



Death with Dignity

A Study by the League of Women Voters of Utah

January 2016

The League of Women Voters is a nonpartisan political organization that encourages informed and active participation in government, works to increase understanding of major public policy issues, and influences public policy through education and advocacy.

Study Committee

Vickie Samuelson, Chair

Tish Buroker
Carol Jenson
Jill Lesh
Sandy Peck
A.J. Schanfield
Liana Teteberg

Study Editors

Kathryn Fitzgerald
John O'Connell

Interviews

Margaret Pabst Battin Ph. D
Distinguished Professor of Philosophy and Adjunct Professor of Internal Medicine,
Division of Medical Ethics, University of Utah

Rebecca Chavez-Houck
Utah House of Representative, Chief Sponsor of the 2015 HB391 Death with Dignity Act

League of Women Voters of Utah
Death with Dignity State Study
Table of Contents

Purpose of This Study4

Historical Summary4

What Do the Death with Dignity Laws Allow?5

Which States Have Death with Dignity Laws?6

States With Pending Legislation7

What Are the Arguments for and Against Death with Dignity
Legislation?7

What Are the Impacts of End-of-Life Legislation?9

Positions of Key Medical Organizations11

Positions of Other Organizations13

Religious Positions14

Conclusion15

Appendix A: Historical Timeline17

Appendix B: Glossary28

Bibliography30

Purpose of this Study

The purpose of this study is to educate the League of Women Voters of Utah (LWVUT) membership and come to consensus on Death with Dignity legislation. Currently there is no League of Women Voters of the United States (LWVUS) position on Death with Dignity.

Death with Dignity legislation has become of increasing public interest and concern. Currently five (5) states have legislation allowing physician aid in dying - Oregon, Washington, Montana, Vermont and California. Additionally, interpretation of physician assisted dying legal standing is under review in New Mexico.

To date, 19 other states and Washington, D.C., have considered Death with Dignity legislation. However, currently, in 45 states assisted “suicide” is illegal: 38 states have laws prohibiting assisted suicide; three (3) states (Alabama, Massachusetts, West Virginia and D.C. prohibit assisted “suicide” by common law and four (4) states (Nevada, North Carolina, Utah and Wyoming) have no specific laws regarding assisted “suicide”.¹

The League became especially interested in this issue after House Bill 391 was introduced in the Utah Legislature in January 2015 by Representative Rebecca Chavez-Houck. The bill was referred to interim committee for further study and was expected be reintroduced in the 2016 general session of the legislature.

It is anticipated that this issue will remain on legislative agendas not just in Utah, but many other states as well.

Historical Summary

This section provides an historical summary of aid in dying in the United States, which provides a backdrop for today’s local and national discussion on the topic of “death with dignity”. A more detailed history of euthanasia and suicide in the Western World, including Greece and Rome and the Hippocratic Oath as well as Christians and Jews in the Middle Ages, can be found in Appendix A.

The common law approach of the early American Colonies considered self-murder “most unnatural”, thus not prohibiting suicide, but also not supporting it. Throughout the 1700s and 1800s until about 1870, because of an increase in religious fervor during the Great Awakening, assisted suicide was not supported, and in fact, outlawed in most states. The Field Penal Code, drafted in New York between 1857 and 1865, became the model for statutes in the western states. It prohibited aiding a suicide, specifically by furnishing another person with any deadly weapon or poisonous drug, knowing that the person intended to use it in taking his/her life. However, subsequent to the availability of morphine and other analgesics beginning in the early 1800s, public discussion and

¹ (<https://www.deathwithdignity.org/take-action>)

journal articles dealing with the issues of euthanasia and assisted suicide surged briefly until the early part of the 20th century.

Public support for euthanasia increased in 1915 when a Dr. Harry J. Haiselden led the charge of allowing badly deformed infants to die for the good of society. And during the hard times of the 1930's Depression, Americans began again talking about suicide and controlled dying. In 1937, public opinion polls indicated 45% of Americans favored mercy killing of infants born with permanent deformities or mental handicaps. Concomitantly, groups were founded and legislation was proposed in both England and the U.S. to advocate for patients' autonomy in deciding their own exit strategy.

World War II (WWII) eclipsed, but did not eliminate, the discussion of euthanasia. The Nazi use of involuntary euthanasia, especially the atrocities against the mentally ill and handicapped children, affected public perception of aid in dying in the United States, putting the euthanasia movement on the defensive.

Subsequent to WWII, national and international organizations made several attempts to allow euthanasia, but failed. The conversation continued, spearheaded by the Euthanasia Society of America, which was formed in 1962.

The distinction between active and passive euthanasia in 1967 was pivotal to the euthanasia movement. Medical advances such as respirators made it possible to extend life beyond consciousness; death was re-defined as 'irreversible coma' in 1968. The American Hospital Association adopted the "Patient's Bill of Rights" in 1973, which recognized a patient's right to refuse treatment. The Society for the Right to Die, formerly known as the Euthanasia Society of America, reenergized their campaign to legalize active euthanasia through the political process.

In 1976 the New Jersey Supreme Court ruled that Karen Quinlan, declared by doctors to be in a "persistent vegetative state," could be detached from her respirator. That year California became the first state to recognize living wills as legally binding documents that authorize the removal of life-sustaining treatment in the face of imminent death. Other states followed, and end-of-life directives became an increasingly common part of the medical landscape. In 2005 Terri Schiavo's feeding tube was removed after a long court battle. The subsequent argument that resonated in support of euthanasia was autonomy - the right of a person to choose how much suffering to tolerate and when to die.²

What Do Death with Dignity Laws Allow?

They all include qualifying criteria:

- a competent adult over the age of 18 can request a prescription to end his or her life only if diagnosed as terminally ill and likely to die within six months
- the request for a prescription from licensed physicians must be made both in writing and orally
- the individual must be able to self-administer the medication
- the individual must be of sound mind and capable of clear communication

² <http://www.motherjones.com/politics/2016/01/assisted-suicide-legalization-california-kevin-drum>

- the laws often require a series of requests and waiting periods to guard against abuse. Patients diagnosed with mental illness and people with disabilities are ineligible.

Which States Have Death with Dignity State Laws?

