If a law does not say what you want it to say, attempt to change the “terms” of the argument and continue to argue that the law really says what you wish it did – until others believe you. This was the strategy employed by euthanasia advocates in 2011 in their efforts to force their pro-death agenda on the people of Idaho. Compassion & Choices, formerly known as the Hemlock Society, argued that “aid in dying”—a deceitful euphemism for the dangerous practice of physician-assisted suicide—was permitted under Idaho law. The people of Idaho widely disagreed, and the legislature, with the help of Americans United for Life, enacted a law explicitly prohibiting the practice. In 2012, Georgia and Massachusetts continued this life-saving trend. In response to a state Supreme Court decision striking down a 1994 law prohibiting publicly advertising suicide assistance, Georgia enacted a law that makes it a felony to assist in another person’s suicide. In Massachusetts, voters rejected a 2012 ballot initiative legalizing physician-assisted suicide. The actions in Idaho, Georgia, and Massachusetts were major victories for life after nearly two decades of attacks by pro-euthanasia advocates.

To many, legal euthanasia in the United States seems to be an impossibility, but euthanasia advocates are diligently at work, incrementally advancing their agenda. They cleverly promote hastening the deaths of the nation’s most vulnerable citizens as advancing “compassion,” “choice,” and “patient autonomy.”

Euthanasia advocates were first successful in 1994 with the legalization of physician-assisted suicide under Oregon’s “Death with Dignity Act.” In November 2008, Washington became the second state to legalize physician-assisted suicide. Even more troubling, in December 2008, a trial court in Montana created a “right to die,” claiming that this “right” is encompassed in Montana’s constitutional provisions protecting individual privacy and human dignity. While the Montana Supreme Court did not fully agree with the trial court and did not rule on whether a person has a “right” to assisted suicide under the state constitution, it did conclude that a physician who assists in a suicide can raise a “consent” defense if he or she is later prosecuted.

Prior to November 2008, the Death with Dignity National Center called its targeted plan “Oregon plus One.” According to this plan, if just one other state besides Oregon were to legalize physician-assisted suicide, the rest of the nation would soon follow. It appeared that Washington and Montana set this plan in motion; however, the new laws in Idaho and Georgia drastically curbed any perceived momentum. Clearly, it is critical to stop and reverse a “toppling” toward assisted suicide, euthanasia, and the further devaluing of human life.

Further, seemingly innocuous advance planning statutes, regulations, and documents may be used to support an agenda antithetical to protecting life. While it is laudable for one to voluntarily clarify his or her wishes regarding treatment at the end of life, many laws have the effect—intentional or not—of pressuring the vulnerable to make decisions they would not otherwise make, and of insufficiently protecting those who are unable to speak for themselves.
In 2012, in direct response to a decision by the Georgia Supreme Court striking down a 1994 law prohibiting publicly advertising suicide assistance, the state enacted a law making it a felony to assist in another person’s suicide. In Massachusetts, voters rejected a 2012 ballot initiative legalizing physician assisted-suicide. A year earlier, the State of Idaho enacted a measure explicitly prohibiting physician-assisted suicide. These three states dealt a significant blow to the agenda of euthanasia advocates, and should light a fire within those who want to protect dying, elderly, sick, and disabled Americans. Euthanasia advocacy groups like Compassion & Choices and the Death with Dignity National Center deceptively claim that unbearable suffering and patient “choice” are justifications for their mission to export the practice of physician-assisted suicide (and, ultimately, euthanasia, the actual killing of one person by or with the physical assistance of another) to all 50 states. While the people of Georgia, Massachusetts, and Idaho joined the majority of states by firmly closing the door on these anti-life efforts, it is time for the 12 states that have not explicitly prohibited physician-assisted suicide to follow.

While the United States Supreme Court did not weigh-in on end of life issues until 1990, states have enacted laws impacting the end of life since the beginning of the Nation. In fact, Anglo-American common law has addressed hastening death at the end of life for at least 700 years by punishing or prohibiting suicide, assisted suicide, and murder.1

AUL is educating and encouraging lawmakers and citizens to continue the fight against the culture of death promulgated by supporters of euthanasia, physician-assisted suicide, and other initiatives intended to shorten life, and to ensure that end of life laws do not inadvertently cause harm to vulnerable Americans.

Current federal and state laws generally address three broad end of life areas: 1) assisted suicide and euthanasia; 2) advance planning and related issues; and 3) palliative care and treatment for acute and chronic pain.

**Physician-Assisted Suicide**

Euthanasia advocates in the United States argue that they support “aid in dying” rather than suicide. However, “aid in dying”—which Kathryn L. Tucker, the Director of Legal Affairs for Compassion & Choices defines as “the practice of a physician prescribing medication that a mentally competent, terminally-ill patient can ingest to bring about a peaceful death if the dying process becomes unbearable”2—is simply physician-assisted suicide by another—intentionally misleading—name. The terms “aid in dying,” “death with dignity,” and “patient-directed dying” are merely euphemisms for the deadly practice. In fact, these terms are not recognized by the medical community and are simply used by suicide advocates to mask what they advocate.

Nonetheless, today, two states—Oregon and Washington—statutorily authorize physician-assisted suicide under the term “death with dignity.” Further, in recent years, at least six other states have considered legalizing physician-assisted suicide.

