

Live Free or Die Hard: Assisted Suicide in the United States¹

This IPRO report examines the parameters of existing assisted suicide programs in the United States.

Definitions

Assisted Suicide: The act of aiding a terminally ill patient in dying by prescription medications. In most legislation, assisted suicide is available to patients who have less than six months to live, who are 18 or older, and who are declared mentally competent.

Euthanasia: The act of “painlessly but deliberately causing the death of another who is suffering from an incurable, painful disease or condition.”² The most common form of euthanasia is lethal injection. This IPRO report will not explore euthanasia.

Death with Dignity or Physician-Assisted Death (PAD): Terminally ill and mentally competent patients can request a prescription to hasten their deaths. In addition to being mentally competent, patients must be able to self-administer and ingest the medication. A physician’s participation, however, must be voluntary; a physician may choose to abstain altogether.³

Mentally Competent: Able to understand the options at hand and the consequences of each of them. Patients who are mentally competent can make their own decisions regarding their own medical care while fully aware of the outcome it may yield.

Overview

The practice of assisted suicide has been debated, analyzed, and explored since the early 1990s. Oregon passed the Death with Dignity Act in 1994, which went into effect in 1997. While nationally the act of suicide is not legally forbidden, the legality of assisted suicide is ambiguous, and debates for and against the practice involve not only logistical and medical concerns but also ethical and moral concerns.

Arguments For

Respect for Autonomy: Individuals have a right to their autonomy, and thus to the planning of their own end-of-life stage.^{4, 5, 6, 7}

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²“Terminology.” *Death With Dignity*. Death With Dignity National Center. Web. 19 September 2011.

³ Ibid.

⁴ Pretzer, Michael. “Assisted Suicide: Should It Be Legal?” CNN Health. Turner Broadcasting System, Inc., 25 January 2000. Web. 19 September 2011.

⁵ Harris, D, Richard, B and Khanna, P. “Assisted Dying: The Ongoing Debate.” *Postgraduate Medical Journal* 82.970 (2006): 479-482. Web. 2 Oct. 2011.

⁶ Ersek, Mary. “The Continuing Challenge of Assisted Death.” *Journal of Hospice and Palliative Nursing* 6.1 (2004): n. pag. Web. 3 Oct. 2011.

⁷ “Physician Aid-in-Dying.” *Ethics in Medicine*. University of Washington School of Medicine. 25 Oct. 2010. Web. 3 Oct. 2011.

Justice: Some terminally ill patients may hasten their deaths by refusing medical treatments or by voluntarily stopping eating or drinking, so the choice to hasten death through prescribed medication is only fair.^{8,9}

Compassion: Hastened death may be a way to relieve unbearable suffering, which may include pain but which also includes “other physical, existential, social and psychological burdens such as the loss of independence, loss of sense of self, and functional capacities that some patients feel jeopardize their dignity.”^{10, 11, 12, 13, 14}

Honesty and Transparency: Legal or not, assisted deaths do occur, often in secret, so legalizing “Death with Dignity” type legislation would allow them to be documented and regimented. Such legalization would also allow doctors and patients to engage in an open discussion of PAD.^{15, 16, 17}

Arguments Against

Sanctity of Life: To many citizens, taking life under any circumstances conflicts with religious and moral beliefs. Included in this moral and religious argument is the idea of a “passive versus active” distinction, where a refusal of treatment is passive and justifiable, PAD requires a deliberate and active step to be taken and therefore is not justifiable.^{18, 19, 20, 21}

⁸ Pretzer, Michael. “Assisted Suicide: Should It Be Legal?” CNN Health. Turner Broadcasting System, Inc., 25 January 2000. Web. 19 September 2011.

⁹ “Physician Aid-in-Dying.” *Ethics in Medicine*. University of Washington School of Medicine. 25 Oct. 2010. Web. 3 Oct. 2011.

¹⁰ Pretzer, Michael. “Assisted Suicide: Should It Be Legal?” CNN Health. Turner Broadcasting System, Inc., 25 January 2000. Web. 19 September 2011.