Five (5) states have laws that allow aid in dying.

(Information in this section was taken from healthcare.findlaw.com.)³

1. Oregon: November 08, 1994 (ORS 127.800-997)
Oregon has the distinction of passing the first **Death with Dignity Act** in the nation. The law was passed by voter initiative in 1994. An immediate attempt to repeal it delayed implementation until 1997, when a ballot measure attempting to repeal the law failed with 60 percent of voters opposing the repeal. Subsequently, the law was upheld by the U.S. Supreme Court in 2006.
2. Washington: November 04, 2008 (RCW 70.245)
Washington's **Death with Dignity Act**, based on the Oregon law, passed by voter initiative with 58 percent of the vote in 2008.
3. Montana: December 31, 2009
Montana recognized a terminally ill patient's right to use prescribed life-ending medications in a 2009 state Supreme Court decision, *Baxter v. State of Montana* - the only state to do so by judicial decision.⁴

The court ruled that Montana's **Rights of the Terminally Ill Act** shielded physicians from criminal liability for homicide (aiding or soliciting suicide) if they acted according to the end of life written requests of consenting, mentally competent, terminally ill patients who are at least 18 years old and able to self-administer the prescribed medication. The Court posited that while the state constitution did not guarantee the right to receive aid in dying, there is "nothing in Montana Supreme Court precedent or Montana state statutes indicating that physician aid in dying is against public policy."

The Montana legislature has introduced several bills to clarify the state Supreme Court's opinion, establish rules and procedures for assisted suicide, or make medical aid in dying a criminal offense, but none have passed.

4. Vermont: May 20, 2013 (S77)
In 2013, Vermont's **Patient Choice and Control at End of Life Act** was the first Death with Dignity Law to be passed by a state legislature instead of by voter initiative. It is based on the Oregon law and protects physicians, who follow the steps outlined in the Act, from liability.

³ <http://healthcare.findlaw.com/patient-rights/death-with-dignity-laws-by-state.html>

⁴ <https://www.compassionatechoices.org/userfiles/Montana-Supreme-Court-Opinion.pdf>

5. California: October 5, 2015

The **End of Life Option Act** (SB 128), signed by Governor Jerry Brown in 2015, is the latest Death with Dignity law. It is based on the Oregon law, but with the unique provision of sun setting in 10 years.

States with Pending Legislation

New Mexico: August 11, 2015

Currently New Mexico statutes continue to list physician-assisted suicide as a fourth-degree felony. The practice of allowed mentally competent, terminally ill patients to choose their own time to die with aid from a licensed physician had been made legal in early 2014, when the 2nd District Court in Albuquerque ruled that aid-in-dying is a fundamental liberty interest under the New Mexico Constitution. As in Montana, the ruling provided a defense for doctors who help eligible patients die, although it did not provide a regulatory framework. However, on August 11, 2015, a New Mexico appeals court reversed that ruling. The case has gone to the New Mexico Supreme Court, which heard oral arguments beginning Oct. 26, 2015, but had not reached decision at the time of this publication.⁵

Utah:

Representative Rebecca Chavez-Houck introduced **HB 391 Utah Death with Dignity Act** in the 2015 legislative session.⁶ This bill was fashioned after the Oregon law. It was sent to interim for study. A similar bill entitled **End of Life Options Act** is expected to be introduced in the 2016 legislative session.

What Are the Arguments for and Against Death with Dignity Legislation?

Margaret Pabst (Peggy) Battin, professor of philosophy and medical ethics at the University of Utah, has studied and written extensively about end-of-life issues. She has distilled the arguments for and against Death with Dignity legislation to their essential elements. The Pro and Con chart below is frequently seen in her publications and is reprinted with permission.

⁵ <http://krqe.com/2015/10/26/new-mexico-supreme-court-hears-assisted-suicide-case/>

⁶ le.utah.gov/v2015/bills/static/ab0391.html

The Debate	
Pro	Con
<i>The argument from autonomy, self-determination</i>	<i>The argument from the intrinsic wrongness of killing</i>
	<i>The argument concerning the integrity of the medical profession</i>
<i>The argument from mercy, or avoidance of pain and suffering</i>	<i>The argument concerning abuse: The risk of the “slippery slope”</i>

Courtesy of Margaret Battin, PhD

Pro Arguments

The argument for autonomy in end-of-life decision-making advocates for a person being able to determine how she/he lives and dies. Many individuals want to be involved in as many aspects of their end-of-life decisions as possible, including having the option of determining when he/she will die. Advocates for autonomy see no reason why they shouldn't have the right to die “on their own terms,” a phrase made famous by Bill Moyers in his 2000 PBS television mini-series on the end of life, “On Our Own Terms: Moyers on Dying.”

Relief from pain and suffering is the other primary argument for the legalization of Death with Dignity. One's quality of life is diminished by pain and suffering in various forms, including mental anguish, loss of physical capabilities and dignity. This argument is often advanced by people who, having personally witnessed the agonizing death of a friend or family member, do not want themselves or anyone else to suffer in a similar situation. Palliative care and hospice can be very effective in managing pain and other symptoms at the end of life, but these efforts are not effective in all cases, and common methods of pain control can have unwanted side effects like reduced cognition.

These two arguments, autonomy and relief from pain and suffering, can be viewed as the necessary criteria to safeguard against abuse. The patient must view accelerating death as the only acceptable way to alleviate his or her intolerable pain and suffering.

Con Arguments

Most people have a strong conviction about the wrongness of killing. If this conviction were extended to every life and death situation, regardless of circumstance, it would prohibit support of any assistance in dying, even when death is desired by a competent, terminally ill adult to alleviate pain and suffering. Furthermore, it would also prohibit capital punishment and killing in self-defense, in defense of innocent others, and in war.

It is also argued that Death with Dignity is suicide, and that suicide is intrinsically wrong. This argument is made particularly by religious groups. However, others argue that aid-in-dying and suicide are quite different matters, and all the Death with Dignity laws passed in the U.S. so far stipulate that such deaths are not to be construed as suicide for any legal or practical purpose, including insurance. Death certificates list the cause of death as the underlying terminal illness. On this view, aid-in-dying should be seen as the hastening of a death that was already in progress. The distinction between suicide and aid in dying can be distilled as follows: individuals choosing suicide do so because they no longer wish to live; those seeking aid in dying usually want very much to live but have come to realize that death is imminent and potentially wrought with pain and suffering.

