

1           **Death with Dignity, Policy No. \_\_\_\_REPLACING Policy # 8123 (01/01/1981)**

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3           The American Public Health Association recognizes that for the seriously ill and  
4 infirm, death is sometimes preferable to any alternative, and a fraction of dying patients  
5 confront a dying process so prolonged and marked by such extreme suffering and  
6 deterioration that they determine hastening impending death is the best alternative.<sup>1,2</sup>

7           APHA holds that health care policy should emphasize quality of life, dignity of death,  
8 self-determination, and the right to refuse treatment, rather than blindly stress the  
9 continuation of life and prolongation of the dying process. Unfortunately, the nation's  
10 technologically-oriented health system frequently supports the futile prolongation of dying<sup>3</sup>  
11 and ignores the emotional and physical needs of the terminally ill and their families.<sup>4,5</sup>

12           The APHA also acknowledges that a majority of Americans believe that the option of  
13 aid in dying should be open to those facing a terminal illness marked by extreme suffering  
14 and loss of dignity.<sup>6</sup>

15           The Oregon model

16           The APHA recognizes that Oregon's experience with aid in dying is a model for other  
17 states. Oregon has implemented a law permitting physician aid in dying since 1997, the  
18 Oregon Death with Dignity Act (Dignity Act).<sup>7</sup>

19           The Dignity Act establishes procedures under which a competent, terminally ill adult  
20 in the care of an attending physician may obtain a prescription for medication to provide  
21 control over the time, place, and manner of his or her impending death.<sup>8</sup> The attending  
22 physician must determine, among other things, that the patient is mentally competent, and an  
23 Oregon resident.<sup>9</sup> To qualify as "terminally ill" the attending physician must find that the

1 patient has “an incurable and irreversible disease that has been medically confirmed and will,  
2 within reasonable medical judgment, produce death within six months.”<sup>10</sup> The attending  
3 physician also must inform persons requesting such medication of their diagnosis and  
4 prognosis, the risks and probable results of taking the medication, and alternatives to  
5 hastening their deaths, including, but not limited to, hospice care and pain relief.<sup>11</sup> A  
6 consulting physician must confirm the attending physician’s prognosis.<sup>12</sup>

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

13       The Dignity Act requires healthcare providers to file reports with the State  
14 documenting their actions.<sup>14</sup> Oregon’s experience with aid in dying has been extensively  
15 documented and studied.<sup>15</sup> Related reports and articles have also been published in leading  
16 medical journals.<sup>16</sup> These reports constitute the only data regarding the experience of legal,  
17 regulated physician-assisted dying in America.

18       The experience in Oregon has demonstrated patients are not put at risk when a  
19 carefully drafted law is in place.<sup>17</sup> The Oregon experience has caused even previously staunch  
20 opponents to acknowledge that continued opposition to such a law can only be based on  
21 personal moral or religious grounds.<sup>18</sup>

22       The Oregon reports have shown the dire predictions of those initially opposed to the  
23 Dignity Act to be baseless. Studies show that the option of physician-assisted dying has not

1 been unwillingly forced on the poor, uneducated, uninsured or otherwise disadvantaged.<sup>19</sup>  
2 For example, the *Eighth Annual Report* found that a higher level of education is strongly  
3 associated with the use of physician-assisted dying; those with a baccalaureate degree or  
4 higher were 7.9 times more likely than those without a high school diploma to choose  
5 physician-assisted dying.<sup>20</sup> The *Report* found that 100% of patients opting for physician-  
6 assisted dying during the Dignity Act's first six years had either private health insurance or  
7 Medicare/Medicaid, and 92% were enrolled in hospice care.<sup>21</sup>

8 Furthermore, use of physician-assisted dying is rare. Only 292 Oregonians chose to  
9 utilize physician-assisted dying during the first nine years it has been a legal option.<sup>22</sup> While  
10 there has been a gradual increase in the rate of those opting for physician-assisted dying, the  
11 overall rate remains very low: the 38 terminally ill adults who chose this option in 2005  
12 represented only 12 deaths for every 10,000 Oregonians who died that year.<sup>23</sup> A 2000 survey  
13 of Oregon physicians found that they granted 1 in 6 requests for aid in dying, and that only 1  
14 in 10 requests resulted in hastened death.<sup>24</sup>