¹¹ Harris, D, Richard, B and Khanna, P. “Assisted Dying: The Ongoing Debate.” *Postgraduate Medical Journal* 82.970 (2006): 479-482. Web. 2 Oct. 2011.

¹² Ersek, Mary. “The Continuing Challenge of Assisted Death.” *Journal of Hospice and Palliative Nursing* 6.1 (2004): n. pag. Web. 3 Oct. 2011.

¹³ “Physician Aid-in-Dying.” *Ethics in Medicine*. University of Washington School of Medicine. 25 Oct. 2010. Web. 3 Oct. 2011.

¹⁴ Ibid.

¹⁵ Pretzer, Michael. “Assisted Suicide: Should It Be Legal?” CNN Health. Turner Broadcasting System, Inc., 25 January 2000. Web. 19 September 2011.

¹⁶ Ersek, Mary. “The Continuing Challenge of Assisted Death.” *Journal of Hospice and Palliative Nursing* 6.1 (2004): n. pag. Web. 3 Oct. 2011.

¹⁷ “Physician Aid-in-Dying.” *Ethics in Medicine*. University of Washington School of Medicine. 25 Oct. 2010. Web. 3 Oct. 2011.

¹⁸ Pretzer, Michael. “Assisted Suicide: Should It Be Legal?” CNN Health. Turner Broadcasting System, Inc., 25 January 2000. Web. 19 September 2011.

¹⁹ Harris, D, Richard, B and Khanna, P. “Assisted Dying: The Ongoing Debate.” *Postgraduate Medical Journal* 82.970 (2006): 479-482. Web. 2 Oct. 2011.

²⁰ Ersek, Mary. “The Continuing Challenge of Assisted Death.” *Journal of Hospice and Palliative Nursing* 6.1 (2004): n. pag. Web. 3 Oct. 2011.

²¹ “Physician Aid-in-Dying.” *Ethics in Medicine*. University of Washington School of Medicine. 25 Oct. 2010. Web. 3 Oct. 2011.

Potential for Abuse: There are many fears that vulnerable populations, such as those “lacking access to quality care and support” may be pressured into pursuing PAD. There are also fears that PAD will be used by families and health care providers as a cost containment strategy.^{22, 23, 24, 25}

Professional Integrity: According to historical ethical traditions in medicine (such as the Hippocratic oath), taking life, even if the patient requests that act, is a break in ethics.^{26, 27, 28}

Fallibility of the Profession: The public may lose confidence in the medical profession if it becomes a routine part of a physician’s job to help people kill themselves. Furthermore, sometimes physicians are wrong about estimating how much time a patient has left, therefore leading to the potential for unnecessary deaths, thus lessening the reliability of professionals who “rush” death.^{29, 30, 31}

Scholarly Studies

Attitudes Towards PAD and Vulnerable Demographics

In a study published in the *Journal of the American Medical Association* in 2000, authors found that there are various factors that significantly lessen or heighten a patient’s interest in and subsequent use of PAD. Out of the 988 terminally ill patients that were surveyed, and of those, 60 percent supported euthanasia or PAD in a hypothetical situation. However, 11 percent seriously considered euthanasia or PAD as an option for themselves. The factors most associated with being less likely to consider euthanasia or PAD were “feeling appreciated,” “being aged 65 years or older,” and “being African American.” The factors most associated with being more likely to consider euthanasia or PAD were “depressive symptoms,” “substantial caregiving needs,” and “pain.”³²

Another study published in 2007 focused more narrowly on vulnerable groups and their rates of PAD. Some vulnerable groups identified in the study were the elderly, the poor, women, minorities,

²² Pretzer, Michael. “Assisted Suicide: Should It Be Legal?” CNN Health. Turner Broadcasting System, Inc., 25 January 2000. Web. 19 September 2011.

²³ Harris, D, Richard, B and Khanna, P. “Assisted Dying: The Ongoing Debate.” *Postgraduate Medical Journal* 82.970 (2006): 479-482. Web. 2 Oct. 2011.

²⁴ Ersek, Mary. “The Continuing Challenge of Assisted Death.” *Journal of Hospice and Palliative Nursing* 6.1 (2004): n. pag. Web. 3 Oct. 2011.

