

**D1: Patients' Rights to Self-Determination at the End of Life**

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The American Public Health Association has long recognized patients' rights to self-determination at the end of life. 1. These rights include patients' ability to express their wishes in an advance directive and appoint a surrogate to make care decisions when the patient is no longer able to do so, and to have these wishes honored by health care providers.

The right to self-determination also requires that dying persons be afforded effective pain management and palliative care, including palliative sedation.

The APHA also recognizes that for some terminally ill people, death can sometimes be preferable to any alternative, and that a fraction of dying persons confront a dying process so prolonged and marked by such extreme suffering that they determine hastening impending death is the best alternative. 1,2.

The APHA notes that many Americans believe that the option of aid in dying (AID) should be open to those facing a terminal illness marked by extreme suffering. 3.

The Oregon Model

Oregon has implemented a law permitting AID dying since 1997, the Oregon Death with Dignity Act. 4. The Death with Dignity Act establishes procedures under which a competent, terminally ill adult in the care of an attending physician may obtain a prescription for medication to provide control over the time, place, and manner of his or her impending death. 5. The attending

1 physician must determine, among other things, that the person is mentally competent, and an  
2 Oregon resident. 6. To qualify as “terminally ill” the attending physician must find that the  
3 person has “an incurable and irreversible disease that has been medically confirmed and will,  
4 within reasonable medical judgment, produce death within six months.”<sup>7</sup> The attending  
5 physician also must inform persons requesting such medication of their diagnosis and prognosis,  
6 the risks and probable results of taking the medication, and alternatives to hastening their deaths,  
7 including, but not limited to, hospice care and pain relief. 8. A consulting physician must  
8 confirm the attending physician’s prognosis. 9.

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10 Once a request from a qualifying person has been properly documented and witnessed, and all  
11 waiting periods have expired, the attending physician may prescribe, but not administer,  
12 medication to enable the person to hasten death in a humane and dignified manner. 10. The  
13 Death with Dignity Act immunizes physicians and pharmacists who act in compliance with its  
14 comprehensive procedures from civil or criminal sanctions, as well as any professional  
15 disciplinary actions.

16  
17 The Death with Dignity Act requires healthcare providers to file reports with the State  
18 documenting their actions. 11. Oregon’s experience with AID has been documented, with  
19 annual data reported, and published by the State in aggregate form in Annual Reports. 12.  
20 Related reports and articles have also been published in medical journals. 13.

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22 The evidence demonstrates that patients are not put at risk when a carefully drafted AID law is in  
23 place. 14.

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The evidence shows that the option of AID has not been unwillingly forced on the poor, uneducated, uninsured or otherwise disadvantaged. The Oregon law does not require specific data collection concerning whether persons choosing to use the Death with Dignity Act have disabilities which pre-existed their terminal illness; however there is no evidence that legalized AID has a disproportionate impact on person in vulnerable populations, including persons with disabilities. 15. Some in the disability community remain concerned that AID poses a threat to persons with disabilities.

The evidence shows that a higher level of education is strongly associated with the use of AID; those with a baccalaureate degree or higher were 7.9 times more likely than those without a high school diploma to choose AID. 16. The evidence shows that 100% of patients opting for AID during the Act's first six years had either private health insurance or Medicare/Medicaid, and 92% were enrolled in hospice care. 16.

The evidence shows use of AID is rare. During the first 10 years it has been a legal option, only 341 Oregonians chose to utilize AID. 17. While there has been a gradual increase in the rate of those opting for AID, the overall rate remains very low: the 38 terminally ill adults who chose this option in 2005 represented only 12 deaths for every 10,000 Oregonians who died that year. 18. A 2000 survey of Oregon physicians found that they granted 1 in 6 requests for AID, and that only 1 in 10 requests resulted in hastened death. 20.

