



Answers To Misconceptions About A Death with Dignity Law

For a combined 30 years, aid in dying has been authorized and implemented in Oregon, Washington, Vermont and Montana. In those combined 30 years of evidence, not a single case of abuse or coercion has occurred. Specifically, in the thoroughly public and transparent 18-year record of death with dignity in Oregon, state health officials have [documented](#) it, university scientists have studied it, and the news media has investigated it. And it is irrefutable that none of the fears and what-ifs opponents have repeatedly raised has ever materialized.

Aid in dying is a medical practice that is entirely in the hands of a dying patient, and entirely voluntary for health providers. Passing the death-with-dignity act will not mandate this medical practice for anyone, but it will make a compassionate option available to a relative few for whom palliative care is insufficient to relieve their pain and suffering.

Isn't aid in dying physician-assisted suicide?

No. Those facing a terminal illness are not choosing to die but — by definition — are dying. They are facing an imminent death and want the option to avoid unbearable suffering. Further, terminally ill patients who choose aid in dying find the word “suicide” offensive, inaccurate and hurtful. Suicides bring shock and tragedy to families and friends; people who access aid in dying almost universally die peacefully and supported by their loved ones. Suicides are secretive, and often impulsive and violent, but requesting, obtaining and deciding whether to take medication to achieve a peaceful death requires time, an enduring request, planning and support.

The term “physician-assisted suicide” has been officially rejected by the American Academy of Hospice and Palliative Medicine, the American College of Legal Medicine, the American Public Health Association, the American Medical Women’s Association and the American Medical Student Association.

The American Public Health Association (APHA) [statement](#) supporting death with dignity explains why aid in dying is not “assisted suicide:”

The APHA “[r]ejects the use of inaccurate terms such as “suicide” and “assisted suicide” to refer to the choice of a mentally competent terminally ill patient to seek medications to bring about a peaceful and dignified death. The American Psychological Association has recognized, “It is important to remember that the reasoning on which a terminally ill person (whose judgments are not impaired by mental disorders) bases a decision to end his or her life is fundamentally different from the reasoning a clinically depressed person uses to justify suicide.” Medical and legal experts have recognized that the term ‘suicide’ or ‘assisted suicide’ is inappropriate when discussing the choice of a mentally competent terminally ill patient to seek medications that he or she could consume to bring about a peaceful and dignified death.”

Importantly, Maryland’s death-with-dignity law will specify that the death certificate of an individual who accesses it will indicate the underlying illness as the cause of death. **As a result, insurance companies honor whatever life insurance policies were in effect and cannot void those contracts as they can when the cause of death is suicide.**

This is just a slippery slope to euthanasia.

No. This law clearly prevents that. The medication must be self-administered, only by the patient. It empowers patients; it does not take choice away. Medical personnel are present at the time the patient self-administers the medication only if the patient requests it. Typically, however, the patient chooses to be surrounded by family and loved ones when they take their medication. **Euthanasia will continue to be illegal in Maryland and throughout the United States.**

What is to stop someone from being coerced to choose aid in dying by unscrupulous family members?

There has never been any evidence of abuse or coercion in 18 years of Oregon’s thoroughly documented law. There is no evidence of a disproportionate impact on patients in vulnerable groups (*Journal of Medical Ethics* study, 2007). The dying patient must obtain permission from two witnesses, one of whom can not be related in any way, in addition to having their request reviewed by two doctors. The laws include substantial felony penalties for coercion.

If there were evidence of abuse, coercion or harassment of vulnerable and disabled populations, it would be public knowledge. The law in Oregon is completely transparent, by design. It is documented by the health department and continues to be examined by health policy experts and journalists.

Scenarios that opponents publicize in effort to undermine support for death with dignity usually have nothing to do with death-with-dignity laws. That is, they are things that would have happened whether or not the law was in effect.

Aren't other options good enough, like palliative treatments?

Even one of the most vocal opponents of death with dignity, Dr. Ira Byock, will tell you that for some dying people, there is no pain treatment to give them relief at life's end. He believes that's something the field of medicine should work on, and we agree. But the fact is there are always cases of people whose pain, suffering and discomfort during the dying process cannot be managed. Those people deserve the medical option of aid in dying.