Euthanasia advocates continue to turn to the courts to achieve what they cannot accomplish democratically through legislatures. While the United States Supreme Court held in 1997 that there is no federal constitutional right to assisted suicide under the Due Process or Equal Protection Clauses of the Fourteenth Amendment,3 courts have considered whether a “right” to assisted suicide exists under state constitutions. In December 2008, a Montana trial court created such a right under the Montana Constitution.4 Upon review, the Montana Supreme
Court did not reach the issue of whether there is a state constitutional “right” to physician-assisted suicide; however, the court ruled that existing state laws and policies did not preclude it. Physicians who assist in suicides can, therefore, raise a “consent” defense if later prosecuted.5

Recently, however, states have rejected the overtures of euthanasia advocates. In 2012, Georgia responded to an adverse state Supreme Court decision by enacting a law that makes it a felony to assist in another person’s suicide. In 2011, the people of Idaho responded to pressure from advocates to “find” legal recognition of physician-assisted suicide within their law by enacting a new law prohibiting it.

Rather than “empowering” individuals facing terminal illness to make their own decisions, the mere availability of physician-assisted suicide can pressure sick, depressed, chronically ill, elderly, or disabled patients to end their lives.

In fact, in court filings, euthanasia advocates define the phrase “terminally ill” so broadly that virtually all persons could claim some sort of need for or “right” to physician-assisted suicide. In the Montana case Baxter v. State, suicide advocates, led by Compassion & Choices, defined “terminally ill adult patient” as a person 18 years of age or older who has an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of his or her attending physician, result in death within a relatively short time.8

This definition is not at all limited to “terminal illnesses” or any specific set of illnesses, conditions, or diseases. Therefore, it could be used in any number of “incurable” or “irreversible” medical situations, including diabetes or asthma.

As discussed below, the dangers inherent in the legalization of physician-assisted suicide range from untreated depression to elder abuse to the slippery slope toward outright euthanasia. In order to avert these dangers and affirm that the lives of all Americans are valuable, states must reject efforts to legalize suicide.

**Depression**

Most if not all terminally ill patients who express a wish to die meet diagnostic criteria for major depression or other mental conditions. Depression is frequently underdiagnosed and undertreated, especially in elderly individuals and patients with chronic or terminal medical conditions. Importantly, in one study, treatment for depression resulted in the cessation of suicidal ideation (thoughts about or plans to commit suicide) for 90 percent of the patients.

Despite these statistics, “safeguards” in Washington and Oregon, where physician-assisted suicide is legal, are failing to protect patients, as there are no requirements that patients receive psychological evaluation or treatment prior to receiving lethal drugs. In 2010, only 1 out of 65 patients in Oregon who died as a
result of physician-assisted suicide was referred for psychiatric or psychological counseling. In Washington, the Department of Health received a psychiatric/psychological consulting form for only three of 87 patients choosing physician-assisted suicide and no information is available as to whether these patients were treated for any mental complications.

Further, most patients who request physician-assisted suicide do not have longstanding relationships with the physicians who provide the lethal drugs. In Oregon, some physicians prescribe lethal drugs for patients whom they have known as little as one week or less. In Washington in 2010, half of the patients had a “relationship” with their physician for only three to 24 weeks. This lack of a long-term relationship between doctor and patient precludes a doctor from truly understanding a patient’s psychological condition, and encourages “physician shopping.”

**Pain**

Euthanasia advocates wrongfully claim that assisted suicide is “needed” for those terminally ill patients who face, or fear, great pain. But most experts in pain management believe that 95 to 98 percent of such pain can be relieved. In most cases, patients who request assisted suicide on the basis of pain will withdraw the request after pain management, depression, and other concerns are addressed.

Given that our healthcare system often fails to diagnose and treat depression or provide adequate palliative care, the legalization of physician-assisted suicide is profoundly dangerous for individuals who are ill and vulnerable or “whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized social group.”

Critically, the availability of assisted suicide may lead to a decrease in or failure to increase the availability of pain management and palliative care. In fact, proper palliative care is languishing in Oregon. In 2004, Oregon nurses reported that the inadequacy of meeting patients’ needs had increased “up to 50 percent” and that “[m]ost of the small hospitals in the state do not have pain consultation teams at all.”

Further, the American Medical Association (AMA) does not support physician-assisted suicide, even for individuals facing the end of life. The AMA states that “allowing physicians to participate in assisted suicide would cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks.” The AMA advocates that multidisciplinary interventions be sought, including specialty consultation, hospice care, pastoral support, family counseling, emotional support, comfort care, and pain control.

**Coercion**

Many patients who request physician-assisted suicide are coerced or pressured by family members. Some patients believe they will be a “burden” on their families. There have been documented accounts of individuals committing suicide under pressure and/or duress from family members, friends, and/or suicide advocates present at the ingestion of lethal drugs. In 2010, over one-fourth (¼) of patients who died after ingesting a lethal dose of medicine in Oregon and Washington did so because, at least in part, they did not want to be a “burden” on family members, raising the concern that patients were pushed into suicide.

The “Death with Dignity Act” in Oregon provides an example of how this coercion is embedded in the state’s law. While the Act requires two witnesses at the time of a request for physician-assisted suicide, one of those witnesses can be a relative who stands to inherit from the patient, and the second witness can simply be a friend of that relative. The witness requirement, therefore, does not adequately protect against coercion.

