



compassion & choices

Support. Educate. Advocate. Choice & Care at the End of Life.

Students' Guide to Aid in Dying

A Brief History of the Aid-In-Dying Movement
as Well as Current Efforts for Decriminalization

prepared by

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Introduction

We are always happy to respond to student requests for information on the subject of aid in dying. Whether or not one supports the rights of terminally ill adults to make their own end-of-life decisions, the practice is presently legal only in Oregon, Washington and Montana. Legislation is being introduced to enact similar “death with dignity” laws in other states.

Although a separate section of this guide describes the terms most commonly used when discussing end-of-life options, it is important to note here that Compassion & Choices does not support euthanasia, a process in which a suffering patient requests that a third party, usually a medical professional, helps them end their life through the administration of a lethal dose of medication, most often by injection. In such a scenario it is the healthcare professional, not the patient, who controls the situation.

On the other hand, aid in dying, which we do support, allows a competent, terminally ill adult the legal right to ask his or her physician for a prescription for a lethal dose of medication to help end that patient’s suffering. It is up to the patient to decide whether to get the prescription filled, and then determine when, and if, he or she wants to self-administer the medication as implicit in the law. Other states considering Oregon-style laws explicitly include provisions for self-administration. In this way ultimate control rests with the patient at all times.

Please note this guide is a work in progress and is updated as new questions are asked or as changes in the law occur. If you have a question that is not answered here please feel free to contact us at:

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A Brief History of the Right-to-Die Movement

The debate over an individual's right to end his or her own life with the help of a physician is not new in this country. The first attempt at legalization was presented to the Ohio legislature in 1906, where it was promptly defeated. Little else happened until 1938, when the Euthanasia Society of America was founded; but being too radical for its time, the Society ultimately changed its focus to confront the issues of informed consent and the right to refuse unwanted medical treatment.

It would not be until thirty-six years later, in the *Matter of Quinlan* (1976), that the right-to-die movement took a significant step forward. Karen Ann Quinlan was just 21 years old when she stopped breathing from what is believed to have been an overdose of drugs and alcohol. Although she was revived, her brain had been deprived of oxygen for too long, rendering her in a comatose state and unable to breathe without the aid of a respirator. When it became apparent she would never regain consciousness, her parents asked that her respirator be removed. Her physicians refused, claiming that discontinuing life support would result in her death, and that would be murder.

Karen was one of the first victims of medical technology, a confluence of doctors and science coming together to prolong a life that otherwise would be lost. In most cases the use of advances like respirators and artificial feeding do indeed save lives, and many patients have full recoveries. But Karen would not be one of them. The Quinlan's case eventually found its way to the New Jersey Supreme Court. In reaching its decision in favor of the parents the Court stated:

"We have no doubt, in these unhappy circumstances, that if Karen were herself miraculously lucid for an interval...and perceptive of her irreversible condition, she could effectively decide upon discontinuance of the life-support apparatus, even if it meant the prospect of natural death."

Up until this time the medical profession was paternalistic, with physicians making decisions based on what they felt was best for the patient, often without the patient's input and in some cases without the patient's consent. Patients rarely questioned their physician, even when surgical procedures were involved and it was not unusual for physicians to withhold information from their patients, for example not informing patients if they had an incurable illness. In ruling on behalf of the parents, the Court for the first time recognized that a patient (or in this case a family member) and not a paternalistic medical profession, was in the best position to make decisions as to the type of medical

care and treatment that was appropriate, even if such decision included the withholding or withdrawal of life sustaining equipment. This “shift in power” would rapidly change the physician/patient relationship and the way medicine was practiced.

The dilemma that faced the Quinlans would not have occurred just fifty years earlier. At the beginning of the 20th century when someone sustained an injury or became ill they either recovered or they died. But with the 1950’s a new era of medical miracles was being ushered in with the seeming cry of “the more medicine the better” (Porter, 1998). During this time period the first successful open-heart by-pass surgery took place, soon to be followed by the first organ transplant. Widespread use of penicillin was introduced to counter once-fatal infections, and a vaccine for polio was perfected. Technological inventions like the pacemaker, improved dialysis equipment and diagnostic scanners that could “look” inside the body without invasive surgery were all hailed as medical breakthroughs. In the last fifty years these advances have been responsible, at least in part, for an increase in the average adult life expectancy, which has gone from 68.2 years in 1950 to its current 78 years (and climbing). As a result the very definition of what it meant to be “elderly” was also changing.

