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A policy mapping analysis of the U.S. Congressional approach to medical aid-in-dying

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**Abstract**

This study examines the goals of medical aid-in-dying (MAID) legislation introduced to the US Congress from 1994-2020 using a policy mapping analysis approach. Using congress.gov, we identify 98 bills, 23 bills were analyzed in this study. Most of the bills aimed to restrict the use of federal funds, to regulate the drugs commonly used for MAID, to prohibit the development of policies or practices supporting MAID, and to regulate practitioners' roles in MAID. In practice, these bills would limit patient access to MAID by restricting drugs, funds, health care services, legal assistance, policy, and research. These findings suggest there lacks congressional support for MAID, even though polls of the public are divided yet favorable. Policymakers who support MAID should consider affirmative policies that 1) prevent MAID policies from discriminating against vulnerable groups, 2) support funding to study the use of MAID, and 3) build avenues to allow all qualified people to access MAID in places where it is legal.

## Introduction

Death is often a difficult subject. If the topic of death is generally difficult to discuss, then the way in which a person dies is an even more challenging conversation. Medical Aid-in-Dying (MAID), also called death with dignity (Andersen, 2020), physician-assisted suicide or assisted suicide (Mishara & Weisstub, 2015), are all terms that refer to when a medical doctor gives a terminally ill patient the information or means needed to end their own life (Death with Dignity, n. d.). Death with dignity allows for people who have a terminal illness and are at the end of their life to end their physical and mental suffering in a medically safe way. This practice is rooted in controversy. Many supporters of MAID argue that it is a safe practice that allows for patients to determine their own quality of life and choose whether or not they want to continue to live in that condition (Dugdale, Lerner, & Callahan, 2019). Some opponents equate it with suicide or homicide, while others believe the desire for death with dignity stems from a lack of financial resources, health insurance or access to palliative care (Hedberg & New, 2017).

It is not uncommon for MAID to be confused with euthanasia, which is “also called mercy killing, [it] refers to the administration of a lethal medication to an incurably suffering patient. It may be voluntary (the patient requests it) or involuntary” (Dugdale, Lerner, & Callahan, 2019, p. 1). Euthanasia is illegal in the United States under our homicide laws (Hanson, Mautz, & Betts, 2018). Euthanasia is different than MAID, as MAID laws do not allow a physician to administer the drug to the patient; the patient must be able to self-administer the drug (Hedberg & New, 2017). Under most laws in the U.S., in order to utilize MAID practices, a person must have a prognosis of less than 6 months to live due to a terminal illness. Two different doctors must then confirm the patient's diagnosis and prognosis. Then the patient must make two separate oral requests for MAID at least 15 days apart, with one request being written

by a witness to the request. Finally, the patient must be offered all of the different options they have at that time, including the option of hospice if it has not previously been offered (Hedberg, & New, 2017). Doctors are also not required to prescribe a life-ending-drug; they have the right to refuse (Hedberg & New, 2017).

While permissive regulations exist in several U.S. states, many people in the United States associate MAID with physician assisted suicide. Many Americans were introduced to assisted suicide in the 1990s when Dr. Jack Kevorkian, a physician who advocated for the ability of those with terminal illnesses to end their own lives, was tried and convicted of physician-assisted suicide. In the United States, MAID has been debated in court through similar trials while others that have challenged both individuals and the laws themselves. This controversy has also remained in the court of public opinion for many years due to perception that MAID could be a form of suicide, or from physician's point-of-view that there are concerns about the risks to their professional practice as well as the patient-physician relationship (Simmons, 2018; Hanson, Mautz, & Betts, 2018). Specifically, there are outstanding questions to whether such laws devalue a physician's ethical responsibility to their patient or contradict the societal role of physicians such as the obligation to first do no harm (Hedberg & New, 2017), because of differing beliefs about whether MAID prevents harm by relieving suffering, or causes harm by facilitating death. There is also strong opposition to MAID legislation from both religious and disability rights organizations (Cunningham, 2014; Behuniak, 2011).

