

BACKGROUND BRIEF

DEATH WITH DIGNITY—WHAT WE FIGHT FOR

Death with Dignity's mission focuses on ensuring that all people with a terminal illness have a range of end-of-life options available to them. The paradoxical nature of our current medical system means that people with incurable diseases are living longer than ever before, but also, experience more unnecessary suffering at the end of life. It is undeniable. And, it's unacceptable. We work to provide people with the freedom of choice in alleviating their suffering.

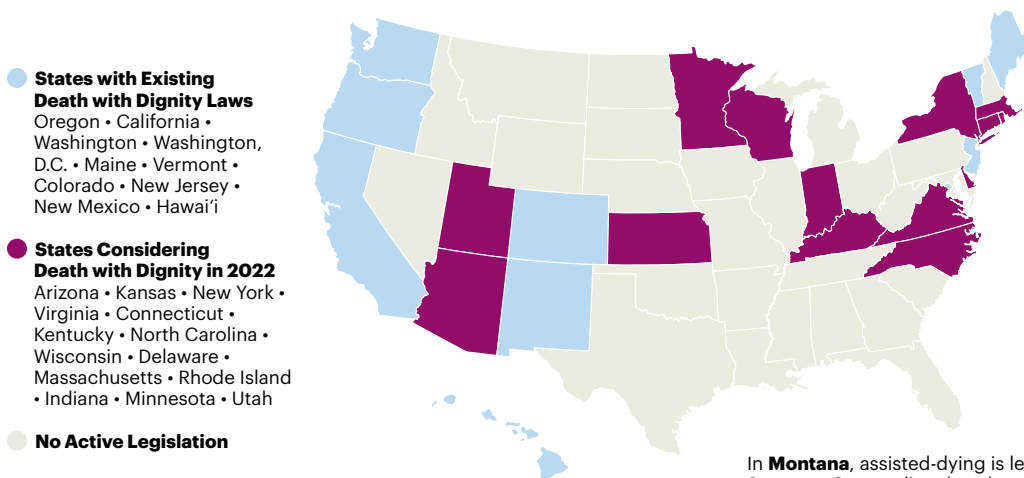
WHAT IS DEATH WITH DIGNITY?

Death with Dignity is an end-of-life option, governed by state legislation, that allows certain qualified people at the end stages of a terminal illness to voluntarily and legally request and receive prescription medication from their health care provider to hasten death in a peaceful, humane, and dignified manner. A patient must be deemed mentally competent, can stop the process at any time, and may choose to never fill the prescription or ingest the medication.

DEATH WITH DIGNITY HAS STRONG SUPPORT

Oregon became the first state in the nation to pass a Death with Dignity law in 1994. Since then, nine jurisdictions have passed laws on this model, and many states are continuing to fight for Death with Dignity each year. Proven safe, effective, and above all, meaningful, the Oregon Death with Dignity Act works exactly as intended, without fail.

WHERE IS DEATH WITH DIGNITY LEGAL?



In **Montana**, assisted-dying is legal by State Supreme Court ruling, but they do not have an existing Death with Dignity law.

What is Death with Dignity NOT?

Death with Dignity is NOT Euthanasia, Suicide, or Assisted Suicide. Death with Dignity laws involve the use of prescribed medication, not lethal injection, to hasten dying for individuals with terminal illness. Patients must self-administer the medication.

Death with Dignity is NOT an option for patients with Alzheimer's or similar conditions. Only a licensed health care provider can determine whether a patient qualifies for Death with Dignity, however, patients with Alzheimer's or a similar condition, where they no longer have the ability to make and communicate their own health care decisions, would not qualify, as the laws require that a patient be mentally competent, as well as terminally ill, at the time of request.

Death with Dignity is NOT an option for all people with terminal illness. To qualify for Death with Dignity, a patient must meet ALL criteria of the law, without exception. For example, a patient with COVID-19, who may be confirmed terminally ill, would likely no longer be conscious and/or able to self-administer the medication without assistance, deeming them ineligible for this option.

Death with Dignity is NOT an option that can be requested in an advance directive. Death with Dignity can only be requested by the patient, meaning that a patient cannot designate Death with Dignity in an advance directive or other legal document, for a proxy to carry out the process on their behalf.

HOW DEATH WITH DIGNITY LAWS WORK

Death with Dignity laws allow qualified patients to have autonomy over their deaths. No one qualifies for Death with Dignity solely on the basis of age or disability.

To qualify for Death with Dignity, the patient must be all of the following:

- An adult in a state with an existing Death with Dignity law (as confirmed by the prescribing health care provider).
- Capable of making and communicating their own health decisions.
- Diagnosed with a terminal illness that will lead to death within six months, as confirmed by two qualified health care providers.
- Capable of self-administering and ingesting medications.

Patients who think they qualify for Death with Dignity work directly with their health care provider, and do not apply through our organization, their state health departments, or other entities. It is up to eligible patients and licensed health care providers to implement Death with Dignity on an individual, case-by-case basis.

