

Death with Dignity: Frequently Asked Questions

WHAT IS DEATH WITH DIGNITY?

Death with dignity can refer to

- an **end-of-life option** that allows certain eligible individuals to legally request and obtain medications from their physician to end their life in a peaceful, humane, and dignified manner;
- state **legislation** codifying such an end-of-life option
- a family of **organizations** promoting the end-of-life option around the United States.

DEATH WITH DIGNITY AS AN END-OF-LIFE OPTION

WHAT IS THE DEATH WITH DIGNITY END-OF-LIFE OPTION?

Death with dignity is an end-of-life option that allows certain terminally ill people to voluntarily and legally request and receive a prescription medication from their physician to hasten their death in a peaceful, humane, and dignified manner. It is governed by state legislation.

WHAT ARE SOME OTHER TERMS USED TO REFER TO DEATH WITH DIGNITY?

Death with dignity is a term originating in the title of the Oregon statute governing the prescribing of life-ending medications to eligible terminally ill people; because our organization's founders authored the Oregon law, our family of organizations bears its name and it's our preferred term for the practice.

Other terms include

- physician-assisted death / physician-assisted dying
- physician-hastened death / dying
- aid in dying / physician aid in dying / medical aid in dying

Incorrect and inaccurate terms that opponents of physician-assisted dying use in order to mislead the public include:

- "assisted suicide"
- "doctor-assisted suicide"
- "physician-assisted suicide"
- "euthanasia" / "active euthanasia"

HOW CAN I USE A DEATH WITH DIGNITY LAW?

A legal prescription for life-ending medications is only available in states with death with dignity laws.

As of September 2019, **California, Colorado, District of Columbia, Hawai'i, Maine, New Jersey, Oregon, Vermont, and Washington** have physician-assisted dying statutes.

Physician-assisted dying is also legal in **Montana** by way of a 2009 State Supreme Court ruling.

To qualify under death with dignity statutes, you must be

- an adult resident of a jurisdiction where such a law is in effect (CA, CO, DC, HI, ME, NJ, OR, VT, WA);
- mentally competent, i.e. capable of making and communicating your healthcare decisions;
- diagnosed with a terminal illness that will lead to death within six months, as confirmed by two physicians; and
- capable of self-administering and ingesting medications without assistance.

The process entails two oral requests, one written request, waiting periods, and other requirements.

SHOULD I TELL MY FAMILY I WANT TO USE THE OPTION?

Every family is different, and many families have had strained relations. However, even if there has been little communication for years, the months or weeks before death is a time when many people attempt to open up to each other. It is amazing how many families reestablish communication and offer support.

It is in the best interest of those who will be left behind that you tell your family what you are planning, and give them the option to accept or reject it, or to work out personal past differences. This helps those family members cope better after you die, as they have some good, positive memories. Even if your family cannot support you in what you are choosing to do, by starting the dialogue you have at least given them the chance to understand and grow. And most families rise to the occasion by providing help, support, and understanding.

However, if after thought and consideration, you still feel strongly that telling your family would not be helpful, we encourage you to discuss this with a neutral third party like a friend, a religious counselor, or a social worker.

HOW CAN I FIND A DOCTOR IN CALIFORNIA, COLORADO, DISTRICT OF COLUMBIA, HAWAII, MONTANA, MAINE, NEW JERSEY, OREGON, VERMONT, OR WASHINGTON WHO WILL PRESCRIBE LIFE-ENDING MEDICATIONS?

There are no lists of physicians who participate in physician-assisted dying laws, for both confidentiality and safety reasons. Doctor participation in the law is strictly voluntary.

You are more likely to find a participating physician in a non-faith-based hospital and in larger cities. End of Life Washington has compiled information about which activities each hospital in the state permits or restricts when a patient asks for assistance using their Act.

To find out if your doctor is willing to participate in the law, make an appointment with them to discuss your end-of-life goals and concerns, including the option available under the state's death with dignity law.

Ask any kind of doctor: your hospice doctor, oncologist, pulmonologist, neurologist, or even your dermatologist or psychiatrist. Any physician licensed to practice in a "death with dignity state" is allowed to participate if s/he agrees; the law also says every physician has the choice not to participate.

If the first physician says yes, ask them for a referral to another doctor who will participate or ask another of your (probably many) doctors if they will participate. Both physicians need to certify that you meet the criteria under the law.

The first physician will be your attending physician for the law. They will guide you through all the requirements of the law and, if you qualify, will write the life-ending medication prescription for you. The second certifying doctor will be the consulting physician under the law who has to certify all the criteria under the law have been met.

