | Yes – Persons aged 18 and above.

Table 1. Comparative Overview of Key Criteria to Access PAD in Oregon and E/PAD in the Netherlands
<table>
<thead>
<tr>
<th>Jurisdiction &amp; Legislation</th>
<th>Voluntary Request</th>
<th>External Pressure Examinable</th>
<th>Duress or Coercion Examinable</th>
<th>Undue Influence Examinable</th>
<th>Terms Defined</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Netherlands - Termination of Life on request and Assisted-suicide (Review Procedures) Act 2002</td>
<td>Yes – 1) Physician must hold the conviction that the request by the patient was ‘voluntary’. 2) A second independent physician must give an opinion that the request by the patient was voluntary.</td>
<td>No – However, voluntary has been interpreted to include examination of external pressure.</td>
<td>No</td>
<td>No</td>
<td>No – Voluntary is not defined</td>
</tr>
<tr>
<td>Oregon – Death with Dignity Act, Or. Rev. Stat. 127.800 - .897 (2015)</td>
<td>Yes – 1) Attending physician must determine that the person ‘has made the request voluntarily.’ 2) Consulting physician must confirm that the patient ‘is acting voluntarily.’ 3) Two witnesses must attest that to the best of their knowledge and belief the patient is ‘acting voluntarily.’</td>
<td>No</td>
<td>Yes – 1) Two witnesses must attest to the best of their knowledge and belief that the patient ‘is not being coerced to sign the request’ and must declare that the person did not appear to be under duress.</td>
<td>Yes – 1) Two witnesses must declare that the person did not appear to be under undue influence.</td>
<td>No – Voluntary is not defined</td>
</tr>
</tbody>
</table>
1. Oregon

Oregon was one of the first jurisdictions globally to legalise PAD by enacting the DWDA in 1994. However, the legalisation of PAD was not accepted uncritically, and legal challenges which sought to invalidate the DWDA ultimately delayed its operation until October 27, 1997. The DWDA has now been operational for over twenty years.

Eligibility Criteria and Safeguards

To be eligible to make a request for PAD under the DWDA several key eligibility criteria must be met. First, the person must be resident in Oregon. Second, the person must be over 18 years old and diagnosed with a terminal disease that will produce death within six months. Finally, only persons who have voluntarily expressed their wish to die may make a request.

The DWDA includes the requirement that the patient is making an informed decision, making the request voluntarily and is capable. The terms “capable” and “informed decision” are both defined under the statute. However, neither “voluntarily” nor “voluntary” are defined under the law (see Table 2).

Ensuring that the patient is making an informed decision is critical to the process and must be medically confirmed. Here the attending physician must inform the patient of their medical diagnosis and prognosis, the risks and probable result of taking the medication and alternatives such as hospice care, comfort care and pain control. As a precaution against misdiagnosis or error, these requirements must be medically confirmed by a second physician. Additionally, if either physician suspects that the patient has impaired judgment or that they are suffering from pathological depression, then the patient must be referred for counseling. This is an important step in the process, as persons deemed to have impaired

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12. However, see above n 4, for discussion on the Rights of the Terminally Ill Act, 1995 (NT).
14. ORS, 127.805 § 2.01, supra note 2.
15. Ibid; and see, ORS 127.800 § 1.01(12).
16. Ibid. See Table 1 for an overview of the criteria.
17. Ibid, § 3.01(a).
18. See ibid, § 1.01. Voluntariness will be discussed in greater detail below.
19. Ibid.
21. Ibid, 127.825 § 3.03.
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judgment or depression can be precluded from accessing lethal medication under the DWDA.\textsuperscript{22}

Additional requirements under the DWDA are that the patient must make repeated requests to the same attending physician. The patient must make two oral requests at least 15 days apart, as well as a written request,\textsuperscript{23} signed in the presence of two witnesses.\textsuperscript{24} Importantly, at the time of making the second oral request, the opportunity to rescind the request must be provided and recorded on the patient’s medical record.\textsuperscript{25} Finally, 48 hours must lapse between the patient’s request being authorised and the medication being dispensed.\textsuperscript{26}

\textit{Voluntariness and Absence of External Pressure}

In the DWDA, the word “voluntarily” can be found throughout the statute. For example, the person must have “made the request voluntarily,”\textsuperscript{27} must be “acting voluntarily,”\textsuperscript{28} and must have “voluntarily expressed [a] wish to die.”\textsuperscript{29} It is mandated that voluntariness be assessed by two physicians. However, what “acting voluntarily” involves is not defined. Thus, the brevity of discussion on PAD under the DWDA makes it difficult to critically examine the law.

When the DWDA came into force, The Center for Ethics in Health Care at the Oregon Health & Science University published a guidebook to provide expert multi-disciplinary insight into how to comply with the legal requirements.\textsuperscript{30} However, while the guidebook is detailed, the discussion on the “voluntary” requirements under the DWDA is again limited. The guidebook suggests that both the attending and consulting physician should be aware of the “broader circumstances and a sensitivity to any indication that the patient’s request is coerced or the product of the undue influence of friends, family, or others.”\textsuperscript{31} Moreover, the guidebook

\begin{itemize}
  \item \textsuperscript{22} However, it is important to highlight that persons suffering from a form of depression are not definitively precluded from accessing PAD. The decisive factor in these cases will rest upon the severity the illness and the effect it has on their judgment, thus ensuring that persons are not unfairly excluded from accessing PAD because of the mere presence of depression.
  \item \textsuperscript{23} \textit{Ibid}, 127.840 §§ 3.06, 3.08.
  \item \textsuperscript{24} \textit{Ibid}, 127.810 § 2.02.
  \item \textsuperscript{25} \textit{Ibid}, 127.845 § 3.07.
  \item \textsuperscript{26} \textit{Ibid}, 127.850 § 3.08.
  \item \textsuperscript{27} \textit{Ibid}, 127.815 § 3.01(1)(a).
  \item \textsuperscript{28} \textit{Ibid}, 127.810 § 2.02(2).
  \item \textsuperscript{29} \textit{Ibid}, 127.805 § 2.01(1).
  \item \textsuperscript{30} Patrick Dumm et al., The Oregon Death with Dignity Act: A Guidebook for Healthcare Professionals (Oregon: The Task Force to Improve the Care of Terminally Ill Oregonians 2008), online: <http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWUTHDIGNITYACT/Pages/publications.aspx>.
  \item \textsuperscript{31} \textit{Ibid} at 95.
\end{itemize}
suggests that requests for PAD should not be authorized where there are any remaining doubts concerning volition.\textsuperscript{32}

