

Compassion & Choices

Medical Aid in Dying Fact Sheet

What Is Medical Aid in Dying?

Medical aid in dying (also known as death with dignity) is when a terminally ill, mentally capable person who has a prognosis of six months or less to live requests, obtains and—if his or her suffering becomes unbearable—self-ingests medication that brings about a peaceful death.

Prior to providing a prescription for such medication, doctors must confirm that the person is fully informed and provide the person with information about additional end-of-life options, including comfort care, hospice and pain control.

Why Is Medical Aid in Dying a Safe Practice?

Medical aid in dying is a safe and trusted medical practice because the eligibility requirements ensure that only mentally capable, terminally ill adults with a prognosis of six months or less who want the choice of a peaceful death are able to request and obtain aid-in-dying medication. And the prestigious and peer-reviewed *Journal of Palliative Medicine* published clinical criteria for medical aid in dying which physicians use to ensure that the practice meets the highest standards of medical care.⁶

The states that authorized aid in dying through legislation modeled their bills after Oregon's Death With Dignity Act¹. In those states, medical aid in dying is available to adults who are terminally ill, with six months or less to live. They must be mentally capable of making their own healthcare decisions and health providers, family and friends must not influence their decisions.

Where Is Medical Aid in Dying Authorized?

Medical aid in dying is currently authorized in five states, either through statute or court decision:

- > Oregon (1994, ballot initiative)¹
- > Washington (2008, ballot initiative)²
- > Montana (2009, state Supreme Court decision)³
- > Vermont (2013, legislation)⁴
- > California (2015, legislation)⁵

Each state's regulatory and procedural requirements are slightly different, but all the legislation includes the following provisions, among others:

- > The person must be fully informed of all their options
- > The person must request the prescription from a physician and be free from undue influence or coercion
- > The person must be able to take and ingest the medication by themselves
- > The physician must offer the person multiple opportunities to take back the request for aid-in-dying medication
- > Two witnesses must sign the request form confirming that the request is voluntary
- > Wills, contracts, insurance and annuity policies are not affected by a person choosing aid in dying
- > Aid in dying is not considered suicide or assisted suicide

How Well Has Medical Aid in Dying Worked in the States That Have Authorized It?

In the more than 30 combined years of medical aid in dying in the authorized states, there has not been a single instance of documented abuse. Almost two decades of rigorously observed and documented experience in Oregon shows us the law has worked as intended, with none of the problems opponents had predicted.

In Oregon:

- > End-of-life care has improved overall since the law's implementation, in large part due to the dialogue the Death With Dignity Act encourages between people and their doctors.⁷
- > Hospice use is high and referrals are up⁸, as is other use of palliative care. Some hospice programs in Oregon reported a 20 percent increase in referrals since the medical aid in dying was authorized.⁹
- > In-hospital death rates are the lowest in the nation and at-home death rates are the highest in the nation, and violent suicide among hospice patients has virtually disappeared.⁷

Where Does the American Public Stand on Medical Aid in Dying?

The American public consistently supports medical aid in dying by large majorities and is of great importance to voters, as measured by national independent polling outlets such as Gallup (68 percent support in May 2015)¹⁰ and The Harris Poll (74 percent support in November 2014)¹¹. State-by-state polling also indicates majority support that cuts across demographics.

Why Is It Wrong to Equate Medical Aid in Dying With Euthanasia?

Medical aid in dying is fundamentally different from euthanasia. Medical aid in dying is authorized in five states. With aid in dying, the terminally ill person must take the medication themselves, and therefore, always remains in control.

Euthanasia is commonly given as a lethal injection by a third party. It is often performed on somebody who does not have a terminal diagnosis and is illegal throughout the United States. Compassion & Choices doesn't support euthanasia because someone else – not the dying person – chooses and acts to cause death.

Why Is It Wrong to Equate Medical Aid in Dying With Assisted Suicide?

Factually, legally and medically speaking, it is inaccurate to equate aid in dying with assisted suicide. People who consider aid in dying find the suggestion that they are committing suicide deeply offensive, stigmatizing and inaccurate. The Oregon¹, Washington², Vermont⁴ and California⁵ laws emphasize that:

“Actions taken in accordance with [the Act] shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law.”

This is because a person who is choosing medical aid in dying already has a terminal prognosis of six months or less to live. They are not choosing to die; the disease is taking their life. The terminally ill person who chooses aid in dying is simply choosing not to prolong a difficult and painful dying process.

Which Organizations Support Medical Aid in Dying?

In addition to Compassion & Choices, national public health and medical organizations such as the American Public Health Association, American Medical Women's Association and American Medical Student Association have adopted supportive positions on medical aid in dying at the national level.

In California, the End of Life Option Act (signed into law in October 2015) was endorsed by more than 75 organizations including the American Nurses Association/California, California Psychological Association and California Primary Care Association.

The California Medical Association dropped its 28-year opposition to medical aid in dying and adopted a neutral position on the legislation, concluding: "As physicians, we want to provide the best care possible for our patients. However, despite the remarkable medical breakthroughs we've made and the world-class hospice or palliative care we can provide, it isn't always enough ... it's up to the patient and their physician to choose the course of treatment best suited for the situation."¹²