The Legislature of the State of Vermont commissioned a task force to review the Oregon experience and issued a report which concluded that "it is [quite] apparent from credible sources

1 in and out of Oregon that the Death with Dignity Act has not had an adverse impact on end-of-  
2 life care and in all probability has enhanced the other options.” 21. Observers have reached  
3 similar conclusions: “I was worried about people being pressured to do this. But this data  
4 confirms that the policy in Oregon is working. There is no evidence of abuse or coercion or  
5 misuse of the policy.” 22.

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7 The evidence shows the Death with Dignity Act has galvanized significant improvements in the  
8 care of the dying in Oregon. Oregon doctors report that since passage, efforts have been made to  
9 improve their ability to provide adequate end-of-life care. These efforts include improving their  
10 knowledge of the use of pain medications for the terminally ill, improving their ability to  
11 recognize depression and other psychiatric disorders, and referring their patients to hospice  
12 programs more frequently. 23. A survey of Oregon physicians on their efforts to improve end of  
13 life care since 1994 found that 30% of respondents increased their number of referrals to hospice  
14 care and 76% made efforts to increase their knowledge of pain medication. 24. A survey of  
15 hospice nurses and social workers in Oregon reveals that they observed an increase in physician  
16 knowledge of palliative care and willingness to refer and care for hospice patients from 1998 to  
17 2003. 25.

18  
19 The evidence shows that having the option of AID provides important psychological benefits for  
20 the terminally ill because it gives the terminally ill autonomy, control and choice, which  
21 physicians in Oregon have identified as the overwhelming motivational factor behind the  
22 decision to request AID. 26.

23

1 The APHA recognizes that having a legal option for AID prevents real and significant harms  
2 inherent in the ongoing, covert, back alley practice. Physicians throughout the country report  
3 that they regularly receive requests for assistance in dying. The evidence shows that  
4 complications are more likely when AID occurs in a covert, unsanctioned and unregulated  
5 practice. 27. For example, there is greater chance of an extended time until death after  
6 consuming lethal medications if the practice is unregulated or unsanctioned. 27. In addition, the  
7 stress and anxiety for the patient and family is much higher when no physician can legally be  
8 involved to counsel the patient and family and provide a prescription. 27.

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#### 10 Need for Accurate Language and Complete Information

11 The APHA recognizes the importance of using accurate language to describe care options. The  
12 choice of a mentally competent, terminally ill patient to self-administer medications to bring  
13 about a peaceful death is accurately reflected in the term “aid in dying”. APHA does not support  
14 the use of inaccurate terms such as “suicide” or “assisted suicide” to refer to the choice of a  
15 mentally competent terminally ill patient to seek medications to bring about a peaceful and  
16 dignified death. 28.

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18 The Oregon Death with Dignity Act states: “Actions taken in accordance with ORS 127.800 to  
19 127.897 shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or  
20 homicide, under the law.” 29. The Oregon Department of Human Services, which is vested with  
21 responsibility to report on the Dignity Act, rejects referring to this as "assisted suicide" or  
22 "physician assisted suicide". 30.

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1 Profound psychological differences distinguish suicide from actions under the Dignity Act. 31.  
2 The American Psychological Association has recognized: "It is important to remember that the  
3 reasoning on which a terminally ill person (whose judgments are not impaired by mental  
4 disorders) bases a decision to end his or her life is fundamentally different from the reasoning a  
5 clinically depressed person uses to justify suicide." 32.

6  
7 Medical and legal experts have recognized that the term "suicide" or "assisted suicide" is  
8 inappropriate when discussing the choice of a mentally competent terminally ill patient to seek  
9 medications that he or she could consume to bring about a peaceful and dignified death. 33, 34.

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#### 11 Need for Provision of Full Range of Information

12 Empirical and anecdotal evidence reflect that health care providers do not inform terminally ill  
13 patients of all options legal in the state in which the patient is receiving care. 35. As a result,  
14 patients are not able to make fully informed decisions about care at the end of life. APHA rejects  
15 providing only partial information on which to base health decisions. 36.

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#### 17 Recommendations

18 Accordingly, the American Public Health Association:

19

20 Supports allowing a mentally competent, terminally ill adult to obtain a prescription for  
21 medication which the person could self administer to control the time, place, and manner of his  
22 or her impending death, where safeguards equivalent to those in the Oregon Death with Dignity  
23 Act are in place. 37. APHA refers to this practice as aid in dying.