15 The Legislature of the State of Vermont commissioned a task force to review the Oregon  
16 experience and issued a report concluding that "it is [quite] apparent from credible sources in  
17 and out of Oregon that the Death with Dignity Act has not had an adverse impact on end-of-  
18 life care and in all probability has enhanced the other options."<sup>25</sup> Leading scholars have  
19 reached similar conclusions: "I was worried about people being pressured to do this," said  
20 Arthur Caplan, Director of the Center for Bioethics at the University of Pennsylvania School  
21 of Medicine "But this data confirms that the policy in Oregon is working. There is no  
22 evidence of abuse or coercion or misuse of the policy."<sup>26</sup>

1           The Dignity Act has galvanized significant improvements in the care of the dying in  
2 Oregon. Oregon doctors report that since the passage of the Dignity Act, efforts have been  
3 made to improve their ability to provide adequate end-of-life care. These efforts include  
4 improving their knowledge of the use of pain medications for the terminally ill, improving  
5 their ability to recognize depression and other psychiatric disorders, and referring their  
6 patients to hospice programs more frequently.<sup>27</sup> A survey of Oregon physicians on their  
7 efforts to improve end of life care since 1994 found that 30% of respondents increased their  
8 number of referrals to hospice care and 76% made efforts to increase their knowledge of pain  
9 medication.<sup>28</sup> A survey of hospice nurses and social workers in Oregon reveals that they  
10 observed an increase in physician knowledge of palliative care and willingness to refer and  
11 care for hospice patients from 1998 to 2003.<sup>29</sup>

12           In addition to the improvement of end of life care, the legal option of physician-  
13 assisted death has psychological benefits for the terminally ill. The availability of the option  
14 of aid in dying gives the terminally ill autonomy, control and choice, which physicians in  
15 Oregon have identified as the overwhelming motivational factor behind the decision to  
16 request assistance in dying.<sup>30</sup>

17 Covert aid-in-dying outside of Oregon

18 The APHA also recognizes that legalization of aid in dying prevents the harms inherent in the  
19 ongoing, covert, backalley practice. Physicians throughout the country report that they  
20 regularly receive requests for assistance in dying. 18-24% of primary care physicians and 46-  
21 57% of oncologists in the US report having been asked for their assistance in a patient's  
22 hastened death. One quarter of them complied, despite unlawfulness of the practice.<sup>31</sup>

1 The question is not whether assisted dying will occur. The question is whether it will occur in  
2 a regulated and controlled fashion with safeguards and scrutiny, or covertly, in a random,  
3 dangerous and unregulated manner. Studies show that complications are more likely when aid  
4 in dying occurs in a covert, unsanctioned and unregulated practice.<sup>32</sup> For example, there is  
5 greater chance of an extended time until death after consuming lethal medications if the  
6 practice is unregulated or unsanctioned.<sup>33</sup> In addition, the stress and anxiety for the patient  
7 and family is much higher when no physician can legally be involved to counsel the patient  
8 and family and provide a prescription.<sup>34</sup> This situation is reminiscent of the era when women  
9 could not legally choose to terminate an unwanted pregnancy and had to resort to the ‘back  
10 alley’, where perhaps a rusty hanger would be the implement used to end the pregnancy,  
11 resulting in countless injuries, deaths, and trauma.<sup>35</sup>

12

13 Need for accurate language and complete information

14 The APHA further supports the use of accurate language to describe the choice of a  
15 mentally competent, terminally ill patient to self-administer medications to bring about a  
16 peaceful death, including use of the term “aid in dying”. APHA rejects use of inaccurate terms  
17 such as “suicide” or “assisted suicide” to refer to the choice of a mentally competent  
18 terminally ill patient to seek medications to bring about a peaceful and dignified death.<sup>36,37,38</sup>