Resources

- ¹Oregon Death With Dignity Act. Oregon Revised Statute. Chapter 127. Enacted October 1997. Available from <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ors.aspx>.
- ²Washington Death With Dignity Act. Complete Chapter 70.245 RCW. Enacted November 2008. Available from <http://apps.leg.wa.gov/RCW/default.aspx?cite=70.245>.
- ³Montana Supreme Court Ruling Baxter v. Montana. December 2009. Available from <https://www.compassionandchoices.org/userfiles/Montana-Supreme-Court-Opinion.pdf>.
- ⁴Vermont Patient Choice and Control at the End of Life Act. Act 039, Chapter 113. Enacted May 2013. Available from <http://www.leg.state.vt.us/docs/2014/Acts/ACT039.pdf>.
- ⁵California End of Life Option Act. ABX2-15 End of life. Enacted October 2015. Available from: http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520162AB15.
- ⁶Orentlicher, D., Pope, T.M., Rich, B.A. (2015) Clinical Criteria for Physician Aid in Dying. *Journal of Palliative Medicine*. 18(x): 1-4.
- ⁷Wang, S, Aldridge, MD, Gross, CP, Canavan, M, Cherlin, E, Johnson-Hurzeler, R., et al. (2015) Geographic Variation of Hospice Use Patterns at the End of Life. *Journal of Palliative Medicine*. 18(9), p.778.
- ⁸Ibid., p.775.
- ⁹Lee, M,A, & Tolle, S.W. (1996) Oregon's assisted suicide vote: The silver lining. *Annals of Internal Medicine*. 124(2), 267-269.
- ¹⁰Dugan, A. In U.S., Support Up for Doctor-Assisted Suicide. Gallup. May 2015. Available from http://www.gallup.com/poll/183425/support-doctor-assisted-suicide.aspx?utm_source=Politics&utm_medium=newsfeed&utm_campaign=tiles.
- ¹¹Thompson, D. Most Americans Agree With Right-to-Die Movement. The Harris Poll. December 2014. Available from <http://www.theharrispoll.com/health-and-life/Most-Americans-Agree-With-Right-to-Die-Movement.html>.
- ¹²California Medical Association. Excerpted from: CMA changes stance on physician aid in dying, takes neutral position on End of Life Option Act. June 2, 2015. Available at <http://www.cmanet.org/news/detail/?article=cma-changes-stance-on-physician-aid-in-dying>.

End-Of-Life: Options for Care and Choice

Background

The goal of good end-of-life care is to provide as much physical and emotional comfort as possible. Not aimed at curing illness, the following options focus on comfort, dignity and quality of life. For many, it is reassuring just to know that options exist. There is no one right answer or choice; preferences vary from person to person.

Candid conversation is crucial to ensuring we get the care we want at the end of life, so it's important to discuss priorities with loved ones, healthcare providers and others close to us. Our End-of-Life Information Center offers additional resources on end-of-life options and how to talk about them.

Pain and Symptom Management

Pain and symptom management involves the use of medications and other therapies, such as massage, acupuncture and aromatherapy, to bring comfort. Symptoms may be disease-related, such as pain, shortness of breath or sleeplessness. Or they may be side effects of treatment, such as nausea from chemotherapy.

Things to consider about this option:

- > Palliative pain and symptom management can be used at any time, with or without a terminal prognosis.
- > Palliative care is available in medical or assisted living settings and in the home.

Hospice

Hospice care focuses on quality of life rather than the length of life, with the goal of comfort. It is a holistic approach combining medical care, auxiliary therapy and mental health support, and can involve the family in the process. Hospice care usually involves a team of professionals including doctors, nurses, home health aides, social workers, chaplains and others. Services may include nursing care, medical supplies and equipment, home health aide services, respite services (relief for the caregiver), medications to manage symptoms, and spiritual support.

To qualify for hospice, a doctor must estimate a prognosis of six months or less. Typically, treatments intended to cure the illness or extend life are not available once a person enters hospice care. Surprisingly, evidence indicates people sometimes live longer once they make this transition from curative to palliative treatment. Through the Medicare Care Choices Model, the Centers for Medicare & Medicaid Services also provides an option for Medicare beneficiaries that allows them to continue curative treatments while obtaining palliative care. This is available through a limited number of hospice providers.

Things to consider about this option:

- > To be eligible, prognosis must be six months or less to live.
- > Hospice also provides counseling, family support and end-of-life planning.
- > Hospice care usually takes place in the home, often with help from family members or others.

Voluntarily Stopping of Eating and Drinking (VSED)

Often, as death nears bodily changes can take away appetite. For some people, the decision to voluntarily stop eating and drinking, meaning declining food, liquids and artificial feeding, shortens the dying process.

Things to consider about this option:

- > VSED includes pain and symptom management to minimize discomfort.
- > Some people feel hunger and thirst during the first few days.
- > Everyone has the right to refuse food and fluids.
- > Working with hospice or a medical team is highly recommended.
- > Families of those in a care facility may need to work closely with staff to ensure staff will honor this choice.
- > When VSED is sought at home, it should be medically managed to minimize discomfort.

Declining or Stopping Life-Sustaining Treatment

Treatments for health conditions or to prolong life, such as use of a ventilator, a feeding tube, IV hydration, antibiotics or cardiopulmonary resuscitation (CPR), can be refused or stopped at any time. Sometimes, more treatment is helpful, and can prolong the dying process and increase suffering without improving quality of life.

Things to consider about this option:

- > Pain and symptom management are used to ease any discomfort.
- > Anyone can refuse medical treatments.
- > Those in a care facility may need to work closely with staff to ensure they will honor this choice.

Palliative Sedation

Sometimes called terminal sedation, this option involves being medicated to reduce consciousness. Typically the person remains unconscious until death. At the same time, all nutrition and fluids are stopped. Sedation may bring some relief for extreme pain and suffering. However, it may not totally relieve symptoms.

Things to consider about this option:

- > Palliative sedation must be medically managed by a healthcare provider.
- > Those seeking this option must ensure their healthcare provider will honor it.

Medical Aid in Dying

Medical aid in dying allows terminally ill adults to receive a prescription for medication that will bring about a peaceful death. To qualify, one must be mentally capable, able to self-administer the medication and have a prognosis of six months or less.

Things to consider about this option:

- > For some people, simply having the prescription brings comfort whether or not they use it.
- > Five states currently authorize medical aid in dying: California, Montana, Oregon, Vermont and Washington.
- > This option can be used at home.

Get more information or schedule an appointment with a Compassion & Choices End-of-Life Consultant [here](#).

Medical Aid in Dying and People Living with Disabilities

Compassion & Choices Supports the Disability Rights Community

The medical aid in dying and disability rights movements share important core values: autonomy, independence and self-determination. We strongly support the right of people living with disabilities to remain in control of decisions about their healthcare and their life.

What Is Medical Aid in Dying?