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APHA encourages that where such option is available to persons who have a disability which existed prior to the terminal illness, data be collected on the incidence with which aid in dying is used by persons with disabilities independent of their terminal illness.

APHA supports measures to ensure that patients eligible to choose aid in dying receive information about, and are able to choose alternatives such as aggressive pain and symptom management, palliative care, hospice care, and care to maximize quality of life and independence.

APHA supports provision of information about the full range of end of life care options to terminally ill patients permitted by law in the state in which the patient is receiving care, including e.g. voluntarily stopping eating and drinking, palliative sedation and aid in dying. 38.

#### References

1. Death with Dignity, Policy No. 8123, American Public Health Association (1981).
2. Robert Pearlman & Helen E. Starks, *Why Do People Seek Physician-Assisted Death?*, PHYSICIAN-ASSISTED DYING, THE CASE FOR PALLIATIVE CARE & PATIENT CHOICE, 91, 93 (Timothy E. Quill & Margaret P. Battin, eds., Johns Hopkins Univ. Press 2004).
3. See, e.g., Pew Research Center for the People and the Press, *Strong Public Support for Right to Die*, (Jan. 5, 2006) available at <http://people-press.org/reports/display.php3?ReportID=266> (60% of Americans “believe a person has a moral right to end their life if they are suffering great pain and have no hope of improvement”, an increase of nearly 20 percentage points since 1975,

1 and 53% “believe a person has a moral right to end their life if suffering from an incurable  
2 disease); Humphrey Taylor, *The Harris Poll #2, 2-to-1 Majorities Continue to Support Rights to*  
3 *Both Euthanasia and Doctor-Assisted Suicide* (Jan. 9, 2002) available at  
4 [http://www.harrisinteractive.com/harris\\_poll/index.asp?PID=278](http://www.harrisinteractive.com/harris_poll/index.asp?PID=278) (65% of respondents support  
5 legalization of the right to physician-assisted dying and 61% favored implementation of a  
6 version of the Oregon Death with Dignity Act in their own state); Andrew Batavia, *The*  
7 *Relevance of Data on Physicians and Disability on the Right to Assisted Suicide: Can Empirical*  
8 *Studies Resolve the Issue*, 6 PSYCHOL. PUB. POL’Y & L. 546, 552-53 (2000) (citing W. Breitbart et  
9 al., *Interest in Physician-Assisted Suicide Among Ambulatory HIV Infected Patients*, 153 AM. J.  
10 PSYCHIATRY, 238-42 (1996); and B. Tindall et al., *Attitudes to Euthanasia and Assisted Suicide*  
11 *in a Group of Homosexual Men with Advanced HIV Disease*, 6 J. OF ACQUIRED IMMUNE  
12 DEFICIENCY SYNDROME 1069 (1993)) (between 63 and 90% of people with a terminal illness  
13 support a right to physician-assisted dying and would like to have the option available to them).  
14 A minority of citizens do not support aid in dying and would not choose this for themselves. See  
15 e.g., Robert Salamanca, “I Don’t Want a Choice to Die,” *San Francisco Chronicle*, February 19,  
16 1997.

17 4. OR. REV. STAT. §§ 127.800-127.995 (2003). The Dignity Act was recently considered,  
18 and upheld, by the United States Supreme Court. *Gonzales v. Oregon*, 546 U.S. 243 (2006) (the  
19 United States Supreme Court rejected the U.S. Attorney General’s claim of authority to declare  
20 what constitutes a legitimate practice of medicine, leaving that determination to the States. The  
21 Court accepted Oregon’s determination that the Dignity Act is a legitimate medical practice.).  
22 The APHA filed an amicus brief in the case, supporting the OR law, stating: “Researchers have  
23 consistently found that experience in Oregon does not bear out concerns that physician-

1 assistance 'would be disproportionately chosen by or forced on terminally ill patients who were  
2 poor, uneducated, uninsured, or fearful of the financial consequences of their illness.’”