Terminally ill patients also face a form of coercion from health insurance companies and other healthcare payers who provide coverage for suicide assistance, but not for treatment of disease or palliative care. This poses a significant threat to vulnerable persons who may not have adequate access to medical care. Clearly, a lack of options may effectively pressure patients into assisted suicide.
For example, in 2008, Barbara Wagner was denied coverage under her Oregon state health plan for medication that would treat her cancer and extend her life; instead, the state health plan offered to pay for the cost-effective option of ending her life by physician-assisted suicide.24

The Elderly

Physician-assisted suicide can be the ultimate manifestation of elder abuse. The National Center on Elder Abuse estimates that one to two million Americans aged 65 or older “have been injured, exploited, or otherwise mistreated by someone on whom they depended for care or protection.25 Too often, the physicians and family members to whom a terminally ill patient looks for support and protection are the same ones counseling that suicide may be the best option for the patient. Facing deteriorating health and increasing age, the elderly are at a greater risk of suicide than any other age group.26

Physician-assisted suicide greatly increases the risk of elder abuse and suicide among the elderly by creating yet another path of abuse against older individuals—abuse which is often subtle and extremely difficult to detect. In fact, legalized physician-assisted suicide may hide abuse of elderly and disabled Americans by providing complete liability protection for doctors and promoting secrecy.

For example, in Oregon, physicians providing physician-assisted suicide are self-reporting; death certificates are required to report a “natural” death (as opposed to a suicide); and there are no requirements that witnesses be present at the time of death. Further, Oregon collects information about the time and circumstances of patients’ deaths only when the physician or another healthcare provider is present at the time of death. Yet in 2010, physicians were present in only 25 of the deaths27—meaning that information on over 60 percent of the patients’ deaths is unknown. This creates unacceptable gaps in Oregon’s data. Further, a publication of the AMA has reported that the Oregon Department of Human Services “has no regulatory authority or resources to ensure compliance with the law.”28

The Disabled and Other Vulnerable Americans

Additionally, none of the reasons frequently cited by patients requesting physician-assisted suicide—a fear of loss of autonomy, a fear of loss of dignity, and a decreasing ability to participate in activities that make life enjoyable29—are unique to terminally ill patients. For example, a person left paralyzed after an accident or illness could also use these reasons to claim a “need” or a “right” to physician-assisted suicide.

Ultimately, if our laws embrace physician-assisted suicide, it will be difficult, if not impossible, to limit physician-assisted suicide to “competent, terminally ill patients.” Individuals who are not competent, who are not terminally ill (but potentially in more pain than a terminally ill patient), or who cannot self-administer lethal drugs will also seek the option of physician-assisted suicide, and no principled basis will exist to deny them this “right.” For instance, an Oregon Deputy Attorney General has opined that the Americans with Disabilities Act (ADA) would likely require the state to offer “reasonable accommodation” to “enable the disabled to avail themselves” of the state’s “Death with Dignity Act.”30

The Slippery Slope

Physician-assisted suicide and euthanasia have been legal in the Netherlands and Belgium for years. Yet instead of strengthening autonomy at the end of life, the legalization of physician-assisted suicide and euthanasia have proven to degrade and dehumanize patients, resulting in physicians routinely performing euthanasia without the consent of their patients. As the New York State Task Force on Life and the Law concluded, “[A]ssisted suicide and euthanasia are
closely linked; as experience in the Netherlands has shown, once assisted suicide is embraced, euthanasia will seem only a neater and simpler option to doctors and their patients.”

A 2003 report commissioned by the Dutch government demonstrated that more than half of euthanasia and assisted-suicide-related deaths were involuntary. At least half of Dutch physicians actively suggest euthanasia to their patients. Moreover, studies in 1997 and 2005 revealed that eight percent of infants who died in the Netherlands were euthanized by doctors.

The “slippery slope” toward euthanasia is also manifest in Belgium. A recent study published in the Canadian Medical Association Journal showed that out of 1,265 nurses questioned, 120 of them (almost ten percent) reported that their last patient was involuntarily euthanized. Only four percent of nurses involved in involuntary euthanasia reported that the patients had ever expressed their wishes about euthanasia. Most of the patients euthanized without consent were over 80 years old, reaffirming the fact that assisted suicide and euthanasia quickly lead to elder abuse. The researchers acknowledged that nurses are likely reluctant to report illegal acts (here, euthanizing a patient without physician involvement)—thus, it is possible that the number of nurses killing their patients without physician involvement is actually much higher than revealed by the study. The researchers concluded that “[i]t seems the current law… and a control system do not prevent nurses from administering life-ending drugs.” In other words, the purported “safeguards” championed by suicide advocates simply do not work.

Refusal or Withdrawal of Life-Sustaining Treatment Is Not Physician-Assisted Suicide

Despite the claims of euthanasia advocates to the contrary, there is a medically and court-recognized difference between the withdrawal of life-sustaining treatment, which allows death, and the use of lethal drugs or other means to directly cause death.

For instance, while the AMA opposes physician-assisted suicide, it finds it ethically acceptable to withdraw or withhold life-sustaining treatment at the request of a patient who possesses decision-making capacity. The New York State Task Force on Life and the Law also distinguished between assisted suicide and the withdrawal or refusal of life-sustaining treatment, concluding that the State’s interest in protecting patients and criminalizing physician-assisted suicide outweighed any claims of individual autonomy. In contrast, the Task Force found that the “constitutional balancing of individual and state interests yields an entirely different result for decisions to forgo life-sustaining treatment… [state] interests are best served by permitting the refusal of treatment in accord with appropriate guidelines, and individual decision making about treatment will ultimately promote the public good.”