Palliative sedation is another option. It is the continuous administering of such high doses of pain medication that the patient becomes unconscious. It cannot alleviate suffering in every case, and some people cannot tolerate the idea of lingering in a comatose state. People should have access to a full range of end-of-life choices, including forgoing treatment, palliative care, hospice and aid in dying. Many people find that having a prescription gives them comfort and do not end up taking the medication. In the 18 years the Oregon law has been in practice, 1,173 people have received DWDA prescriptions and 752 have taken the medication. Death with dignity is a kind of insurance against the worst possible scenario.

If only a small number of people will access this bill, why are we spending our time on this when there are so many other pressing concerns and reforms needed in the healthcare system?

Death with dignity is part of an ongoing conversation about end-of-life care and options. We strongly support hospice and palliative care, advance planning, and utilizing POLST (Physician Orders for Life Sustaining Treatment) options. A death-with-dignity law gives doctors and patients the freedom to discuss all options in a safe and legal manner. Even though only a small number of people have requested medication, thousands of people are able to have open, honest and frank conversations about what options they would like at the end of life. Only when all options are safe and legal can people make clear and informed decisions on what type of treatment to use and when.

Is there evidence that some doctors are overzealously writing prescriptions or otherwise advocating for the death with dignity option?

None whatsoever. In fact, in Oregon doctors report that since the law was implemented, they have made a point of improving their knowledge of pain

management, hospice and other-end-of-life treatments. As a result, overall end-of-life care in that state is improved. For example, more Oregonians are able to die at home than in any other state. Being at home is the one thing Americans consistently express about how they wish to die when the time comes.

What if a doctor does not wish to provide aid in dying medication to a patient?

The Act specifically states that healthcare professionals, doctors and pharmacist cannot be forced, disciplined or penalized for not participating in aid in dying.

The AMA is against aid-in-dying laws; aren't all healthcare providers?

No. The American Public Health Association is the largest organization of health professionals in the country, and they have endorsed aid in dying. The American College of Legal Medicine, the American Medical Women's Association and the American Medical Student Association – the future of the AMA – all support open access to aid in dying.

The AMA represents a declining number of American doctors; somewhere between 20 and 30% of doctors are AMA members. In a recent survey of physicians conducted by the physician recruitment firm Jackson & Coker, fully 77% of physicians rejected the premise that the AMA currently reflects their profession.

Debates about the origins and relevance of the Hippocratic Oath are ongoing in the medical community, and many doctors believe that their highest obligation is to relieve suffering. In its endorsement of aid in dying legislation in Colorado, the Denver Medical Society wrote: "We believe it is consistent with physicians' duty to support patient autonomy and to ease suffering. Hospice and palliative care are essential tools in end of life care but they do not meet the needs and values of all patients."

Shouldn't every one who requests aid in dying receive a psychiatric evaluation?

Family doctors and specialists like oncologists are all MDs who are authorized to prescribe psychiatric medications for their patients – and they do so regularly. They are trained to evaluate their patients' mental health conditions. The death-with-dignity law will require two physicians to review any dying person's request for aid in dying medication, and that is more than adequate to ensure the patient is mentally competent to make this decision.

What type of medication is used, and how do DWDA patients administer this medication?

A central part of aid in dying is that it preserves the relationship between patients and doctors. It allows doctors to recognize a patient's unique conditions and circumstances when writing the prescription, just as they do in writing every prescription. There are no stipulations about what type of medication needs to be used or how it is ingested, except that the patient must self-administer. As with other care practices, the standard of care is established within the medical community, and a community of physicians knowledgeable in prescribing medication for aid in dying exists to advise and support those whose patients request a prescription.

The Death with Dignity Act is too far ahead of the culture.

Death with dignity is supported by 74% of Americans, according to a 2014 Harris poll. A majority of physicians support it, too (54%). As with many other issues, legislators lag behind public opinion, but they are starting to catch up: new laws will be introduced in more than a dozen states in 2015, including diverse states like New York and California.

When people access aid in dying, aren't they giving up on a cure that might be around the corner? For example, HIV/AIDS was a terminal disease and is not any longer.