### **The State, Federal, and International Policy Landscape**

In 1994, Oregon became the first U.S. state to legalize MAID through a ballot initiative that permitted physicians to provide medications to those with life-limiting conditions who requested it. While it passed in 1994, it did not become law until 1997 due to legal appeals,

which resulted in a new ballot initiative. While legal activity was taking place at the state level in Oregon, federal courts were also considering questions related to MAID. In March 1996, San Francisco's 9th U.S. Circuit Court of Appeals ruled that mentally competent, terminally ill adults have a constitutional right to aid in dying from doctors, health care workers and family members (Kamisar, 1997). This occasion was the first time a federal court ruled in favor of MAID. Just over a year later, the U.S. Supreme Court ruled in the opposite direction, with a decision stating that state governments could decide on their own whether or not to ban doctor-assisted suicide (Death with Dignity, n. d.). Since then, Alabama has explicitly banned MAID. Seven states (California, Washington, Colorado, Maine, New Jersey, Hawaii, and Vermont) and the District of Columbia have passed legislation enabling MAID for people with life-limiting conditions. The eighth state of Montana, unlike these states, permitted MAID by a state Supreme Court ruling on *Baxter v. Montana*. The lower courts determined that MAID was allowed based on privacy and individual dignity, as set out in the Montana Constitution. Further, the Montana Supreme Court ruled that MAID was allowed under the 1991 state law that allowed competent and terminally ill patients to refuse life support devices and choose a "humane and dignified death" (Svenson, 2010, p. 3). North Carolina has a similar permissive practice, in which assisting in a suicide is not a criminal offense (Pope, 2020). Both Montana and North Carolina and several other states, such as Arizona, Florida, Kentucky, Maryland, Massachusetts, New York, Connecticut, and New Mexico have introduced bills in their state legislatures in favor of MAID. So far, among them only the New Mexico senate passed its MAID bill in 2021 (Elizabeth Whitefield end-of-life options act, HB 47, 2021).

In Europe, MAID was first legalized in Switzerland by the Penal Code in 1942. However, it was not until the 1990s that other European countries to begin to legalize MAID. In addition to

being the first, Switzerland's MAID laws are different from those of other countries in two ways. One is that volunteers from non-profit organizations assist suicide by assessing whether those who want MAID are legally competent, have a persistent and consistent desire to die, are suffering intolerable pain, or are experiencing severe disability, with doctors playing a limited role in prescribing lethal drugs and assessing the patient's decisional ability. The other is that the Swiss Penal Code does not require special medical conditions (Andorno, 2013; Field & Curtice, 2009). Switzerland was internationally criticized for enabling assisted suicide even for people who do not have a terminal illness. For this reason, Switzerland considered amending the Penal Code in 2011 but decided to keep the existing legislation (Grosse & Grosse, 2015).

Among other European countries, the Netherlands for many years permitted both euthanasia and physician-assisted suicide though it was technically illegal (van der Maas et al., 1996). In the early 1990's legislators conducted the first formal study of euthanasia and physician-assisted suicide in the Netherlands to understand the scope of its practice and changed how such deaths were reported (van der Maas et al., 1996). The Netherlands and Belgium enacted MAID in 2002, with Luxembourg enacting legislation in 2009 (Emanuel et al., 2016). The Netherlands, Belgium, and Luxembourg all permit MAID and euthanasia for physical and mental suffering under the Benelux Law (Grosse & Grosse, 2015). In both MAID and euthanasia, the patient has to express a clear intention to end life. The difference between MAID and euthanasia is that in the case of MAID, patients self-administer lethal drugs to end their life, whereas euthanasia is administered by a doctor (Onwuteaka-Philipsen et al., 2012). Each of these three countries has different regulations on euthanasia decision-making processes for incapacitated patients. For example, a person who has requested MAID or euthanasia in their advance directive can access euthanasia when they become unconscious in all three countries,

whereas only in the Netherlands can the person access it when they become incompetent (Grosse & Grosse, 2015). Meanwhile, France adopted a law in 2016 to provide terminally ill patients with sedative treatments instead of MAID (Aubry, 2016).