Saving lives is ingrained in all healthcare professionals, from physicians and nurses to lab technicians. They are committed to healing and saving lives. Physicians take the Hippocratic Oath. Being asked to help a patient end his/her life could put the professional in a position of intense inner conflict.

The possibility that a Death with Dignity law opens the doors for potential abuse raises fears and strong objections. In some situations, it is claimed, family members may want to hasten the death of a sick relative in order to receive their inheritance, or end the cost and burden of care giving. Or a family who wants to be relieved of the stigma associated with having a disabled person might encourage this person to end their life, even though the person is mentally competent.

What Are the Impacts of End-of-Life Legislation?

To date nearly all information and data about impact on patients, physicians and the health care system are based on the Oregon Death with Dignity Law. Since Oregon's law went into effect in 1997, the number of people who have received a prescription (the drugs Secobarbital and Pentobarbital are commonly prescribed) has increased six-fold (from 24 per year to 155 per year) between 1998 and 2014. Likewise, the number of people who died as the result of taking the medication increased six-fold (from 16 per year to 105 per year) during the same time period. Consistently over this 16-year time frame, 60-68% of those receiving the prescription actually took the medication. Overall, 0.2% of all Oregon deaths were associated with the Death with Dignity law.

Typical Patients Who Received the Prescription

- were over age 65 (67.6%)
- had cancer (68.8%)
- were white (95.2%)
- were well educated (47.6% had baccalaureate degrees)
- died at home (89.5%)
- were enrolled in hospice (93%)
- had some form of health insurance (100%)

Reasons Given for Electing the End-of-Life Option

The reasons people have given for choosing the end-of-life option have been consistent:

- loss of autonomy (91.4%)
- decreasing ability to participate in activities that made life enjoyable (86.7%)
- loss of dignity (71.4%)⁷

Impact on Vulnerable Groups

A 10-year study showed no evidence that vulnerable populations were disproportionately impacted. Vulnerable groups include the elderly, women, the uninsured, people with low educational status, the poor, the physically disabled, minors, people with psychiatric illnesses, and racial/ethnic minority groups.⁸

Reviewing 15 years of data in the aggregate, 1,050 terminally ill patients have received prescribed medications, and 673 of these patients have ingested the prescribed medications to hasten their deaths, while 377 chose not to take the drug. Over 15 years, only two (2) percent of the people who used the law did not have insurance coverage. In 2012, excluding those few for which insurance status was unknown, all of the participants were covered by some form of insurance.⁹

Slippery Slope Effects

D.E. Lee in the Hastings Center Report concluded that there is no evidence of any slippery slope following enactment of the Oregon Death with Dignity Act.¹⁰

Anecdotally, when health care providers have diligently worked to alleviate patients' pain and suffering, the "need" for assistance via Death with Dignity has decreased rather than increased. Data are inconclusive at this time to determine the extent to which improving palliative care might change the number of requests for prescriptions allowing termination of one's life.

In testimony presented before U.S. Senate Judiciary Committee, Ann Jackson, Executive Director of the Oregon Hospice Association, noted that there had been no evidence of abuse under the Oregon law in its first eight years, and that violent suicide among hospice patients is almost nonexistent since the Act was implemented.¹¹

Impact on Oregon's Health Care Delivery System

While the causal relationship between the Death with Dignity Law and improved health care delivery is unclear, several obstacles to care for the terminally ill have been alleviated since 1997. For example, hospice programs have increased by 20%; large prepaid health plans have removed the cap on hospice benefits; and physician reimbursement for palliative care has increased. The hospice model now provides interdisciplinary teams who act as consultants on comfort care not only for terminally ill patients, but for others who have life-threatening illnesses.¹²

⁷ <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf>

⁸ Legal physician assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in "vulnerable" groups (2007) Battin, M.P., van der Heide, A., Ganzini, L., van der Wal, G., Onwuteaka-Philipsen, B.D. *Journal of Medical Ethics*. 33:591-597.

⁹ http://www.americanbar.org/publications/gp_solo/2013/july_august/twenty_years_living_the_oregon_death_dignity_act.html

¹⁰ "Physician assisted suicide: A conservative critique of intervention" (2003). Lee, D.E. *Hastings Center Report*, 33(1), 17-19.

Oregon's assisted suicide vote: The silver lining. (1996). Lee, M.A. & Tolle, S.W. *Annals of Internal Medicine*. 124(2), 267-269.

¹¹ http://judiciary.senate.gov/testimony.cfm?id=1916&wit_id=5378

¹² <http://www.medscape.com/features/slideshow/public/ethics2014-part1>

Findings from various sources conclude that physicians in Oregon have made efforts to improve their care for patients with terminal illnesses. They seem to have more conversations with patients about end-of-life care, especially about managing pain and suffering.¹³

Yet, according to an Institute of Medicine Report, released in late 2014, despite efforts to build hospice and palliative care programs across the country, dying in America has not become less painful since the last report in 2000. In addition, in that same time period, depression in the last year of life has increased by more than 26%.¹⁴

Impact on Physicians' Attitudes toward Physician Assisted Suicide

In a 1998 survey, 17,000 physicians were queried on their attitude toward aiding patients to end their lives. Fifty-four percent agreed that physician assisted suicide should be allowed, 31% opposed it and 15% said "it depends."

Oregon physicians, according to studies by Ganzini, et al, have a more favorable attitude toward legalized physician assisted suicide compared to other surveyed groups.¹⁵

Impact on Health Care Spending

The 1998 study also examined the economic impact of Death with Dignity Laws. The most reasonable estimate of savings was 0.07% of total U.S. health care expenditures or \$627 million. The study concluded that "Death with Dignity laws are not likely to save substantial amounts of money in absolute or relative terms, either for particular institutions or for the nation as a whole."¹⁶

Positions of Key Medical Organizations

American College of Physicians - American Society of Internal Medicine (ACP-ASIM)

Neither professional group supports the legalization of physician-assisted suicide. They believe legalization would undermine the physician-patient relationship and the trust necessary to sustain it, alter the medical profession's role in society, and endanger the value our society places on life. This is the case especially in the lives of disabled, incompetent, and vulnerable individuals. The ACP-ASIM remains thoroughly committed to improving palliative care for patients at the end of life.¹⁷

American Medical Association (AMA)

Physician assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

¹³ "Oregon physicians' attitudes about and experiences with end-of-life care since passage of the Oregon death with dignity act." (2001) Ganzini, L., Nelson, H.D., Lee, M.A., Kraemer, D.F., Schmidt, T.A. & Delorit, M.A. Journal of American Medical Association. 285.2363-2369.