3 [http://www.drugpolicy.org/docUploads/APHA\\_Oregon\\_brief2004.pdf](http://www.drugpolicy.org/docUploads/APHA_Oregon_brief2004.pdf) at p. 18.

4 A measure modeled after the Dignity Act was introduced in California in 2007. AB 374,  
5 the California Compassionate Choices Act. The California Public Health Association, North, was  
6 among the broad coalition of groups supporting passage. Other states have considered but also  
7 not yet passed laws making aid in dying affirmatively legal. In Washington State an Initiative  
8 Campaign is underway to pass the Washington Death with Dignity Act, Initiative 1000, modeled  
9 upon the Oregon Dignity Act, in the November 2008 election. **The Washington State Public  
10 Health Association has endorsed the Washington Death with Dignity Act.**

11 Oregon’s law and that State’s experience with implementation of that law over  
12 the past decade is discussed in detail in this Policy because it represents the one jurisdiction in  
13 the United States which has affirmatively legalized aid in dying. Some other countries, including  
14 the Netherlands, Switzerland, and Belgium, also have made this option legal, however the  
15 differences in laws, culture and customs make it difficult to extrapolate from the experiences in  
16 those jurisdictions. It should be noted however, that studies have found no adverse impact on  
17 vulnerable populations and no evidence of a slide down a ‘slippery slope’ in the Netherlands. See  
18 e.g., Margaret P. Battin et al., Legal Physician-Assisted Dying in Oregon and the Netherlands:  
19 Evidence Concerning the Impact on Patients in “Vulnerable” Groups, 33 J. Med. Ethics 591  
20 (2007).

21 5. OR. REV. STAT. § 127.805 (2006).

22 6. OR. REV. STAT. § 127.815 (2006).

23 7. OR. REV. STAT. § 127.800(12) (2006).

- 1 8. OR. REV. STAT. § 127.800(7) (2006).
- 2 9. OR. REV. STAT. § 127.800(8) (2006); OR. REV. STAT. § 127.820 (2006).
- 3 10. OR. REV. STAT. §§ 127.840-127.850 (2006).
- 4 11. OR. REV. STAT. § 127.865 (2006). Some in the disability community have argued that these  
5 many protections and safeguards are insufficient and posit that no safeguards would ever be  
6 sufficient. Concerns about whether enough data is collected, and whether the collected data is  
7 preserved for a long enough period of time have been raised by opponents of aid in dying.  
8 Opponents also suggest that unreported instances of aid in dying may be occurring in Oregon;  
9 however there is no data to support this contention.
- 10 12. The Oregon Health Division and/or the Oregon Department of Human Service Office of  
11 Disease Prevention and Epidemiology issue annual reports that present and evaluate the state's  
12 experience with the Dignity Act. *Annual Reports on Oregon's Death with Dignity Act,*  
13 *Department of Human Services Office of Disease Prevention and Epidemiology, Available at the*  
14 *Oregon Department of Human Services website, <http://www.ohd.hr.state.or.us/chs/pas/pas.cfm>.*
- 15 13. See, e.g., Amy D. Sullivan et al., *Legalized Physician-Assisted Suicide in Oregon-The*  
16 *Second Year*, 342 NEW ENG. J. MED. 598 (2000); Arthur E. Chin et al., *Legalized Physician-*  
17 *Assisted Suicide in Oregon, The First Year's Experience*, 340 NEW ENG. J. MED. 577 (1999);  
18 Andrew I. Batavia, *So Far So Good: Observations on the First Year of Oregon's Death With*  
19 *Dignity Act*, 6 PSYCH. PUB. POL. & L. 291 (2000); David Orentlicher, *The Implementation of*  
20 *Oregon's Death With Dignity Act: Reassuring, but More Data Are Needed*, 6 Psych. PUB. POL. &  
21 L. 489 (2000) (implementation of Oregon law has so far been limited to terminally ill patients  
22 with a clear, persistent, and voluntary request for hastened death).