19 The Oregon Death with Dignity Act states: “Actions taken in accordance with ORS  
20 127.800 to 127.897 shall not, for any purpose, constitute suicide, assisted suicide, mercy  
21 killing or homicide, under the law.”<sup>39</sup> The Oregon Department of Human Services, which is  
22 vested with responsibility to report on the Dignity Act, rejects referring to this as “assisted  
23 suicide” or “physician assisted suicide”.<sup>40</sup>

1           From a mental health perspective, “suicide” is starkly different from the choice of a  
2 dying patient to hasten impending death in a peaceful and dignified manner. Profound  
3 psychological differences distinguish suicide from actions under the Dignity Act.<sup>41</sup> The  
4 American Psychological Association has recognized: “It is important to remember that the  
5 reasoning on which a terminally ill person (whose judgments are not impaired by mental  
6 disorders) bases a decision to end his or her life is fundamentally different from the reasoning  
7 a clinically depressed person uses to justify suicide.”<sup>42</sup>

8           Medical experts<sup>43</sup> and legal experts<sup>44</sup> recognize that the term “suicide” or “assisted  
9 suicide” is inappropriate when discussing the choice of a mentally competent terminally ill  
10 patient to seek medications that he or she could consume to bring about a peaceful and  
11 dignified death.

12           The APHA supports provision of the full range of end of life care options to terminally  
13 ill patients permitted by law in the state in which the patient is receiving care, including e.g.  
14 voluntarily stopping eating and drinking, palliative sedation<sup>45</sup> and aid in dying. Empirical and  
15 anecdotal evidence reflect that health care providers do not inform terminally ill patients of all  
16 options, and as a result patients are not able to make fully informed decisions about care at the  
17 end of life.<sup>46</sup> APHA rejects providing only partial information on which to base health  
18 decisions.<sup>47</sup>

#### 19 Recommendations

20 A national policy on long-term care would be grossly inadequate without recognizing the  
21 patient's right to die. Therefore, the American Public Health Association:

- 22       1. Encourages states and the federal government to continue to implement advance  
23       directive laws<sup>48</sup> that:

- 1           • Provide a general right of the patient to refuse treatment of all kinds,
- 2           • Provide that this right be exercised in a document that takes legal effect after
- 3           patient incompetency,
- 4           • Provide for the naming of a person to help exercise this right after patient
- 5           incompetency, and
- 6           • Provide for legal immunity for following the patient's wishes as well as civil
- 7           and criminal penalties for ignoring them<sup>49,50</sup>;
- 8       2. Supports further study to better delineate the ethical, legal, and medical issues
- 9       involved in the concept of the right to die;
- 10      3. Supports strong protections of patients' rights to informed consent, including
- 11      provision of culturally-competent patient and family information about end-of-life
- 12      options;
- 13      4. Supports nondiscriminatory provision of pain management and palliative care; and
- 14      5. Supports passage of laws under which a competent, terminally ill<sup>51</sup> adult may obtain a
- 15      prescription for medication to allow control over the time, place, and manner of his or
- 16      her impending death.

17

18 Previous policy addressing Death with Dignity, 8123, should be archived upon adoption of  
19 this policy.

- 20      1. Death with Dignity, Policy No. 8123, American Public Health Association (1981).
- 21      2. Robert Pearlman & Helen E. Starks, Why Do People Seek Physician-Assisted Death?,
- 22      PHYSICIAN-ASSISTED DYING, THE CASE FOR PALLIATIVE CARE &