Additionally, two independent witnesses must attest on the written request for PAD that the patient is acting voluntarily.\textsuperscript{33} The witnesses need not be personally known to the person making the request for PAD, however some exclusionary criteria apply. For instance, one witness cannot be a relative of the person by either blood, marriage or adoption;\textsuperscript{34} a beneficiary entitled to a portion of the estate;\textsuperscript{35} or an owner/operator or employee of a “health care facility where the qualified person is receiving medical treatment.”\textsuperscript{36}

As an added safeguard, the witnesses must also declare that the person making the request was not influenced by certain behaviours that operate to undermine voluntariness. They are required to attest that the person was not coerced to sign the request nor acting under duress or undue influence.\textsuperscript{37} This tripartite test is a peculiar feature of the DWDA, as these requirements go beyond assessing for mere external pressure by considering three distinct forms of behaviour—coercion, duress and undue influence.

This strict approach reflects the position that external pressures are nuanced and operate at varying degrees, ranging from the subtle (undue influence), through to the extreme (coercion/duress), all of which are unacceptable under the DWDA. This tripartite test appears to be intended to operate more rigorously than a catch all term such as “external pressure.” However, again the key terms here—duress, coercion and undue influence—are not defined under the DWDA.

Having a seemingly strong stance on safeguarding voluntariness is indeed justified in the circumstances and is not challenged here. Witnesses, especially if they are personally known to the person making a request, are likely in a better position to assess for varying kinds of external pressure that a physician and arguably provides additional assurance of voluntariness. However, it remains to be seen what utility such a strong stance has on safeguarding against unlawful external pressures if the majority of persons called upon to attest to the non-existence of these behaviours are unlikely

\textsuperscript{32} Ibid.
\textsuperscript{33} ORS, 127.815 § 3.01(1)(a).
\textsuperscript{34} Ibid, 127.810 § 2.02(2)(a).
\textsuperscript{35} Ibid, § 2.02(2)(b).
\textsuperscript{36} Ibid, § 2.02(2)(c).
\textsuperscript{37} Ibid.
\textsuperscript{38} It is important to state that under the DWDA the term ‘external pressure’ is not used to in the statute. However, external pressure is used as an umbrella term to refer to the many forms of behaviour that are included in the DWDA.
to know what they are assessing for. Surely, witnesses would benefit from additional guidance here. The inclusion of coercion, duress and undue influence as safeguards will be critiqued in Part III.

2. The Netherlands
In the Netherlands, euthanasia and assisted suicide remain criminal offences under Articles 293 and 294 of the Criminal Code. However, a physician can lawfully perform euthanasia or assisted suicide if they adhere to the six due care criteria stipulated in Review Procedures Act 2002 which came into force on 1 April 2002.

Due Care Criteria and Safeguards
To be eligible for E/PAD under the Review Procedures Act, the physician must:

a. be satisfied that the patient’s request is voluntary and well considered;

b. be satisfied that the patient’s suffering is unbearable, with no prospect of improvement;

c. have informed the patient about his situation and prognosis;

d. have come to the conclusion, together with the patient, that there is no reasonable alternative in the patient’s situation;

e. have consulted at least one other, independent physician, who must see the patient and give a written opinion on whether the due care criteria set out in (a) to (d) have been fulfilled;


40. Prior to the enactment of the Review Procedures Act, the courts had recognised that doctors could raise the defence of necessity if they assisted a person to die either through administering euthanasia or assisted suicide subject to certain conditions. Thus, the courts played a seminal role in shaping the parameters of lawful euthanasia and these rules have largely been retained in the Review Procedures Act. However, critical examination of the seminal cases and the review procedure prior to the enactment of the Review Procedures Act is beyond the scope of this article. For Discussion see Guenter Lewy, Assisted Death in Europe and America: Four Regimes and Their Lessons (New York: Oxford University Press, 2011) at 18-68.

41. Prior to the enactment of the Review Procedures Act, the courts had recognised that doctors could raise the defence of necessity if they assisted a person to die either through administering euthanasia or assisted suicide subject to certain conditions. Thus, the courts played a seminal role in shaping the parameters of lawful euthanasia and these rules have largely been retained in the Review Procedures Act. However, critical examination of the seminal cases and the review procedure prior to the enactment of the Review Procedures Act is beyond the scope of this article. For Discussion see Guenter Lewy, Assisted Death in Europe and America: Four Regimes and Their Lessons (New York: Oxford University Press, 2011) at 18-68.
f. have exercised due medical care and attention in terminating the patient’s life or assisting in his suicide [own emphasis].

The first due-care criterion (s 1(a)), requires that the physician must be “satisfied that the patient’s request is voluntary and well-considered.” The voluntary nature of the request must also be considered by a second independent physician. However, the physician who performs E/PAD—the attending physician—not the independent physician, bears the burden of demonstrating that they properly assessed the voluntary nature of the request. It is the attending physician who will be criminally liable under the Review Procedures Act. It is also important to highlight that the second independent physician does not have to agree with the primary physician’s findings and E/PAD can be performed despite any professional disagreement. The referral itself is likely to satisfy the due care criteria.

For example, consider a hypothetical clinical situation where a patient requests euthanasia from their primary physician. The primary physician has been the patient’s physician for years and determines that the request was voluntary, well considered and the patient’s suffering was unbearable with no prospect of improvement; they had informed the patient of their prognosis and possible treatment options and both came to the conclusion together the euthanasia was the best option. However, to lawfully perform euthanasia, the primary physician must consult a second independent physician. In examining the patient, the second physician raises doubts about the volition of the request and has concerns about external pressure exerted on the patient by a close relative. However, the primary physician had no such concerns about volition and administers euthanasia. Under the Review Procedures Act, there is no requirement for consensus amongst

42. Review Procedures Act, ibid, § 2(1)(a). It is necessary to note that prior to the enactment of the Review Procedures Act in 2002, euthanasia and assisted suicide could be performed in limited circumstances by a medical practitioner if they demonstrated that they acted out of necessity. However, because this thesis is focused on statutory models of E/PAD, reference to the judicial decisions prior to the enactment of the Review Procedures Act will be limited and considered when necessary. However, it is important to note that these decisions informed the principles in the Review Procedures Act and therefore, is still applicable.
43. Ibid.
44. Ibid, § 2(1)(e).
45. Discussion on the multi-disciplinary composition of the Review Committees established under the Review Procedures Act will be addressed later.
the physicians. The act of referral alone would mean that the primary physician is likely to have acted with due care, thus satisfying the elements of the statutory defence. However, if such a case did arise, and the facts of this hypothetical scenario are not so fanciful as to render this scenario improbable, it would be prudent for the primary physician to seek another expert opinion. The lack of consensus should not be overlooked and greater caution in such cases would lead to greater protection for the physician, and importantly, the patient. However, consensus is not mandatory under the law.