In the Americas, Colombia legalized MAID and euthanasia in 1997, the same year as Oregon, by court ruling (Emanuel et al., 2016). Quebec, Canada legalized MAID under Bill 52 in 2014 (Emanuel et al., 2016). Following that, the Canadian Supreme Court ruled in the 2015 *Carter v. Canada* case that sections 241(b) and s14 of the Criminal Code could not prohibit physician-assisted death of competent adults. Based on this ruling, the Canadian Parliament legalized MAID and euthanasia across Canada in 2016 (Emanuel et al., 2016).

While many countries move towards the adoption of MAID legislation, the U.S. continues to experience deep differences in opinion and controversy regarding the acceptability of MAID. A recent Pew Research Center poll found U.S. respondents split nearly down the middle regarding MAID, with 47% in support and 49% opposed (Lipka, 2014). Whereas a HealthDay Harris Poll conducted around the same time found that 74% of American adults believe that patients who are terminally ill and in great pain have the right to end their lives, with 14% percent opposed (Thompson, 2014). A 2018 Gallup poll also reflects a preference for MAID, with 72% believing that if a patient has a disease that cannot be cured doctors should be allowed to end the patient's life by painless means if the patient or their family requests it (Brenan, 2018). The United States has a similar political system to Canada in that the states, like the provinces, do have some autonomy to create policies that are different from those on the national level, and that one province legalized MAID at a time when it was not legal across the country. However, despite MAID being legal in at least one state for nearly 30 years, questions remain on why the United States has not adopted federal legislation for MAID practices.



### Current Study

Despite a rich academic literature exploring the legal and ethical considerations of MAID, very little research has explored congressional actions either for or against MAID policies. In this study, we aimed to address this gap by categorizing and quantifying the U.S. congressional approach to MAID by exploring bills introduced and/or passed in the U.S. Congress in the years since MAID was legalized in Oregon. We used the policy mapping technique introduced by Burris et al. (2010) and expanded on by Groseclose and Buckeridge (2017) and Bowen and Irish (2019). Specifically, policy mapping uses content analysis techniques to study a specific policy area closely. Methods are tracked systematically to allow the analysis to be replicated. Bowen and Irish (2019) used these techniques to explore opioid legislation, and we replicated their model in this analysis.

Our research questions were as follows: (1) What are the goals of legislation that has been introduced in the U.S. Congress that relates to medical aid-in-dying?; (2) What federal legislation has increased or decreased access to medical aid-in-dying as it exists in state and territorial statute?; and (3) To what extent has increasing or decreasing access been an additional or indirect consequence of legislation that has been introduced? Our research questions are grounded on the principle that MAID exists along a continuum of end-of-life care policies and that legislation can either increase or decrease access to a range of care options.

Our inquiry also considers the role of policy in creating or decreasing access for particular populations. Policy goals may vary and are rooted in underlying assumptions. Dudley and Luft (1999) argue that healthcare systems' goals and the policies that influence them are to maximize health care quality, minimize government costs for health care, and distribute the benefits of quality health care and the burden of costs across the population. These goals are

often in conflict with each other, and different politicians hold different views on them, particularly regarding the last one. Some argue that in an attempt to minimize costs, the distribution of health care to some segments of the population, such as those who cannot afford to access it, is less important. In order to get legislation passed, compromises may need to be made between legislators, such that pieces of many different goals may exist in the same bill. Health policy debates aside, the discussion of MAID has the additional facet that some do not consider it to be healthcare at all, but an ethical dilemma that amounts to murder.

## **Methods**

### **Data Collection and Parameters**

This study considered bills introduced in the U.S. Congress between 1994 and 2020. As noted earlier, this represents the time period in which MAID has been legal in at least one U.S. State (Oregon). We used the congress.gov website to search for bills, amendments, and resolutions related to MAID introduced in the U.S. House and Senate. The bills retrieved from the congress.gov include resolutions and amendments. Since bills, resolutions, and amendments are all legislative proposals, all retrieved bills, resolutions, and amendments in this paper are collectively referred to as bills.