- 1 14. Overviews of the Oregon experience are set forth in the following articles: Joseph Straton,  
2 *Physician Assistance with Dying : Reframing the Debate*, 15 TEMP POL. & CIV RTS. L. REV. 475  
3 (2006); Timothy E. Quill & Christine K. Cassel, *Professional Organizations' Position*  
4 *Statements on Physician-Assisted Suicide: A Case for Studied Neutrality*, 138(3) ANNALS OF  
5 INTERNAL MED. 208-11 (2003); Linda Ganzini, et al., *Oregon Physicians' Attitudes About and*  
6 *Experiences With End-of-Life Care Since Passage of the Oregon Death With Dignity Act*, 285  
7 JAMA 2363-69 (2001); M.A. Lee & S.W. Tolle, *Oregon's Assisted Suicide Vote: The Silver*  
8 *Lining*, 124 ANNALS OF INTERNAL MED. 267, 267-69 (1996).
- 9 15. Margaret P. Battin et al., *Legal Physician-Assisted Dying in Oregon and the Netherlands:*  
10 *Evidence Concerning the Impact on Patients in "Vulnerable" Groups*, 33 J. Med. Ethics 591  
11 (2007); See also, Declaration of Robert Joondeph, Executive Director Oregon Advocacy Center,  
12 submitted to APHA NOV. 2007(testifying that no complaints about the Oregon law adversely  
13 impacting persons with disabilities have been received by OAC); *First Annual Report* at 7.  
14 ("Patients who chose physician-assisted suicide were *not* disproportionately poor (as measured  
15 by Medicaid status), less educated, lacking in insurance coverage, or lacking in access to hospice  
16 care.").
- 17 16. *Eighth Annual Report*, at 12.
- 18 17. *Eighth Annual Repor*, at 23.
- 19 18. *Ninth Annual Report*. Some commentators have observed that legal medical interventions  
20 that will bring about death, such as removal of feeding tubes, are reluctantly taken, and have  
21 reasoned from this that if aid in dying were legal it would also be rare. See, Orentlicher and  
22 Callahan, *Feeding Tubes, Slippery Slopes, and Physician-Assisted Suicide*, 25 J. LEGAL MED.  
23 389 (2004). The Oregon data supports this contention.

- 1 19. Eighth Annual Report, at 5. The annual reports reveal that each year a significant number of  
2 patients obtain the medications but do not go on to take them, reflecting that these patients are  
3 comforted to have this option, but do not make use of it.
- 4 20. Linda Ganzini, Heidi D. Nelson, Terry A. Schmidt, Dale F. Kraemer, Molly A. Delorit,  
5 Melinda A. Lee, *Physicians' Experiences with the Oregon Death with Dignity Act*, 342 NEW  
6 ENG J. MED. 557 (2000) (palliative care led some, but not all, patients to change their mind about  
7 hastened death).
- 8 21. *Oregon's Death with Dignity Law and Euthanasia in the Netherlands: Factual Disputes*,  
9 2004 at 30. Available at  
10 [http://www.leg.state.vt.us/reports/04Death/Death\\_With\\_Dignity\\_Report.htm](http://www.leg.state.vt.us/reports/04Death/Death_With_Dignity_Report.htm). The Vermont  
11 House of Representative declined to pass a law to allow aid in dying. *See House Votes Down*  
12 *Doctor-Assisted Death*, The Burlington Free Press, 3/21/07 available at  
13 <http://www.burlingtonfreepress.com/apps/pbcs.dll/article?AID=2007703210309>.
- 14 22. William McCall, *Assisted-Suicide Cases Down in '04*, THE COLUMBIAN, Mar. 11, 2005, at  
15 C.2 (quoting Arthur Caplan, Director of the Center for Bioethics at the University of  
16 Pennsylvania School of Medicine). Some observers remain critical of the data and the Act. See,  
17 e.g., Gregory Hamilton, "Oregon's Culture of Silence," in *The Case Against Assisted Suicide*,  
18 Johns Hopkins Press, (2002).
- 19 23. See e.g., Quill & Cassel, *supra*; Ganzini et al.; Lee & Tolle *supra*; Lawrence J.  
20 Schneiderman, 293(4) JAMA 501 (2005) (reviewing the book, "*Physician-Assisted Dying: The*  
21 *Case for Palliative Care and Patient Choice* (T. Quill, M. Battin eds., Johns Hopkins University  
22 Press 2004) ("Indeed, one of the unexpected yet undeniable consequences of Oregon's Death  
23 with Dignity Act permitting physician aid in dying is that 'many important and measurable