But it was not all good news. With longer life spans came the emergence of degenerative age-related diseases such as Alzheimer’s, stroke and arthritis, creating a need for hospitals and nursing homes where people were sent to die rather than be cured. As medicine and technology continued to advance, there came the haunting realization that futile prolongation of life was often going too far. Living longer was not always living better and the demand for the quality of life, versus quantity, was beginning.

In January of 1950, the Gallup Organization conducted its first public opinion poll that asked the question, “When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient’s life by some means if the patient and his family request it?” At that time only 36 percent of respondents agreed, but when that same question was asked in May of 2006, the “yeses” had grown to 69 percent. Fears over “a fate worse than death” were behind the increased desire for personal control over one’s own end-of-life choices.

Aid-in-Dying Advocacy Groups Form

Out of these concerns, the Hemlock Society formed in 1980 with the purpose of educating the public about the worsening state of dying in America. The group simultaneously worked to pass laws that would offer patients the legal option of hastening their own death if their suffering became intolerable. In 1993, Compassion in Dying was founded in Washington state to offer comfort and support to terminally ill patients and their families, including providing information on humane and safe methods to hasten their deaths. An important goal was to help individuals avoid what otherwise might be potentially violent deaths.¹ Other grassroots “right-to-die” groups formed in cities across the country, some merely acting as conduits for education, others offering information on effective methods of hastening death.

Early Efforts to Pass Aid-in-Dying Laws

During this same time period legislative bills and voter initiatives aimed at legalizing aid-in-dying were being introduced at the state level. This included voter initiatives in Washington, California and Michigan. While these first efforts were unsuccessful, a 1994 voter initiative succeeded in Oregon, making it the first state to legalize aid in dying² under an extensive list of regulations designed to prevent abuse. Although supporters have been actively trying to pass laws similar to Oregon’s in other states, strong religious opposition has thus far defeated their efforts. However, by 2008, voters in Washington state and a judge in Montana determined that people should have the right to control the manner and timing of their deaths.

Detractors of Aid in Dying

Some religious denominations state that all life is sacred and that only God can decide when someone’s life should end, even when the person is in a comatose state without any chance of ever regaining consciousness. The Roman Catholic Church and other religious institutions have contributed tens of millions of dollars towards defeating “death with dignity” laws in other states and in trying to overturn the Oregon law (Hillyard & Dombink, 2001). But these defeats have not dampened the growing desire for decriminalization of aid in dying. Polls consistently show public support in the 70 percent range, and none of the “catastrophes” opponents predicted would happen when Oregon’s law took effect ever occurred, further demonstrating that under safeguards and controls legalization can work.

¹ As a historical note, in 2003 Hemlock changed the name of its parent organization to End-of-Life Choices, which merged with Compassion in Dying in January of 2005 to become Compassion & Choices.

² Due to challenges by opponents of the Death with Dignity Act, an injunction delayed implementation and the law did not go into effect until 1997.

The Current State of Dying in America

Today in America over 70 percent of deaths occur in hospitals or nursing homes (Center for Gerontology and Health Care Research, 2004), frequently involving some level of futile or unwanted treatment. An extensive study funded by the Robert Wood Johnson Foundation (SUPPORT, 1995) revealed that over 50 percent of those dying in hospitals were dying in pain.

Other studies found a similar percentage of pain among dying residents in nursing homes (Center for Gerontology and Health Care Research, 2004). Not surprisingly, many people say they would not want to “live” this way. A recent AARP survey (2005) found that among those nursing home patients interviewed, 80 percent said they did not want to be kept alive by artificial means, and in a similar poll (Pew Research Center, 2005), when asked whether respondents would want to discontinue treatment if they “had a disease with no hope of improvement and [you] were suffering a great deal of physical pain,” 53 percent responded affirmatively.