MAID is used interchangeably with various terms such as assisted suicide, assisted dying, death with dignity, mercy killing, and, while not congruent, euthanasia. Accordingly, the following terms were used to search for legislation: "assisted suicide," "mercy killing," "death with dignity," "assisted death," "assisted dying," "aid in dying," "end of life options," "medically assisted suicide," "medically assisted death," "assistance in dying," "dignity in dying," "dying with dignity," "facilitated suicide," "facilitated death," "facilitated dying," "right to die," and "euthanasia." Additionally, we excluded bills that included the terms "animal" and "veterinary"

after a brief review of the initial findings revealed that our original search terms brought up a number of bills related to farming and animal husbandry.

As shown in Figure 1, the first search found 98 bills, amendments, and resolutions. Each bill was carefully reviewed, and 34 bills unrelated to MAID were excluded in the first review. These 34 bills had no MAID-related content at all. In the second review, 33 bills were excluded. Of these, 18 were related to the Assisted Suicide Funding Restriction Act of 1997 but did not directly relate to MAID. The Assisted Suicide Funding Restriction Act (ASFRA) was passed in 1997 in response to the legalization of MAID in Oregon. It bans the use of U.S. federal funding for anything related to MAID. It includes funds through Medicare, the federal portion of Medicaid, the Veterans' Administration, and community health services funded by block grants. This Act is important because any legislation that proposed to do away with block grants mentioned the ASFRA because eliminating block grants would require amending the ASFRA to remove sections that mention block grants. To wit: of these 18 bills, six bills related to the ASFRA that we eliminated were bills requiring the abolition of the items specifying block grants in the Assisted Suicide Funding Restriction Act of 1997. Four bills were bills partially amending the items of the Assisted Suicide Funding Restriction Act of 1997. However, they were intended to clarify the meaning of the bill rather than provide a substantial amendment to the contents of the Act. Eight bills came up in our search whose only mention of MAID was text confirming that their content did not violate the Assisted Suicide Funding Restriction Act of 1997; they were eliminated because they were not related to MAID. Of the remaining 15 bills, eight bills claimed their bill does not assume to permit of MAID. Seven bills were focused on palliative care or pain management and stated not to permit MAID during palliative care or pain management.

\*Insert Figure 1 here\*

In the final review, we manually identified and compared the remaining bills with each other. We identified four bills that had substantially identical content and were introduced into two Congresses, of which the older version was removed, and only the latest two were kept for coding. We also identified 11 bills introduced more than once by the same Congress with the same content, five were retained, and six were removed. Of these, there were six bills introduced by the House and the Senate respectively, of which only three, the House version, was maintained. Accordingly, in this paper, the remaining 23 bills were analyzed.

### **Coding Categories**

Our first set of coding categories was based on Bowen and Irish's (2019) policy analysis and consisted of descriptors about the bills. Basic information collected includes bill type, the chamber in which it was introduced, the party of the sponsor, the presence or absence of bipartisan support, tracker, and congress. Bill type classified the attributes of Resolution, Bill, Act, and Amendment, the chamber is classified as House or Senate. The party of the sponsor is classified as Democrat or Republican as attributes. Bipartisan support represents information on co-sponsor(s) that support the bill and includes attributes when bill co-sponsors belong to one party, belong to two or more parties, or the bill has no co-sponsors. Tracker represents the bill's progress through the legislative process, and separate tracker categories were created according to resolution, bill and act, and amendment.

Substantive categories were created based on a literature review. These categories were based on whether the proposed legislation expanded or restricted MAID, and the stated goal of the bill. The category "expand or restrict MAID" indicated only whether the bill was initiated to expand or restrict access to MAID. Then we coded the bills as to what goals they contained. We

developed the list of goals through literature review and review of coding legislation. Eighteen goals were chosen a priori from the literature, while 10 were found in the legislation.