¹⁴ <http://kaiserhealthnews.org/news/study-suffering-at-the-end-of-life-getting-worse-not-better.org>

¹⁵ "Physicians Experiences with the Oregon death with dignity act." (2000). Ganzini, L., Nelson, H.D., Schmidt, T.A., Kraemer, D.F., Delorit, M.A. & Lee, M.A. NEJM 342(8), 557-563.

¹⁶ "What are the potential cost savings from legalizing physician assisted suicide?" (1998). Emanuel, E.J., & Battin, M.P. The New England Journal of Medicine. (339), 167-172.

¹⁷ American College of Physicians-American Society of Internal Medicine (ACP-ASIM). (August 2001) Position Paper, Physician Assisted Suicide, P 209.

The AMA has concluded that 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.

Instead of participating in assisted suicide, physicians are urged to respond aggressively to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible and multidisciplinary interventions should be sought including specialty consultation, hospice care, pastoral support, family counseling, and other modalities. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication.¹⁸

American Medical Women's Association (AMWA)

The AMWA supports patient autonomy and the right of terminally ill patients to hasten death. AMWA also believes the physician should have the right to engage in physician assisted dying. In addition, the AMWA strongly supports the use of palliative care measures and hospice care for terminally ill patients."¹⁹

American Nurses Association (ANA)

Despite philosophical and legal arguments in favor of assisted suicide, it is the position of the ANA as specified in the Code that nurses participation in assisted suicide and euthanasia is strictly prohibited. Nurses are expected to remain informed and be cognizant of shifting moral landscapes, legislative activity, and ongoing debate related to assisted suicide and euthanasia. The ANA Center of Ethics and Human Rights is available to provide consultation to nurses who are confronted with these ethical dilemmas to assist them in upholding their professional responsibilities, despite the moral distress they may encounter when confronted with these situations".²⁰

American Public Health Association (APHA)

The American Public Health Association has long recognized patient rights to self-determination at the end of life and that for some terminally ill people, death can sometimes be preferable to any alternative. These rights include patients' ability to express their wishes in an advance directive, to appoint a surrogate to make care decisions when the patient is no longer able to do so, and to have these wishes honored by health care providers.²¹

A small fraction of dying people confront a dying process so prolonged and marked by such extreme suffering that they determine hastening impending death to be the best alternative. Many Americans believe that the option of death with dignity should be open to those facing a terminal illness marked by extreme suffering.

National Hospice & Palliative Care Organization (NHPCO)

¹⁸ McMurray, Richard J., MD, et al. (April 22, 1992). Decisions Near the End of Life. JAMA. 1992;267(16):2229-2233

¹⁹ American Medical Women's Association (AMWA). (2012). Position papers for 2012 aid in dying. <http://www.amwadocs.org>

²⁰ <http://www.aahpm.org/positions/default/suicide.html>

²¹ Patients Rights to Self Determination at the End of Life dated Oct.28 2008 Policy Number 20086

The NHPCO document, “Resolution on Physician Assisted Suicide” (dated 2005) summarizes what was a lengthy, complex, and iterative decision-making process leading to the resolution. These considerations lead to the resolution that the NHPCO does not support the legalization of physician-assisted suicide.²²

Positions of Other Organizations

Veterans Administration

The Veterans Administration serves veterans as a center for resources, emphasizing a multidisciplinary approach including hospice, palliative care, and emotional support. The VA does not prescribe lethal medication nor help a veteran fill out the paperwork relating to Death with Dignity.²³

AARP

AARP has no formal opinion about physician assisted death, however, a strong emphasis is placed upon palliative and hospice care. AARP also provides resources for making end-of-life decisions.²⁴

American Civil Liberties Union (ACLU)

To the question “Should Euthanasia or Physician assisted Suicide Be Legal?” In response to a 1997 Supreme Court decision that held that the Constitution does not protect the right of terminally ill patients to doctor assisted suicide, Steven R. Shapiro, the ACLU's National Legal Director, said that each of us should have the right to die in a humane and dignified manner. The exercise of this right is as central to personal autonomy and bodily integrity as rights safeguarded by this Court's decision relating to marriage, family relationships, procreation, contraception, child rearing and the refusal or termination of life-saving medical treatment. “There is nothing new about the desire of terminally ill patient to end their suffering by hastening their death. Developments in modern health care have simply brought into the open a previously private [sic] that society has long condoned.”²⁵

Religious Positions

Much of the information on selected religious positions below is quoted or paraphrased from <http://www.deathwithdignity.org/history/facts/religion>²⁶. Please refer to this source for positions taken by additional religions.

²² www.nhpco.org

²³ Integrated Ethics Handbook 2015-2016. Internet

²⁴ AARP Policy Book 2015-2016 Health Chapter 7 7-129

²⁵ <https://www.aclu.org/news/high-court-rejects-constitutional-right-doctor-assisted-suicide>

²⁶ <http://www.deathwithdignity.org/history/facts/religion>

Baptist

The American Baptist Church and Southern Baptist Convention differ in their statements regarding assisted dying. The American Baptists have adopted the policy to “advocate within the medical community for increased emphasis on the caring goals of medicine which preserve the dignity and minimize the suffering of the individual and respect personal choice for end of life care.” In contrast the Southern Baptists state the practice violates the sanctity of human life.

Buddhism

Buddhists are not unanimous in their view of physician assisted dying, and the teachings of the Buddha don't explicitly deal with this topic. The Buddha himself showed tolerance of suicide by monks in two cases. The Japanese Buddhist Tradition includes many stories of suicide by monks, and suicide was used as a political weapon by the Buddhist monks during the Vietnam war. In Buddhism, the way life ends has a profound impact on the way the new life will begin. So a person's state of mind at the time of death is important - their thoughts should be selfless and enlightened, free of anger, hate, or fear.