Turning back now to the interpretation of a voluntary decision, it is important to highlight that the first due care criterion requires that the request be “voluntary and well considered.” At law this has been interpreted as a two-limb test each of which requires consideration of distinct facts. This discussion will only focus on the first limb—the voluntary criterion—as “well considered” lies beyond the narrow focus of this discussion.

‘Voluntary’ is not defined in the text of the Review Procedures Act. However, there is considerable discussion on the parameters of this criterion by the Regional Euthanasia Review Committees (Regionale Toetsingscommissies Euthanasie) (Committees). The Committees’ have defined voluntary as consisting of two separate elements, stating that:

There are two aspects to this [voluntary]. The request must be internally voluntary, i.e. the patient must have the mental capacity to determine his own wishes freely, and externally voluntary, i.e. he must not have made his request under pressure or unacceptable influence from those around him.

Thus, it can be seen that this criterion itself requires consideration of complex factors which are not explicitly evident on the face of the law. However, this article is concerned with external voluntariness, not internal

47. Review Procedures Act, supra note 38, s 2(1)(a).
48. Ibid.
49. The role of the regional review committee will be discussed in Part II of this article. As the committees play an integral role in interpreting and applying the due care criteria, it is not possible to isolate them from this discussion in Part I. This can be distinguished from the procedure in Oregon, as the Oregon Health Authority do not have such a strong role or influence in interpreting the law. This point of difference will be considered in Part III of this article.
voluntariness, \textsuperscript{51} therefore this discussion will be narrowed further and will only consider the external voluntariness element of the “voluntary” criterion.

\textit{External Voluntariness} \\
External voluntariness looks beyond the individual’s decision-making competence and instead focuses on their social environment for unacceptable external pressure placed on them to request E/PAD. When considering external voluntariness, the physician must demonstrate how they determined that the person making the request was not “under pressure or unacceptable influence from those around him [or her].”\textsuperscript{52} This must be explicitly documented in the report sent to the Committees. To ensure transparency and clarity with the due care criteria under the \textit{Review Procedures Act}, the Committees perennially make information on their judgments publicly available.

The Committees can, at their discretion, publish individual case reports on their website. This discretion is usually exercised when a case raises novel issues with the interpretation of the due care criteria or where it has been determined that a physician did not terminate life in accordance with the due care criteria. It is important to note that there currently exists a scarcity of discussion of cases in English where external voluntariness is considered in detail. Until recently, most of the individual case reports were only available in Dutch. The Committees have, however, started to reproduce these reports in English, presumably to provide greater transparency into how the substantive legal criteria are interpreted. Currently, judgments from 13 individual case reports (2014-2016) have been published in English,\textsuperscript{53} yet external voluntariness has not been an issue in any of these cases. However, in these judgments, it is evident that that the families were included in the discussions on E/PAD in most cases.\textsuperscript{54} Thus, the involvement of the family in the decision-making process appears to be important. This supports the relational approach

\textsuperscript{51} Internal voluntariness focuses on the competence of the person requesting euthanasia. Critical to this element is the requirement for the patient to be decisionally competent. Decisional competence refers to the requirement ‘that the patient is able to understand relevant information about his [sic] situation and prognosis, consider any alternatives and assess the implications of his [sic] decision.’ For discussion on the elements of internal voluntariness see Regional Euthanasia Review Committee, \textit{Code of Practice} (April 2015), online: <www.euthanasiecommissie.nl/de-toetsingscommissies/uitspraken/brochures/brochures/code-of-practice/1/code-of-practice>.

\textsuperscript{52} See Regional Euthanasia Review Committee, \textit{supra} note 50.


\textsuperscript{54} See \textit{ibid}. 

\textsuperscript{50}
However, important questions remain. When does acceptable familial involvement transform into unacceptable external pressure and thus vitiate external voluntariness? When does the invisible line get crossed? In an attempt to answer this, individual case reports, along with the Annual Reports and other authoritative material released by the Committees will be used to provide a foundation of what external voluntariness means under the Review Procedures Act.

However, it must be acknowledged that this discussion may not be a complete representation of the information available on external voluntariness under the Review Procedures Act. It is likely that there is more diverse, in depth information in Dutch. However, as access to information beyond the English translations of the Annual Reports was not possible, this discussion is limited in its scope.

A logical starting point for this discussion is the existence of a physician-patient relationship. Although not prescriptive in the legislation, it was initially considered that for E/PAD to be administered with due care it must “presuppose some kind of clinical relationship with the patient.”

This used to be considered essential to determine the external voluntariness of a request. Doctor/patient relationships that were solely confined to the performance of euthanasia were likely to fail to meet this due care criterion because it was assumed that external voluntariness could not be properly assessed under these circumstances.

However, in recent years this principle has been eroded with the emergence of SLK End-of-Life Clinics in 2012, whose sole responsibility

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55. Familial involvement and support is viewed as an important factor influencing assessment of the due care criteria and it has been argued that the erosion of the long-standing physician/patient relationship has placed greater emphasis on familial input in decision making for E/PAD, see Marianne Suijdewind, Dick Willems et al, “A Study of the First Year of the End-of-Life Clinic for Physician-Assisted Dying in the Netherlands” (2015) 175:10 JAMA Intern Med 1633 at 1639.


57. Ibid at 16-18. In 2002 a doctor who euthanised a patient after being in a clinical relationship with them for only one day did not act with the due care and the case was referred to the Board of Procurators-General. Pertinent to the Committees’ referral was, amongst other things, the brevity of the physician/patient relationship.

58. Ibid at 16.
is confined to the provision of E/PAD.\(^{59}\) SLK physicians consult patients on an average of three visits prior to approving/administering E/PAD, thus departing from the previous model relationship.\(^{60}\) This was initially recognised as a point for concern by the Committees when reviewing cases and consequently, all notifications received from SLK were listed as non-straightforward, and therefore required mandatory discussion at the monthly Committee meetings.\(^{61}\) However, in 2015, the Committees indicated that they now apply the same procedure, as in other cases, for notifications received from SLK, thus meaning that notifications are not, as a matter of policy, automatically considered non-straightforward.\(^{62}\) The Committee Secretary can now use their discretion regarding how to categorise notifications received from SLK.