Nurse practitioners and physician's assistants, while they can treat your basic disease, are not allowed to act as licensed physicians for the law.

WHERE CAN I TAKE THE MEDICATION?

You can take (self-administer and ingest) the medications at a place of your choosing. Most people (92 percent in Oregon) choose to take the medications at home; those who reside in assisted-living or nursing home facilities tend to take them there.

The aid-in-dying laws required your physician to advise you not to take the medication in a public place.

The laws also stipulate consequences for taking the medication in a public place by allowing

governmental entities that incur resulting costs to recoup them from your estate. For example, California's End of Life Option Act states that:

443.21. Any governmental entity that incurs costs resulting from a qualified individual terminating his or her life pursuant to the provisions of this part in a public place shall have a claim against the estate of the qualified individual to recover those costs and reasonable attorney fees related to enforcing the claim.

An additional issue is the need for a funeral home to be able to reach the area so as to remove your remains; most funeral homes refuse to do so in a public place.

If you take a dose prescribed under a death with dignity law outside the state where you obtained it, you may lose the legal protections afforded by the law in question. For example, your death may be ruled a suicide under another state's law, with resulting effects on your insurance policies.

WHAT KIND OF PRESCRIPTION WILL I RECEIVE?

None of the medical aid-in-dying laws tell your physician exactly what prescription to give you, but all medications under these laws require the attending physician's prescription. It is up to the physician to determine the prescription.

To date, most patients have received a prescription for an oral dosage of a barbiturate (pentobarbital or secobarbital). Beginning in 2015, compound medications have also been used, also to be used orally dissolved in a liquid. Some patients have been reported to self-administer and ingest the medication via a feeding tube.

HOW MUCH DOES THE MEDICATION COST?

Cost varies based on medication type and availability as well as the protocol used (additional medications must be consumed prior to the lethal medications at an extra cost). The following are only estimates as prices and availability change. The actual prescription depends on the physician's assessment.

Pentobarbital in liquid form cost about \$500 until about 2012, when the price rose to between \$15,000 and \$25,000. The price increase was caused by the European Union's ban on exports to the U.S. because of the drug being used in capital punishment, a practice that is illegal and deemed deplorable there; many international pharmaceutical companies don't export the drug to the United States for the same reason. Pentobarbital is no longer prescribed and used under death with dignity laws.

The legal dose of secobarbital (brand name Seconal) costs \$3,000 to \$5,000.

Due to the increase in the cost of Seconal, alternate mixtures of medications have been developed by physicians in Washington state. The phenobarbital/chloral hydrate/morphine sulfate mix produces a lethal dose that is similar in effect to Seconal. The cost of this alternate

mix is approximately \$450 to \$500.

A second alternative, consisting of morphine sulfate, Propranolol (Inderal), Diazepam (Valium), Digoxin and a buffer suspension costs about \$600. A compounding pharmacy must prepare each mixture.

WHEN WILL I KNOW IT IS THE TIME TO TAKE THE MEDICATION?

No one can answer this question for you.