²⁵ “Physician Aid-in-Dying.” *Ethics in Medicine*. University of Washington School of Medicine. 25 Oct. 2010. Web. 3 Oct. 2011.

²⁶ Pretzer, Michael. “Assisted Suicide: Should It Be Legal?” CNN Health. Turner Broadcasting System, Inc., 25 January 2000. Web. 19 September 2011.

²⁷ Ersek, Mary. “The Continuing Challenge of Assisted Death.” *Journal of Hospice and Palliative Nursing* 6.1 (2004): n. pag. Web. 3 Oct. 2011.

²⁸ “Physician Aid-in-Dying.” *Ethics in Medicine*. University of Washington School of Medicine. 25 Oct. 2010. Web. 3 Oct. 2011.

²⁹ Pretzer, Michael. “Assisted Suicide: Should It Be Legal?” CNN Health. Turner Broadcasting System, Inc., 25 January 2000. Web. 19 September 2011.

³⁰ Harris, D, Richard, B and Khanna, P. “Assisted Dying: The Ongoing Debate.” *Postgraduate Medical Journal* 82.970 (2006): 479-482. Web. 2 Oct. 2011.

³¹ “Physician Aid-in-Dying.” *Ethics in Medicine*. University of Washington School of Medicine. 25 Oct. 2010. Web. 3 Oct. 2011.

³² Emanuel, Ezekiel J., Fairclough, Diane L., and Emanuel, Linda L. “Attitudes and Desires Related to Euthanasia and Physician-Assisted Suicide Among Terminally Ill Patients and Their Caregivers.” *Journal of the American Medical Association* 284.19 (2000): 2460-2468. Web. 3 Oct. 2011.

the uninsured, minors, the chronically ill, the less educated, and psychiatric patients. This study, conducted using the *Death With Dignity* legislation in Oregon and the Netherlands “found that legalizing physician-assisted suicide...did not result in a disproportionate number of deaths among” these “vulnerable” groups. Of the groups examined, “only AIDS patients used doctor-assisted suicides at elevated rates.”³³ Conclusions from the study include the fact that “[t]hose who received physician-assisted dying in the jurisdictions studied appeared to enjoy comparative social, economic, educational, professional and other privileges.”³⁴ In fact, other studies have found that in Oregon “people who have chosen assisted dying are generally younger, with above average educational attainment, higher socioeconomic class, and are not motivated by poor social support.”³⁵

*Economic Benefits*³⁶

Considering the great cost of palliative care it sometimes takes to keep a terminally ill patient alive, it would follow that PAD could have considerable economic benefits concerning a cutback in the costs of keeping a terminally ill patient alive. However, an article published in 1998 in the *New England Journal of Medicine* found that while the economic benefits have the potential for being great, in practice these benefits are not realized due to the fact that a very small number of terminally ill patients actually chose to go through with PAD. The article goes on to identify six factors that would lead to an overestimation of economic costs and benefits of assisted suicide.

At the end of the article, the authors identify that when considering the rate of PAD, the average amount (4 weeks) of life forgone, and the medical costs in the last month of life for each patient, the most reasonable estimate for savings from PAD would be approximately \$627 million (in 1995 dollars). This is “less than 0.07 percent of total U.S. health care expenditures.” However, the authors emphasize that while “the costs of savings to the United States and most managed-care plans are likely to be small, it is important to recognize that the savings to specific terminally ill patients and their families could be substantial” in regards to families with little or no health insurance (and even to those that do have health insurance).

State Action

Existing Action

*Oregon*³⁷

In 1994, Oregon voters passed the first *Death with Dignity Act* in the United States. After a series of challenges, the law went into effect in 1997. Under the law, patients must meet four requirements in order to request a physician-assisted death.³⁸

³³ “Doctor-Aided Suicide: No Slippery Slope, Study Finds.” *ScienceDaily*. 29 Sept. 2007. Web. 3 Oct. 2011.