It might be said that this rule is still flexible as there is no rigid requirement concerning the duration of a physician-patient relationship. The important factor is that the physician must know the patient long enough to carefully examine the voluntary nature of the request.

A case reported in 2003\(^{63}\) provides insight into external voluntariness as it considers an important threshold question for external pressure. In this case, the physician identified that there was some external pressure on the person to request E/PAD from relatives. However, they concluded that the pressure was not strong enough to vitiate external voluntariness. Although this example does not provide comprehensive insight into the technical/nuanced elements of external voluntariness, it does suggest that some pressure can permissibly be exerted on persons to request E/PAD.

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Turning to the broader information available, the Code of Practice (the Code) published by the Committees, provides basic information regarding the parameters of external voluntariness.\footnote{Regional Euthanasia Review Committee, Code of Practice (April 2015) at 11, online: <www.euthanasiecommissie.nl/de-toetsingscommissies/uitspraken/brochures/brochures/code-of-practice/1/code-of-practice>. The Code of Practice of the Regional Euthanasia Review Committees was published by the Committees after the second evaluation of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 2002 (Nth) was completed. The second evaluation indicated that information on how the Committees operate and how they interpret the statutory due care criteria should be made more accessible. However, shortly after writing this article, the Committees released the Euthanasie Code 2018, which replaces the Code of Practice 2015 discussed here, see Regionale Toetsingscommissies Euthanasie, Euthanasie Code 2018 (2018), online: <www.euthanasiecommissie.nl/uitspraken/brochures/brochures/euthanasiecode/2018/euthanasiecode2018>. The Euthanasie Code 2018 is yet to be released in an English Translation, moreover, likely due to its recent release, there is no discussion of the Euthanasie Code in the academic literature. Therefore, it is acknowledged that the information provided here under the Code of Practice may have been updated, expanded upon or superseded by the Euthanasie Code 2018. However, further discussion on this is not available.} The Code seeks to provide information on behaviour that may indicate external voluntariness is being undermined. For example, the Code states that a “request must have been made without any undue influence from others.”\footnote{Ibid.} In particular the Code suggests that physicians should be cautious “when a close relative of the patient becomes too overtly involved in the conversation between the physician and the patient, or repeatedly gives answers that the physician wishes to hear from the patient.”\footnote{Code of Practice (April 2015), ibid at 11.} The existence of such behaviour may indicate that the person may not be exercising their free will to request euthanasia, thus not satisfying the requirement that the request be externally voluntary. In such cases, it is suggested that physicians should consult with the patient privately and explore the issue of external voluntariness directly with the patient.\footnote{Ibid at 23-24.}

The pivotal issue here is that a request for euthanasia must come from a patient—it cannot be made by a third party.\footnote{Ibid.} If there is any doubt concerning external pressure then this should put the physician on notice that the request may not be made voluntarily. If after consultation there is any residual doubt, then on the face of the law, they should not grant the request. However, as discussed in the preceding paragraph, there is some acceptance of the principle that some external pressure may be lawfully applied and this will not necessarily vitiate external voluntariness. This is an issue to address comprehensively and is a question of fact and degree, taking into consideration the individual circumstances of the individual patient.
It is therefore evident that safeguarding a voluntary decision under the DWDA and the Review Procedures Act is critical and seemingly elaborate safeguards have been mandated to ensure that voluntariness is well protected. However, in both jurisdictions the legal response to safeguarding voluntariness is vastly different. Under the DWDA, witnesses play a significant role and are called upon to declare the non-existence of behaviours that seek to undermine voluntariness—under the Review Procedures Act no such requirement is made. However, in the Netherlands it has been recognised that family members play a significant role for physicians in assessing the due care criteria. Moreover, under the Review Procedures Act, the Regional Review Committees play an integral role in defining and shaping the parameters of the “voluntary” criterion and have published some information on what “voluntary” means. However, in comparison, there is little information publicly available on what “acting voluntarily” means. The Oregon Health Authority maintain this silence, thus precluding critical examination of this requirement. The review procedure and the role of the Oregon Health Authority and the Regional Euthanasia Review Committee in the Netherlands will now be considered.

II. Review Procedure of Granted Requests
After eligibility has been determined and assistance provided, the next critical step mandated by the respective legislative instruments is that an external review committee must review the request and determine whether the physician complied with the legislative criteria. Thus, compliance with the law is verified *a posteriori* in both jurisdictions. In Oregon the body mandated with this task is the Oregon Health Authority (OHA), and in the Netherlands this task is performed by one of five Regional Euthanasia Review Committees (the Committees). It is important to highlight that in Oregon and the Netherlands the review procedure commences after the performance of different acts. In Oregon, the review procedure occurs after the lethal prescription has been authorised, given that the physician’s involvement ceases once the prescription has been written. However, in the Netherlands this process does not commence until after E/PAD has been administered and the patient is deceased. Additionally, each review committee only reviews cases where the request was granted—refused requests are not examined. For clarity of discussion, the key differences in the review procedure have been tabulated (Table 3).

69. *ORS, 127.865 § 3.01(2), supra note 2; Oregon Administrative Rules, 333-009-0010.*
<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Review Procedure Performed By</th>
<th>Qualifications of Members</th>
<th>Review Documents</th>
<th>Power to Penalise for Non-Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon</td>
<td>Oregon Health Authority (OHA)</td>
<td>• State Health Officer who is a qualified medical doctor (MD); and&lt;br&gt;• Research Analyst who maintains files and records.</td>
<td>• The attending physician must submit the patient’s written request and either the:&lt;br&gt;a) “Attending Physician’s Compliance Form”; or&lt;br&gt;b) “Attending Physician’s Compliance Short Form” and the patient’s medical record; and&lt;br&gt;• “Consulting Physicians Compliance Form”; and&lt;br&gt;• “Psychiatric/Psychological Consultant’s Compliance Form” (if necessary).</td>
<td>No – All cases of non-compliance must be referred to the Oregon Medical Board for determination</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>Regional Euthanasia Review Committee – Five committees have been established in total covering a defined geographical area</td>
<td>• Each Committee must be comprised of at least one legal expert, one physician and one expert on ethical and moral issues. &lt;br&gt;• Each Committee has a secretary who is a legal expert to provide advise at Committee meetings</td>
<td>• After performing euthanasia, the physician must notify the municipal pathologist of the cause of death in accordance with s 7(2) of the Burial and Cremation Act (Nth). &lt;br&gt;• The physician must forward a detailed report defending how they terminated life with due care.</td>
<td>No – all cases of non-compliance are referred to the Board of Procurators General and the regional healthcare inspector for determination.</td>
</tr>
</tbody>
</table>
1. **Oregon Review Procedure**

The Oregon Health Authority (OHA) are the authorised body to review all reported cases of PAD under the DWDA. After a prescription has been authorised, the prescribing physician must forward all documentation to the OHA, which determines whether the legislative criteria have been complied with. However, the OHA’s power is not absolute, and cases of non-compliance must be referred to the Oregon Medical Board, which ultimately decides whether to sanction the physician. The DWDA itself is silent on the composition of the OHA who provide the review procedure, however it has been advised by the OHA that this task is performed by a State Medical Officer who holds a medical degree, and a Research Analyst who maintains all the patient files and records.