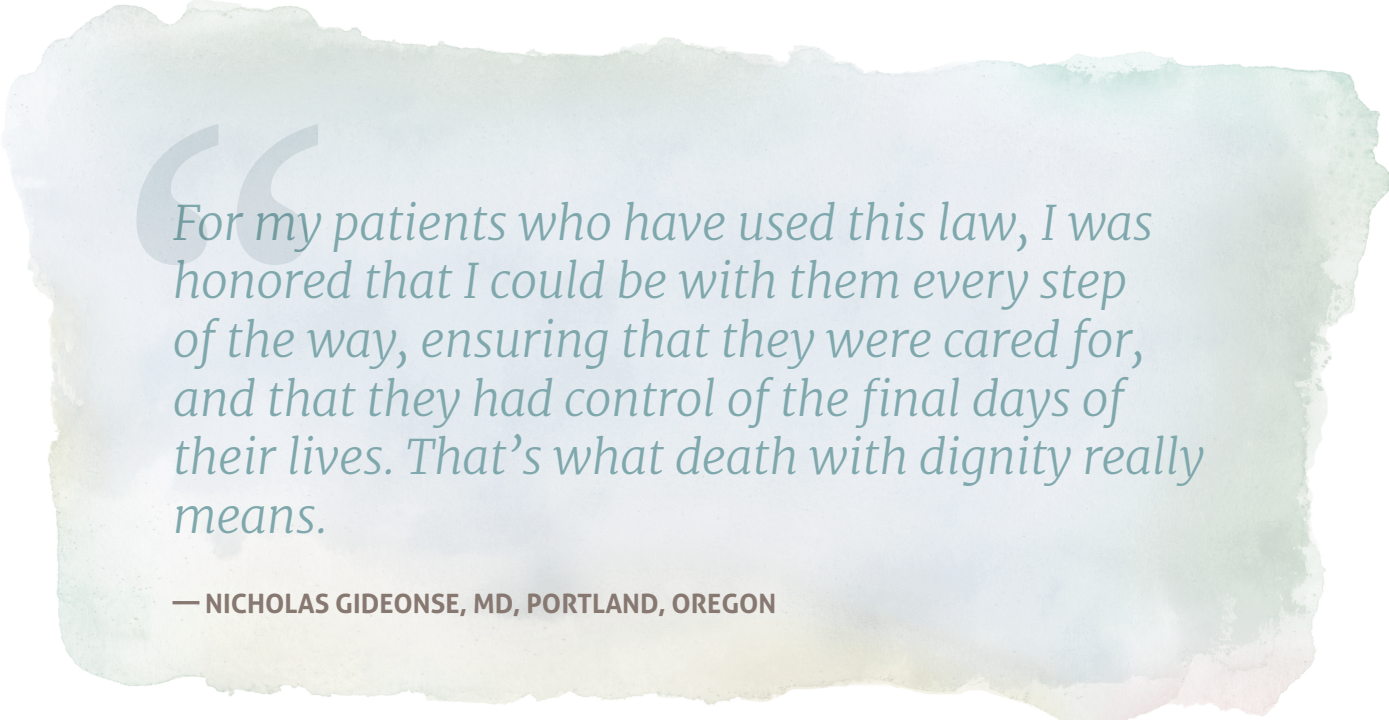
Some people know when it's time, when they've reached a point where their disease or the pain and suffering it causes has robbed them of the quality of life they find essential.

If you decide the time is not right, that's fine; it only means your state's death with dignity law is working as intended because it has given you the freedom and empowerment to set your own timeframe. Some people (about one in three) never take the medication. Simply knowing they have this option, if they need it, gives them comfort.

WHAT HAPPENS WITH UNUSED MEDICATIONS?

As controlled, Schedule 2 substances, medications prescribed under death with dignity laws are regulated by federal statutes. These medications are carefully tracked from the date they are prescribed to the date the person for whom they are prescribed dies. Physicians must report all prescriptions for lethal medications to their state's health department. Similarly, pharmacists must report on dispensing these medications.

The medications must be taken by the person prescribed to; criminal penalties may ensue if



For my patients who have used this law, I was honored that I could be with them every step of the way, ensuring that they were cared for, and that they had control of the final days of their lives. That's what death with dignity really means.

— NICHOLAS GIDEONSE, MD, PORTLAND, OREGON

another person takes them.

One in three people who obtain medications under aid-in-dying laws choose not to take them.

Anyone who chooses not to ingest a prescribed dose or anyone in possession of any portion of the unused dose must dispose of the dose in a legal manner as determined by the federal Drug Enforcement Agency or their state laws, if any.

The California End of Life Option Act stipulates that,

"A person who has custody or control of any unused aid-in-dying drugs prescribed pursuant to this part after the death of the patient shall personally deliver the unused aid-in-dying drugs for disposal by delivering it to the nearest qualified facility that properly disposes of controlled substances, or if none is available, shall dispose of it by lawful means in accordance with guidelines promulgated by the California State Board of Pharmacy or a federal Drug Enforcement Administration approved take-back program."

Because nine in ten of all patients who use the death with dignity laws are enrolled in hospice care at the time of their death, it is the responsibility of hospice to have a policy about drugs left after a patient's death, including the legally prescribed lethal doses of medication, and to educate the deceased patient's family about the disposal of such medications.

In those few cases where the patient is not enrolled in hospice at his/her death any unused medications have been disposed of by those who are present at the time the patient dies.

There have been no reported cases of misuse of the medications during more than 20 years Oregon's law has been in effect nor during ten years in Washington and five years in Vermont.

The objection that simply having the lethal dose of medicine results in its misuse fails to account for any other medications patients around the country have, e.g. Oxycontin, Oxycodone, morphine, anti-depressants, sleeping sedatives, etc., all of which could be misused and in some cases are misused.

The laws in the U.S. are very clear: legally prescribed medications must be taken by the person for whom they are prescribed and it is illegal for such medications to be used by others.