Aid in dying (also known as death with dignity) is a medical practice in which a terminally ill, mentally capable adult with a prognosis of six months or less to live may request, obtain and - if their suffering becomes unbearable - self-ingest medication that brings about a peaceful death. Prior to providing a prescription for such medication, two doctors must confirm that the person is fully informed and provide the person with information about additional end-of-life options, including comfort care, hospice and pain control.

Medical Aid in Dying Has Strong Support from People Living With Disabilities

The Disabilities Rights Legal Center, which has a successful track record of litigating on behalf of disabled Americans, is an active supporter of medical aid in dying. It has declared that medical aid in dying "poses no threat to people with disabilities."¹ Furthermore, it has an End of Life Liberty Project that has litigated on behalf of disabled Americans to secure their right to determine the way in which they die, including medical aid in dying.

Compassion & Choices supports the disability rights movement and shares important core values of self-determination and autonomy.

State polls show a strong majority of voters living with disabilities support medical aid in dying in Connecticut (65%), Massachusetts (74%) and New Jersey (63%). And their average support level is nearly identical to all voters in these three states (Connecticut: 66%²; Massachusetts: 71%³; New Jersey: 62%⁴).

Supporter Profile

Dustin Hankinson

At age three, Dustin was diagnosed with a genetic disorder called Duchenne muscular dystrophy. A lifelong disability rights activist, he has diligently advocated for passage of aid-in-dying legislation.

"Like others, we want the freedom to enjoy life. This freedom should include the full range of options at the end of life, including hospice, palliative care and aid in dying. If you have a terminal illness and are in great pain, I think you should have the right to end your life ... It is discrimination against the disabled to deny them the right ... that able-bodied people have ... We should not take away the freedom of the individual to choose to die. I believe one should have control of one's life, including its ending."

Medical Aid in Dying Has a Proven Safety Record

Medical aid in dying is a safe and trusted medical practice. In the more than 30 combined years of medical aid in dying in the authorized states, there

has not been a single instance of abuse or coercion. Almost two decades of experience in Oregon shows us the law has worked as intended, with none of the problems that opponents had predicted.⁵ Core safeguards in medical aid in dying laws ensure that people in vulnerable circumstances are protected from coercion or abuse, including two doctors and two witnesses who must attest that the person requesting the medication for aid in dying is not being coerced or under undue influence. Coercing someone to utilize medical aid in dying is a felony.

Careful studies of the law's 18-year record in Oregon, the first state to pass an aid-in-dying law, demonstrate that concerns the law would target the disabled, elderly, frail, uninsured or any vulnerable groups have not materialized.^{6,7} Disability Rights Oregon, charged with protecting Oregonians with disabilities, has never received a complaint of abuse or attempted abuse under the Oregon Death With Dignity Act.⁸ The eligibility requirements ensure that only mentally capable, terminally ill adults with a prognosis of six months or less who want the choice of a peaceful death are able to request and obtain aid-in-dying medication. Medical aid-in-dying laws specifically state that no person can qualify for aid-in-dying medication based solely on their disability or age.

Medical Aid-in-Dying Laws Have Sound Oversight and Investigation Processes in Place

States that authorize medical aid in dying thoroughly monitor the practice with stringent eligibility and qualification processes, mandatory state reporting by the medical team, medical board oversight, and justice department investigatory power when appropriate. Not a single reputable researcher or research institution has ever suggested that the oversight of the laws or the data are unsound or in any way unreliable.

Medical Aid in Dying Improves Overall End-of-Life Care

Medical aid in dying not only expands choice, but improves care at the end of life because palliative care and hospice systems grow stronger in states that authorize the practice. End-of-life care has improved overall since the Oregon law's implementation, in large part due to the dialogue the Death With Dignity Act encourages between people and their doctors.⁹ Oregon is a leader in end-of-life care and policy, receiving a grade of A from The Center to Advance Palliative Care. And Oregon, Washington and Vermont, where medical aid in dying is authorized, are among only seven states that receive a grade of A for palliative care.¹⁰ A *Journal of Palliative Medicine* article suggests that medical aid in dying in Oregon has resulted in "more appropriate palliative care training of physicians."¹¹

There Is No Financial Pressure to Use Medical Aid in Dying

Independent research published in the *New England Journal of Medicine* concluded that insurers have no financial incentive to pressure terminally ill patients to accelerate their deaths using medical aid in dying, because there are no substantial cost savings. The authors state "savings can be predicted to be very small — less than 0.1 percent of both total healthcare spending in the United States and an individual managed-care plan's budget."¹²

Medical Aid in Dying Is Not Assisted Suicide

Factually, legally and medically speaking, it is inaccurate to equate aid in dying with assisted suicide. People who consider aid in dying find the suggestion that they are committing suicide deeply offensive, stigmatizing and inaccurate. The Oregon¹³, Washington¹⁴, Vermont¹⁵ and California¹⁶ medical aid-in-dying laws emphasize that:

"Actions taken in accordance with [the Act] shall

not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law.”

This is because a person who is choosing medical aid in dying already has a terminal prognosis of six months or less to live. They are not choosing to die; a disease is taking their life. The terminally ill person who pursues aid in dying is simply choosing not to prolong a difficult and painful dying process.

Medical Aid in Dying Is Not Euthanasia

Medical aid in dying and euthanasia are two fundamentally different practices, the chief differentiator between the two being who makes the choice to end a terminally ill person’s life. Compassion & Choices does not support euthanasia.

- > Aid in dying is a medical practice by which a terminally ill, mentally capable person who has a prognosis of six months or less requests, obtains and — if their suffering becomes unbearable — self-administers medication that brings about a peaceful death.
- > Euthanasia, sometimes called “mercy killing,” is an intentional act by which another person (not the terminally ill or dying person) chooses and acts to cause death. Medical aid-in-dying laws expressly prohibit euthanasia.¹⁷ Euthanasia is illegal in the United States, whereas medical aid in dying is currently authorized in five states.

Most Americans Support Medical Aid in Dying

The American public consistently supports medical aid in dying by large majorities, and the issue is of great importance to voters, as measured by national independent polling outlets such as Gallup (68 percent support in May 2015) and The Harris Poll (74 percent support in November 2014). State-by-state polling also indicates that majority support cuts across demographic groups. Since Oregon passed its law, medical aid in dying has been authorized in Washington, Montana, Vermont and

California. In 2015, proposed legislation authorizing medical aid in dying was introduced in 27 states and the District of Columbia, and 217 state legislators across the country sponsored medical aid-in-dying bills.