To facilitate the review procedure, the OHA have issued administrative rules—the Oregon Administrative Rules (OAR). The OARs stipulate that the physician must forward all documentation to the OHA within 7 days of authorising a prescription. There are two review methods the physician can choose. The first form requires the physician to submit to the OHA the patient’s written request for medication along with the “Attending Physicians Compliance Form,” the “Consulting Physicians Compliance Form” and, if a referral was made, the “Psychiatric/Psychological Physicians Compliance Form.” All requisite forms have been drafted by the OHA and can be accessed on their website. The compliance forms and the patient’s request form have been drafted in such a way that they require minimal substantive information to be added by the physician. For example, both the attending and consulting physician’s compliance form predominantly require the physicians to check boxes confirming that they have undertaken the substantive elements, with no requirement

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70. Ibid, 127.865 § 3.11(1)(a).
71. The requisite documentation required under the DWDA and supplementary administrative rules will be considered further below.
72. Email from Michaela E Okninski to the Oregon Health Authority, 18 August 2017.
73. *Oregon Administrative Rules* (OAR), 333-009-0010 (1),(a); see also *ORS*, 127.865 § 3.11(2) (2015).
75. Ibid, (b)(a)-(d).
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to defend how they came to a determination. The physician is merely required to check a box indicating they determined that the patient is “acting voluntarily” without being required to justify how such a determination was made. This is a stark point of contrast with the review procedure in the Netherlands, where the physician must compile a detailed report for the Committee, defending how they complied with each due care criteria. This contrast will be drawn out in Part III.

The Second type of review permitted by the OARs is a short form of review. The only difference with the review method here is that the “Attending Physician’s Compliance Form” is replaced by the “Attending Physician’s Compliance Short Form” (the Short Form). The Short Form authorises the OHA to review the relevant sections of the patient’s medical record to determine compliance with the DWDA. The attending physician must, therefore, forward the medical record to the DWDA to perform this task. This second review method would arguably provide a more robust form of review due to detailed information the OHA are required to review in the patient’s medical record. However, it has been advised by the OHA that the preferred method of review is the former review method; by submitting the “Attending Physician Compliance Form.” In fact, very few cases have been reviewed by using the Short Form method. The information collected by the OHA forms part of the annual reports on PAD which must be published.

77. See ibid. The physician is not required to provide the OHA with a detailed report on how voluntariness was determined. However, the DWDA requires specific detailed information to be recorded on the patient’s medical file see ORS, 127.855 § 3.09 (2015). This information is not reviewed by the OHA.

78. The lack of detailed reporting to determine compliance with the law was subject to criticism when the DWDA first came into force, however, the reporting procedure has not been amended


80. Email From Michaela E Okninski to the Oregon Health Authority, 23 August 2017.

81. OAR, supra note 73 333-009-0020; for further discussion on the reporting system see Oregon Health Authority, Methods (November 2015), online: <www.oregon.gov/oha/PH/ PROVIDERP ARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/ Pages/ar-index.aspx>. The OHA also require physicians to complete a follow up questionnaire after a patient dies by ingesting the medication see 333-0090-0010 s 2.
Oregon has now released 19 annual statistical reports. As explicitly stated in the DWDA, the reports are purely statistical and do not provide insight into how integral provisions of the DWDA have been interpreted and applied. Additionally, the annual reports indicate that compliance with the DWDA is high. Since the DWDA came into force, 22 referrals to the Oregon Medical Board have been made. In all cases, no disciplinary proceedings were brought against physicians for non-compliance. However, while the evidence demonstrates near perfect compliance with the DWDA, this does not necessarily mean that the law is functioning well to safeguard voluntariness and weed out coercion and undue influence. In Part 3, I will argue that the OHA’s review procedure may be insufficient to ensure voluntariness is protected.

82. This figure is correct at the time of writing this article (2017). For access to the annual statistical reports see Oregon Health Authority, Death with Dignity Act Annual Reports (February 2017), online: <www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx>. The DWDA came into force in 1997, however no prescriptions were authorised in this year.

83. OHS 127.865 § 3.11(3).


2. The Netherlands

Review Procedure

Determination of whether a medical practitioner has properly “satisfied [themselves] that the request is voluntary” is decided a posteriori—after E/PAD has been performed. The Review Procedures Act mandates that immediately following the death, the medical practitioner who performed E/PAD must notify the municipal pathologist of the cause of death and submit a report demonstrating compliance with the due care criteria. The physician must also submit a copy of the independent physician’s report and any other documentation that will assist the Committee in making a determination. The municipal pathologist does not assess the report but then forwards the documentation to the relevant Committee established under the Review Procedures Act.

There are five committees established throughout the Netherlands and each is comprised of physicians, lawyers and ethicists who review all reported cases of E/PAD. This multi-disciplinary composition is mandatory for each of the Committees, because each discipline reviews reported cases through their own professional lens and each brings essential insight into determining compliance with the different elements of the due care criteria. In performing the review procedure, the Committees divide cases into two categories of notifications: 1) straightforward notifications; and 2) notifications that raise questions. The majority of notifications are categorised as straightforward (75%) and are reviewed by all committee members digitally. However, if any issues arise during the digital review process then the case is referred to the monthly committee meetings, where the more complex cases are discussed in detail.