- 1 PATIENT CHOICE, 91, 93 (Timothy E. Quill & Margaret P. Battin, eds., Johns  
2 Hopkins Univ. Press 2004).
- 3 3. The Oxford English Dictionary defines futile as “incapable of producing any result”.  
4 OXFORD ENGLISH DICTIONARY (2nd ed. 1989). See also American Medical  
5 Association Council on Ethical and Judicial Affairs, Code of Medical Ethics: Opinion  
6 E-2.037 Medical Futility in End-of-Life Care (1995-2007), available at  
7 <http://www.ama->  
8 [assn.org/apps/pf\\_new/pf\\_online?f\\_n=browse&doc=policyfiles/HnE/E-](http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/E-)  
9 [2.037.HTM&&s\\_t=&st\\_p=&nth=1&prev\\_pol=policyfiles/HnE/E-](http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/E-)  
10 [1.02.HTM&nxt\\_pol=policyfiles/HnE/E-2.01.HTM&](http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/E-) (arguing that the definition of  
11 medical futility inevitably requires value judgments).
- 12 4. Butler RN: *Why Survive? Being Old in America*. New York: Harper & Row, 1975.
- 13 5. Somers AR: *Toward a New National Health Policy for the Elderly: A Suggested*  
14 *Agenda for the 1981 White House Conference on Aging*. Based on a paper presented  
15 to the Fourth Annual Symposium on Aging, University of California, San Francisco,  
16 November 16, 1980.
- 17 6. See, e.g., Pew Research Center for the People and the Press, *Strong Public Support for*  
18 *Right to Die*, (Jan. 5, 2006) available at <http://people->  
19 [press.org/reports/display.php3?ReportID=266](http://people-press.org/reports/display.php3?ReportID=266) (60% of Americans “believe a person  
20 has a moral right to end their life if they are suffering great pain and have no hope of  
21 improvement”, an increase of nearly 20 percentage points since 1975, and 53%  
22 “believe a person has a moral right to end their life if suffering from an incurable  
23 disease); Humphrey Taylor, *The Harris Poll #2, 2-to-1 Majorities Continue to Support*

- 1 Rights to Both Euthanasia and Doctor-Assisted Suicide (Jan. 9, 2002) available at  
2 [http://www.harrisinteractive.com/harris\\_poll/index.asp?PID=278](http://www.harrisinteractive.com/harris_poll/index.asp?PID=278) (65% of respondents  
3 support legalization of the right to physician-assisted dying and 61% favored  
4 implementation of a version of the Oregon Death with Dignity Act in their own state);  
5 Andrew Batavia, The Relevance of Data on Physicians and Disability on the Right to  
6 Assisted Suicide: Can Empirical Studies Resolve the Issue, 6 PSYCHOL. PUB.  
7 POL'Y & L. 546, 552-53 (2000) (citing W. Breibart et al., Interest in Physician-  
8 Assisted Suicide Among Ambulatory HIV Infected Patients, 153 AM. J.  
9 PSYCHIATRY, 238-42 (1996); and B. Tindall et al., Attitudes to Euthanasia and  
10 Assisted Suicide in a Group of Homosexual Men with Advanced HIV Disease, 6 J. OF  
11 ACQUIRED IMMUNE DEFICIENCY SYNDROME 1069 (1993)) (between 63 and  
12 90% of people with a terminal illness support a right to physician-assisted dying and  
13 would like to have the option available to them).
- 14 7. OR. REV. STAT. §§ 127.800-127.995 (2003). The Dignity Act was recently  
15 considered, and left intact, by the United States Supreme Court. *Gonzales v. Oregon*,  
16 546 U.S. 243 (2006) (the United States Supreme Court rejected the U.S. Attorney  
17 General's claim of authority to declare what constitutes a legitimate practice of  
18 medicine, leaving that determination to the States. The Court accepted Oregon's  
19 determination that the Dignity Act is a legitimate medical practice.). A measure  
20 modeled after the Dignity Act was introduced in California in 2007. AB 374, the  
21 California Compassionate Choices Act. The California Public Health Association,  
22 North, was among the broad coalition of groups supporting passage.
- 23 8. OR. REV. STAT. § 127.805 (2006).