Many Professional Healthcare Associations and National Organizations Support Medical Aid In Dying.

A growing number of national and state organizations representing healthcare professionals have endorsed or accepted medical aid in dying as an end-of-life option for terminally ill, mentally capable adults. And the prestigious and peer-reviewed Journal of Palliative Medicine published clinical criteria for medical aid in dying which physicians use to ensure that the practice meets the highest standards of medical care.¹⁸

The medical practice is supported by the American Public Health Association, the American Medical Students Association, the American Medical Women’s Association, the American College of Legal Medicine, National Association of Social Workers, state chapters of the American Civil Liberties Union and the Gay and Lesbian Medical Association. The New York Times editorial board and major newspaper editorial boards across the country have also endorsed this end-of-life option after examining its record. In addition, a 2014 Medscape survey of 17,000 U.S. doctors representing 28 medical specialties agreed by a 23-percent margin (54% vs. 31%) that medical aid in dying should be available as an end-of-life option.¹⁹

Resources

¹Disability Rights Legal Center - End-of-Life Liberty Project. Available from: <https://disabilityrightslegalcenter.org/end-life-liberty-project>

²Recent Polling in CT. Purple Insights. February 2014. Available from <https://drive.google.com/a/compassionandchoices.org/file/d/0B3luDjCAxxv7bF9ETDgzS1B2RmJ1aWdMUGRqeHJibVdiUWIO/view?usp=sharing>.

³Recent Polling in MA. Purple Insights. February 2014. Available from <https://drive.google.com/open?id=0B3luDjCAxxv7eXdPUXJtTEtYcONZNFfoSDJWYkNvTIM4aWk0>

⁴Recent Polling in NJ. Purple Insights. February 2014. Available from www.compassionandchoices.org/userfiles/New-Jersey-Purple-Poll-Memo-February-2014.pdf.

⁵Oregon Death With Dignity Act: 2015 Data Summary. Oregon Public Health Division, Feb. 4, 2016. Available from <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf>

⁶Wang, S, Aldridge, MD, Gross, CP, Canavan, M, Cherlin, E, Johnson-Hurzeler, R., et al. (2015) Geographic Variation of Hospice Use Patterns at the End of Life. *Journal of Palliative Medicine*. 18(9), 778.

⁷Lee, M,A, & Tolle, S.W. (1996) Oregon's assisted suicide vote: The silver lining. *Annals of Internal Medicine*. 124(2), 267-269.

⁸Robert Joondepth, Executive Director of Disability Rights Oregon declaration in testimony before the American Health Public Health Association that Disability Rights Oregon has never received a complaint of abuse or attempted abuse under the Oregon Death with Dignity Act. Available from <https://drive.google.com/file/d/0B3luDjCAxxv7WEw0UThRMHRQeXc/view?usp=sharing>.

⁹Wang, S, Aldridge, MD, Gross, CP, Canavan, M, Cherlin, E, Johnson-Hurzeler, R., et al. (2015) Geographic Variation of Hospice Use Patterns at the End of Life. *Journal of Palliative Medicine*. 18(9), 778.

¹⁰Center for Advanced Palliative Care: 2015 State-By-State Report Card on Access to Palliative Care in Our Nation's Hospitals. Available at <http://reportcard.capc.org/>

¹¹Wang, S, Aldridge, MD, Gross, CP, Canavan, M, Cherlin, E, Johnson-Hurzeler, R., et al. (2015) Geographic Variation of Hospice Use Patterns at the End of Life. *Journal of Palliative Medicine*. 18(9), 778.

¹²Emanuel M.D., Ph.D, Ezekiel. Battin Ph.D., Margaret P. New England Journal of Medicine. July 16, 1998. "What Are the Potential Cost Savings from Legalizing Physician-Assisted Suicide?" <http://www.nejm.org/doi/full/10.1056/NEJM199807163390306>

¹³Oregon Death With Dignity Act. Oregon Revised Statute. Chapter 127. Enacted October 1997. Available from: <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ors.aspx>.

¹⁴Washington Death With Dignity Act. Complete Chapter 70.245 RCW. Enacted November 2008. Available from: http://www.wsha.org/wp-content/uploads/Death-with-Dignity_i1000-text.pdf.

¹⁵Vermont Patient Choice and Control at the End of Life Act. Act 039, Chapter 113. Enacted May 2013. Available from: <http://www.leg.state.vt.us/docs/2014/Acts/ACT039.pdf>.

¹⁶California End of Life Option Act. ABX2-15 End of life. Enacted October 2015. Available from:

http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520162AB15

¹⁷ORS Chapter 127.880 - Oregon Death With Dignity Act <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ors.aspx>

¹⁸Orentlicher, D., Pope, T.M., Rich, B.A. (2015) Clinical Criteria for Physician Aid in Dying. *Journal of Palliative Medicine*. 18(x): 1-4.

¹⁹Kane, L. Medscape Ethics Report 2014, Part 1: Life, Death, and Pain. Medscape Ethics Center. December 2014. Available from <http://www.medscape.com/features/slideshow/public/ethics2014-part1#2>.