86. Law of 7 March 1991 (Wet op de lijkbezorging). An English translation of the relevant provisions of the Burial and Cremation Act can be found in the annual reports released by the Committees, see Regional Euthanasia Review Committee, Annual Report 2015 (2016) at 46, online: <https://english.euthanasiecommissie.nl/the-committees/documents/publications/annual-reports/2002/annual-reports/annual-reports>.
87. Regional Euthanasia Review Committee, supra note 50 at 8.
88. Ibid. For an overview of the review procedure see Regional Euthanasia Review Committee, Review Procedure in Text, online: <english.euthanasiecommissie.nl/review-procedure/review-procedure-in-text>.
89. Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 2002 (Nth) s 3(2).
90. Regional Euthanasia Review Committee, supra note 50 at 8.
91. Categorizing cases as straightforward and non-straightforward is a relatively new procedure that commenced in 2012. In 2016, 80 per cent of the notifications were considered to be straightforward, see Regional Euthanasia Review Committee, Annual Report 2016 (March 2017) at 19, online: <english.euthanasiecommissie.nl/the-committees/documents/publications/annual-reports/2002/annual-reports/annual-reports>.
92. Regional Euthanasia Review Committee, supra note 50 at 8.
The Committees are vested with quasi-judicial power. They have the power to determine compliance with the due care criteria and to develop the law, thus playing a significant role in interpreting external pressure.\textsuperscript{93} The fact that the Committees are vested with such broad discretionary power has not been accepted uncritically though. Boer argues the recent dramatic yearly increases in reported cases of euthanasia can be attributed to the liberties bestowed upon the Committees to interpret the due care criteria. He argues that this has resulted in a marked shift in the pathology of euthanasia practice in the Netherlands.\textsuperscript{94} However, despite this ostensible liberty, the scope of the Committees’ power is limited in cases of non-compliance and they cannot impose a penalty or commence disciplinary proceedings. This is consistent with the scope of the OHA’s power discussed in the preceding section. The decision to commence disciplinary action or prosecute the physician vests in the regional health care inspector and the Board of Procurators General.\textsuperscript{95} However, prior to making any referral, the Committee will afford the physician the opportunity to adduce additional information to justify their action. It is important to note that prosecutions for non-compliance with the due care criteria are extremely rare.\textsuperscript{96} The annual empirical data published by the Committees demonstrate that to date there have been no prosecutions for cases referred by the Committees to the Board of Procurators General.\textsuperscript{97}

Thus, while the review procedure to determine compliance with the legislative criteria is verified a posteriori in both Oregon and the

\textsuperscript{93} Decisions of the Committee and how external pressure has been defined was considered in detail in Part I of this article.


\textsuperscript{95} Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 2002 (Nth) s 8(1). Decisions whether to prosecute physicians who violate the due-care criteria are based upon the “Instructions on prosecution decisions in the matter of termination of life on request and assisted suicide” (Aanwijzing vervolgensbeslissing levensbeeindiging op verzoek (euthanasie en hulp bij zelfdoding)).

\textsuperscript{96} See Miller & Kim, supra note 8. Miller and Kim conducted comprehensive research on cases where the due care criteria were not met and concluded that between 2002–2016, 89 out of 49,287 reported cases for E/PAD were found not to meet the due care criteria.

\textsuperscript{97} See Regional Euthanasia Review Committee, Annual Report 2016 (March 2017) at 7, online: <english.euthanasiecommissie.nl/the-committees/documents/publications/annual-reports/2002/annual-reports/annual-reports>. However, after writing this article, it was announced that four cases performed in 2017 have been referred to the Board of Procurators General for investigation. The outcome of these cases is not yet known. In two of these cases, the complaint concerns failure to properly determine that the request was voluntary. Thus, this could potentially provide further insight into the operation of the due care criterion to ascertain that the request was voluntary, see Daniel Boffey, “Dutch Prosecutors to Investigate Euthanasia Cases After Sharp Rise,” The Guardian (12 March 2018), online: <www.theguardian.com/world/2018/mar/12/dutch-prosecutors-investigate-euthanasia-cases-sharp-rise-doctor-assisted-deaths-netherlands>. 
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Netherlands, there are critical differences in how the review procedure is performed. In Oregon this happens after the physician authorises the lethal prescription, and in the Netherlands this occurs after E/PAD has been administered and life has been terminated. Additionally in Oregon the review procedure is largely performed by the physician checking boxes indicating compliance with the legislative criteria and they are not required to defend how they determined the person was acting voluntarily. This is a stark point of contrast with the requirement under the Review Procedures Act where the physician must submit a detailed report defending how they determined the request was voluntary. Moreover, in the Netherlands the composition of the review committee is multi-disciplinary and each discipline views each reported case through its own professional lens. Whereas in Oregon, a medically qualified State Medical Officer primarily performs this duty. The key differences with the legislative safeguards and review procedure will now be considered and strengths and limitations will now be discussed.

III. Comparative Analysis to the Two Jurisdictions

In both Oregon and the Netherlands it is fundamental that physicians must ensure that requests for PAD or E/PAD are voluntary and not the product of external pressure. However, there are critical differences between the two jurisdictions concerning how voluntariness is safeguarded and how the review procedure is performed. Key differences will now be considered, and strengths and limitations will be drawn out. The aim here is to provide a comparative analysis to highlight identified strengths and limitations with some of the legislative criteria, which will hopefully prove useful for jurisdictions still considering legalizing some form of assisted dying. The first part of this critical comparative analysis will focus on the provisions that aim to safeguard voluntariness under each statute, drawing on the discussion in Part I. This will then be followed by a comparative analysis of the review procedure in Oregon and the Netherlands, which was considered in detail in Part II of this article.

1. The Legislative Safeguards

Both jurisdictions have seemingly strict safeguards in place to protect a voluntary decision. However, there are fundamental differences in the approach taken to safeguard a voluntary decision. The most notable difference was the inclusion of witnesses in requests for PAD in Oregon. The witness provisions will be discussed first. The second associated issue that will be considered is the omission to define the key terms under the statute. These requirements have been described in detail in Part I, they will, therefore, not be repeated here.
**Witness Provisions**

The inclusion of witnesses to safeguard a voluntary decision is a fundamental element of a valid request for PAD in Oregon. In the Netherlands, there is no requirement for witnesses to sign a request for euthanasia, as assessing voluntariness is primarily the responsibility of the attending physician. It may, at first, seem prudent to call upon additional persons to attest to the voluntariness of the request. Indeed, they may have more in depth personal knowledge of the individual and their social environment, therefore placing them in a better position than the physician to determine unacceptable social influences. However, there are limitations with this approach which arguably weaken the ideology behind this safeguard.