Advance Planning and Related Documents

Advance planning can serve an important purpose. Without a healthcare proxy, patients will find that many healthcare providers and institutions will make important decisions for them, or a court may appoint a guardian to make those decisions who is unfamiliar with the patient and his or her wishes. Thus, advance directives are intended to allow a person to state his or her preferences regarding future healthcare decisions in the event he or she later becomes unable to do so. Such documents take several forms, such as living wills, durable powers of attorney for healthcare decisions, “informal statements of preferences,” and “Do Not Resuscitate” (DNR) orders.

Yet while advance directives are widely accepted and promoted in the United States, they are not always effective. One study listed the following reasons why advance directives are sometimes unhelpful: failure of patients to complete advance directives; failure to understand the form’s language and implications of their decisions; failure to revisit advance directives when “goals and preferences for care” change; proxy decision makers often do not understand patients’
wishes; frequent unavailability of advance directives when needed; and confusion among healthcare providers over when to apply the directives. The study concluded that “advance directives typically do not affect patient care.”

These challenges have accelerated the nationwide movement toward the newest advance directive option: the “Physician Orders for Life Sustaining Treatment” (POLST) form. Created in Oregon in 1991, it was designed “to convert patient preferences for life-sustaining treatment into immediately actionable medical orders” using standardized forms that provide specific treatment orders for cardio-pulmonary resuscitation, medical interventions, artificial nutrition, and antibiotics.

The advent of what is known as the TR Paradigm has shifted the timing of advance planning from when individuals are healthy to when they are potentially facing the end of life. It also directly involves healthcare providers in the planning—they execute the forms as medical orders. Further, POLST forms are followed by first responders, making a POLST form more like a DNR order than a living will, extending the “decisions beyond the administration of CPR in an emergency situation to the use of other life-sustaining measures in the course of long term care, including but not limited to the administration of antibiotics and ‘artificially administered nutrition.’”

Thus, as POLST forms gain traction across the country as the documents primarily relied upon by first responders and emergency room personnel, the withholding or withdrawal of antibiotics and/or nutrition and hydration may become as widely accepted as the withholding of CPR.

Notably, POLST forms may suffer from the same inadequacies as other advance planning documents, and POLST programs are also plagued by their own potential problems. Because a physician is directly involved in the execution of a POLST form, a patient may feel pressured by his or her physician’s perspective and physical presence to make certain designations. Additionally, end of life care is expensive, and the widespread use of POLST forms may increasingly be viewed as a legitimate or even expected cost-containment measure. Patients may be pressured into making decisions about end of life care based on financial concerns rather than what is in their best interests. Further, POLST may be harmful to people with disabilities but who are not at the end of life. A task force in Oregon has noted that persons with significant disabilities, developmental disabilities, and/or significant mental health conditions “have been subject to biases resulting in under-treatment and/or had their chronic health conditions mistaken as an illness [sic] nearing the end of life.”

While laws pertaining to advance planning are generally the purview of state legislatures, in recent years the federal government has become more involved in promoting the use of advance directives. For example, the “Patient Self-Determination Act” (PSDA) requires healthcare institutions that receive federal funding to ask patients if they have an advance directive, and to provide written information to patients informing them of their “rights under State law” to make decisions concerning medical care, “including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.”

Advance planning, when done voluntarily and with appropriate safeguards (e.g., appointing a durable power of attorney rather than relying upon a written document alone), can be helpful and life-affirming. However, states have the responsibility to ensure that life-sustaining care is not easily withheld or withdrawn from incapacitated patients, particularly when implementing a POLST program.
Surrogate Decision-Making and Refusal of Life-Sustaining Care

Over the last few decades, services that were once considered basic “humane care” have been redefined as “medical treatment,” and may, therefore, be rejected by individuals in their advance planning documents, or by surrogates when patients are incapacitated. For example, food and water supplied through a feeding tube has been redefined by some as “medical treatment,” with the term “artificial nutrition” coined to analogize the process to “medical treatment” rather than “humane care.”

Feedin\_harm||Dont\_treat\_Disease
| MEETS A BASIC HUMAN NEED | WITHOUT HYDRATION AND NUTRITION, A PERSON WILL DIE IN A SHORT PERIOD OF TIME REGARDLESS OF HIS OR HER MEDICAL PROGNOSIS.

Today, the American Medical Association (AMA) defines “life-sustaining treatment” as “includ[ing], but not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration” based upon the subjective goal of “patient autonomy.” Remarkably, the AMA notes that “[e]ven if the patient is not terminally ill or permanently unconscious, it is not unethical to discontinue all means of life-sustaining medical treatment in accordance with a proper substituted judgment or best interests analysis.”

Nonetheless, many states still treat nutrition and hydration as care that cannot be easily withdrawn, at least by surrogate decision-makers. For example, at least 23 states “impose explicit limitations on substituted consent to forgo life-sustaining treatments via their advance directive or default surrogate laws. These limitations either focus on all life-sustaining interventions . . . or on only artificial nutrition and hydration.” Additionally, in the absence of any form of advance directive, some states have a rebuttable presumption in favor of continuing food and water and restricting the powers of healthcare proxies or surrogates to remove artificial nutrition and hydration.

Such laws protecting patients from the arbitrary withdrawal of nutrition and hydration are constitutional. In *Cruzan v. Missouri Department of Health*, the United States Supreme Court held that the Constitution does not forbid states from requiring “clear and convincing evidence” of a patient’s wishes before the withdrawal of food and hydration. Thus, states may legitimately seek to safeguard patients through the imposition of heightened evidentiary requirements.