Dan Diaz

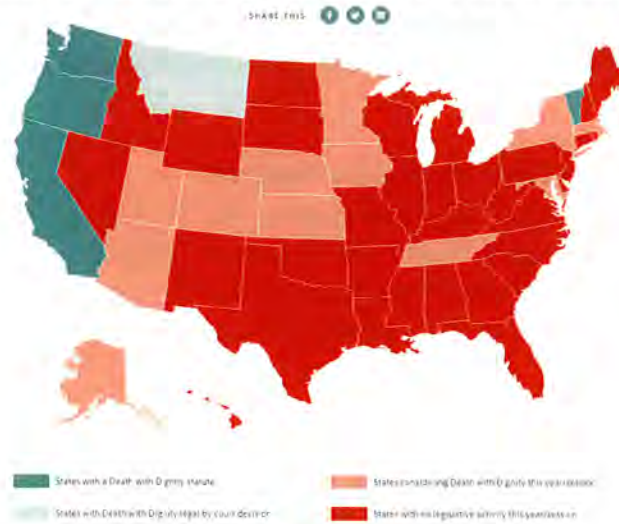
Advocate – End of Life Options

Dan is the husband of Brittany Maynard, the 29 year old woman who died in November 2014 from a brain tumor. The couple moved from California to Oregon, one of five states that has authorized medical aid in dying in order for Brittany to have the option of a gentle dying process. As a result of Brittany's story, legislators have introduced bills to authorize medical aid in dying in 25 states and Washington DC. Dan advocates for expanding the availability of end-of-life options for terminally ill individuals and has partnered with the non-profit organization Compassion & Choices. Dan's efforts were instrumental in securing the passage of the legislation in California, and his efforts continue in the other states across the country.

Please support H.B. 264. This bill creates the Utah End of Life Options Act.

What is the Utah End of Life Options Act?

The proposed bill, Utah End of Life Options Act, would affirm the right of a qualified, terminally ill adult to obtain a prescription from their physician for medication that they may choose to self-administer for a humane and dignified death. This medical practice, called physician aid in dying, is currently authorized in five states: Oregon, Washington, Vermont, Montana, and California. Similar legislation is being considered in several other states in 2016 so far, as shown in the map below.



The Utah End of Life Options Act includes

- The patient must be a **mentally competent adult** who is a legal resident of Utah and is diagnosed with an **irreversible and incurable illness** that will result in the patient's death in six months or less.
- The process includes **two separate requests for medication** separated by a minimum waiting period of fifteen days, with a second physician confirming that the patient will likely die in six months or less.
- *If either physician suspects the patient may be acting out of duress, is under coercion, may be suffering from depression, or may lack the ability to fully appreciate the nature of the request, then the patient must be referred for a psychological evaluation.*
- **The patient must be counseled on all feasible alternative treatment options, including hospice, pain management and palliative care.**
- The patient must be able to **self-administer** the medication; no one else can assist.
- The proposed law does not permit euthanasia, mercy killing or assisting a suicide, all of which remain felonies under Utah law.
- A death under the law will not invalidate a life insurance policy or annuity.
- Provided all of the procedures have been followed and documented, no doctor, pharmacist or healthcare provider can be held civilly or criminally liable.
- Health care providers opposed to death with dignity are not required to participate.

The Record on Death with Dignity Laws in Oregon and Washington

The Oregon Death with Dignity Act (DWDA) has been in effect for 18 years and the Washington Death with Dignity act has been in effect for seven years. The experience in these states has demonstrated that any objections or legitimate concerns that were initially raised have been absolutely and categorically shown to be unfounded. Contrary to what many expected, the law is sparingly used: less than 1 in 500 deaths (60 or 70 a year out of a total of over 30,000 deaths) in Oregon, with comparable numbers in Washington. The Oregon Public Health Division is required by the DWDA to collect compliance information and to issue an annual report; the [2014 report](#) showed that since the law was passed 18 years ago, a total of 1,327 people have had DWDA prescriptions written and of those, 859 patients have died from ingesting medications prescribed under the DWDA.

Patients Want this Option with Their Physicians' Support

This private, personal decision belongs to all Americans – free from government interference. Every mentally competent, terminally ill adult deserves this medical option. It is an entirely patient-directed practice, and its mere availability demonstrably provides a tremendous peace of mind and improves the quality of life at the end of life – whether or not the patient chooses to ingest the prescription.

Improvements in End-Of-Life Care

Studies have shown that following enactment of similar laws, overall end of life care improved. Physicians reported making 30% more hospice referrals, increasing their knowledge of diagnosing mental health conditions, and felt they were better prepared to treat pain in dying patients. On average, 93% of patients using the law were enrolled in hospice. Additional studies have shown that because patients and physicians were able to openly talk about end of life concerns, most terminally ill patients went on to explore other treatment alternatives, including hospice, pain management and palliative care. Significantly, Oregon also has the highest number of at-home deaths of any state; dying at home is a wish Americans consistently express.

This bill would allow Utahns to make end-of-life decisions on their time and on their terms.

For more information contact:

Elizabeth Converse, House Democratic Caucus
Communications Director
801.835.7087
econverse@le.utah.gov

Oregon's Death with Dignity Act (DWDA), enacted in late 1997, allows terminally-ill adult Oregonians to obtain and use prescriptions from their physicians for self-administered, lethal doses of medications. The Oregon Public Health Division is required by the DWDA to collect compliance information and to issue an annual report. Additional statistics and tables can be found at: <http://www.healthoregon.org/dwd>.

Facts vs. Myths

Myth: Someone will be coerced into taking the medication.

Fact: Under existing laws, two physicians have to certify that the patient's request is a willing and informed one, and two witnesses who personally know the patient have to attest that in their opinion no coercion is involved. In addition, since only the patient can self-administer the medication, it is extremely unlikely coercion could take place. **To date there has been no single documented case of coercion taking place.**

Myth: Someone other than the patient might take the medication by accident.

Fact: Of the most commonly used medicines, one requires 100 capsules so it would be hard to swallow all 100 by accident. The other medication is in liquid form and the entire bottle needs to be ingested. Given these medications are extremely bitter and are normally mixed with something else to mask the taste, it is unlikely an accidental ingestion would take place. **To date there are no known cases of this having occurred.**

Myth: Someone with a mental illness might obtain the medication.

Fact: If either prescribing physician suspects the patient is incapable of understanding the nature of the request, then the patient has to submit to a psychological or psychiatric evaluation. In addition, the patient's medical records are examined to see if there is a history of clinical depression or previous attempts at suicide.

Myth: People will flock to Utah to use the Death with Dignity Law.

Fact: The law requires that legal residency be furnished to the physician as evidence by such proof as a valid driver's license, state issued ID, proof of filing an income tax return for the most recent year, or proof of owning or leasing property in the state.

Myth: The marginalized populations will be targeted.