First, the witness is not required to be personally known to the person making the request. There are exclusionary criteria that preclude people as witnesses, namely those who seek to gain financially from a premature death.\(^9^8\) Yet there are no minimum mandatory requirements for persons to act as witnesses, such as the minimum length of the relationship. Assessing for voluntariness and the absence of duress, coercion and undue influence in a request for PAD presupposes some kind of personal relationship with the person, yet this is not currently mandatory. For such a safeguard to operate properly, at least one witness should be personally known to the person to enable them to make a proper assessment of voluntariness. Under the DWDA, the witness provisions appear to be a formality rather than a safeguard, that offers limited protection for a voluntary decision.

This issue is exacerbated by the failure to define the key terms under the legislation. Witnesses are required to attest to the non-existence of certain complex behaviours under the DWDA—duress, coercion and undue influence.\(^9^9\) This seemingly strict approach reflects the position that external pressures are nuanced and operate at varying degrees, ranging from subtle unacceptable persuasions (undue influence), through to the extreme (coercion/duress). Thus, under the DWDA, it appears that more is required than examination of “external pressure.” However, none of these key terms are defined in the DWDA and there is no guidance or framework available for witnesses that would assist them to discharge this requirement in a meaningful way.

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98. See Part I for discussion on the witness requirements. The appropriateness of undue influence as a safeguard for a voluntary decision has been considered in the past elsewhere, see Thaddeus Pope & Michaela Okninski, “Legal Standards for Brain Death and Undue Influence in Euthanasia Laws” (2016) 13:2 J Bio Inq at 173-78; Michaela Okninski, “Commentary on Undue Influence Provisions under Oregon’s Death with Dignity Act and California’s End of Life Option Act” (2017) 25:1 J Law & Medicine 77.

99. See Table 2.
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Thus, it is likely that persons called upon to be witnesses, unless perhaps legally trained (and expert in equity), would know the difference between these behaviours. Furthermore, the inclusion of undue influence, which is a subtle form of unacceptable external pressure, is not a term that exists in the ordinary English lexicon, but rather, is a complex legal doctrine. The inclusion of a complex legal doctrine coupled with the failure to define key terms means that it is unlikely that this approach will provide meaningful protection.

In contrast, the Netherlands do not require witnesses to safeguard voluntariness or sign a request for E/PAD. This is solely the responsibility of the attending physician. However, it is unlikely that Oregon’s witness requirements offer any advantages over the protections that exist in the Netherlands’ Review Procedures Act.

Defining Key Terms

The associated issue that arises with the voluntariness safeguards is the failure to define key terms. In Oregon two physicians must agree that the person was “acting voluntarily.” However, “acting voluntarily” is not defined. Moreover, the OHA does not provide any guidance on how acting voluntarily should be determined and what should be considered when determining voluntariness. In fact, there is an overall lack of clarity concerning this criterion and how it should be examined. Acting voluntarily is critical to the operation of the DWDA, yet it remains overlooked, arguably weakening the effect of this safeguard. Given the gravity of what the DWDA legalizes and the finality of PAD, detailed guidance and discussion on this criterion is needed.

Refer to Part I, especially Table 2, for an overview of the legislative safeguards.

100. Undue influence recognizes that subtle forms of influence and pressure, in the right circumstances, can become unlawful and vitiate voluntariness, thus negating a voluntary decision see for example Slusarenko v Slusarenko, 147 P 3d 920; Reddaway v Reddaway, 329 P 2d 886; see also Sarah Worthington, Equity (Oxford University Press, 2003) 192-199. If a decision was made pursuant to the undue influence of another it is said to not be made freely and the law will not permit the decision to stand see, for example, Barclays Bank plc v O’Brien, [1994] 1 AC 180; Royal Bank of Scotland v Etridge, [2001] 4 All ER 449. For judicial consideration of undue influence in refusal of medical treatment in England see (Re T (Adult: refusal of medical treatment), [1993] C.A. Fam 95. Furthermore, in recent years California completed a research project to devise a screening tool for undue influence for use in Adult Protective Services (APS), whose primary responsibility is to work with adults at risk of elder abuse. Thus, it can be said that it is being recognised that undue influence is a concern and educating people who role it is to work with vulnerable people is of critical importance, see Mary Joy Quinn et al, “Developing an Undue Influence Screening Tool for Adult Protective Services” (2017) 29 J Elder Abuse & Neglect 157.

101. Refer to Part I, especially Table 2, for an overview of the legislative safeguards.

102. The role of the OHA will be considered further below.

103. The role of the OHA and the limited data they collect is not a new criticism, see Kathleen Foley & Herbert Hendin, “The Oregon Report: Don’t Ask, Don’t Tell” (1999) 29:3 Hastings Centre Report at 37-42.
should be made available if it is to operate effectively as a safeguard. This is a stark point of contrast with the position in the Netherlands, where the Committee strive to provide transparency and guidance into how to properly assess voluntariness.

The *Review Procedures Act* itself is evasive and does not define what a voluntary request is. While this lack of definition and overall guidance can be perceived as a limitation, this is not the case. The Committees play an integral role in defining the parameters of voluntariness and have published a considerable amount of literature to clarify what voluntary means.104 Judgments of reported cases are routinely published on the Committees’ website and any cases that raise novel or complex issues are usually made publicly available. It is the mandate of the Committees to ensure that the law is transparent, and that guidance is provided as to how external voluntariness should be assessed.105 In comparison this appears to be a marked improvement on the position under the DWDA, where there is a sustained lack of transparency. Under the DWDA, physicians should be made to rigorously defend their position on how they determined a decision was voluntary and not be required to tick a box indicating that they complied with this criterion.106 Moreover, the OHA should play a more active role and require detailed information to be submitted concerning how compliance with the law was determined then important information based upon previous decisions of the OHA concerning this criterion should be published. Providing insight and transparency into this requirement could strengthen the legislative safeguards.

2. **Review Procedure**

Reviewing reported cases of PAD and E/PAD to determine whether the legislative criteria have been complied with is an important aspect of regulation. The review procedure in both Oregon and the Netherlands is retrospective and occurs after assistance has been provided. The Oregon Health Authority and the Regional Euthanasia Review Committee are vested with this duty. They can determine compliance with the law, however they do not have the authority to sanction physicians for non-compliance.

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104. See Part I for discussion on this. It was also considered in Part I that the request must be externally voluntary and not the result of unacceptable pressure.