WHAT OPTIONS DO I HAVE IF MY STATE DOES NOT ALLOW PHYSICIAN AID IN DYING?

You can

- voluntarily stop eating and drinking
- stop treatment or not start treatment at all (every competent individual has a right to refuse medical therapies)
- use palliative sedation

Such measures can take anywhere from several days to several weeks to result in death. Stopping

treatment or medication may lead to unanticipated effects or pain.

Your end-of-life concerns can also be addressed by hospice or palliative care.

Discuss your options with your physician.

DEATH WITH DIGNITY LEGISLATION

WHAT IS DEATH WITH DIGNITY LEGISLATION?

Death with dignity, or medical aid-in-dying, statutes allow certain terminally ill adults to request and obtain a prescription for medication to end their lives in a peaceful manner. The acts outline the process of obtaining such medication, including safeguards to protect both patients and physicians.

In states where physician-assisted dying is legal, there is no state program for participation in the existing aid-in-dying laws and people do not apply to state health departments. It is up to eligible patients and licensed physicians to implement the act on an individual, case-by-case basis.

As of August 2019, physician-assisted dying statutes are in effect in eight states and the nation's capital:

- **Oregon** since 1997 (the law was first passed in 1994)
- **Washington** since 2009 (2008)
- **Vermont** since 2013
- **California** since 2016 (2015)
- **Colorado** since 2016
- **District of Columbia** since 2017 (2016)
- **Hawai'i** since 2019 (2018)
- **New Jersey** since August 2019
- **Maine** since September 2019

In **Montana**, physician-assisted death is legal (since 2009) by the state Supreme Court ruling.

WHO CAN PARTICIPATE IN PHYSICIAN-ASSISTED DYING LAWS?

Anyone who meets the eligibility criteria can use their state's physician aid in dying law. Participation in the law is strictly voluntary.

To qualify for a prescription of medication under a physician-assisted dying law, you must be

- an adult resident of **California, Colorado, District of Columbia, Hawai'i, Maine, New Jersey, Oregon, Vermont, or Washington;**
- mentally competent, i.e. capable of making and communicating your healthcare decisions;
- diagnosed with a terminal illness that will lead to death within six months;
- able to self-administer and ingest the prescribed medication.

Two physicians must determine whether all these criteria have been met. The process entails two oral requests, one written request, waiting periods, and other requirements.

There are no exceptions to these requirements.

CAN MY FAMILY MEMBER OR A PROXY REQUEST PARTICIPATION IN MEDICAL AID IN DYING ON MY BEHALF (FOR EXAMPLE, IF I AM IN A COMA OR SUFFER FROM ALZHEIMER'S DISEASE)?

No.

The law requires that you ask to participate voluntarily on your own behalf and meet all the eligibility criteria at the time of your request.

CAN PHYSICIAN-ASSISTED DEATH LAWS BE USED WITH ADVANCE DIRECTIVES?

Advance Directives are legal documents that describe what you as a dying person want done (or not done) medically if you can no longer communicate.

The aid in dying laws cannot be used under Advance Directives because you would no longer be of sound mind when the advance directives kick in.

WHAT ARE THE RESIDENCY REQUIREMENTS UNDER DEATH WITH DIGNITY LAWS?

Legal state residency is a requirement for accessing death with dignity laws. You must provide adequate documentation to the attending physician to verify that you are a current resident of the jurisdiction with an aid-in-dying statute. It is up to the attending physician to determine you have adequately established residency.

There is no length-of-residency requirement. You must simply be able to establish that you are currently a state resident.

In **California, Colorado, Hawai'i, Oregon, and Washington**, you may prove residency with any or a combination of the following:

- a state-issued ID or driver license;
- a lease agreement or property ownership document showing that you rent or own property in the state;
- a state voter registration; or
- a recent state tax return.

In **Maine**, you may use the above as well as documents showing you occupy the location of a dwelling, including received mail, hunting/fishing license, receipt of any public benefit conditioned upon residency, or "any other objective facts tending to indicate [your] place of residence."

In **New Jersey**, proof of renting or owning property isn't acceptable, but you can use "any other government record that the attending physician reasonably believes to demonstrate the individual's current residency in this State" in addition to the other three on the list.

In **Vermont**, the law does not specify how residency may be proven. We recommend following the rules above.