Ultimately, there is disagreement even among like-minded individuals over whether nutrition and hydration should be considered “medical treatment” that can be refused or withdrawn, and if so, under what circumstances and by whom. Feeding does not treat a disease; rather, it meets a basic human need. Without hydration and nutrition, a person will die in a short period of time regardless of his or her medical prognosis. Therefore, while the provision of “artificial” nutrition and hydration requires medical intervention, it should be provided unless a patient explicitly refuses it, its provision is excessively burdensome to the patient, or the patient cannot assimilate it. Further, when a patient has been diagnosed as being in a “persistent vegetative state” (PVS), he or she has not lost human dignity and is entitled to nutrition and hydration. States should maintain or enact statutes to ensure that nutrition and hydration are not withheld or withdrawn from an incapacitated patient not facing imminent death.

Futility Protocols and Patient Treatment Pending Transfer

“Futile care theory” is rapidly penetrating hospital care protocols. This theory provides that a doctor or institution may unilaterally withhold medical treatment because a healthcare provider believes that a patient’s quality of life is not worth continuing, or it is simply not cost effective to provide the treatment, despite the wishes of the patient or the patient’s family. “Futile care theory” contradicts “choice” and “patient autonomy.” It creates a risk that subjective devaluation of the worth of another’s life will lead to death by deliberate medical neglect. “Futile care theory,” if not checked by proper legal and ethical standards, could also undermine the equal dignity of
all human life, and allow doctors, hospitals, or even third-party payers (i.e., health insurers) to determine which lives are of sufficient “quality” to be worth caring for and sustaining.

Patients who desire to receive care that is refused by a medical professional or institution based on futility protocols benefit from state laws requiring life-sustaining treatment pending transfer of that patient to another provider. States that do not currently provide this protection should enact laws providing that, if a healthcare provider declines to follow a patient’s instructions, the provider must promptly inform the patient or proxy of that refusal, provide continuing care to the patient until a transfer can be effected, and make reasonable efforts to assist in the transfer of the patient to a willing healthcare provider or institution.

**Pain Management and Palliative Care**

Pain management and symptom control are critical issues for terminally ill patients. Yet, a 2004 study published in the *Journal of the American Medical Association* points out that nearly 25 percent of families report that their loved ones did not receive good care at the end of life, especially in managing pain. Both physicians and patients are often ill-informed when it comes to the breadth of possibilities in end of life care. Among the most-cited barriers is that doctors remain uneducated about palliative care and specifically about the most current techniques in proper pain management. Medical schools and nursing schools are generally not teaching palliative techniques to students, nor do textbooks and lectures address the use of pain medications. As a result, healthcare providers often enter their professions ill-equipped to manage chronic pain.

In the states, the organizations exerting the most influence on pain management law and policy are the state medical boards and hospital accreditation agencies. But while the medical profession is taking positive steps to improve its own practices in pain management, legislation can assist these efforts by encouraging pain-management education, protecting doctors from litigation for properly prescribing certain medications for pain management, and fostering better communication between doctors and patients about pain management and palliative care options, including palliative sedation (the controlled administration of sedatives to a terminally ill patient whose death is imminent to the minimum extent necessary to render intolerable pain, which cannot be otherwise relieved, tolerable. While palliative sedation may render a patient unconscious, that is not the intent. Properly administered, palliative sedation does not cause death).

However, palliative sedation should not be used when there are other means to alleviate suffering—and there usually are. With today’s modern medicine—advanced pain medications, antidepressants, anti-anxiety medications, implantable devices for pain management, improved surgical procedures, relaxation techniques, and counseling—“it is believed that nearly 98 percent of all pain in the terminally ill can be properly managed.”

If death is imminent, it is not ethically necessary to initiate artificial hydration for a sedated patient; however, ethical issues arise if sedation is continued for more than one or two days without hydration since the patient will become dehydrated, which can lead to death. Highlighting the concerns raised by palliative sedation without nutrition and hydration, are comments by Dr. Michael Irwin, a prominent member of the Voluntary Euthanasia Society in the UK. Irwin approves the role dehydration can play in causing death. He equated “terminal sedation” to “slow euthanasia.” Irwin writes that terminal sedation without hydration is tantamount to euthanasia “because the comatose patient often dies from the combination of two intentional acts by a doctor—the induction of unconsciousness, and the withholding of food and water.”

Because of these dangers, states should enact laws encouraging better education for doctors on the proper use of palliative sedation.
**KEY TERMS**

**ADVANCE DIRECTIVE** is a legal document expressing an individual’s healthcare decision preferences and is to be used in circumstances where he or she becomes incapacitated or unable to make those decisions. A living will is a declaration, signed and witnessed (or notarized), instructing physicians and healthcare providers as to what treatments to withhold, withdraw, or provide if the person is in a terminal condition and unable to make the decision to consent to or refuse certain medical treatment. A durable power of attorney for healthcare is a document, signed and witnessed (or notarized), designating an agent to make healthcare decisions for the person if the person is temporarily or permanently unable to do so. A combination advance directive provides a designated agent with specific instructions to follow in making healthcare decisions if the patient is unable to do so. An informal statement of preferences can be used to specify treatment preferences when a patient has not elected to create a formal, legal document.

**ASSISTED SUICIDE** is the act of suicide with the help of another party. Physician-assisted suicide specifically involves the help of a physician in performing the act of suicide. Such assistance usually entails the prescribing or dispensing of controlled substances in lethal quantities that hasten death.

**DO-NOT-RESUSCITATE (DNR) ORDER** is a medical order intended for use when death is imminent, and typically pertains to withholding cardiopulmonary resuscitation (CPR) when a patient is in a “terminal condition” or “permanently unconscious state” (i.e., no brain waves, no heartbeat).