1 improvements in end-of-life care' occurred following the Act's implementation. Rather than  
2 becoming the brutal abattoir for hapless patients that some critics predicted, the state is a leader  
3 in providing excellent and compassionate palliative care."'). See also [GAO Report to the Hon.](#)  
4 [Ron Wyden, US Senate, 2007, p.14 www.gao.gov/new.items/d0866.pdf](#)  
5 ("Representatives of a hospice-based palliative care provider in Oregon stated that the physicians  
6 they work with are more comfortable discussing end-of-life issues with their patients since the  
7 enactment of the Death with Dignity Act, which focused attention on end-of-life care and the  
8 options available to individuals."); One study suggested conflicting findings: Fromme, Tilden,  
9 Drach, Tolle, 2004(suggesting that high-quality of end-of-life palliative care has actually been  
10 reduced.)

11 24. Linda Ganzini, Heidi Nelson, Melinda A. Lee, Dale F. Kraemer, Terri A. Schmidt, Molly A.  
12 Delorit, *Oregon Physicians' Attitudes About and Experiences With End-of-Life Care Since*  
13 *Passage of the Oregon Death with Dignity Act*, 285 JAMA 2363 (2001).

14 25. ER Goy, A. Jackson, T. Harvath, LL Miller, MA Delorit, L. Ganzini, *Oregon Hospice*  
15 *Nurses and Social Workers' Assessment of Physician Progress in Palliative Care Over the Past*  
16 *5 Years*, 1 PALLIAT. SUPPORT CARE 215 (2003).

17 26. Kathy L. Cerminara & Alina Perez, *Empirical Research Relevant to the Law: Existing*  
18 *Findings and Future Directions, Therapeutic Death: A Look at Oregon's Law*, 6 PSYCH. PUB.  
19 POL & L. 503, 512-13 (2000) (acknowledging possible negative effects of legalized aid in dying,  
20 but the data from Oregon in one year justifies optimistic view). See also L. Ganzini, SK  
21 Dobscha, RT Heintz, N. Press, *Oregon Physicians' Perceptions of Patients who Request Assisted*  
22 *Suicide and Their Families*, 6 J. PALLIAT. MED. 381 (2003) (finding physicians receiving  
23 requests for lethal medication perceive patients as wanting to control their deaths; Linda Ganzini,

1 Thereas A. Harvath, Ann Jackson, Elizabeth R. Goy, Lois L. Miller, Molly A. Delorit,  
2 *Experiences of Oregon Nurses and Social Workers with Hospice Patients who Requested*  
3 *Assistance with Suicide*, 347 NEW ENG. J. MED. 582 (2002) (nurses and social workers rated  
4 desire to control circumstances of death as most important reason for requesting aid in dying).  
5 27. H. Starks et al, *Family Member Involvement in Hastened Death*, 31 DEATH STUDIES 105-30  
6 (2007). When patients must go underground for medical care, the risk of encountering a provider  
7 who does not practice competent, ethical medicine is greatly increased. The most well known  
8 ‘back alley’ provider for patients seeking control over their own death may be Jack Kevorkian,  
9 the Michigan pathologist who assisted patients with chronic and terminal conditions to end their  
10 lives, often in the back of an old Volkswagon van. Kevorkian was ultimately convicted of  
11 homicide in the death of Thomas Youk. After serving part of his prison sentence Kevorkian was  
12 granted parole and released on June 1, 2007.