Catholic

The official position of the Roman Catholic Church remains that killing of a human being, even by an act of omission to eliminate suffering, violates divine law and offends the dignity of the human person. However, many Catholics, particularly in the United States, cite various quotations by Pope Benedict XVI as a source for continued disagreement and controversy regarding controversial issues. To compound confusion, physician assisted dying is frequently and erroneously considered euthanasia.

Episcopal

Some Episcopalians believe it is morally wrong to take human life with medication to relieve suffering caused by incurable illness. Other Episcopalians approve of assisted dying in rare cases.

Church of Jesus Christ of Latter-Day Saints

Euthanasia is condemned. Anyone who takes part in euthanasia, including “Assisted Suicide”, is regarded as having violated the Commandments of God. However, the Church recognizes that when a person is in the final states of terminal illness there may be difficulties since there is a gray area within the Handbook of Priesthood Leadership. The Church states that when dying becomes inevitable, death should be looked upon as a blessing and a purposeful part of an eternal existence. Members should not feel obligated to extend mortal life by means that are unreasonable.²⁷

Judaism

The Union of Orthodox Jewish Congregations has been heavily involved in efforts, in both Congress and the courts, to restrict physician-assisted death. Conservative and

²⁷ <https://www.lds.org/search?lang=eng&query=euthanasia>

Reform leaders have called for increased discussion of end-of-life issues, but have not issued official position on assisted dying.

Methodist

Methodists generally accept the individual's freedom of conscience to determine the means and the timing of death. Some regional conferences have endorsed the legalization of physician assisted dying.

Presbyterian Church in America

The 1998 Presbyterian Church in America (PCA) paper on "heroic measures" states that "Euthanasia, or mercy killing of a patient by a physician or by anyone else, including the patient himself (suicide) is murder." To withhold or to withdraw medical treatment, as is being discussed here, does not constitute euthanasia and should not be placed into the same category. However, the PCA is devoting further study and discussion to the specific issue of physician assisted dying.

Unitarian Universalist

The right to self-determination includes the choice of hastened dying. Unitarians support immunity from prosecution for those who, with proper safeguards, honor the request of terminally ill patients.

Conclusion: What Can League Members Do with the Information in This Study?

It is clear from our study that citizens, health care professionals, and other stakeholders are divided on the issue of assisting terminally ill people in ending their lives. An average of multiple public polls suggests that approximately 61% support aid in dying, 32% oppose it and 7% are generally undecided on the topic.

So far only five states have adopted laws allowing citizens to choose to die. The laws of these states are similar, all based on Oregon's law, which was the first to pass. They provide protection both for the patients considering their own death to be sure that they are acting on their own free will and for doctors who prescribe lethal drugs to be sure they cannot be accused of murder.

Many of the forty-five states without such laws are currently considering them. In those states, including Utah, citizens must thoughtfully consider the moral, ethical and legal questions surrounding the issue.

This study has given an overview of the major ethical questions and of the positions of religious and non-religious organizations regarding the right to assisted suicide. The experience in Oregon, where the law has been in effect for 18 years, has been instructive in that there has been increasing acceptance by physicians, as well as greater focus on care of terminally ill patients by the healthcare community. There does not seem to be any evidence supporting the "slippery slope" argument according to available data.

However, the incidence and results of failed attempts has not been examined in the literature. Future review of issues such as safeguards, protection of vulnerable populations, and individual civil rights and public rights, may inform the likelihood of adopting any Death with Dignity legislation here in Utah and elsewhere.

We hope this study will help League of Women Voters members and others to gain perspective on this important issue.

APPENDIX A: Historical Timeline

Source: ProCon.org 7/23/2013

500 BC - 16th Century AD

In ancient Greece and Rome, before the coming of Christianity, attitudes toward infanticide, active euthanasia, and suicide tended to be tolerant. Many ancient Greeks and Romans had no cogently defined belief in the inherent value of individual human life, and pagan physicians likely performed both voluntary and involuntary mercy killings. Although the Hippocratic Oath (written in the 5th century BC) prohibited doctors from giving a deadly drug to anybody, not even if asked for, or from suggesting such a course of action, few ancient Greek or Roman physicians followed the oath faithfully. Throughout classical antiquity, there was widespread support for voluntary death as opposed to prolonged agony, and physicians complied by often giving their patients the poisons they requested. In the Middle Ages Christians and Jews tend to oppose euthanasia, as inconsistent with the human good and with responsibilities to God.

12th Century-15th Century

The ascendancy of Christianity, with its view that human life is a trust from God, reinforced the views of the Hippocratic school (which forbade euthanasia). By the twelfth through the fifteenth centuries, Christianity and Hippocratic School culminated in the near unanimity of medical opinion in opposing euthanasia.

13th Century

During Middle Ages Christians and Jews tend to oppose suicide as inconsistent with the human good and with responsibilities of God. Thomas Aquinas espoused Catholic teaching about suicide in arguments that would shape Christian thought about suicide for centuries.

17th Century

The American Colonies adopted the common law approach. For example, the legislators of the Providence Plantations, which would later become Rhode Island, declared in 1647 that self-murder is by all agreed to be the most unnatural and it is by this present Assembly declared to be that wherein he that doth it, kills himself out of a premeditated hatred against his own life or other humor...his goods and chattels are the king's custom.

18th Century

American evangelical Christians leadership rejected suicide and euthanasia. A vigorous religious counterattack gained momentum as the late eighteenth century drew to a close. The various waves of religious revivalism, starting with the Great Awakening of the mid-1700, prevented secularists and agnostics on either side of the Atlantic Ocean from generating popular support for taking one's life. These events dovetailed with the Second Great Awakening of intense evangelical fervor in the first years of the nineteenth century and strengthened the condemnation of suicide and euthanasia that

stretched back to the earliest days of colonial America. The rejection of suicide and euthanasia remained firm, even after many of the new states decriminalized suicide in the wake of the Revolutionary War. The majority of Americans rejected suicide's common-law punishment. But no matter how sympathetic they were toward the suicide's family, most Americans stopped far short of condoning self-murder. As late as the antebellum period there existed in the United States a firm consensus ... against suicide and mercy killing.