**DOUBLE EFFECT** is a traditional doctrine justifying palliative sedation. The doctrine holds three requirements: 1) the action itself (e.g., sedation) is not morally wrong; 2) the secondary effect (e.g., unconsciousness) is not merely a means to accomplish the intended benefit (e.g., pain relief); and 3) proportionality exists between the intended effects and the unintended secondary effects.

**EUTHANASIA** involves the killing of one person by or with the physical assistance of another. Voluntary euthanasia is the ending of one life by another at the patient’s request. Non-voluntary euthanasia describes “a physician’s ending the life of a patient incapable of giving or refusing consent.” Involuntary euthanasia describes the termination of a competent patient’s life without his or her consent.

**FUTILE CARE THEORY** proposes that physicians or other healthcare providers may unilaterally disregard requests for life-sustaining treatment made by a patient or a patient’s family member if the quality of the patient’s life is deemed not “worth” living. Guidelines on how to deny requested life-sustaining care have been adopted and put into practice by some hospitals.

**HOSPICE** is “support and care for persons in the last phase of an incurable disease so that they may live as fully and comfortably as possible.”

**IMMINENT DEATH** is a prognosis of death within 14 days, or “days to weeks.”

**OPIOIDS** are “strong pain medications derived from opium, or synthesized to behave like opium derivatives. Examples of opioids include morphine, codeine, oxycodone, methadone, and fentanyl.”

**PALLIATIVE CARE** is “an approach [to medicine] that emphasizes pain relief, symptom control, and spiritual and emotional care for the dying and their families.” It generally entails the use of analgesic medications, such as
codeine and morphine. However, other pain relief techniques, such as physical therapy and neurosurgery, are also used.

**PALLIATIVE SEDATION** is the controlled administration of sedatives to a terminally ill patient whose death is imminent to the minimum extent necessary to render intolerable pain, which cannot be otherwise relieved, tolerable. While palliative sedation may render a patient unconscious, that is not the intent. Properly administered, palliative sedation does not cause death. The National Hospice and Palliative Care Organization (NHPCO) issued a statement supporting the option of palliative sedation delivered by “highly trained healthcare professionals” for “the small number of imminently dying patients whose suffering is intolerable and refractory.

**PERSISTENT VEGETATIVE STATE (PSV)** is the clinical diagnosis of a condition in which an individual has lost cognitive neurological function and awareness of his or her surroundings with certain characteristics of maintaining sleep-wake cycles, responding to stimulation in only a reflexive way, and showing no evidence of meaningful response to the environment.

**PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)** are immediately actionable medical orders that provide “specific treatment orders for cardiopulmonary resuscitation, medical interventions, artificial nutrition, and antibiotics.” The form is completed following conversations between healthcare providers and the patient and/or the patient’s proxy, “in conjunction with any existing advance directive for incapacitated patients.” POLST are also known as Medical Orders for Life-Sustaining Treatment (MOLST), Physician Orders for Scope of Treatment (POST), Medical Orders for Scope of Treatment (MOST), or Clinician Orders for Life-Sustaining Treatment (COLST).

**PROPORTIONALITY** is a principle used to “argue that the benefits of any intervention should outweigh the burdens of that intervention....[I]nterventions with any risk of harm should be administered only to the degree necessary to confer the desired amount of therapeutic benefit.” Specifically, “[i]n palliative sedation, proportionality is used to argue that any level of sedation in excess of that required to render suffering tolerable as defined by the patient cannot be justified.”

**TERMINALLY ILL** means a patient is expected to live six months or less.
**Physician-Assisted Suicide**

**Myth:** If a physician prescribes or administers high doses of medication to relieve pain or other discomfort in a terminally ill patient and that action results in death, he or she will be criminally prosecuted.

**Fact:** If the death was not intended, such treatments are not murder or assisted suicide.

**Myth:** Allowing assisted suicide will not encourage the legalization of euthanasia. Safeguards can be put into place to ensure that physician-assisted suicide is only available for competent, terminally ill patients.

**Fact:** The tragic example of the Netherlands refutes this claim (see discussion in article above). Further, if physician-assisted suicide is accepted for the terminally ill without intractable pain, then those Americans with severe chronic pain who, unlike the terminally ill, must live with such severe pain for many years to come, would also seem to have a legitimate claim to physician-assisted suicide. Thus, it is reasonable to expect physician-assisted suicide to be made available to severe chronic pain sufferers, and then to non-severe chronic pain sufferers, and then to those suffering from psychological pain or distress, as has happened in the Netherlands. Arguably, allowing one group of patients to use physician-assisted suicide but denying it to another could be considered unconstitutional.

**Myth:** Physician-assisted suicide allows terminally ill patients a “choice” and preserves autonomy and dignity.

**Fact:** Physician-assisted suicide “will ultimately weaken the autonomy of patients at the end of life.” Not only is human dignity found in more than a healthy body and autonomous lifestyle, but “the dignity of human life itself precludes policies that would allow it to be disposed of so easily.” Additionally, many vulnerable patients are coerced into suicide because of familial pressures and a desire not to be a burden and often feel a need to justify their decisions to stay alive. This is not the essence of choice, autonomy, or human dignity.

**Myth:** To say that “the so-called right to die all too easily becomes a duty to die” is mere rhetoric.

**Fact:** After examining end of life issues for almost ten years, the non-partisan New York State Task Force on Life and the Law reached the conclusion that “the so-called right to die all too easily becomes a duty to die.” The group unanimously concluded that the dangers of physician-assisted suicide vastly exceed any possible benefits.