- 1 9. OR. REV. STAT. § 127.815 (2006).
- 2 10. OR. REV. STAT. § 127.800(12) (2006).
- 3 11. OR. REV. STAT. § 127.800(7) (2006).
- 4 12. OR. REV. STAT. § 127.800(8) (2006); OR. REV. STAT. § 127.820 (2006).
- 5 13. OR. REV. STAT. §§ 127.840-127.850 (2006).
- 6 14. OR. REV. STAT. § 127.865 (2006).
- 7 15. To date, the Oregon Health Division and/or the Oregon Department of Human Service  
8 Office of Disease Prevention and Epidemiology have issued nine annual reports that  
9 present and evaluate the state's experience with the Dignity Act. See Annual Reports  
10 on Oregon's Death with Dignity Act, Department of Human Services Office of  
11 Disease Prevention and Epidemiology, Available at the Oregon Department of  
12 Human Services website, <http://www.ohd.hr.state.or.us/chs/pas/pas.cfm>.
- 13 16. See, e.g., Amy D. Sullivan et al., Legalized Physician-Assisted Suicide in Oregon-The  
14 Second Year, 342 NEW ENG. J. MED. 598 (2000); Arthur E. Chin et al., Legalized  
15 Physician-Assisted Suicide in Oregon, The First Year's Experience, 340 NEW ENG.  
16 J. MED. 577 (1999); Andrew I. Batavia, So Far So Good: Observations on the First  
17 Year of Oregon's Death With Dignity Act, 6 PSYCH. PUB. POL. & L. 291 (2000);  
18 David Orentlicher, The Implementation of Oregon's Death With Dignity Act:  
19 Reassuring, but More Data Are Needed, 6 Psych. PUB. POL. & L. 489 (2000)  
20 (implementation of Oregon law has so far been limited to terminally ill patients with a  
21 clear, persistent, and voluntary request for hastened death).
- 22 17. For a recent comprehensive overview of the Oregon experience, urging that medical  
23 associations adopt a position of neutrality on assisted dying laws, see Timothy E. Quill

- 1           & Christine K. Cassel, Professional Organizations' Position Statements on Physician-  
2           Assisted Suicide: A Case for Studied Neutrality, 138(3) ANNALS OF INTERNAL  
3           MED. 208-11 (2003). See also Linda Ganzini, et al., Oregon Physicians' Attitudes  
4           About and Experiences With End-of-Life Care Since Passage of the Oregon Death  
5           With Dignity Act, 285 JAMA 2363-69 (2001); M.A. Lee & S.W. Tolle, Oregon's  
6           Assisted Suicide Vote: The Silver Lining, 124 ANNALS OF INTERNAL MED. 267,  
7           267-69 (1996); see also, Joseph Straton, Physician Assistance with Dying : Reframing  
8           the Debate, 15 TEMP POL. & CIV RTS. L. REV. 475 (2006).
- 9           18. See Daniel Lee, Physician-Assisted Suicide: A Conservative Critique of Intervention,  
10           HASTINGS CENTER REPORT at 17-19 (2003).
- 11           19. See, e.g., First Annual Report at 7. ("Patients who chose physician-assisted suicide  
12           were not disproportionately poor (as measured by Medicaid status), less educated,  
13           lacking in insurance coverage, or lacking in access to hospice care.").
- 14           20. Eighth Annual Report, at 12.
- 15           21. Id. at 23.
- 16           22. Ninth Annual Report, . Some commentators have observed that legal medical  
17           interventions that will bring about death, such as removal of feeding tubes, are  
18           reluctantly taken, and have reasoned from this that if aid in dying were legal it would  
19           also be rare. See, Orentlicher and Callahan, Feeding Tubes, Slippery Slopes, and  
20           Physician-Assisted Suicide, 25 J. LEGAL MED. 389 (2004). The Oregon data  
21           supports this contention.
- 22           23. Eighth Annual Report, at 5.