1828

The first U.S. statute outlawing assisted suicide is enacted in New York. Dec.10,1828, (cxh.20, s4,1828 N.Y. Laws 19). Many of the new states and territories followed New York's example. Between 1857 and 1865, a New York commission led by Dudley Field drafted a criminal code that prohibited aiding a suicide and specifically furnishing another person with any deadly weapon or poisonous drug, knowing that such person intends to use such weapon or drug in taking his/her life. By the time the Fourteenth Amendment to the Constitution was ratified, it was a crime in most States to assist a suicide. The Field Penal Code was adopted in the Dakota Territory in 1877 and in New York in 1881, and its language served as a model for several other western States statutes in the late 19th and early 20th centuries. California, for example, codified its assisted suicide prohibition in 1874, using language similar to the Field Code.

1870

Samuel Williams begins to publicly advocate using morphine and other drugs for euthanasia. An important milestone in the debate was the isolation of morphine in the nineteenth century and its widespread use as an analgesic (a pain-relieving agent). When the practice of analgesia had become reasonably well established, Samuel Williams a non-physician, began to advocate the use of these drugs not only to alleviate terminal pain, but to intentionally end a patient's life. During the late 1800's Williams euthanasia proposal received serious attention in the medical journals and at scientific meetings. Still, most physicians held the view that pain medication could be administered to alleviate pain, but not to hasten death.

1885

The Journal of the American Medical Association attacks Samuel Williams' euthanasia proposal as an attempt to make "the physician don the robes of an executioner."

1905-1906

By the turn of the century, medical science had made great strides. As physicians who used the modern scientific method and modern principles of pharmacology consolidated their control over university and medical school training, the euthanasia debate entered the lay press and political forums. In 1905-1906 a bill to legalize euthanasia was defeated in the Ohio legislature by a vote of 79 to 23. In 1906 a similar initiative that would legalize euthanasia not only for terminal adults, but also for hideously deformed or idiotic children was introduced and defeated as well. After that the public interest in euthanasia receded.

1915

Dr. Harry Haiselden, a 45-year-old chief of staff, is called to the German-American Hospital where Anna Bollinger gave birth to her fourth child, a seven-pound, blue and badly deformed baby boy. After conferring with the father, the doctor diagnosed a litany of physical defects. He predicted that without surgery the child would die shortly. He declined to operate, and almost single handedly managed to accomplish what other defenders of euthanasia before him had not. He not only got more Americans than ever before talking about euthanasia, but also won endorsements from numerous prominent figures. The publicity surrounding his professional conduct, briefly eclipsing news from World War I, inspired other Americans to speak out in favor of letting deformed infants die for the good of society. Haiselden demonstrated how support for euthanasia was nurtured by a cultural climate punctuated by science, naturalism and humanitarian reform.

1930

Public support for euthanasia catches fire again in the 1930's, making these years a pivotal juncture in the history of euthanasia in America. With the coming of the Depression and more troubled economic times, Americans began talking about suicide and controlled dying. Public opinion polls indicated in 1937 that fully 45 percent of Americans had caught up with Harry Haiselden's belief that the mercy killing of infants born permanently deformed or mentally handicapped was permissible.

1935

The Voluntary Euthanasia Legislation Society is founded in England by C. Killick Millard, a retired public health physician.

1936

The euthanasia debate was not limited to this side of the Atlantic. A bill to legalize euthanasia was debated in the British House of Lords in 1936 and rejected. The defeat of this bill, along with the outbreak of World War II and the subsequent discovery of the Nazi death camps quelled but did not eliminate discussion of the euthanasia question.

1937

Nebraska Senator John Comstock introduces legislation called the Voluntary Euthanasia Act, which calls for the legalization of active euthanasia. It is never voted on but demonstrates an emerging interest in legislating euthanasia.

1938

The National Society for the Legalization of Euthanasia, which is soon renamed the Euthanasia Society of America (ESA) is founded by Charles Francis Potter on January 16, 1938. According to TIME magazine "he and a sizable group of other notable men believed so strongly in the right of an incurably diseased individual to have his life terminated gently that they organized the National Society for the Legalization of Euthanasia. Its trustees included Dr. Clarence Cook Little of the American Society for

the Control of Cancer and the American Birth Control League, and Secretary Leon Fradley Whitney of the American Eugenics Society.

1940

Nazi use of involuntary euthanasia changes the public perception of euthanasia in the U.S. When the 1940's dawned, many in the euthanasia movement believed it was only a matter of time before euthanasia became legal in the U.S. But World War II broke out and as Hitler's war machine marched eastward across Europe, news of Nazi atrocities against mental patients and handicapped children filtered back to America. As word spread in the late 1940's, the euthanasia movement found itself increasingly on the defensive, scrambling to deny that the form of euthanasia it supported was the same as Nazi murder.

1946

The Committee of 1776 Physicians for Legalizing Voluntary Euthanasia is founded in New York.

1950

The World Medical Association votes to recommend to all national medical associations that euthanasia be condemned "under all circumstances." In the same year, the American Medical Association issued a statement that the majority of doctors do not believe in euthanasia. When an opinion poll in 1950 asked Americans whether they approved of allowing physicians to, by law, end incurably ill patient's lives by painless means if they and their families requested it, only 36 percent answered yes, approximately 10 percent less than in the late 1930s.

1952

The British and American Euthanasia Societies submit a petition to the United Nations Commission on Human Rights to amend the U.N. Declaration of Human Rights to include the right of incurable sufferers to euthanasia or merciful death. "Inasmuch as this right is, then, not only consonant with the rights and freedoms set forth in the Declaration of Human Rights but essential to their realization, we hereby petition the United Nations to proclaim the right of incurable sufferers to euthanasia."

Eleanor Roosevelt, the chairperson of the commission, did not present the petition to the commission.