Moreover, the “duty to die” is demonstrated in Oregon, where the state actively promotes assisted suicide over continuing medical care. In just one month in 2008, at least two different terminally ill patients were denied treatment under the state health insurance plan, and were instead told that the state would pay for their suicides. The message was clear: “We won’t treat you, but we will help you die.”

**Myth:** The availability of physician-assisted suicide will not inhibit the availability of palliative care.

**Fact:** Palliative care actually “languishes as a consequence” of the easy availability of physician-assisted suicide and euthanasia. Physicians are likely to grant requests for physician-assisted suicide before all avenues of palliative care have been explored. In addition, physicians are not encouraged to better educate themselves on palliative care, and researchers spend less time looking for better palliative medications and techniques.
Nutrition and Hydration and Advance Planning

Myth: When food and hydration is withdrawn, the patient dies from an underlying disease or condition.

Fact: When food and hydration are withdrawn, the person may die from starvation and dehydration. If a patient is not in the process of dying, a deliberate decision to remove or withhold food and water is tantamount to euthanasia.

Myth: A persistent vegetative state (PVS) is a certain diagnosis and the person has no chance of recovery.

Fact: PVS is a clinical diagnosis based on subjective assessments from an attending physician. In many instances, patients will wake instantaneously without any warning within the first month of being in a persistent vegetative state. Regardless of a PVS patient’s potential for recovery, he or she is a person with dignity, is not “dying,” and, therefore, is entitled to humane care.

Pain Management and Palliative Care

Myth: Opioids pose a great risk for respiratory depression that hastens death, even when monitored carefully.

Fact: Where the pain is properly assessed and dosages are carefully monitored, the chances of causing an overdose in a suffering patient are extremely unlikely. “[E]mpirical studies have failed to show an association between increases in doses of sedatives during the last hours of life and decreases in survival. Therefore, when dosed appropriately to relieve specific symptoms, palliative medications do not appear to hasten death.” In fact, morphine use may prolong life by enabling a suffering patient to breathe more easily and effectively.

Myth: Pain is an unfortunate and untreatable consequence of certain illnesses.

Fact: More than 90 percent of cancer pain can be controlled with proper treatment and approximately 95 percent of all chronic pain in the terminally ill can be likewise controlled, commonly through use of opioids.

Myth: Palliative medications have unbearable side effects and may hasten death.

Fact: Fears about side effects and the hastening of death are unfounded. In fact, those patients with severe pain actually become tolerant of palliative medicines, minimizing side effects. There is also no evidence that pain medications hasten death if such medications are used correctly. In addition, doses can be increased to alleviate intensified pain as diseases progress.

Myth: Opioids may cause addiction, even in patients experiencing severe pain.

Fact: “[I]t is a fact that when narcotics are prescribed for the legitimate purpose of treating pain, they essentially never cause addiction. In studies of addiction with a total population of over 24,000 patients, only seven could be documented as having become totally addicted as a result of receiving opioids for pain relief.”
10. *Id.* at 32.
11. *Id.* at 26.


27. Oregon Death with Dignity Act Annual Report for Year 13, supra.

28. L. Prager, Details emerge on Oregon’s first assisted suicides, AMER. MED. NEWS (Sept. 7, 1998).

29. See Oregon Death with Dignity Act Annual Report for Year 13, supra.

30. See Correspondence of Deputy Attorney General David Schuman to state Senator Neil Bryant (Mar. 15, 1999).


35. E. Inghelbrecht et al., The role of nurses in physician-assisted deaths in Belgium, CAN. MED. ASS’N J. (June 15, 2010).


37. Task Force, supra, at 73

38. Id. at 74-75.

39. Vacco, 521 U.S. at 800-01, 808.


41. S.E. Hickman et al., The POLST (Physician Orders for Life-Sustaining Treatment) Paradigm to Improve End of life Care: Potential State Legal Barriers to Implementation, 36 J. L. MED. & ETHICS 119 (Spring 2008).

42. Id.

43. See L.G. Black, The Danger of POLST Orders: An Innovation on the DNR, ETHICS AND MEDICS 35.6 (June 2010) (citing L.R. Robley, POLST Sweeps the Nation, NURSING CRITICAL CARE 4.1, 19-20 (Jan. 2009)).


45. See M.M. Mahon, supra, at 801. The law also prohibits an institution from “condition[ing] the provision of care or otherwise discriminate[ing] against an individual based on whether or not the individual has executed an advance directive,” and requires the institution “to ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives at facilities of the provider or organization . . . and to provide (individually or with others) for education for staff and the community on issues concerning advance directives.” “The Patient Self Determination Act,” Pub. L. No. 101-508, §§ 4206, 4751, 104 Stat. 1388 (codified at 42 U.S.C. §§ 1395cc(f), 1396a(w) (1994)).


48. Id.

49. S.E. Hickman et al., supra, at 121.


52. M.J. Silveira et al., Patients’ Knowledge of Options at the End of Life: Ignorance in the Face of Death, 284 J.A.M.A. 2483 (2000) (“A national poll conducted by the American Medical Association in 1997 found that 40% of respondents did not know it is legal to give pain medicine that could have the additional effect of hastening death (double effect), and 35% were not familiar with the terms hospice or palliative care.”) (emphasis in original).

53. See, e.g., M.W. Rabow et al., End of life Care Content in 50 Textbooks from Multiple Specialties, 238 J.A.M.A. 771 (Feb. 2000) (“In general, students and physicians feel ill prepared to provide end of life care.”).