Likewise, the **District of Columbia** Death with Dignity Act does not stipulate ways to prove residency. However, the D.C. Department of Health has established rules for patients to prove residency, specifically by submitting any two (2) of the following original documents that include a valid address in the District of Columbia:

- recent utility bill ("recent" being within the past 60 days in this and all other instances below);
- recent telephone bill;
- deed, mortgage, or settlement agreement;
- unexpired lease or rental agreement;
- recent property tax bill or tax assessment;
- unexpired homeowner's or renter's insurance policy;
- recent letter with picture from the Court Services and Offender Supervision Agency or D.C. Department of Corrections;
- DMV proof of residency form and a copy of unexpired D.C. Driver License or D.C. identification card;
- bank, credit union, credit card, or investment account statement;
- piece of official mail received from any government agency;
- recent form from a social service provider;
- recent medical bill;
- recent student loan statement;
- recent home line of equity statement;
- recent car or personal loan statement; or
- recent home security system bill.

CAN I MOVE TO A "DEATH WITH DIGNITY STATE" IN ORDER TO USE THE LAW?

There is nothing in death with dignity statutes that prevents you from doing this. You must simply must be able to prove to the attending physician that you are currently a resident.

However, relocating in and of itself, not to mention across state lines, is a challenge, particularly if you are terminally ill and if you are elderly (the median age of aid-in-dying participants in Oregon is 72).

We work to ensure every state has a death with dignity statute so that no one should have to uproot to use another state's statute.

CAN I JUST FLY TO CALIFORNIA, COLORADO, DISTRICT OF COLUMBIA, HAWAI'I, MAINE, NEW JERSEY, OREGON, VERMONT, OR WASHINGTON AND FLY HOME WITH THE MEDICATION?

No.

You must be a resident of one of these states and be planning to die in that state. Taking the medication prescribed under one state's physician-assisted dying law outside that state may result in your and your physician's losing the legal protections afforded by the law in question.

HOW DO AID-IN-DYING LAWS PROTECT PATIENTS?

Death with dignity statutes contain a number of safeguards, protecting patients from abuse and coercion:

- Patients must meet stringent eligibility requirements, including being an adult, state resident, mentally competent, and having a terminal diagnosis with a 6-month prognosis as confirmed by two licensed physicians.
- Only the patient him or herself can make the oral requests for medication, in person. It is impossible to stipulate the request in an advance directive, living will, or any other end-of-life care document.
- The patient must make two oral requests, at least 15 days apart.
- The written request must be witnessed by at least two people, who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request. One of the witnesses cannot be a relative of the patient by blood, marriage or adoption; anyone who would be entitled to any portion of the patient's estate; an owner, operator or employee of a health care facility where the eligible patient is receiving medical treatment or is a resident or the patient's attending physician.
- The patient must be deemed capable to take (self-administer and ingest) the medication themselves, without assistance.
- The patient may rescind the request at any time.
- Two physicians, one of whom is the patient's attending physician, familiar with the patient's case, must confirm the diagnosis. Each physician must be licensed by the state to practice medicine and certified to prescribe medications.
- If either physician determines the patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, they must refer the patient for evaluation by a state licensed psychiatrist or psychologist to determine their mental competency. Medication cannot be prescribed until such evaluation determines the patient is mentally competent.
- The attending physician must mail or hand-deliver the prescription to the pharmacy.
- The patient must wait 48 hours from their written request to fill their prescription.
- The request process must stop immediately if there is any suspicion or evidence of coercion.

- The physicians must meet strict reporting requirements for each request.
- Anyone who falsifies a request, destroys a rescission of a request or who coerces or exerts undue influence on a patient to request medication under the law or to destroy a rescission of such a request commits a Class A felony. The law also does not limit liability for negligence or intentional misconduct, and criminal penalties also apply for conduct that is inconsistent with it.

Data and studies show these safeguards work as intended, protecting patients and preventing misuse. No evidence of coercion or abuse has been documented in the Oregon since 1998 and Washington since 2009, when these states' respective laws went into effect.

HOW DO DEATH WITH DIGNITY STATUTES SAFEGUARD CONFIDENTIALITY?

Federal statutes, such as HIPAA, protect confidentiality of all patient records.

While states with physician-assisted dying laws do collect the names of patients in order to cross-check death certificates, the laws guarantee the confidentiality of all participating patients as well as physicians. Patients' or doctors' identifying information is never released to the public or media. The identity of participating physicians is coded, but the identity of individual patients is not recorded in any manner. In Oregon, all source documentation, including any patient or physician documentation, is destroyed approximately one year from the publication of annual reports.