Fact: Studies show that this has not happened in Oregon. Only the patient him or herself can request the medication and only the patient can self-administer it. Of all the deaths under the Oregon DWDA, cancer was most often the underlying illness (79%). Most people (68.7%) were aged 65 years or older, and the median age at death was 71-years. Decedents are commonly white (97.1%) and well-educated (45.9% had a least a baccalaureate degree).

Myth: Life insurance companies will not pay a death benefit.

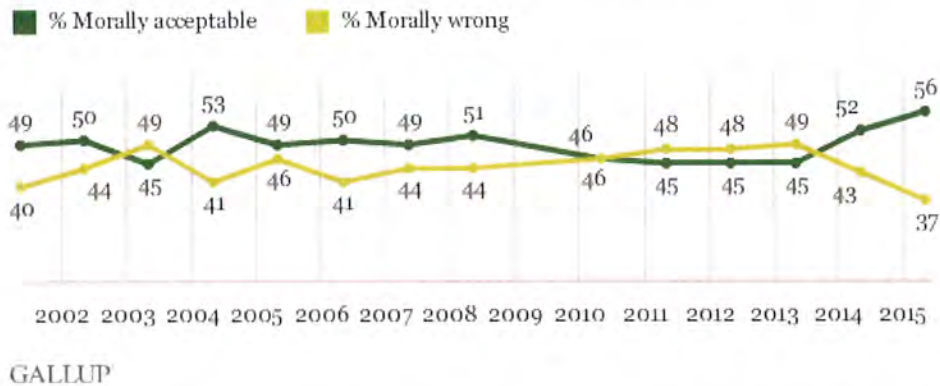
Fact: The issuer of a life insurance or annuity policy cannot deny payment because a policyholder used the law. Most insurance policies have a two year incontestability clause, meaning that the company has a two year due diligence period in which it can invalidate the policy. After two years the benefits must be paid unless there is fraud or failure to pay the premium. In addition, the death certificate indicates the cause of death as the underlying illness.

Myth: Poisoning is painful. The patient will experience a painful death.

Fact: The drugs used cause rapid unconsciousness. Very few complications have been reported (less than 3%), but the patients did not regain consciousness nor did family members report the patient appeared to be in pain. In the one case where someone ingested the medication but did not die immediately, the patient never mentioned any pain or discomfort from the medication.

Changing Trends

In a single year, and across demographic groups, approval of physician aid in dying increased by an average of 11%. This trend will continue as more people become aware of end-of-life options that give people the liberty to choose how the end of their life progresses. The 2015 Gallup poll also shows the growing opinions of Americans on the morality of providing this end-of-life option.



A 2014 Poll displays the Gallup findings – across demographics, across the board, people should have the option to end their life when facing terminal illness, even if they never use it.

"How much do you agree with the following statement? Individuals who are terminally ill, in great pain and who have no chance for recovery, have the right to choose to end their own life."

	Total 2011	Total 2014	Generation				Education				Political Party		
			Millennials (18-37)	Gen X (38-49)	Baby Boomers (50-68)	Matures (69+)	High School	Some College	College Grad	Post Grad	Rep.	Dem.	Ind.
			%	%	%	%	%	%	%	%	%	%	%
Agree (NET)	70	74	75	76	74	68	75	74	72	76	64	78	78
Very much agree	49	54	52	58	56	48	55	55	52	53	42	60	57
Somewhat agree	21	20	23	18	18	20	20	19	20	23	22	18	21
Disagree (NET)	17	14	12	14	15	20	13	15	15	16	23	11	13
Somewhat disagree	4	4	4	4	3	4	3	4	6	4	5	3	4
Very much disagree	13	10	8	10	11	16	10	11	10	12	18	8	8
Not at all sure	8	8	7	7	8	11	9	7	10	6	9	8	6

Note: Percentages may not add up exactly to 100% due to rounding.

DOCTORS' ROLE WITH TERMINALLY ILL PATIENTS

"Do you think doctors should be allowed to advise terminally ill patients who request the information on alternatives to medical treatment, and/or ways to end their own lives?"

Base: All Adults

	Total 2011	Total 2014	Gender		Party Identification		
			Male	Female	Rep.	Dem.	Ind.
	%	%	%	%	%	%	%
Yes (NET)	67	72	74	71	63	76	76
Yes, in all cases	27	32	36	28	25	37	31
Yes, in certain cases	40	40	38	43	38	39	46
No, never	19	15	15	15	25	12	11
Not at all sure	15	13	12	14	12	12	13

Note: Percentages may not add up exactly to 100% due to rounding.

Annual reports on 18 years of the DWDA in Oregon can be found at:

<https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>

Polls can be found at:

<http://www.harrisinteractive.com/NewsRoom/HarrisPolls/tabid/447/ctl/ReadCustom%20Default/mid/1508/ArticleId/1531/Default.aspx>

Medical Aid in Dying Improves Care at the End of Life

What Is Palliative Care?

Palliative care, sometimes called “comfort care,” is person- and family-centered care that optimizes quality of life by anticipating, preventing and treating suffering. Palliative care throughout the continuum of illness addresses physical, intellectual, emotional, social and spiritual needs and facilitates patient autonomy, access to information and choice in care.¹

How Does Medical Aid in Dying Improve Palliative Care Outcomes?

Medical aid in dying — one option on the palliative care spectrum — enhances palliative care in several ways. Prior to providing a medical aid-in-dying prescription, physicians are required to confirm that their patient is fully informed of all their care options.

Palliative care physicians report that a patient’s questions about medical aid in dying prompt in-depth conversations between doctors and patients about the full-range of end-of-life care options, including hospice, pain management and emotional support in addition to aid in dying.