54. C.M. Scaduto, Terminal Sedation Can be Licit, ETHICS & MEDICs 35.6 (June 2010) (citing American Pain Foundation, End of Life (updated July 16, 2009)). See also T.W. Kirk & M.M. Mahon, National Hospice and Palliative Care Organization (NHPCO) Position Statement and Commentary on the Use of Palliative Sedation in Imminently Dying Terminally Ill Patients, 39 J. OF PAIN AND SYMPTOM MGT. 914, 915-16 (May 2010) (providing that the National Hospice and Palliative Care Organization (NHPCO) does not endorse the use of palliative sedation for “existential suffering” and stating that “[p]roperly administered, palliative sedation of patients who are imminently dying is not the proximate cause of patient death, nor is death a means to achieve symptom relief in palliative sedation.”).


56. Id.

57. G. Black, supra.


59. Task Force, supra, at 13 (emphasis added).

60. Id. at 92.

61. See W.J. Smith, supra, at 196-213.

62. Center to Advance Palliative Care Manual: How to Establish a Palliative Care Program (C. F. Von Gunten et al., eds. 2001).

63. T.W. Kirk & M.M. Mahon, supra, at 916.


70. T.W. Kirk & M.M. Mahon, supra, at 915 (defining “refractory suffering” as “suffering that ‘cannot be adequately controlled despite aggressive efforts to identify tolerable therapy that does not compromise consciousness’”).


72. S.E. Hickman et al., supra (emphasis added).

73. T.W. Kirk & M.M. Mahon, supra, at 917.

74. Id.

75. See, e.g., the story of “Netty Boomsma” in H. Hendin, supra, at 76-83. Few advocates of PAS argue that the right to physician-assisted suicide should be limited to the terminally ill. Task Force, supra, at 74 n.113.

76. E. Chevlen, The Limits of Prognostication, 35 DUQ. L. REV. 337, 348 (1996) (“If autonomy is the guiding principle and the determination of pain and suffering is so subjective, then any competent person... has the right to choose euthanasia.”) H. Hendin, supra, at 122. The New York State Task Force concluded that “it will be difficult, if not impossible, to contain the option to such a limited group.... [N]o principled basis will exist to deny [other patients] this right.” New York State Task Force on Life and the Law, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUtHANAsIA IN THE MEDICAL CONTEXT 5 (Supp. 1997) [hereinafter “Task Force Supp.”]. The Task Force explains that if the right to refuse medical treatment is not limited to the terminally ill, then physician-assisted suicide will not be limitable, either. Id. at 12-13

77. Id. at 18; see also Task Force, supra, at 134 (stating that while the “autonomy” of some patients may be extended, the autonomy of many others would be compromised with the legalization of physician-assisted suicide).

78. Task Force, supra, at 138.

79. See, e.g., H. Hendin, supra, at 50-56, 61, 128-32, 142.

80. Task Force, supra, at 95

81. Id. at 99

82. Id. at ix, 120

83. H. Hendin, supra, at 244.


85. See, e.g., H. Hendin, supra, at 15.

86. Id. at 318. See also J.E. Brody, Facing Up to the Inevitable: In Search of a Good Death, NEW YORK TIMES, Dec. 30, 2003, at F5 (according to Elizabeth Ford Pitorak, director of the Hospice Institute of Hospice of the Western Reserve of Cleveland, no evidence supports that such drugs hasten death); S.E.M. Buzzee, Comment, The Pain Relief Promotion Act: Congress’s Misguided Intervention into End of life, 70 U. CIN. L. REV. 217, 242 (2001); B. Lo & G. Rubenfeld, supra, at 1815; L. C. Kaldjian et al., Internists’ Attitudes Towards Terminal Sedation in End of Life Care, 30 J. MED. ETHICS 499 (2004) (“Although physiological concerns exist about the possibility that opioids and benzodiazepines may hasten death by suppressing respirations, there is a paucity of empirical data to support these concerns. . . . Even more provocative are suggestions that sedation toward the end of life may actually prolong life rather than hasten death, due to dampening of increased metabolic demands caused by pain and distress in patients who are fragile.”).

87. B. Lo & G. Rubenfeld, supra, at 1815.

88. R. Ryan, supra, at 318.


Laws Against Assisted Suicide

38 STATES criminalize assisted suicide: AK, AR, AZ, CA, CO, CT, DE, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MI, MN, MS, MO, NE, NH, NJ, NM, NY, ND, OK, PA, RI, SC, SD, TN, TX, VA, and WI.

SIX STATES prohibit assisted suicide under common law of crimes or judicial interpretation of homicide statutes: AL, MA, NC, OH, VT, and WV.

TWO STATES permit physician-assisted suicide: OR and WA.

THREE STATES and DISTRICT OF COLUMBIA have left the legal status of assisted suicide undetermined: DC, NV, UT, and WY.

ONE STATE permits physician-assisted suicide by recognizing a statutory “consent” defense for those “aiding” a suicide: MT.
Only **ONE STATE** has amended its medical school curriculum requirements to add instruction on pain management and end-of-life issues: CA.

**ONE STATE** requires annual training in pain recognition and management for nursing home staff: CT.

**FOUR STATES** formed advisory councils on pain management to make recommendations on medical school curricula, continuing education, and other guidelines for pain management: AR, MI, MO, and NM.

**ONE STATE** passed legislation encouraging licensing boards or individual physicians to pursue improving pain management education and treatment: NE.