Definitions

It is necessary to understand the terminology used as it relates to this guide, as there is frequently confusion about these terms, for example aid in dying versus euthanasia, and many of these terms are not universal in their definitions. Some deaths in the United States that are classified as “natural” would be considered euthanasia deaths in other countries. For example the common practice in the United States involving the withdrawal of life support for severely injured or incapacitated patients when further treatment is deemed futile would be considered euthanasia in some European countries. In these countries, the act of the physician “pulling the plug” ultimately brought about the patient’s death. The prevailing argument used in this country is that the patient was simply allowed to die, versus being helped to die (passive versus active), but many critics claim there is no rational difference between the two (Rachels, 1975).

advance directive - This is a document, sometimes referred to as a “living will,” in which adults can outline, in writing, their own end-of-life care treatment wishes in the event they can no longer communicate for themselves. Such wishes could include discontinuing artificial life support if the person is in an unconscious state with no reasonable medical probability of recovering. Conversely, the person could request to be kept alive as long as reasonably possible in the hope of an eventual cure. An advance directive only becomes effective upon the incapacitation of the patient who has completed the form and that patient, while lucid, can override or rescind the directive at any time.

aid in dying - Legal only in Oregon, Washington and Montana, this is the process that allows mentally competent, terminally ill adults to request a prescription for life-ending medication from their physician. The medication must be self-administered.

Death with Dignity - The current law in Oregon, Washington and Montana that allows a competent, terminally ill adult the legal right to ask his or her physician for a prescription for a lethal dose of medication that the patient can then self-administer to achieve a peaceful death.

double-effect - The possibility that efforts to relieve a patient’s pain and suffering may also unintentionally hasten the patient’s death. In theory double-effect differs from physician aid in dying because the intent of the physician is only to relieve the patient’s pain and suffering, even when the death is quite foreseeable (for example see palliative sedation).

durable power of attorney for health care - Refers to a legal document executed by the patient that transfers authority for end-of-life decision-making to a third party, most often a spouse or child, in the event the patient is no longer able to communicate for him or herself.

euthanasia - The intentional ending of another person's life upon the request of that person, and is performed by a physician or other medical health care professional, usually by lethal injection. Euthanasia is illegal in the United States.

health care representative or proxy - A person appointed in a durable power of attorney that the patient has authorized to make health care decisions on that patient's behalf should he or she become incapacitated. The agent's authority is not activated unless the patient is unable to make decisions on his or her own and, similar to an advance directive, while lucid the patient can rescind the representative's (or proxy's) authority at any time.

palliative care - Sometimes called "comfort care," is aimed at relieving a patient's physical and sometimes emotional pain, through medication, physical therapy, spiritual counseling or other methods, and with the understanding (and acceptance) of the patient that the treatment is not intended to cure or prolong the patient's life.

palliative / total sedation - Also referred to as terminal sedation. The continuous administration of medication to relieve severe, intractable symptoms that cannot be controlled while keeping the patient conscious. This state is maintained until death occurs.

physician aid in dying - A protocol in which a terminally ill adult requests and receives a prescription from his or her doctor for a lethal dose of medication that can then be used to end that patient's life. However, unlike euthanasia, the ultimate decision to take the medication rests solely with the patient and only the patient can self-administer the medication. Several common abbreviations or terms are often used to refer to this practice, including the inaccurate term assisted suicide).

terminal, terminally - Describes an illness for which the medical expectation is death.

voluntary stopping of eating and drinking (VSED) - The conscious refusal to accept fluids or nutrition. This procedure is gaining in popularity and acceptance as a method of hastening death because the process seems more natural, especially taking into account that when nearing death patients usually lose their desire to eat and drink. Studies have reported that aside from initial thirst, which can be managed with ice chips or swabbing the inside of the mouth, the resulting death is usually a peaceful one (Ganzini, et al., 2003). However, depending upon the state of a patient's health, the process can take a week or longer, which is more distressing to the family and loved ones than to the patient, who usually lapses into a coma following several days without fluids. It is also becoming more common for patients, as expressed through an advance health care directive, to state that if they are no longer able to communicate for themselves (for example if they lapse into a coma or succumb to severe dementia) and are no longer able to feed themselves, they do not want anyone else to attempt to feed them, including the insertion of a feeding tube or intravenous (IV) line to introduce hydration.