³⁴ Battin, Margaret. “Legal physician-assisted dying in Oregon and the Netherlands.” 10 July 2007. <http://jme.bmj.com/content/33/10/591.abstract>

³⁵ Harris, D, Richard, B and Khanna, P. “Assisted Dying: The Ongoing Debate.” *Postgraduate Medical Journal* 82.970 (2006): 479-482. Web. 2 Oct. 2011.

³⁶ Emanuel, Ezekiel J. and Battin, Margaret P. “What Are the Potential Cost Savings from Legalizing Physician-Assisted Suicide?” *The New England Journal of Medicine* 339.3 (1998): 167-172. Web. 3 Oct. 2011.

³⁷ “Frequently Asked Questions.” *Death With Dignity Act*. Oregon Health Authority. Web. 19 September 2011.

³⁸ Patients must be: 18 years or older; an Oregon resident; capable of making and communicating health conditions himself or herself; and diagnosed with a terminal illness that will lead to death within six months.

The Death with Dignity Act did not establish a state assisted suicide program; patients wishing to pursue death with dignity do not apply directly to Oregon. Instead, qualified patients and licensed physicians perform the suicide on an individual basis. Lawmakers in Oregon have taken great care to include safeguards that ensure that both the participating patients and physicians do so on the basis of their own personal decisions. Patients cannot be forced into assisted suicide, and family members cannot request assisted suicide on behalf of a patient. Patients must articulate their desire for assisted suicide themselves. In addition, a physician may refuse to participate, and it is up to the patient to locate a physician who will prescribe the medicine used to hasten death. The patient must self-administer the medication, though the prescribing physician may be present.

For privacy and security reasons, Oregon does not keep a list of physicians who will participate in the act. Oregon does publish annual reports that include statistics and details about:

- how many people request the medication;
- how many people ingest the medication;
- how many people die because of the medication;
- how many people die because of their underlying illness.

Oregon also keeps records of who is requesting assisted suicide, not in terms of personal identity but in terms of age, race, income level, education level.

Washington

In 2008, Washington passed The Washington Death with Dignity Act (initiative 100). Having been based on the Oregon legislation, this law held similar provisions for the requirements for the patient and attending physicians.^{39, 40}

Among patients who voluntarily participated, their largest end of life concern was that of the loss of autonomy. Of those who participated in 2009 and 2010, the percentage of patients whose underlying illness was cancer, was 79 and 78 respectively.⁴¹

Montana

In 2009, the Montana Supreme Court ruled that a doctor who prescribes lethal medication to a willing terminally ill patient who administers the medication himself or herself cannot be held liable for criminal homicide under Montana Law. In a four to three ruling, the court claimed there was “nothing in Montana Supreme Court precedent or Montana statutes indicating that physician aid in dying is against public policy.”^{42, 43}

³⁹ Initiative 100 required the patient to: be a Washington resident; be 18 years or older; have made the request voluntarily; be terminally ill with less than six months to live; be informed of all other options (hospice and palliative care); have been verified by two physicians as having the capacity to make such decisions; and have made two written requests and one oral request before the prescription of medication.

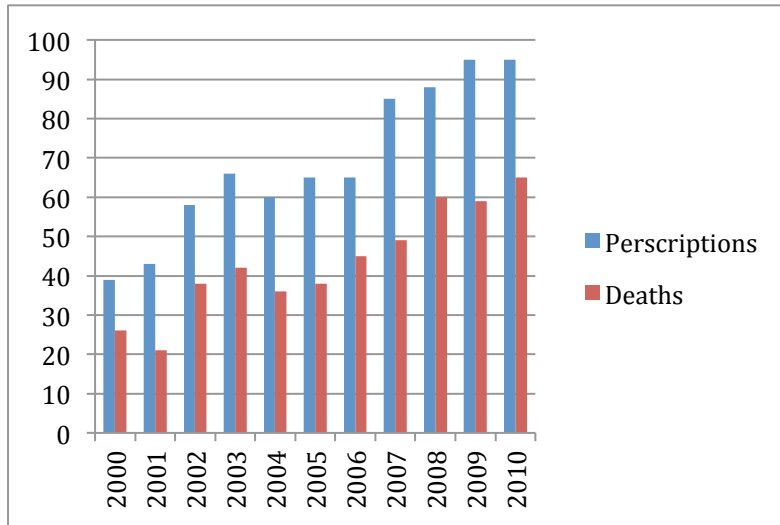
⁴⁰ Initiative Measure no. 1000. “The Washington Death With Dignity Act” 24 January 2008.
<http://www.secstate.wa.gov/elections/initiatives/text/i1000.pdf>