If your death results from taking medications legally prescribed and obtained under a physician aid-in-dying statute, your death certificate will list your underlying illness as the cause of death.

HOW DOES USING A DEATH WITH DIGNITY LAW IMPACT MY INSURANCE?

Physician-assisted death statutes do not specify who must pay for the services. Individual insurers determine whether the procedure is covered under their policies, just as they do with any other medical procedure. Federal funding, including Medicaid and Medicare, cannot be used for services or medications received under these laws.

Physician aid in dying statutes specify that participation under them is not suicide. Therefore, your decision to end your life under an aid-in-dying statute has no effect on your life, health, or accident insurance or annuity policy.

HOW MANY PEOPLE USE DEATH WITH DIGNITY LAWS?

In 2018, a total of 249 terminally-ill adult Oregonians received a prescription for medications under the provisions of the **Oregon** Death with Dignity Act from 103 physicians; 168 of these patients (67.5 percent) ingested the medications to die peacefully. This corresponds to 46 Death with Dignity Act deaths per 10,000 total deaths, or 0.37 percent.

Since 1998, when the first person in Oregon took medication prescribed under the Death with Dignity Act, a total of 2,216 patients have received the prescription, of whom 1,459 (65.8 percent) ingested it and died.

In **Washington**, in 2017, 212 individuals received prescriptions from 115 physicians; 164 died after ingesting the medication, 19 died without having ingested the medication, and for the remaining 13 people who died ingestion status is unknown. Since Washington's law was passed in 2008, a total of 1,399 people have had prescriptions written under the Act.

These figures highlight that:

- only a small number of people use the law to die; and
- about one third of those who obtain the medication prescribed under the law never take it.

The existing death with dignity statutes continue to work flawlessly, protect patients and physicians, and provide ease of mind and relief to people facing the end of life.

WHO USES PHYSICIAN-ASSISTED DEATH LAWS? WHAT ARE THEIR DEMOGRAPHICS?

People who access physician-assisted dying laws tend to be well educated and have excellent health care, good insurance, access to hospice, and financial, emotional, and physical support.

In Oregon, 72.8 percent of patients using the law are aged 65 years or older; the median age at death is 72 years. Most patients have cancer (75.9 percent) or ALS (8 percent). Most people die at home (92.4 percent) and are enrolled in hospice care (90.2 percent).

The three most frequently mentioned end-of-life concerns are loss of autonomy (90.6 percent of patients cited this concern), decreasing ability to participate in activities that made life enjoyable (89.1 percent), and loss of dignity (74.4 percent); the least important concerns are being a burden on family/friends/caregivers (44.8 percent), inadequate pain control or concern about it (25.7 percent), and financial implications of treatment (3.9 percent).

DO AID-IN-DYING STATUTES OBLIGATE OR ENCOURAGE ANYONE TO USE THEM?

Participation in assisted dying is strictly voluntary, for both patients and physicians. No one is encouraged or obligated to use these laws; they merely provide an option to those who wish to use them.

No one qualifies under aid-in-dying laws solely on the basis of age or disability. Many seniors and people with disabilities support physician-assisted dying laws, not because they are disabled but because they are people.

Opponents of aid-in-dying laws like to allege that the mere existence of these laws encourages the elderly, people with disabilities, minorities, or poor, undereducated, uninsured and other marginalized persons to prematurely end their lives.

Physician-assisted death laws, however, provide a voluntary option to anyone who qualifies and wishes to voluntarily use it. No one is forced, obligated, or encouraged to use these laws; access to these laws by any one person does not preclude others from opting out.

DO PEOPLE MOVE TO STATES WITH ASSISTED DYING LAWS IN ORDER TO USE THEM?

There are no statistics about people moving to Oregon, Washington, or Vermont in order to use physician aid-in-dying laws.

Because only residency matters under aid-in-dying laws, annual reports released by the Oregon Department of Human Services and Washington State Department of Health do not contain information about how many individuals moved to these states in order to avail themselves of their respective death with dignity statutes (Vermont's Patient Choice and Control at End of Life Act does not have a reporting requirement).

Anecdotally, there is evidence that people are compelled to move to states with aid-in-dying laws. We believe that no one should have to move to use medical aid in dying as an end of life option.

CAN THE FEDERAL GOVERNMENT OVERTURN OREGON'S LAW?

The George W. Bush administration in the early 2000s attempted to use the federal Controlled Substances Act to overturn the Oregon law, both through Congress and the courts. However, since the Controlled Substances Act bans the use and trafficking of illegal drugs and regulates the use of legal narcotics for approved medical purposes, and the Oregon Death with Dignity Act specifies only the use of legal narcotics for physician-assisted dying, their efforts failed.