A Note on Terminology

Exactly who coined the phrase “physician-assisted suicide” is unclear, but for a time it seemed an accurate enough description: a physician providing a suffering patient with the means to end his or her life. However, as the debate over legalizing the act as an accepted medical procedure evolved, so did the argument that “suicide” was not in fact an accurate term to describe the rational and often deliberative process that went into a terminally ill person’s decision to end their suffering.

Shortly before his death in December of 2005, terminally ill cancer patient Jack Newbold (2005) told a press conference that he resented media reports announcing that he was going to kill himself. “I’m not committing suicide and I don’t want to die. But I am dying...I’m not killing myself; cancer is taking care of that. I may take the option of shortening the agony of my final hours.” Other terminally ill patients echo Newbold’s sentiment saying, given the choice, they too would want to live, but lacking that option they are instead left with choosing one form of death over another – the least worst death.

Acknowledging the distinction, the Oregon Department of Human Services (ODHS), which oversees reporting of deaths under the Oregon Death with Dignity Act, announced in October of 2006 that it would discontinue using the term “physician-assisted suicide” in its reports and literature, and instead will use the term “deaths under the Oregon Death with Dignity Act.” Similarly, in November of 2006, the American Public Health Association passed a resolution recommending APHA members use the phrase “aid in dying” or “patient-directed dying.” The American Academy of Hospice and Palliative Medicine (AAHPM) notes in a Position Statement on Physician Assisted Death: “The term PAD (Physician Assisted Death) is utilized in this document with the belief that it captures the essence of the process in a more accurately descriptive fashion than the more emotionally charged designation Physician-assisted Suicide. Subject to safeguards, PAD has been legal and carefully studied in Oregon since 1997. In all other states, PAD remains prohibited by law, although there is an underground practice that remains largely unstudied.”

Other organizations can be expected to adopt similar language in the future. For this reason, students should use the term “aid in dying” whenever possible unless the literature specifically refers to “physician-assisted suicide” or other terminology.

Frequently Asked Questions

Who is Compassion & Choices and what does your organization do? Compassion & Choices is a nonprofit organization working to improve care and expand choice at the end of life. The organization is non-judgmental, affirmative and inclusive. It was formed by the unification of the leading choice-in-dying organizations in the country, Compassion in Dying and End-of-Life Choices, in 2005. End-of-Life Choices was formerly known as the Hemlock Society. Compassion & Choices supports, educates and advocates.

Support

Compassion & Choices' Consultation program uses the power of choice and comfort to restore hope to individuals and their loved ones at the end of life. Our professional staff and trained volunteers help thousands of clients each year by listening without judgment to their fears and guiding their search for a peaceful, humane death. We help clients with advance directives, local service referrals, and pain and symptom management. We offer information on self-determined dying when appropriate and provide emotional support through a difficult time.

Educate

Compassion & Choices promotes informed end-of-life decision-making by educating the public and advising health care professionals. Too many health care professionals turn away from their dying patients. Too many Americans are unprepared to navigate the complex options and restrictions surrounding the end of life. We employ educational training programs, media outreach and online and print publications to change healthcare practice, inform policy-makers, influence public opinion and empower individuals.

Advocate

Compassion & Choices devotes itself to creative legal and legislative initiatives to secure comprehensive and compassionate options at the end of life. We set national standards for end-of-life care and assert constitutional protection for aid in dying. Our team of litigators and legislative experts fights bills that would force patients to endure futile, invasive treatment; sets enforceability standards for advance directives; mandates pain and palliative care training for physicians; monitors legislative and policy initiatives; and ultimately shapes best-practice standards for end-of-life care.

Why do the terminally ill people seek this form of help?