Numerous studies in Oregon and Washington, along with a host of national surveys, link the availability of medical aid in dying as a palliative care option to a number of positive outcomes for end-of-life care. A few of these findings are summarized below:

- > **Research conducted in Oregon suggests that having medical aid in dying as an option relieves worries about future discomfort, pain and loss of control.** A study of hospice nurses

Medical aid in dying expands choice, and improves care at the end of life. As noted below, multiple studies demonstrate that when states authorize medical aid in dying, palliative care and hospice systems grow stronger, improving care.

and social workers in Oregon reported that symptoms of pain, depression, anxiety, extreme air hunger and fear of the process of dying were more pronounced among hospice patients who did not request aid-in-dying medication,² indicating a strong palliative care benefit for having an aid-in-dying prescription on hand. University of Pennsylvania’s Center for Bioethics director Arthur Caplan has said, “...the Oregon law probably has benefited many more people than have actually used it.”³

- > **Medical aid in dying promotes appropriate hospice use.** A Journal of Palliative Medicine report on patterns of hospice use noted that Oregon was in both the highest quartile of hospice use and the lowest quartile of potentially concerning patterns of hospice use.⁴ Vermont, where medical aid in dying was authorized in 2013, was in the lowest quartile of all three potentially concerning patterns of hospice use examined.⁴ Posited the researchers, “...it is possible that the Oregon Death With Dignity Act has resulted in or at least reflects more open conversation and careful evaluation of end-of-life options.”⁵ Indeed, 30 percent of Oregon doctors responding to a 1999 survey said that after voters approved medical aid in dying, the number of patients they referred to hospice increased.⁶ Some hospice programs in Oregon, according to the Annals of Internal Medicine, reported a 20 percent jump in referrals since the vote.⁷

- > **Medical aid in dying helps family caregivers prepare for and accept a terminally ill person's death.** Respondents to the previously cited Oregon hospice nurse/social worker study reported family caregivers of patients who chose medical aid in dying "were more likely to find positive meaning in caring for the patient and were more prepared for and accepting of the patient's death" than family caregivers of patients not requesting medical aid in dying.² A mental health survey of 95 Oregonian families whose loved ones chose medical aid in dying after exhausting other palliative care options yielded similar results.⁸
- > **Medical aid in dying has resulted in better physician palliative care training.** The Journal of Palliative Medicine article referenced above also suggested that medical aid in dying in Oregon has resulted in "more appropriate palliative care training of physicians,"⁷ and a New England Journal of Medicine article likewise noted that 88 percent of responding Oregon doctors who had cared for terminally ill patients reported actively improving their knowledge of pain management for those patients.⁹
- > **Terminally ill people who choose medical aid in dying are overwhelmingly in hospice care and able to die at home.** In Oregon, 93 percent of adults who used medical aid-in-dying prescriptions in 2014 were enrolled in hospice care, and 90 percent died at home.¹⁰ In Washington state, 69 percent were enrolled in hospice care, and 92 percent were able to die at home.¹¹
- > **Since the authorization of aid in dying, Oregon hospitals have expanded palliative care for individuals with terminal and life-threatening illnesses.** The Annals of Internal Medicine reported a number of Oregon hospitals had developed or expanded the scope of hospice-modeled "comfort care consultation teams" in the wake of Oregon's Death With Dignity Act's passage. According to the Annals article, "These interdisciplinary teams act as consultants to enhance comfort care not only for terminally ill patients but for other patients who have life-threatening illnesses in various inpatient and outpatient settings."¹²
- > **Adults in Oregon and Washington, where medical aid in dying is authorized, are more knowledgeable about palliative, end-of-life and hospice care.** A poll conducted by National Journal and Regence Foundation found that both Oregonians and Washingtonians were more familiar with the terminology "end-of-life care" than the rest of the country and residents of both states are slightly more aware of the terms palliative and hospice care.¹³

Resources

- ¹An Explanation of Palliative Care. Available from <http://www.nhpco.org/palliative-care-4>
- ²Ganzini, L., T.A. Harvath, A Jackson, et al. (2002) Experiences of Oregon nurses and social workers with hospice patients who requested assistance with suicide. *The New England Journal of Medicine*. 347 (8): 585
- ³Don Colburn. (2005, March 11) Fewer Turn to Assisted Suicide. *The Oregonian*. Available from http://lists.opn.org/pipermail/right-to-die_lists.opn.org/2005-March/000730.html
- ⁴Wang, S, Aldridge, MD, Gross, CP, Canavan, M, Cherlin, E, Johnson-Hurzeler, R., et al. (2015) Geographic Variation of Hospice Use Patterns at the End of Life. *Journal of Palliative Medicine*. 18(9), 775.
- ⁵Ibid., p.778.
- ⁶Ganzini, L, Nelson, HD, Lee, MA, Kraemer, DF, Schmidt, TA, Delorit, MA. (2001) Oregon Physicians' Attitudes About and Experiences with end-of-life care since passage of the Oregon death with dignity act. *JAMA*. 285(18): 2365
- ⁷Lee, M,A, & Tolle, S.W. (1996) Oregon's assisted suicide vote: The silver lining. *Annals of Internal Medicine*. 124(2), 267-269.
- ⁸Ganzini, L., E.R. Goy, S.R. Dobscha & H. Prigerson. (2009) Mental health outcomes of family members of Oregonians who request physician aid in dying. *Journal of Pain Symptom Management*. 38, 807-815
- ⁹Ganzini, L, Nelson, HD, Schmidt, TA, Kraemer, DF, Delorit, MA, Lee, MA. (2000) Physicians' experiences with the Oregon death with dignity act. *New England Journal of Medicine*. 342: 558.
- ¹⁰Oregon Public Health Division, Oregon's Death With Dignity Act-2014, page 2, ninth bullet. Available from <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf>
- ¹¹Washington State Department of Health 2014 Death with Dignity Act Report, Executive Summary, page 9. Available from <http://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2014.pdf>
- ¹²Lee, M,A, & Tolle, S.W. (1996) Oregon's assisted suicide vote: The silver lining. *Annals of Internal Medicine*. 124(2), 268.
- ¹³National Journal/Regence Foundation Poll, "Living Well at the End of Life," 2010-2011. Available from <http://syndication.nationaljournal.com/communications/NationalJournalRegenceToplines.pdf>

Medical Aid in Dying Is Not Assisted Suicide

The Law: State laws explicitly say Aid in Dying is not suicide

Currently, five states authorize medical aid in dying: Oregon, Washington, Montana, Vermont, and California.

- > Aid-in-dying statutes in OR¹, WA², VT³ and CA⁴ expressly prohibit the practice of medical aid in dying from being considered “suicide, assisted suicide, mercy killing or homicide, under the law.”