### **Coding Process**

We created and modified coding categories and attributes for coding accuracy through continuous collaboration and cross-checked the coding results. Basic information was coded using the information provided by congress.gov. To identify the bill's goals, we carefully reviewed the bill's full text. We found that the goals developed during the thorough literature review ended up being different from those we found after reviews of the bills. For example, the literature suggests that for patients, some goals of seeking MAID are avoiding pain and maintaining autonomy so we looked for such goals in the legislation and found none. We did not locate any of the a priori goals in the bills. Table 2 contains the goals we found in the legislation.

\*Insert Table 2 here\*

We chose to retain the goals from the literature in the paper to allow us to discuss the differences between legislation and literature as they relate to MAID.

### **Results**

Table 1 shows the basic characteristics of MAID-related bills, resolutions, and amendments included in this analysis. Bills accounted for 78.3% of the bill type, and of those only 26.3% of the bills became law. The house initiated 60.9% of the bills, and 65.2% of the primary sponsors were Republicans. In total, 65.2% of the bills had co-sponsors from one or both parties. Immediately following MAID's passage in Oregon in 1994, 52.1% of the bills were proposed at the 104th and 105th Congress from 1995 to 1998. All bills were initiated to restrict MAID.

Table 2 shows the policy goals, frequency of goals, policy examples and whether the bill restricts or expands access to MAID. Most bills aimed at restricting the funds for MAIDs (32.3%), followed by regulating the use of drugs for MAID (22.6%), regulating penalties for practitioner who violate the use of drugs for MAID (9.7%), restricting a payment to a health care entity on MAID (6.5%), not discriminating against a health care entity that does not provide MAID (6.5%), prohibiting the development of policies or practice supporting MAID (6.5%), and restricting funding for research and data collection (6.5%) were proposed.

The goals of the proposed bills can be categorized as restricting the use and payment of health care services or drugs for MAID (Goal 1, 3, 4, 7), restricting funding for MAID (Goal 2, 10), supporting the refusal to provide MAID (Goal 5, 6), or limiting policies or legal assistance related to MAID (Goal 8, 9). All bills, resolutions, and amendments initiated since 1995 aimed at reducing access to MAID.

Almost half of the bills were aimed at restricting the use and payment of medical services and drugs related to MAID (Goal 1, 3, 4, 7). These bills could serve to reduce access to MAID by directly preventing the implementation of MAID services. The other half of the bills aimed to regulate the rules for practitioners who do or do not provide MAID (Goal 5, 6) and to restrict legal assistance, policy, and research funding for MAID (Goal 2, 8, 9,10). These bills do not directly limit the implementation of MAID. However, they keep practitioners from advocating for MAID services, legally supporting MAID, or using research to demonstrate effectiveness. Therefore, this type of legislation indirectly hinders patient access to utilizing MAID.

In the policy examples column, the bill, resolution, or amendment corresponding to each policy goal is displayed. Bills introduced in the House of Representatives begin with "H.R." and bills introduced in the Senate begin with "S". Resolutions begin with "H.Res" or "S. Res",

depending on whether they originated in the Senate or House. Amendment begins with "H.Amdt" or "S.Amdt".

It is important to note that there are no bills that support the purposes of MAID identified in the literature, nor any that guide implementation of MAID for patients or healthcare providers. Specifically, no bills addressed avoiding physical pain, reducing the emotional costs of dealing with chronic illness by a patient, respecting autonomy, humanity, dignity, preventing suicide, or forgoing life-sustaining treatment or cease or withhold medical treatment. Concerning the implementation of MAID, bills did not address robust regulations such as preventing MAID abuse, preventing discrimination against vulnerable groups, expanding the degree of inclusion to different populations, ensuring access, safeguards, and conscientious objections, making a consistent application or criteria of procedural requirements, or applying regulations differently by States. Regarding patient care, no bills provided guidance related to providing optimal care to patients who inquire about MAID, maintaining the quality and availability of palliative care, addressing the interaction of hospice providers with MAID, or reducing caregiver burden. In addition no bills were proposed regulating the role of health care providers on MAID or improving the legal certainty of physicians. It seems unlikely that these questions will be able to be answered, as no bills supported research and data collection related to MAID.