13 28. Brief of *Amicus Curiae* Coalition of Mental Health Professionals at 17, *Gonzales v. Oregon*,  
14 126 S. Ct. 904 (2006) (No. 04-623); See also, American Medical Women’s Association Policy  
15 on Aid in Dying, [http://www.amwa-doc.org/index.cfm?objectid=848965C9-D567-0B25-](http://www.amwa-doc.org/index.cfm?objectid=848965C9-D567-0B25-5B22BDF83C2B1744)  
16 [5B22BDF83C2B1744](http://www.amwa-doc.org/index.cfm?objectid=848965C9-D567-0B25-5B22BDF83C2B1744); Charles McKhann, *A Time to Die, the Place for Physician Assistance*,  
17 Yale University Press (1999); Smith and Pollack, *A Psychiatric Defense of Aid in Dying*, 34  
18 COMMUNITY MENTAL HEALTH J. 547 (1998).

19 29. Since it is explicit in the law that the death of a patient under the Dignity Act does not  
20 constitute “suicide”, there is no basis for a suicide exemption under an insurance policy which  
21 excludes payment of benefits in cases of “suicide”.

- 1 30. <http://www.oregon.gov/DHS>; <http://www.ama-assn.org/amednews/2006/11/06/prsc1106.htm>  
2 (Oregon's Dept. of Human Services announced that it no longer would use the term "physician-  
3 assisted suicide" to describe terminally ill patients who ask doctors to help them die.)
- 4 31. Lieberman, E.J.,M.D., Letters to the Editor, *Death with Dignity*, PSYCHIATRIC NEWS, 2006  
5 Aug. 41 (15):29.( "The term 'assisted suicide' is inaccurate and misleading with respect to the  
6 Dignity Act. These patients and the typical suicide are opposites:  
7 · The suicidal patient has no terminal illness but wants to die; the DWD patient has a  
8 terminal illness and wants to live.  
9 · Typical suicides bring shock and tragedy to families and friends; DWD deaths are peaceful  
10 and supported by loved ones.  
11 · Typical suicides are secretive and often impulsive and violent. Death in DWD is planned; it  
12 changes only timing in a minor way, but adds control in a major and socially approved way.  
13 · Suicide is an expression of despair and futility; DWD is a form of affirmation and  
14 empowerment.")
- 15 32. Brief of Amicus Curiae Coalition of Mental Health Professionals, WL 1749170 at 17,  
16 *Gonzales v. Oregon*, 126 S. Ct. 904 (2006) (No. 04-623); see also, Rhea K. Farberman, *Terminal*  
17 *Illness and Hastened Death Requests: The Important Role of the Mental Health Professional*, 28  
18 *PROF. PSYCHOL.: RESEARCH AND PRAC.* 544 (1997); Smith and Pollack, *A Psychiatric Defense of*  
19 *Aid in Dying*, 34 *COMMUNITY MENTAL HEALTH J.* 547 (1998).
- 20 33. American Medical Women's Association, Policy on Aid in Dying, <http://www.amwa->  
21 [doc.org/index.cfm?objectid=848965C9-D567-0B25-5B22BDF83C2B1744](http://www.amwa-); American Medical  
22 Students Association Policy on Aid in Dying , adopted March 2008, available at  
23 [http://www.amsa.org/about/ppp/pas.cfm\(rejecting the term "physician assisted suicide"](http://www.amsa.org/about/ppp/pas.cfm(rejecting%20the%20term%20%22physician%20assisted%20suicide%22)

1 [and adopting the term “aid in dying”](#); American Academy of Hospice and Palliative Medicine  
2 Policy on Physician Assisted Death, adopted February 2007, available at  
3 <http://www.aahpm.org/positions/suicide.html>(rejecting the term Physician Assisted Suicide as  
4 “emotionally charged” and inaccurate); J. Straton, *Physician Assistance with Dying : Reframing*  
5 *the Debate*, 15 TEMP POL. & CIV RTS. L. REV. 45(2006) ("The process of permitting people to  
6 actively end their life before their life-ending disease completely runs its course" ought to be  
7 referred to as "physician assistance with dying"; rejecting use of the term 'physician assisted  
8 suicide'. ); Charles McKhann, *A Time to Die, the Place for Physician Assistance*, Yale University  
9 Press(1999).