The process for accessing Death with Dignity laws (time frames vary slightly by state):

- 1. First Oral Request:** Patient requests medication under their state's Death with Dignity law to their licensed health care provider, who will confirm whether the patient qualifies and has the mental capacity to make their own health decisions. The health care provider must also inform the patient of alternative treatments and request the patient's next-of-kin be informed. A second consulting health care provider then must confirm the diagnosis, prognosis, and mental competence. A mental health evaluation may be ordered at this time if either health care provider feels the patient has impaired judgment (some states require the evaluation).
- 2. First Waiting Period (range dependant on state):** If the oral request is authorized, the patient must wait for the allotted waiting period, per their state's requirements, ranging from 2-20 days. In some states, this waiting period may be waived if the patient is likely to die within the waiting period time frame.
- 3. Second Oral Request:** Patient can make the second oral request after the first waiting period is completed.
- 4. Written Request:** In addition to both oral requests, a qualified patient must submit their request in writing, any time after the first oral request, which must be witnessed by two individuals.
- 5. Second Waiting Period (if mandated by state law):** In some states, the health care provider must wait for an additional time frame from the time of receiving the written request to writing the prescription.
- 6. Prescription:** After completing all steps, the prescribing health care provider will write the prescription.

Every Death with Dignity law has been designed with numerous safeguards, to protect patients from abuse and coercion. These include:

- Patients must meet stringent eligibility requirements, with no exceptions.
- Only the patient may request the medications.
- The written request must be witnessed by two people, attesting they believe the patient is capable, acting voluntarily, and is not being coerced. Additional guidelines exist about who can witness, to further protect the patient from coercion or abuse.
- The patient can rescind the request for Death with Dignity at any time.
- Two licensed health care providers (type of provider varies slightly by state, but must be certified to prescribe medications) must confirm the patient's diagnosis.
- In states that do not require mental health evaluations, if either health care provider is concerned about the patient's mental state, they must refer the patient for a mental health evaluation. Medications cannot be prescribed until the patient is confirmed as mentally capable.
- The process must stop immediately if there exists any suspicion or evidence of coercion.
- The licensed health care providers must comply with strict state reporting requirements. Each state's Board of Medical Examiners and Board of Pharmacy Examiners monitor for law compliance, to further protect patients, family members, and health care providers from criminal prosecution or abuse. Any criminal prosecution would be handled by the district attorney.
- Any illegal or ethically questionable activity conducted outside of Death with Dignity laws would be subject to other state statutes.

KEY TERMS

To avoid any confusion about appropriate terminology, here is a list of key terms related to the Death with Dignity movement and end-of-life care:

Assisted Death: A legal option in states with Death with Dignity laws, which permits mentally competent adult patients with terminal illness to request a prescription for life-ending medications from their physician. The patient must self-administer and ingest the medication without assistance, and can forgo the process at any point.

DNR or DNI: DNR (Do Not Resuscitate) is a specific physician order that means if a patient goes into cardiac arrest, no measures to restart the heart, including CPR or electric shock, will be performed. DNI (Do Not Intubate) is a similar order that means if a patient is under respiratory arrest, a breathing tube will not be placed. A patient may have one or both of these orders in their medical chart and can be changed at any time. Comfort care will be provided if these orders exist, but medical interventions are legally required to be performed if they do not.

KEY TERMS, CONT.

Hospice: A type of care that seeks to optimize quality of life for terminally ill individuals within six months of death who decline further life-sustaining treatments, while neither hindering nor hastening the dying process. Such care can be provided in a licensed facility or in a patient's home. Most people who use aid-in-dying laws are on hospice.

Life-Sustaining Treatment: Any treatment, that if discontinued, will result in death. Examples include feeding tubes, dialysis, ventilators, or antibiotics.

Living Will/Advance Directive: Documents that allow a patient to document their wishes concerning medical treatments at end of life.

Palliative Care: This medical speciality is often associated with hospice; however, it can also be used independently and alongside curative treatments. Palliative care (sometimes called comfort care) is available in every state, appropriate for anyone at any stage of life suffering with a debilitating illness—terminal or not—and focuses on pain management and providing comfort.

POLST, MOLST, or POST: POLST (Physician Orders for Life-Sustaining Treatment), also known as MOLST (Medical Orders for Life-Sustaining Treatment), or POST (Physician Orders for Scope of Treatment) is an end-of-life planning tool, initiated when a patient's doctor expects the patient to live a year or less. It contains instructions for medical treatments for specific health-related emergencies or conditions and is stored in a patient's medical chart.

Terminal (or Palliative) Sedation: Generally practiced during the final days or hours of a dying patient's life, this coma-like state is medically induced through medication when symptoms such as pain, nausea, breathlessness, or delirium cannot be controlled while the patient is conscious. Patients generally die from the sedation's secondary effects of dehydration or other intervening complications. This option is rarely used and requires a health care provider to have speciality knowledge.

Stopping or Not Starting Medical Treatment: For some people with terminal illness, aggressive medical treatment may not be helpful and may prolong the dying process without improving quality of life. Under certain circumstances, treatments can increase suffering, ruin the remaining quality of life, or even shorten life. Stopping treatment can be combined with hospice and palliative care or voluntarily stopping eating and drinking to shorten the dying process and reduce suffering.

Voluntarily Stopping Eating and Drinking (VSED): Declining food, liquids, and artificial feeding as a means of shortening the dying process.