### **Discussion**

In 1972, a hearing on euthanasia was held by the senate's special committee (Death with Dignity, 1972). Since then, the discussion of death with dignity expanded from euthanasia to MAID, and it took over 20 years for MAID to become legalized in its first state in 1994. With this momentum, bills, and amendments related to MAID began to be introduced in earnest at the U.S. Congress. This study comprehensively analyzed the basic characteristics, goals, and access

to MAID of 23 MAID-related bills introduced at the U.S. Congress between 1995 and 2020. Considering the chamber and party that initiated the introduced bills, it can be seen that the House and Republican legislators were more interested in MAID. Half of the bills were initiated from 1995 to 1998, the years immediately after Oregon approved MAID through ballot initiatives, at the 104th and 105th congresses. Since then, almost all Congresses have proposed bills related to MAID, indicating that MAID is an ongoing issue. Despite Congressional attempts to restrict access to MAID, MAID is supported by the legalization of MAID in eight states and Washington, DC since Oregon, with additional bills introduced in many states, including North Carolina, Connecticut, Massachusetts, Maryland, New York, etc. (Death with Dignity, n.d.).

According to state level MAID legislation and the existing literature, the purpose of MAID legislation is to respect patient dignity, autonomy, and humanity, prevent unintentional discrimination in the practice of MAID, and define health providers' role. States were primarily aimed at expanding MAID and were intended to develop rules for making more sophisticated MAID systems. However, the purpose of those 23 bills introduced to the U.S. Congress was quite different. These bills were initiated to block or limit patient access to MAID by restricting drugs, funds, health care services, legal assistance, policy, and research related to MAID.

The purpose of the most prevalent legislation was to limit funds for the implementation of MAID. Ten bills were initiated to amend the Assisted Suicide Funding Restriction Act of 1997 and the acts related to health care for various targets, including managed care consumers, Indians, military, people with disabilities, Peace Corps volunteers, and Medicare beneficiaries. These bills prohibited federal funds from paying for any service, program, item, or procedure that aided in MAID implementation. In other words, these bills block the payment of costs for the implementation of MAID, thereby blocking access to MAID for many groups.



The next most prevalent proposed bill aims to regulate drugs used in MAID. Eight bills tried to restrict or prohibit the administration, dispensation, and distribution of drugs or biologicals prescribed for MAID purposes (to end a person's life), as well as payment for these medications. Under current laws, MAID is only possible by medication. Because the patients must drink the prescribed medication by themselves, MAID cannot be implemented when the administration, dispensation, distribution, and payment of the medication is prohibited. As such, these bills prohibit the use of drugs or biologicals used in MAID, thereby preventing the implementation of MAIDs.

Few bills have been proposed to prohibit healthcare services for MAIDs or restrict the payment of implementing MAIDs in health care entities. Also, bills have been introduced to stipulate penalties or discrimination to restrict practitioners or health care entities from performing medical services related to MAID and prohibiting them from developing policies or legal assistance to support MAID.

All of the bills proposed so far have had the ultimate purpose of deterring patient access to MAID. In particular, the implementation of MAID is fundamentally blocked by restricting the essential elements of MAID implementation, such as funds, drugs, practitioners, health care entities, policy, and legal assistance. Additionally, bills prohibiting discrimination against health care entities who refused to perform MAID, penalizing practitioners who used drugs for MAID, or restricting legal assistance, led practitioners or health care entities not to perform MAID. As a result, the accessibility of patients to MAID is inhibited.