10 34. J. Dallner and S. Manning, *Death with Dignity in Montana*, 65 MONT. L. REV. 309, 314-15  
11 (2004)(“The word ‘suicide’ is well suited to the description of a distraught individual with his  
12 whole life ahead of him, who in a moment of despair, commits a completely senseless and utterly  
13 tragic act. In contrast, “suicide” is not well suited to describe an elderly cancer patient who in  
14 the final days of a horrible and agonizing struggle simply wishes to avoid more needless  
15 suffering and indignity. The first individual’s act destroys what could be a long and productive  
16 life. The elderly cancer patient does not extinguish the hope of a bright future, but rather avoids  
17 the last painful and undignified moments of a life already fully lived...Use of the word  
18 “suicide...arouses the images of tragic loss of life in a situation where the tragedy may be the  
19 continuation of life.”)

20 35. See, e.g., Farr A. Curlin, Ryan E. Lawrence, Marshall H. Chin, & John D. Lantos, *Religion,*  
21 *Conscience, and Controversial Clinical Practices*, 356 NEW ENG. J. MED. 593 (2007)( study  
22 revealing that physicians refuse to provide care and/or referrals on "conscience" grounds,  
23 including palliative sedation) available at <http://content.nejm.org/cgi/content/full/356/6/593>;

1 Christine K. Cassel, John M. Ludden & Grace M. Moon, *Perceptions of Barriers to High-*  
2 *Quality Palliative Care in Hospitals; Lack of Financial Reimbursement has Created an*  
3 *Environment in Which End-of-Life Care is Not a Top Priority for U.S. Hospitals*, HEALTH AFF.  
4 (2000) (arguing that financial concerns in the medical field make palliative care a low priority).  
5 36. See, e.g., *Abstinence and U.S. Abstinence-Only Education Policies: Ethical and Human*  
6 *Rights Concerns*, APHA Policy No: 200610.  
7 37. A “terminal condition” is defined in state statutes. Some states specify a life expectancy of a  
8 year or 6 months, other states refer to expectation of death within a ‘reasonable period of time’.  
9 Compare OR. REV. STAT. § 127.800 (2003) (defining terminal disease as “an incurable and  
10 irreversible disease that has been medically confirmed and will, within reasonable medical  
11 judgment, produce death within six months.”) with WASH. REV. CODE § 70.122.020 (2007)  
12 (defining terminal condition as “an incurable and irreversible condition caused by injury, disease,  
13 or illness, that, within reasonable medical judgment, will cause death within a reasonable period  
14 of time in accordance with accepted medical standards, and where the application of life-  
15 sustaining treatment serves only to prolong the process of dying”). Federal law makes hospice  
16 eligibility contingent on a diagnosis of terminal illness, defined as 6 months life expectancy. 42  
17 U.S.C. § 1395x(dd)(3)(A) (an individual is terminally ill when “the individual has a medical  
18 prognosis that the individual’s life expectancy is 6 months or less”).  
19 38. Palliative sedation is the use of medication to induce sedation to relieve a dying patient’s  
20 severe distress that cannot be controlled despite other aggressive measures. Z. Schuman et al,  
21 *Implementing Institutional Change: An Institutional Case Study of Palliative Sedation*, 8 J.  
22 *PALLIATIVE MED.* 666 (2005); B. Lo, *Palliative Sedation in Dying Patients*, 294 *JAMA* 1810  
23 (2005).

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9

1 AMENDMENT

2

3 The proposed amendment would revise the first recommendation as follows:

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5

6 Supports allowing a mentally competent, terminally ill adult who does not have a disability

7 which pre-existed the terminal illness to obtain a prescription for medication which the person

8 could self administer to control the time, place, and manner of his or her impending death where

9 safeguards equivalent to those in the Oregon Death with Dignity Act are in place.

10