The Medical Community: Medical aid in dying is a medical practice.

Healthcare professionals and medical associations are adopting the term “aid in dying” and supporting its medical practice.

- > The medical community recognizes medical aid in dying is one option in the spectrum of end-of-life care. State medical aid-in-dying laws require doctors to inform terminally ill patients about the full-range of end-of-life care options, including hospice, palliative care and pain management before they write a prescription for aid in dying.
- > National healthcare organizations increasingly support medical aid in dying and reject the terms “suicide” and “assisted suicide” to describe aid in dying. These groups include the American Public Health Association⁵, American College of Legal Medicine⁶, American Medical Women’s Association⁷ and American Medical Student Association⁸. In addition, the American Academy of Hospice and Palliative Medicine has adopted a neutral policy on medical aid in dying⁹.

Medical aid in dying, also known as death with dignity, is a safe and trusted medical practice for which a terminally ill, mentally capable person who has a prognosis of six months or less to live, has the option to request from his/her doctor a prescription for medication which he or she can choose to self-administer through ingestion to peacefully shorten an unbearable dying process.

The Terminally Ill Adult: Aid in dying is distinctly different from suicide.

To a terminally ill person, the term “assisted suicide” is offensive and hurtful. Medical aid in dying has several fundamental differences from suicide.

- > People who seek medical aid in dying have a terminal illness and want to live; the person considering suicide has no terminal illness, but wants to die.
- > People who seek medical aid in dying are suffering life-ending illnesses and understand that their condition is no longer treatable—there is no hope for a better outcome. Those considering suicide see no hope and do not recognize that their problems are treatable¹⁰.
- > People who seek aid in dying are deliberate in their request and often involve family in discussions with their physicians, reflecting a considered process¹¹. The act of suicide is secretive and often impulsive, without involvement of family, friends or healthcare professionals.

The Family: Aid in dying brings families together.

Families are normally included in discussions between the terminally ill patient and physician about end-of-life care options, including aid in dying.

- > Studies demonstrate that medical aid in dying brings families together and allows them to deal successfully with grief¹². Conversely, psychologists report that surviving family members of a person who has committed suicide feel abandoned, disempowered, and resentful—and as though they failed their suicidal loved one¹³.

The Law: Core safeguards are in place to ensure people are protected.

The law ensures protection for terminally ill adults and that the law works as intended.

- > The terminally ill adult must be mentally capable of making his/her own healthcare decisions
- > The physician must make sure his/her patient is fully informed of all other available options
- > The terminally ill adult must request the prescription from a physician and be free from undue influence or coercion
- > Two witnesses need to sign the request form attesting to the voluntary nature of the terminally ill adult's request
- > The terminally ill adult must be able to self-administer and ingest the medication
- > The physician must offer his/her patient multiple opportunities to rescind the request for aid-in-dying medication

As the public and policymakers discuss end-of-life options, it is critical to accurately describe the option of terminally ill adults self-ingesting prescribed medicine to shorten a dying process they find unbearable. Medical aid in dying is the accurate and most neutral term to describe what supporters call "death with dignity" and opponents inaccurately call "assisted suicide."

References

¹ Oregon Death With Dignity Act. Oregon Revised Statute. Chapter 127. Enacted October 27, 1997.

<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ors.aspx>.

² Washington Death With Dignity Act. Complete Chapter 70.245 RCW, Complete Chapter. Enacted November 4, 2008.

http://www.wsha.org/wp-content/uploads/Death-with-Dignity_i1000-text.pdf.

³ Vermont Patient Choice and Control at the End of Life Act. Act 039, Chapter 113. Enacted May 2013.

<http://www.leg.state.vt.us/docs/2014/Acts/ACT039.pdf>.

⁴ California End of Life Option Act. ABX2-15 End of life. Enacted October 2015.

http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520162AB15

⁵ American Public Health Association, Patients' Rights to Self-Determination at the End of Life. October 28, 2008, Policy No. 20086. <http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/29/13/28/patients-rights-to-self-determination-at-the-end-of-life>

⁶ American College of Legal Medicine, ACLM Policy on Aid in Dying. Effective October 6, 2008.

http://c.ymcdn.com/sites/www.aclm.org/resource/collection/11da4cfc-c8bc-4334-90b0-2abbe5748d08/Policy_On_Aid_In_Dying.pdf?hhSearchTerms=%22aid+in+dying%22%22

⁷ American Medical Women's Association, Position Paper on Aid in Dying. Approved September 9, 2007. https://www.amwa-doc.org/wp-content/uploads/2013/12/Aid_in_Dying1.pdf

⁸ American Medical Student Association, Principles Regarding Physician Aid in Dying. In: AMSA Preamble, Purposes and Principles, p.79 <http://www.amsa.org/wp-content/uploads/2015/03/PPP-2015.pdf>

⁹ American Academy of Hospice and Palliative Medicine, Statement on Physician-Assisted Death. February 14, 2007.

<http://aahpm.org/positions/pad>

¹⁰ Reisch, T., et al. (1999) Efficacy of Crisis Intervention. *J of Crisis Intervention and Suicide Prevention*. 20(2): 78-85.

¹¹ Linda Ganzini et al., *Physicians' Experiences with the Death With Dignity Act*, *The New England Journal of Medicine* 342 (8); Linda Ganzini et al., *Mental Health Outcomes of Family Members of Oregonians Who Request Physician Aid in Dying*, 38 *J. of Pain and Symptom Management* 807 (2009); Linda Ganzini, et al., *Oregon Physicians' Attitudes About and Experiences With End-of-Life Care Since Passage of the Oregon Death with Dignity Act*, *J. of the American Medical Association* 285 (2001)

¹² Linda Ganzini et al., *Mental Health Outcomes of Family Members of Oregonians Who Request Physician Aid in Dying*, 38 *J. of Pain and Symptom Management* 807 (2009)

¹³ Ann M. Mitchell et al., *Complicated Grief in Survivors of Suicide*, 25 (1) *J. of Crisis and Suicide Prevention* 12-18 (2004).