⁴¹ Washington State Department of Health. “Death With Dignity Act Report.” 2010.
<http://www.doh.wa.gov/dwda/forms/DWDA2010.pdf>

⁴² Johnson, Kirk. “Montana Ruling Bolsters Doctor-Assisted Suicide.” *New York Times* 31 December 2009. Web. 19 Sept. 2011

This ruling does not legalize physician-assisted suicide because it sidestepped the question of constitutionality. It rather says there is no basis for prosecuting a doctor who aids a patient in dying.⁴⁴

Figure 1⁴⁵
Ending-of-Life medications Prescribed and Number of Deaths
as recorded since Oregon's Death with Dignity Act beginning in 2000.



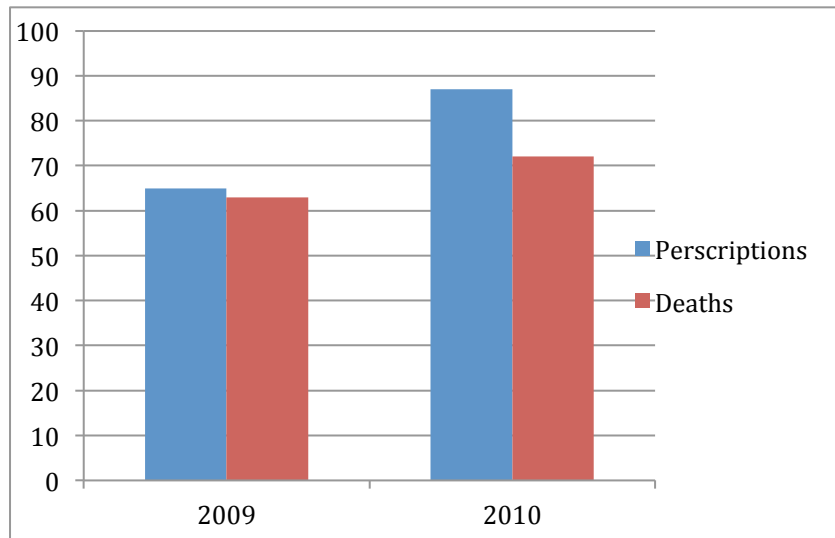
⁴³ Knicherbocker, Brad. "Montana Becomes Third State to Legalize Physician-Assisted Suicide." *The Christian Science Monitor* 2 January 2010. Web. 19 Sept. 2011

⁴⁴ O'Reilly, Kevin B. "Physician-Assisted Suicide Legal in Montana, Court Rules." *American Medical News*. American Medical Association, 18 January 2010. Web. 19 Sept. 2011.

⁴⁵ Oregon Public Health. "Oregon's Death with Dignity Act" 2010.

<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year13.pdf>

Figure 2⁴⁶
Ending-of-Life medications Prescribed and Number of Deaths
as recorded since Washington's Death with Dignity Act



Note

Figures 1 and 2 illustrate the disparity between the number of prescriptions written for the ending of life for a terminally ill patient and the number of deaths by those prescriptions over the course of the programs in Oregon and Washington. Montana has not legislated physician-assisted suicides legally, so records are not disclosed and do not appear in this report.

This report was prepared in October 2011 by the Iowa Policy Research Organization (IPRO), a nonpartisan public policy undergraduate research group at the University of Iowa. For additional research on this or other issues, please visit our website at <http://www.uiowa.edu/~ipro/> or contact us at rene-rocha@uiowa.edu.

⁴⁶ Washington State Department of Health. "Death With Dignity Act Report." 2010. <http://www.doh.wa.gov/dwda/forms/DWDA2010.pdf>