In the U.S., it is the states, not the federal government, that licenses physicians and determines what is and is not legitimate medical practice. In 2006, the U.S. Supreme Court affirmed this by ruling, in the case *Gonzales v. Oregon*, that the federal government overstepped its authority in seeking to punish doctors who prescribed drugs to help terminally ill patients end their lives.

The relief from my terminally-ill patients and their families is palpable. I've helped families accept their family members' final wishes in the face of terrible illness. Aid in dying for terminal patients is an essential part of good, compassionate end of life care.

— NICHOLAS GIDEONSE, MD, PORTLAND, OREGON

IMPACT OF DEATH WITH DIGNITY

WHAT ARE THE BENEFITS OF DEATH WITH DIGNITY LAWS FOR TERMINALLY ILL PEOPLE AND THEIR FAMILIES?

Death with dignity legislation yields numerous direct and indirect benefits.

For the terminally ill, the greatest comfort these laws provide is having the freedom to control their own ending. Most people who obtain medications under these laws value being able to make their own decisions, including the where and when of their death. We know this because people using the law cite loss of autonomy as their chief end-of-life concern.

In addition, if you are terminally ill the option to die a peaceful death at a time and place of your choosing provides you with invaluable peace of mind, which is especially important at the end of life. In fact, so many people get reassurance from simply filling the prescription that one in three choose not to use it.

Most people who are dying wish to die at home. While on the national level only about 20 percent of people die at home, nearly 95 percent of people accessing the Oregon Death with Dignity Act do. The stringent safeguards in these laws also protect patients from possible abuse, coercion, and wrongful medical practice.

Family members, too, derive peace of mind from knowing they will not have to helplessly endure watching a loved one die a horrible death.

WHAT ARE THE BENEFITS OF DEATH WITH DIGNITY LAWS FOR PHYSICIANS?

For physicians, medical aid-in-dying laws codify and bring to light the common practice of giving life-ending medications to their patients. Death with dignity legislation protects physicians by stipulating the steps they must follow and, provided they follow the law, providing them with immunity from civil and criminal liability as well as professional disciplinary action.

WHERE DO PHYSICIANS STAND ON PHYSICIAN-ASSISTED DYING?

A 2016 *Medscape* survey found that 57 percent of medical doctors favor physician-assisted dying, up from 46 percent in 2010. We also know that many physicians who support the end-of-life option are reluctant to declare so publicly for fear of repercussions in their workplace or medical community.

The American Medical Association opposes aid-in-dying laws. However, not only does the AMA represents a declining number of physicians (only about 1 in 3 doctors are AMA members), a 2011 survey of physicians conducted by Jackson & Coker found that 77 percent of physicians believe the AMA no longer reflects their views.

As of 2018, ten AMA state chapters as well as the D.C. chapter have dropped opposition to assisted dying and adopted a neutral position: California, Colorado, Hawai'i, Maine, Maryland, Massachusetts, Nevada, Oregon, Vermont, and Washington.

A number of medical associations have endorsed physician-assisted dying, including:

- American Public Health Association
- American College of Legal Medicine
- American Medical Women's Association
- American Medical Student Association
- American Nurses Association of California, California Psychological Association, California Primary Care Association
- Boulder County Medical Society, Denver Medical Society

DO DEATH WITH DIGNITY LAWS HAVE ANY BROADER, SOCIETAL EFFECTS?

Death with dignity legislation leads to improvements in end-of-life care.

Oregon consistently ranks as a top state in end-of-life care. The Oregon Death with Dignity Act has dramatically improved end-of-life care, particularly in pain management, hospice care, and support services for family members. Reports show that up to 97 percent of people using Oregon's Death with Dignity Act are on hospice at the time of death, as compared to 45 percent in the U.S. overall, according to the National Hospice and Palliative Care Organization. Oregon has some of the best pain, palliative and hospice care in the nation because the law made physicians get better at diagnosing depression, pain management, and hospice referrals.

Residents of states with aid-in-dying laws are better-versed in end-of-life care issues than of those with no such statutes. A poll by *National Journal* and The Regence Foundation has found residents in Oregon and Washington to be more knowledgeable and supportive of a variety of end-of-life options, including hospice and palliative care, than most Americans. According to the same poll, support for death with dignity legislation has grown in both Oregon and Washington, and a 2012 poll found 80 percent of Oregonians support the Act.