- 1       24. Linda Ganzini, Heidi D. Nelson, Terry A. Schmidt, Dale F. Kraemer, Molly A.  
2             Delorit, Melinda A. Lee, Physicians' Experiences with the Oregon Death with Dignity  
3             Act, 342 NEW ENG J. MED. 557 (2000) (palliative care led some, but not all, patients  
4             to change their mind about hastened death).
- 5       25. Oregon's Death with Dignity Law and Euthanasia in the Netherlands: Factual  
6             Disputes, 2004 at 30. Available at  
7             [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  
8             Vermont House of Representative recently voted down an initiative to allow  
9             terminally ill residents to hasten their deaths with the help of a physician. See House  
10            Votes Down Doctor-Assisted Death, The Burlington Free Press, 3/21/07 available at  
11            <http://www.burlingtonfreepress.com/apps/pbcs.dll/article?AID=2007703210309>.
- 12       26. William McCall, Assisted-Suicide Cases Down in '04, THE COLUMBIAN, Mar. 11,  
13             2005, at C.2 (quoting Arthur Caplan, Director of the Center for Bioethics at the  
14             University of Pennsylvania School of Medicine).
- 15       27. *Id.*; see also Quill & Cassel, *supra* note 17; Ganzini et al., *supra* note 17; Lee & Tolle  
16             *supra* note 17; Lawrence J. Schneiderman, 293(4) JAMA 501 (2005) (reviewing the  
17             book, "Physician-Assisted Dying: The Case for Palliative Care and Patient Choice (T.  
18             Quill, M. Battin eds., Johns Hopkins University Press 2004) ("Indeed, one of the  
19             unexpected yet undeniable consequences of Oregon's Death with Dignity Act  
20             permitting physician aid in dying is that 'many important and measurable  
21             improvements in end-of-life care' occurred following the Act's implementation.  
22             Rather than becoming the brutal abattoir for hapless patients that some critics

- 1 predicted, the state is a leader in providing excellent and compassionate palliative  
2 care.”).
- 3 28. Linda Ganzini, Heidi Nelson, Melinda A. Lee, Dale F. Kraemer, Terri A. Schmidt,  
4 Molly A. Delorit, Oregon Physicians’ Attitudes About and Experiences With End-of-  
5 Life Care Since Passage of the Oregon Death with Dignity Act, 285 JAMA 2363  
6 (2001).
- 7 29. ER Goy, A. Jackson, T. Harvath, LL Miller, MA Delorit, L. Ganzini, Oregon Hospice  
8 Nurses and Social Workers’ Assessment of Physician Progress in Palliative Care Over  
9 the Past 5 Years, 1 PALLIAT. SUPPORT CARE 215 (2003).
- 10 30. Kathy L. Cerminara & Alina Perez, Empirical Research Relevant to the Law: Existing  
11 Findings and Future Directions, Therapeutic Death: A Look at Oregon’s Law, 6  
12 PSYCH. PUB. POL & L. 503, 512-13 (2000) (acknowledging possible negative  
13 effects of legalized aid in dying, but the data from Oregon in one year justifies  
14 optimistic view). See also L. Ganzini, SK Dobscha, RT Heintz, N. Press, Oregon  
15 Physicians’ Perceptions of Patients who Request Assisted Suicide and Their Families,  
16 6 J. PALLIAT. MED. 381 (2003) (finding physicians receiving requests for lethal  
17 medication perceive patients as wanting to control their deaths; Linda Ganzini,  
18 Thereas A. Harvath, Ann Jackson, Elizabeth R. Goy, Lois L. Miller, Molly A. Delorit,  
19 Experiences of Oregon Nurses and Social Workers with Hospice Patients who  
20 Requested Assistance with Suicide, 347 NEW ENG. J. MED. 582 (2002) (nurses and  
21 social workers rated desire to control circumstances of death as most important reason  
22 for requesting aid in dying).