1962

Charles Potter dies and theologian Joseph Fletcher assumes Potter's unofficial title as the chief philosopher of the euthanasia movement. Fletcher fashions a new rationale for euthanasia based primarily on the notion of patient autonomy. Pauline Taylor becomes president of the Euthanasia Society of America (ESA). Taylor began the ESA's soul-searching process that led to a major shift in the philosophy of the entire American euthanasia movement. She believed the ESA in the past had overemphasized the soundness of an individual's decision to have his or her life ended if terminally ill and in unbearable pain. Taylor concluded that the time was ripe to begin convincing the public

that letting someone die, instead of resorting to extreme measures, was both human and ethically permissible.

1965

Donald McKinney becomes president of the Euthanasia Society of America (ESA). Over the next two decades McKinney would help to transform the euthanasia movement by leading a sizeable faction opposed to active euthanasia or physician assisted suicide. In the process he eventually concluded that there was a fundamental distinction between passive and active euthanasia.

1967

The first living will be written by attorney Luis Kutner and his arguments for it appears in the Indiana Law Journal.

1968

The Ad Hoc Committee of the Harvard Medical School Committee defines irreversible coma as a criterion for death. The school examines the definition of brain death and publishes its report in the Journal of the American Medical Association in August 1968. The committee defined irreversible coma as a new criterion for death. According to the committee, a new definition of death was needed because of the great burden that trying to revive irreversibly comatose patients puts on the patients themselves, their families, hospitals and the community.

1969

The Hastings Center is founded in 1969 by Daniel Callahan to study ethical problems in medicine and biology, which was instrumental in the development of bioethics as a discipline. The original focus of the center concerned death and dying, genetics, reproductive biology and population issues, and behavior control.

1970

In the early 1970's the widely accepted authority of the medical profession comes under concerted attack in the name of patient autonomy. This challenge has been embodied in the progressive enumeration of patient rights, especially the right to refuse medical care, even life-sustaining care. The goals have been to remove physicians from decision-making and to let individual patients weigh the benefits and burdens of continued life.

1972

The US Senate Special Commission on Aging (SCA) holds the first national hearing on death with dignity entitled "Death with Dignity: An inquiry into Related Public Issues." The SCA hearings, chaired by Idaho Senator Frank Church, proved to be a superb opportunity for professionals and laypeople to discuss a range of issues relating to aging and terminal illness, including the evolving doctor-patient relationship and the difficulties of defining death itself. Overall, the hearings showed that Americans were becoming increasingly unhappy about the brutal irony of medical miracles, which extended the dying process only to diminish patient dignity and quality of life. Church

insisted that the hearings were not about euthanasia but try as he might, he could not keep the subject from surfacing.

1973

The American Hospital Association adopts a "Patient's Bill of Rights," which recognizes the right of patients to refuse treatment.

1974

The founding of the Society for the Right to Die marks a renewed dedication to pursuing the legalization of active euthanasia and a reenergized campaign to seek euthanasia laws through the political process.

1974

The first American hospice opens in New Haven, Connecticut.

Mar. 31, 1976

The New Jersey Supreme Court rules that Karen Quinlan can be detached from her respirator. She had fallen into an irreversible coma at a party in 1974. After doctors declared that she was in a "persistent vegetative state", her parents went to court to have her respirator removed. This case becomes a legal landmark, drawing national and international attention to end-of-life issues.

Oct. 1, 1976

California Governor Edmund G. Brown Jr. signs the California Natural Death Act into law and California becomes the first state in the nation to grant terminally ill persons the right to authorize withdrawal of life sustaining medical treatment when death is believed to be imminent.

1980

The World Federation of Right to Die Societies is founded. Its membership includes dozens of organizations from countries around the world concerned with euthanasia and the right to die.

1980

Derek Humphry forms the Hemlock Society, a grassroots euthanasia organization, in Los Angeles. Humphry ranks as one of the preeminent pioneers of the American euthanasia movement. The Hemlock Society enjoyed a remarkable growth in the 1980's that rivaled anything the other U.S. organizations had achieved. What also distinguished Hemlock from Concern for Dying (CFD) and the Society for the Right to Die (SRD) was its official support for active euthanasia and assisted-suicide.

May 5, 1980

Pope John Paul II issues a declaration opposing mercy killing

1984

The American Medical Association publishes two reports, "Withholding or Withdrawing Life-Prolonging Medical Treatment" and "Withholding or Withdrawing Life-Prolonging Medical Treatment - Patient's Preferences." The reports detailed the American Medical Association's formal position that with informed consent, a physician can withhold or withdraw treatment from a patient who is close to death, and may also discontinue life support of a patient in a permanent coma.

1987

The California State Bar Conference passes Resolution #3-4-87 to become the first major public body to approve of physician aid in dying.

1988

The Unitarian Universalist Association of Congregations passes a national resolution entitled "The Right to Die with Dignity." The resolution favored aid in dying for the terminally ill. Thus the Unitarian Universalist Association of Congregations becomes the first religious body to affirm the right to die.

Jan. 8, 1988

The Journal of the American Medical Association publishes an anonymous article entitled "It's Over Debbie." The article described how a gynecology resident in a large private hospital had injected a patient suffering from painful ovarian cancer with an overdose of morphine. The article stirred controversy and debate and many condemned the resident for what he had done.

1990

The growing interest in the right-to-die movement becomes apparent in public opinion surveys. These showed that more than half of the American public was now in favor of physician-assisted death and membership of the Hemlock Society rose dramatically to reach 50,000. With increased public interest, the stage was set for an explosive swell of activity, in the courts, in professional medical journals and institutions and most significantly in homes of the American people.

June 4, 1990

Physician Jack Kevorkian participates in his first assisted suicide.

June 25, 1990

Cruzan v. Director, Missouri Department of Health comes before the U.S. Supreme Court. The case receives national attention, as it is the first right to die case that the court has agreed to hear. In 1983, a car accident had left Nancy Cruzan permanently unconscious. Her parents requested to withdraw her feeding tube but the Missouri Supreme Court refused. The U.S. Supreme Court ruled that a competent person has a constitutionally protected right to refuse any medical treatment, but upheld Missouri's right to insist on clear and convincing evidence as to the wishes of patients who do not have decision-making capacity. In light of the ruling the Cruzans' lawyer went back to court with new evidence as to Nancy's prior wishes and Nancy's feeding tube was removed. She died on Dec. 26, 1990.