The fact that all of the legislation proposed to date directly or indirectly decreases MAID accessibility shows the perspective that the federal government as a whole has on MAID, and that there is a misalignment between public preference and congressional action towards aid in

dying. MAID is now legalized in Washington DC and nine states, and with legislation pending in many other states, MAID may be legalized in more states in the future. If the federal government maintains its current perspective, conflict may arise due to differences between federal and state laws.

### **Limitations**

This study has some limitations. First of all, this study contains only bills initiated by the US Congress. By introducing only policies developed at the federal level, policies made at the state level were not included. For example, this study does not include information on the legislation introduced to state general assembly or local councils and MAID-related decisions addressed in a state or circuit courts. Therefore, there is a need to conduct a policy analysis that includes legislation or court decisions initiated at the state or local level in the future. Second, as the search for bills for this study was carried out in August 2020, the bills introduced from then to the publication of this study were not included in the analysis of this study. Third, since the presidential election was held in 2020, and the possibility of the bill being rejected after the election is high (Woon & Anderson, 2012), policy makers may have delayed making related policies to MAID in 2020.

### **Conclusion and Implications**

The results of this study provide important insight into the development of MAID policy in the United States. These findings provide future direction to policymakers. Until now, policies have been mainly proposed to limit MAIDs, restricting drugs, medical services, roles of healthcare providers, and funds required to implement MAID. However, with ten states already legalizing MAID, including Washington, DC, there is a need to initiate legislation to guide legalized MAID to operate more efficiently. First, it is necessary to devise a policy to prevent

discriminatory situations in which vulnerable groups are involuntarily targeting by MAID providers. Wellman (2003) pointed out that it may seem compassionate to inform and encourage people in vulnerable groups, such as the poor, older adults, mentally ill, and disabled, about MAID rights. However, people in these groups are vulnerable to abuses of MAID laws since policymakers may see their lives as less valuable than others. Throughout history we have seen cases where people with disabilities or older adults are seen as expendable and less likely to receive medical treatment. Therefore, mechanisms are needed to prevent this group of people from experiencing such discrimination. Advocates have been behind many of the successes at the state level. Advocacy groups should consider channeling some of their efforts towards federal policymakers with the intent to align public preferences into federal laws. Many of the concerns of opposition groups have been addressed in state level debates and in some cases in the protections that have been incorporated into state law. Their efforts could be replicated or expanded on the federal level to address concerns of policymakers and opponents.

Second, legal support is needed to provide funds to study the implementation and results of the MAID. Policymakers need to create policies based on reliable evidence (White & Willmott, 2020), and so better reporting is needed regarding the use and attempted use of MAID. Accordingly, whether policymakers are drafting policies that restrict the implementation of MAIDs or policies that extend the implementation of MAIDs, it is necessary to provide legitimate reasons and evidence when they formulate these policies. Thus, by supporting MAID research and data collection, policymakers can be provided with evidence to formulate MAID policies.

Third, it is necessary to build a system that allows all qualified people to access MAID equally. Various safeguards have been proposed which make it difficult for MAID-qualified

people to access MAID (Miller et al., 1996). However, not all laws employ these safeguards. Therefore, policymakers need to create clear laws that provide access to people eligible for MAID in a variety of populations while still providing safeguards and protections to prevent the abuse of MAID laws. Critiques of such safeguards also exist. For patients with certain illnesses, the ability to communicate their informed consent, the potential for onset of dementia, and the speedy progression of the disease all create challenges to a terminally ill patient to utilize MAID laws for end-of-life (Andersen, 2020). However, without such safeguards, there may be greater opposition to one's right to die.

Another consideration for policymakers is that because MAID qualified people are patients with a lifespan of fewer than six months, they are likely to receive palliative care or hospice services. Accordingly, there is a need to define clear and standardized guidelines so that healthcare providers can introduce and implement MAID with patients using palliative care or hospice services.

Finally, as a society, the court of public opinion is ever-evolving. As the current population ages they may provide a larger influence on end of life decision making, due to the continued incidence of chronic illness and end of life experiences. It is possible they will question existing medical and legal orthodoxies regarding choice at end of life.

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