- 1        31. Arnold et al, Consideration of Hastening Death Among Hospice Patients and Their  
2            Families, 27 J. PAIN SYMPTOM MGMT., 523-32 (2004).
- 3        32. H. Starks et al, Family Member Involvement in Hastened Death, 31 DEATH  
4            STUDIES 105-30 (2007). When patients must go underground for medical care, the  
5            risk of encountering a provider who does not practice competent, ethical medicine is  
6            greatly increased. The most well known ‘back alley’ provider for patients seeking  
7            control over their own death may be Jack Kevorkian, the Michigan pathologist who  
8            assisted patients with chronic and terminal conditions to end their lives, often in the  
9            back of an old Volkswagon van. Kevorkian was ultimately convicted of homicide in  
10           the death of Thomas Youk. After serving part of his prison sentence Kevorkian was  
11           granted parole and released on June 1, 2007.
- 12       33. Id.
- 13       34. Id.
- 14       35. Cf. Douglas R. Miller, The Alley Behind First Street, Northeast: Criminal Abortion in  
15           the Nation’s Capital, 1872-1973, 11 WM. & MARY J. WOMEN & L. 1 (2004)  
16           (detailing history of criminal abortion in Washington, DC before Roe).
- 17       36. Brief of Amicus Curiae Coalition of Mental Health Professionals at 17, Gonzales v.  
18           Oregon, 126 S. Ct. 904 (2006) (No. 04-623).
- 19       37. Charles McKhann, A Time to Die, the Place for Physician Assistance, Yale University  
20           Press (1999).
- 21       38. Smith and Pollack, A Psychiatric Defense of Aid in Dying, 34 COMMUNITY  
22           MENTAL HEALTH J. 547 (1998).

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

4 40. <http://www.oregon.gov/DHS>; <http://www.ama->  
5 [assn.org/amednews/2006/11/06/prsc1106.htm](http://www.ama-assn.org/amednews/2006/11/06/prsc1106.htm) (Oregon's Dept. of Human Services  
6 announced last month that it no longer would use the term "physician-assisted suicide"  
7 to describe terminally ill patients who ask doctors to help them die.)

8 41. Lieberman, E.J., M.D., Letters to the Editor, Death with Dignity, PSYCHIATRIC  
9 NEWS, 2006 Aug. 41 (15):29. (“The term ‘assisted suicide’ is inaccurate and  
10 misleading with respect to the Dignity Act. These patients and the typical suicide are  
11 opposites:

- 12 a. The suicidal patient has no terminal illness but wants to die; the DWD patient  
13 has a terminal illness and wants to live.
- 14 b. Typical suicides bring shock and tragedy to families and friends; DWD deaths  
15 are peaceful and supported by loved ones.
- 16 c. Typical suicides are secretive and often impulsive and violent. Death in DWD  
17 is planned; it changes only timing in a minor way, but adds control in a major  
18 and socially approved way.
- 19 d. Suicide is an expression of despair and futility; DWD is a form of affirmation  
20 and empowerment.”)

21 42. Brief of Amicus Curiae Coalition of Mental Health Professionals, WL 1749170 at 17,  
22 *Gonzales v. Oregon*, 126 S. Ct. 904 (2006) (No. 04-623); see also, Rhea K.  
23 Farberman, Terminal Illness and Hastened Death Requests: The Important Role of the

- 1 Mental Health Professional, 28 PROF. PSYCHOL.: RESEARCH AND PRAC. 544  
2 (1997); Smith and Pollack, A Psychiatric Defense of Aid in Dying, 34 COMMUNITY  
3 MENTAL HEALTH J. 547 (1998).
- 4 43. American Academy of Hospice and Palliative Medicine Policy on Physician Assisted  
5 Death, adopted February 2007, available at  
6 <http://www.aahpm.org/positions/suicide.html>(rejecting the term Physician Assisted  
7 Suicide as “emotionally charged” and inaccurate); J. Straton, Physician Assistance  
8 with Dying : Reframing the Debate, 15 TEMP POL. & CIV RTS. L. REV. 45(2006)  
9 (“The process of permitting people to actively end their life before their life-ending  
10 disease completely runs its course” ought to be referred to as “physician assistance  
11 with dying”; rejecting use of the term ‘physician assisted suicide’. ); Charles  
12 McKhann, A Time to Die, the Place for Physician Assistance, Yale University  
13 Press(1999).
- 14 44. J. Dallner and S. Manning, Death with Dignity in Montana, 65 MONT. L. REV. 309,  
15 314-15 (2004)(“The word ‘suicide’ is well suited to the description of a distraught  
16 individual with his whole life ahead of him, who in a moment of despair, commits a  
17 completely senseless and utterly tragic act. In contrast, “suicide” is not well suited to  
18 describe an elderly cancer patient who in the final days of a horrible and agonizing  
19 struggle simply wishes to avoid more needless suffering and indignity. The first  
20 individual’s act destroys what could be a long and productive life. The elderly cancer  
21 patient does not extinguish the hope of a bright future, but rather avoids the last  
22 painful and undignified moments of a life already fully lived...Use of the word