Many healthy Oregonians and Washingtonians today discuss end-of-life issues with their doctors and increasingly demand active participation and decision making in their own end-of-life care. Oregon and Washington doctors, as a result, today work harder to prolong patients' lives and enhance quality of life, while respecting patients' final wishes when their suffering becomes intolerable. Because of the law's protections, most Oregonians know their doctors won't abandon them when the suffering becomes unbearable and use of the law is requested.

Oregon's medical aid in dying law has also helped foster an open and honest conversation between doctors and patients about end of life.

The experience in California after the End of Life Option Act passed in 2015 has shown that the passage of a physician-assisted dying law, even before it takes effect, heightens the urgency of improving end-of-life care. Whereas conversations in California are only beginning, we know the End of Life Option Act will ultimately lead to improvements in end-of-life care there.

These effects also occur in states without physician-assisted dying legislation where a campaign for passage took place, regardless of whether it succeeded.

In Massachusetts, in 2012, media reported that interest in and preference for hospice rose in response to our campaign to get an aid in dying bill passed in a ballot initiative.

WHAT IS THE CURRENT STATE OF PHYSICIAN-ASSISTED DYING IN AMERICA?

With a history of more than 100 years, and accelerated development beginning in the early 1990s, the aid-in-dying movement enjoys more momentum than ever.

While before 2015, only two or three states at the time considered physician-assisted dying bills, in the 2015 legislative session no fewer than 25 states considered such bills. In 2016, 20 jurisdictions, in 2017, 30 jurisdictions, and in 2018, 25 jurisdictions considered such bills.

We saw our greatest victories in California where the End of Life Option Act went into effect on June 9, 2016; in District of Columbia where the Death with Dignity Act went into effect on June 6, 2017; in Hawai'i, where the Our Care, Our Choice Act went into effect on January 1, 2019; and in Maine, where the Death with Dignity Act went into effect on September 19, 2019.

Though many aid in dying bills fail, it's the way progress happens: victories beget more victories, and even our losses teach us the lessons we need to advance. With polls showing 7 in 10 Americans favoring this legislation, every day we are closer to the day when a large majority of Americans will have what they are asking for: more freedom and control at the end of life.

HOW CAN I PROMOTE DEATH WITH DIGNITY IN MY COMMUNITY?

Anyone can be an advocate for death with dignity. From contacting your legislator to spreading the word on social media to sharing your story to volunteering, your voice matters.

ABOUT DEATH WITH DIGNITY ORGANIZATIONS

WHAT IS THE DEATH WITH DIGNITY FAMILY OF ORGANIZATIONS?

Death with Dignity is an umbrella name for the Death with Dignity National Center, which focuses on education, and Death with Dignity Political Fund, which focuses on political advocacy and lobbying.

WHAT IS THE DEATH WITH DIGNITY NATIONAL CENTER AND WHAT DOES IT DO?

The National Center expands the freedom of all eligible terminally ill Americans to make their own end-of-life decisions, including how they die.

We achieve this by promoting death with dignity laws around the United States based on the groundbreaking Oregon model and by providing information, education, and support about death with dignity as an end-of-life option to patients, family members, legislators, advocates, healthcare and end-of-life care professionals, media, and the interested public.

WHAT IS THE DEATH WITH DIGNITY POLITICAL FUND AND WHAT DOES IT DO?

The Political Fund is a 501(c)(4) nonprofit organization that acts as the political arm of the National Center. The Fund drafts death with dignity laws based on the groundbreaking Oregon model; campaigns, lobbies, and advocates for death with dignity legislation in the states that lack them; and defends death with dignity statutes against legal and legislative challenges.

The Political Fund staff and volunteers authored, passed, and defended the Oregon law (1994/1997/2006); spearheaded the successful efforts to pass death with dignity statutes in Washington (2008), Vermont (2013), California (2015), Washington, D.C. (2017), Hawai'i (2018), and Maine (2019).

HOW LONG HAVE DEATH WITH DIGNITY ORGANIZATIONS BEEN IN EXISTENCE?

The Death with Dignity family of organizations have been advancing physician-assisted dying policy reform for more than 20 years. The earliest predecessor organization, Oregon Right to Die, was established in 1993. In the current form, the Death with Dignity family of organizations has been in existence since 2003.

Note: This publication includes information adapted from FAQs by Oregon Department of Human Services, Washington State Department of Health, and Vermont Department of Health as well as from a guest article by Dr. Carol Parrot, MD.