Terminally ill patients want to know that there is an option to a peaceful and humane death should all other efforts to relieve their suffering fail. Studies in Oregon, the first of three U.S. states to legalize aid in dying, reveal that as long as patients know an option of last resort exists, 90 percent of those patients initially interested in hastening their death will accept or try another alternative form of treatment. Of those who receive the prescription under Oregon's law, only about half actually use it.

Does a patient have the right to refuse unwanted medical care or treatment? YES. The Supreme Court has ruled that a competent adult has the right to refuse unwanted medical treatment. This could include life-saving surgery, removing or withholding artificial life support, stopping of eating and drinking, discontinuing dialysis, refusing antibiotics to combat infection, and the list goes on.

One hundred years ago it was not an issue. When people became sick or injured they either died or got well. There was no CPR, no chemotherapy, antibiotics were still on the verge of discovery and surgery was still somewhat primitive. The Jehovah's Witnesses were one of the first groups to assert a legal right to refuse blood transfusions based upon their religious beliefs. Christian Scientists similarly refused all forms of medical treatment. The only times the court would intervene is where the patient was a minor (under eighteen) and therefore presumably unable to make up his or her own mind; when the patient was pregnant and therefore the life of the unborn child could be affected; or when the patient's mental capacity (ability to make informed decisions) was in question.

A year after the U.S. Supreme Court re-affirmed the right to refuse unwanted medical treatment in the case of *Cruzan v. Director*, the Patient Self-Determination Act was passed. Although this law only affected hospitals and healthcare institutions that received federal funding (such as Medicare and Medicaid), it further established and/or upheld a person's constitutional right to self-determination. The Christian Medical and Dental Association, which is strongly opposed to aid in dying, nonetheless supports patient autonomy and in 1994 passed a resolution stating, in part: "When the patient refuses life-prolonging therapy, we will respect that choice and compassionately support his or her medical, social and spiritual needs."

How do physicians feel about aid in dying? Among the medical community, support exceeds 50 percent according to the latest polls. This does not mean that over half the doctors would themselves participate if a patient asked, but rather they would support a patient's right to make their own health care decisions. Aid in dying is supported by the American Medical Student Association, the American Medical Women's Association, American Public Health Association and Physicians for Human Rights to name several of the more prominent professional medical organizations.

Are doctors required to honor a patient's request for aid in dying? NO. The Oregon and Washington laws (and proposed laws in other states) make participation voluntary. Any physician, pharmacist or healthcare facility opposed to aid in dying is not required to participate. Similarly, only the patient him or herself can initiate a request for help.

What is a nurse's role in aid in dying? Nurses would not have a role per se, other than perhaps being with the patient at the time he or she decided to take the medication (as is sometimes the case where a hospice nurse is involved). In practice most patients who hasten their death have friends and/or family present, and the nurse might act as a guide, simply explaining what is happening (as the person is dying) and reassuring the family that this is a "normal" process.

Wouldn't improvements in end-of-life care make the need for aid in dying go away? Not necessarily. Progress in improving end-of-life care in general has been poor. Today, a person dying in a hospital or nursing home stands a 50 percent chance of dying in pain that can be treated, but isn't, and patients have about a 3 percent chance of dying in excruciating pain. Doctors are reluctant to prescribe adequate pain medication for a number of reasons including: poor or non-existent training in pain management, the fear a terminally ill patient will become addicted to the pain medication, and the biggest fear, that the federal government, which monitors the use of drugs used to treat pain, may suspect the physician of abusing drugs and revoke their prescribing privileges. As a consequence, death in America is getting worse, not better.

We are seeing a dramatic increase in elderly suicides, most often by violent means including handguns, jumping from heights and hanging. Many of these suicides could be prevented were a Death with Dignity law adopted in other states. Simply put, if patients who are considering ending their lives could legally approach a physician regarding the request for assistance, through intervention (such as the counseling mentioned earlier) many would ultimately

select another alternative. In Oregon it is reported that 90 percent of those patients initially interested in taking their own life changed their minds once they had received counseling from their physician. However, the key is to make the option legal so that patients feel safe in openly discussing their concerns, rather than taking matters into their own hands.