- 1           “suicide...arouses the images of tragic loss of life in a situation where the tragedy may  
2           be the continuation of life.”)
- 3           45. Palliative sedation is the use of medication to induce sedation to relieve a dying  
4           patient’s severe distress that cannot be controlled despite other aggressive measures.  
5           Z. Schuman et al, Implementing Institutional Change: An Institutional Case Study of  
6           Palliative Sedation, 8 J. PALLIATIVE MED. 666 (2005); B. Lo, Palliative Sedation in  
7           Dying Patients, 294 JAMA 1810 (2005).
- 8           46. See, e.g., recent study revealing that physicians refuse to provide care and/or referrals  
9           on "conscience" grounds, including palliative sedation. Farr A. Curlin, Ryan E.  
10          Lawrence, Marshall H. Chin, & John D. Lantos, Religion, Conscience, and  
11          Controversial Clinical Practices, 356 NEW ENG. J. MED. 593 (2007) available at  
12          <http://content.nejm.org/cgi/content/full/356/6/593>; Christine K. Cassel, John M.  
13          Ludden & Grace M. Moon, Perceptions of Barriers to High-Quality Palliative Care in  
14          Hospitals; Lack of Financial Reimbursement has Created an Environment in Which  
15          End-of-Life Care is Not a Top Priority for U.S. Hospitals, HEALTH AFF. (2000)  
16          (arguing that financial concerns in the medical field make palliative care a low  
17          priority).
- 18          47. See, e.g., Abstinence and U.S. Abstinence-Only Education Policies: Ethical and  
19          Human Rights Concerns, APHA Policy No: 200610.
- 20          48. Such statutes have been passed in all fifty states and the District of Columbia. See  
21          Melvin I. Urofsky, Do Go Gentle Into That Good Night: Thoughts on Death, Suicide,  
22          Morality, and the Law, 59 ARK. L. REV. 819, 824 (2007) (citing J. Donald Smith,  
23          Right-to-Die Policies in the American States: Judicial and Legislative Innovation

1 (2002). See also ABA Comm'n on Legal Problems of the Elderly, Citations of State  
2 Health Care Decisions Legislation, Winter/Spring BIOETHICS BULL. 23 (1997)  
3 (listing living will and healthcare power of attorney statutes).

4 49. Society for the Right to Die: 1981 Handbook. New York: Society for the Right to Die,  
5 1981.

6 50. Natural Death Act. California Statute, 1976, Chapter 1439, Health and Safety Code,  
7 Section 7185 et seq.

8 51. A "terminal condition" is defined in state statutes. Some states specify a life  
9 expectancy of a year or 6 months, other states refer to expectation of death within a  
10 'reasonable period of time'. Compare OR. REV. STAT. § 127.800 (2003) (defining  
11 terminal disease as "an incurable and irreversible disease that has been medically  
12 confirmed and will, within reasonable medical judgment, produce death within six  
13 months.") with WASH. REV. CODE § 70.122.020 (2007) (defining terminal  
14 condition as "an incurable and irreversible condition caused by injury, disease, or  
15 illness, that, within reasonable medical judgment, will cause death within a reasonable  
16 period of time in accordance with accepted medical standards, and where the  
17 application of life-sustaining treatment serves only to prolong the process of dying").  
18 Federal law makes hospice eligibility contingent on a diagnosis of terminal illness,  
19 defined as 6 months life expectancy. 42 U.S.C. § 1395x(dd)(3)(A) (an individual is  
20 terminally ill when "the individual has a medical prognosis that the individual's life  
21 expectancy is 6 months or less").

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23 **Submitted by:**

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