106. Issues with the review procedure and the box ticking requirement will be considered in detail below.
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and these cases are referred to another authority for determination.\textsuperscript{107} 
Assessment of whether the physician properly considered that the request was voluntary and not the result of external pressure is determined at this stage as well. Key differences with the review procedure will now be critiqued. The review procedure process was described in detail in Part II and will, therefore, not be discussed here.

\textit{Review Procedure Process}

Reviewing reported cases of PAD and E/PAD for compliance with the law is a critical aspect of regulation. Legalising or decriminalising assisted dying is a highly controversial step to take. The review procedure process can reassure the general public that the law is subject to strict scrutiny and that the legislative safeguards are working well. Furthermore, this may assist to dispel the perennial fear that assisted dying legislation will ultimately be abused or misused. However, to ensure that public confidence in the law is maintained, the review procedure process must be both robust and rigorous. The procedure adopted by the OHA raises concerns regarding the quality of the review.

In Part II it was demonstrated that under the OARs there are two forms of review procedure the physician can elect to use. The most common type of review is undertaken by the physician submitting to the OHA a series of compliance forms.\textsuperscript{108} Part C of both the “Attending Physician’s Compliance Form” and the “Consulting Physician’s Compliance Form” contain a list of the substantive legislative criteria that the physicians must adhere to in order to lawfully provide PAD.\textsuperscript{109}

\textsuperscript{107} See Part I. In Oregon this authority is the Oregon Medical Board and in the Netherlands cases of non-compliance are referred to the regional health care inspector and the Board of Procurators General for determination. Referrals for non-compliance are rare in both jurisdictions. In Oregon since the DWDA came into force 22 cases were referred for non-compliance with the DWDA. In all cases, no physicians were penalised by the Oregon Medical Board see Oregon Health Division, \textit{Death with Dignity Act Annual Reports} (21 February 2017), online: <www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx>. At the writing of this article there have been no charges laid against physicians by the Board of Procurators General in the Netherlands for non-compliance with the due care criteria. However, in ‘a handful of cases’ the regional healthcare inspector has commenced disciplinary proceedings see Regional Euthanasia Review Committee, \textit{Annual Report 2016} (March 2017) at 7, online: <english.euthanasiecommissie.nl/the-committees/documents/publications/annual-reports/2002/annual-reports/annual-reports>.\textsuperscript{108} The other type of review discussed in Part II was the short form version where the physician authorised the OHA to review the person’s medical record to determine compliance with the DWDA. However, as this type of review has only been used a few times since the DWDA came into force, it will not be considered in detail here.\textsuperscript{109} Oregon Health Authority, \textit{Death With Dignity Forms} (November 2015), online: <www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/pasforms.aspx>.\textsuperscript{109}
both physicians to rigorously defend how they determined that the person was acting voluntarily, the OHA merely requires the physician to check a box indicating that they determined the person was acting voluntarily.\textsuperscript{110} There is no formal requirement to submit a detailed report beyond the compliance forms. Therefore, the OHA determines compliance with the legislative criteria based upon whether the physician checked a box or not. It remains to be seen how this method can in fact determine compliance with the legislative criteria. The OHAs perform a minimalist function in reviewing reported cases and provides no independent scrutiny of the physicians’ judgment. Furthermore, the apparent lack of critical review of reported cases of PAD undermines the statistical data released by the OHA.\textsuperscript{111} The OHA have consistently argued that there is no evidence to indicate that persons are being coerced or under duress or undue influence to make a request, suggesting that the legislative safeguards are working well at protecting a voluntary decision. However, the foundation of this data is built on precarious ground, as there is no robust or rigorous review of reported cases performed by the OHA. Thus, it is apparent that there are concerning shortfalls with the OHA review procedure. This serves as an interesting contrast with the review procedure in the Netherlands, where physicians are made to rigorously defend how they determined the person making the request was doing so voluntarily and was not being externally pressured to do so.

As well as mandating physicians to substantiate how they determined the person was acting voluntarily, the Committee also review all reported cases through a multi-disciplinary lens, thus ensuring that legal, medical and ethical issues are properly considered in every case. Moreover, selected judgments of the Committees are perennially published to ensure transparency, clarity and consistency in the decisions of the Committee. Moreover, complex cases or cases that raise novel issues are discussed in detail to provide insight and guidance for physicians if they face analogous cases in the future.

However, the role of the Committees in the Netherlands is not without criticism. The very fact that they are vested with discretionary power to interpret the law has led to the broadening of the interpretation of the due care criteria and a dramatic increase in the annual rates of E/PAD.\textsuperscript{112} Speaking of the marked uptake on E/PAD in the Netherlands since the law

\textsuperscript{110} See \textit{ibid}. Similar criticisms of the OHA’s review procedure have been raised in the past see Foley and Hendin, \textit{supra} note 103.

\textsuperscript{111} See Part II for discussion of the empirical data.

was enforced in 2002, Boer argues that it may not be “legalization in itself that leads to these developments, it may be the way in which the Dutch have set the rules: the enormous liberties of the RRCs [the Committees], in combination with the open character of the due care criteria.” However, this criticism speaks more to the broadening of the interpretation of the nature of the unbearable suffering, another important due care criterion, rather than voluntariness, therefore, it is beyond the narrow scope of this article. However, this remains a pertinent criticism of the review procedure and could not go unsaid here. It can be concluded that the review procedure adopted under both jurisdictions have limitations. However, in terms of assessing voluntariness, the procedure adopted in the *Review Procedures Act* appears to be more robust and rigorous than the OHA. Jurisdictions contemplating legalisation of some form of assisted dying should take heed of these concerns.

**Conclusion**

Legalization of some form of assisted dying remains a topical issue in many jurisdictions throughout the world. In the ongoing assisted dying debate, the experience of both Oregon and the Netherlands are highly influential. Many jurisdictions, when drafting laws, draw inspiration from their legislative frameworks and overwhelming experience. However, there are significant differences in the approach to safeguarding a voluntary decision and review procedure under the DWDA and the *Review Procedures Act*. In comparing the two jurisdictions, it is apparent that there are significant limitations with the DWDA concerning how it safeguards voluntariness. Additionally, the review procedure in Oregon, in comparison, appears to be fundamentally flawed. There is no critical scrutiny of reported cases of PAD, and compliance with the DWDA is determined by whether a physician checked a box. Death is irreversible and given this finality, it is essential that the legislative safeguards provide meaningful protection in safeguarding voluntariness and that the review procedure is both robust and rigorous. In conclusion, the position adopted in the Netherlands appears to be superior and is perhaps more desirable as a model in this limited capacity.

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