Better end-of-life care is needed, including better access to pain alleviating drugs, better training of physicians in how to treat pain, relaxed oversight by the Drug Enforcement Administration (DEA) (which presently acts as a barrier for many physicians who want to prescribe high doses of pain medication), and new laws that would hold health care professionals accountable for the failure to treat pain. While such changes will reduce the desire for a self-administered death, it will not entirely eliminate it. For some patients the only way to relieve pain is through extremely high doses of medication rendering them “doped” up or comatose, a state they find unacceptable. Other patients find that while their pain can be managed, the side effects diminish what quality of life might be left. This can include constant nausea, chronic constipation or severe diarrhea, or having to depend on life support to keep them alive when they no longer wish to live.

Why do you say it isn't “suicide” when a dying person ends their life with the help of a doctor? We do not use the term “suicide” for a number of reasons. Suicide is an emotional and irrational act that deprives people of what might otherwise be a full and rewarding life. It is inappropriate to “label” a competent, terminally ill and dying patient as “suicidal” when that patient, in consultation with his or her physician, has made a rational and informed decision to end their life to avoid prolonged suffering.

“Suicide” and the choice of a dying patient to hasten impending death in a peaceful and dignified manner are starkly different from a mental health perspective. Profound psychological differences distinguish suicide from actions under legal aid in dying. As one psychiatrist recently summarized: “The term ‘assisted suicide’ is inaccurate and misleading with respect to the DIGNITY ACT. These patients and the typical suicide are opposites:

- ✓ The suicidal patient has no terminal illness but wants to die; the DWD patient has a terminal illness and wants to live.
- ✓ Typical suicides bring shock and tragedy to families and friends; DWD deaths are peaceful and supported by loved ones.
- ✓ Typical suicides are secretive and often impulsive and violent. Death in DWD is planned; it changes only timing in a minor way, but adds control in a major and socially approved way.

- ✓ Suicide is an expression of despair and futility; DWD is a form of affirmation and empowerment³.”

A working group of the American Psychological Association has recognized: “It is important to remember that the reasoning on which a terminally ill person (whose judgments are not impaired by mental disorders) bases a decision to end his or her life is fundamentally different from the reasoning a clinically depressed person uses to justify suicide.⁴”

Medical experts have discussed in detail why the term “suicide” or “assisted suicide” is inappropriate when discussing the choice of a mentally competent, terminally ill patient to seek medications that he or she could consume to bring about a peaceful and dignified death. The American Academy of Hospice and Palliative Medicine’s Policy on Physician Assisted Death rejecting the “emotionally charged” term “physician-assisted suicide,” adopted in February 2007, is available at: www.aahpm.org/positions/suicide.html.

In Oregon where aid in dying has been documented for the last 11 years, if the procedures are followed, the cause of death is listed as the underlying illness, not a suicide or “other than natural causes.” This is consistent with the Dignity Act itself, which clearly states: “Actions taken in accordance with ORS 127.800 to 127.897 shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law.”

What are some alternatives to aid in dying? Are they as successful? There are many alternatives and in fact 90 percent of those initially seeking a hastened death elect another alternative once they have had the chance to talk about their end-of-life concerns with a physician. Most simply want assurance that if all else fails there is an option of last resort, and as long as that option exists most people will at least try palliative care, hospice, pain control or spiritual counseling. It should be understood that these people do not want to die. Given the choice, if a miracle cure were available, they would want to live. The reality, however, is that they are dying and simply want a good death, either through natural means or through medication if that is the only way possible.

³Lieberman, E.J.,M.D., Letters to the Editor, Death with Dignity, Psychiatric News, 2006 Aug. 41 (15):29.

⁴Brief of Amicus Curiae Coalition of Mental Health Professionals, WL 1749170 at 17, Gonzales v. Oregon, 126 S. Ct. 904 (2006) (No. 04-623).