Regardless of health status, we all have a responsibility to clearly spell out what types of treatment we want and what types of treatments are unwanted at the end of life; when curative therapies are appropriate and when have they run their course. Compassion & Choices above all supports an individual's right to make informed decisions at all stages of care that honor their values and ideas, and the government must respect a competent adult's autonomy in deciding their medical care.

Shouldn't a dying person have to notify their family about their intent to access aid in dying?

Aid in dying is a medical option that a mentally competent adult may choose in consultation with their doctor. Experience shows that those patients who have family members consistently discuss this option and gain family support.

Under the Maryland death-with-dignity act, the patient will be encouraged to notify family members, however it is up to the patient to decide whom he/she informs (HIPPA) and if the person is found to be mentally competent, his or her family should not have the right to overrule the patient.

Won't people living with disabilities be pressured to end their lives?

No. Disability does not qualify a patient under a death with dignity act. Death-with-dignity laws treat individuals with disabilities the same as anyone else with a terminal prognosis. Above all, individuals with disabilities cherish their freedom and autonomy.

Death-with-dignity laws are very clear in establishing felony penalties for anyone who coerces or pressures another individual into accessing aid in dying. There have been zero instances of coercion in the combined 20-plus years of data available from Oregon and Washington.

Is there evidence that some DWDA patients made quick and ill-informed decisions?

No. In fact in 2012, the median length of the relationship between an Oregon DWDA patient and the doctor who prescribed the medication was 19 weeks. The median number of days between a patient requesting medication and death was 47 days. The numbers are similar every year.

This will be used as a way to get rid of disabled and vulnerable populations. After all, many people living with disability have suffered and endured discrimination, pain and suffering.

Nothing could be further from the truth. There is no evidence in Oregon or Washington or other states of any abuse or coercion of anyone who has requested or taken medication. There is no evidence of a disproportionate impact on patients in vulnerable groups. The dying patients must obtain permission from two witnesses. Furthermore, all medication must be self-administered. People who cannot self-administer are not eligible to utilize this law.

Additionally, the United Seniors of Maryland (a coalition of 3.4 million seniors who advocate on behalf of Maryland seniors) does not agree. In testimony they submitted in favor of the bill they wrote, "USM supports HB 1021 which allows seniors as qualified patients to request aid in dying in a safe and medically controlled environment. USM believes the bill allows for proper protections in the narrow scope of access for medical guidance in death."

A six-month prognosis can be arbitrary and inaccurate. If these diagnoses are off, are people likely to prematurely take the medication?

No, because the dying individual remains in charge. One third of eligible patients who get the medication never even take it, and the majority are already in hospice care because their death is imminent. The six-month prognosis helps to prevent the misapplication of the law and promote safeguards. Other safeguards include a 15-day waiting period between the first and second request for the medication by the patient. Furthermore, two expert opinions must concur on the diagnosis. Failure to complete any of these steps could result in severe consequences.

Aren't members of religious communities opposed to aid in dying?

Marylanders hold a wide variety of religious and spiritual beliefs, and some will be opposed to aid in dying for those reasons. But as compassionate end-of-life care, it has the support of many faith leaders in Maryland, and across the country.

The Central Atlantic Conference-United Church of Christ submitted this statement: "This bill permits a legally competent individual confronting imminent death because of a terminal illness to make an informed decision to end her own life. We think religious (i.e., theistic) and political-ethical (i.e., democratic) considerations strongly counsel such permission. We, therefore, respectfully urge a favorable report for Senate Bill 0676."

Rabbi George Driesen testified in support of HB1021:

"There is no virtue in condemning a dying person to months, weeks, or even days of excruciating pain,The Lord is "full of compassion," and we are urged to emulate Him". The law should be changed to enable loving families, physicians, and caregivers to follow that path. (Exodus 34:6; Psalm 103:6; Kol HaNeshamah, Shabbat v'Hagim, (Wyncote, PA 1994) p. 639 (Prayer in memory of the departed).

Rabbi Donald Berlin testified in favor of SB0676:

"Free good people to live wisely and well until they die sooner or later by the special gift you have granted them – a personal decision, informed by medical judgment and based on a personal faith commitment."