What are the reasons a person gives for wanting to end their life with aid in dying? In Oregon, where aid in dying has been a legal option for 11 years, the number one reason given by patients is loss of autonomy. These are generally people who are fiercely independent and used to being in control. As their illness progresses and they begin to lose control of their situation, for example becoming bedridden and dependent upon artificial means of life support, they often find their situation intolerable and state that if they are dying anyway, why can't they "go" while they still have some dignity left.

Loss of autonomy is cited in 87 percent of the cases where patients have chosen to hasten their death. The second most common reason, also cited in 87 percent of the cases (patients often give multiple reasons for their decision), is loss of enjoyment of life. For example, a dying patient whose only remaining joy is the ability to eat solid food, but their disease progresses to the point where they can no longer eat. Also, there are cases of patients who require so much medication to ease their pain they see no point in being kept alive in a "doped" up condition, or patients who suffer from chronic nausea and vomiting either as the result of their illness or medications being taken to control the pain.

The third most common reason is loss of bodily functions, cited in 57 percent of the cases. Some people feel it humiliating and degrading to have their own children change their diapers or have to clean them up (again, keep in mind that most of these people describe themselves as being fiercely independent).

Fourth, cited in 38 percent of the cases, is being a burden on family or friends. In most cases the patient does not want to have to move in with their children, nor have their children turn down career opportunities to become fulltime caregiver for a parent. Fifth, cited in 26 percent of cases, is pain or fear of pain. When cancer has metastasized there is often nothing that can be done to control pain aside from a procedure called "terminal sedation," where the patient is essentially placed into a coma so they do not experience pain. Some patients argue that since they are dying anyway, why prolong their life in a state of unconsciousness.

Finally, cited in only 2 percent of cases, are financial concerns, usually the futility of exhausting their finances, which could otherwise be left to the family, if all they are doing is prolonging their life for a few days or weeks.

What are the safeguards under the Oregon and Washington

Death with Dignity acts? The Oregon law contains over a dozen safeguards to prevent abuse, which include a second concurring medical opinion about the patient's prognosis, multiple requests from the patient; two oral and one written - with a mandatory waiting period between requests, a third psychological opinion if either physician suspects the patient is being coerced or may not be capable of making an informed decision and mandatory counseling on alternative forms of treatment and care including hospice, palliative care, pain management and spiritual counseling.

1. The patient must be a competent adult (age 18 or over).
2. The patient must be a resident of the state of Oregon or Washington.
3. The patient must be capable of self-administration (only the patient can take the medication him or herself).
4. The patient must be terminally ill, defined as someone with an incurable illness who is expected to die within six-months or less.
5. A second physician must confirm the terminal diagnosis.
6. If either physician suspects the request for aid in dying is motivated by depression or coercion, a third examination by a psychologist or psychiatrist is required.
7. Only the patient himself or herself can initiate the request.
8. The patient must make two oral requests for the medication, separated by a minimum 15-day waiting period.
9. The patient must make a third written request witnessed by two people who know the patient and who can testify, if necessary, that the request was an informed and rational one.
10. Witnesses cannot stand to gain financially from the patient's death.
11. Prior to writing the prescription, the physician must confirm that the patient is both still competent and capable of self administration.
12. The physician is required by law to counsel the patient on alternatives to a hastened death, including hospice, palliative care and pain management.
13. The physician must recommend, but not require, that the patient inform his or her family of the decision to hasten death.
14. No insurance policy or contract can be made invalid if a patient uses the law to hasten death.
15. The patient can change his or her mind at any time.
16. Any physician, pharmacist or medical facility opposed to aid in dying does not have to participate.
17. If a death occurs under the law the physician is immune from any civil or criminal liability.

Additional Online Resources

Web Sites

Compassion & Choices www.compassionadchoices.org

Death with Dignity National www.deathwithdignity.org

Longwood University www.longwood.edu/library/suic.htm

Oregon Department of Human Services www.oregon.gov/DHS/ph/pas/

Public Agenda www.publicagenda.org (use the “Issues” drop-down menu and select “right to die”)

Religious Tolerance www.religioustolerance.org/euthanas.htm

Willamette College of Law www.willamette.edu/wucl/pas/

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