Nov. 5, 1990

The U.S. Congress passes the Patient Self-Determination Act, requiring hospitals that receive federal funds to tell patients that they have a right to demand or refuse treatment. It took effect in 1991.

1991

Choice in Dying is formed by the merger of two aid in dying organizations, Concern for Dying and Society for the Right to Die. The new organization became known for defending patient rights and promoting living wills.

Nov. 1991

Washington State introduces ballot Initiative 119 to legalize “physician aid-in-dying.”

Nov. 3, 1992

California voters defeat Proposition 161, the California Death with Dignity Act, which would have allowed physicians to hasten death by actively administering or prescribing medication for self-administration by suffering, terminally ill patients. The vote was 54 to 46 percent.

April 1993

Compassion in Dying is founded in Washington State to counsel the terminally ill and provide information about how to die without suffering and with personal assistance, if necessary, to intentionally hasten death. The group sponsors suits challenging state laws against assisted suicide.

May 1994

The New York Task Force on Life and the Law publishes “When Death is Sought,” a report that argues against the legalization of physician-assisted suicide.

Nov. 1994

The Oregon Death with Dignity Act is passed, becoming the first law in American history permitting physician assisted suicide.

April 30, 1997

President Clinton signs the Assisted Suicide Funding Restriction Act of 1997, which prohibits the use of federal funds to cause a patient’s death.

June 26, 1997

The U.S. Supreme Court rules in *Washington v. Glucksberg* and *Vacco v. Quill* that there is not a constitutional right to die.

Nov. 1997

Oregonians vote 60 to 40 percent in favor of keeping the Death with Dignity Act.

Nov. 1998

Physician Jack Kevorkian is a guest on "60 Minutes," during which he shows a videotape of him administering a lethal injection to Thomas Youk, a man suffering from Lou Gehrig's Disease.

Nov. 1998

Michigan introduces Proposal B to legalize physician-assisted suicide. The proposal fails by a vote of 29 to 71 percent.

1999

A Michigan court convicts Jack Kevorkian for the murder of Thomas York and sentences him to 10-25 years in prison.

2000

Maine introduces a ballot initiative, the Maine Death with Dignity Act that reads "Should a terminally ill adult, who is of sound mind, be allowed to ask for and receive a doctor's help to die?" The initiative was defeated by a margin of 51 to 49 percent.

2001

The Netherlands officially legalizes euthanasia.

2003

U.S. Attorney General John Ashcroft asks the 9th Circuit Court of Appeals to reverse the finding of a lower court judge that the Oregon Death with Dignity Act of 1994 does not contravene federal powers.

2005

Terri Schiavo has her feeding tube removed after a long court battle.

Jan 17, 2006

The U.S. Supreme Court, in a 6-3 opinion in *Gonzales v. Oregon*, holds that the Controlled Substances Act does not authorize the Attorney General to ban the use of controlled substances for physician assisted suicide. Oregon's Death with Dignity Law is upheld.

June 1, 2007

Jack Kevorkian is released on parole.

Feb.19, 2008

The Luxembourg Parliament adopts a law legalizing physician assisted suicide and euthanasia.

Nov. 4, 2008

Washington's Death with Dignity Act is passed making it the second U.S. state to legalize physician-assisted suicide.

Dec. 5, 2008

Montana district judge Dorothy McCarter rules in the case of *Baxter v. State of Montana* that residents have the legal right to physician assisted suicide, thus making it the third U.S. state to legalize physician aid in dying.

Dec. 31, 2009

Montana Supreme Court affirms 4-3 in the case of *Baxter v. State of Montana* that physician assisted suicide is not "against public policy" in Montana. The Court further ruled that state law protects doctors in Montana from prosecution for helping terminally ill patients die. The Court declined to rule on the larger question of whether physician assisted suicide is a right guaranteed under Montana's Constitution.

Nov. 6, 2012

The Massachusetts Death with Dignity ballot measure is defeated by less than 60,000 votes. The measure would have legalized physician-assisted suicide by allowing doctors to prescribe a lethal dosage of medicine to people with less than six months to live.

May 20, 2013

Vermont's Governor Peter Shumlin signs the "End of Life Choices" bill into law, which is the first time physician assisted suicide has been made legal in the U.S. via the legislative process. Vermont's law implements safeguards to govern physicians who are now allowed to prescribe death-inducing medication to terminally ill residents of the state.

Jan. 13, 2014

Physician assisted suicide is ruled legal by New Mexico Judge Nan G. Nash. The decision prohibits the prosecution of physicians who help competent terminally ill patients end their lives. The decision states, "This court cannot envision a right more fundamental more private or more integral to the liberty, safety and happiness of the New Mexican than the right of a competent, terminally ill patient to choose aid in dying." New Mexico Attorney General Gary King has filed an appeal on the ruling to the State Supreme Court.

Mar. 2, 2014

Belgium legalizes euthanasia for terminally and incurably ill children. Belgium became the world's first country to lift all age restrictions on euthanasia.

Feb. 6, 2015

In a unanimous ruling, Canada's Supreme Court strikes down the law that bans doctor assisted-suicide. The court said the law denies people the right to make decisions

concerning their bodily integrity and medical care and leaves them to endure intolerable suffering.

April 30, 2015

A South African court allows assisted suicide. Robin Stransham-Ford, a 65-year-old man diagnosed with terminal prostate cancer in 2013 was granted the right to have a doctor help him end his life by the High Court in Pretoria. Dignity South Africa, the group that helped bring the case to court, noted that Mr. Stransham died peacefully of natural causes the same day the ruling was made.

Aug.11, 2015

The Court of Appeals of the State of New Mexico concludes that aid in dying is not a fundamental liberty interest under the New Mexico Constitution: “Accordingly, we reverse the district court’s order permanently enjoining the State from enforcing Section 30-2-4. In addition, we affirm the district court’s determination that, for statutory construction purposes, Section 30-2-4 prohibits aid in dying.

APPENDIX B: Glossary

Advance Directive

An *advance directive* is a document by which a person makes provision for *health care* decisions, including naming a surrogate decision maker in the event the person is unable to do so.

Active Euthanasia

The medical administration of the lethal agent to a patient in order to relieve intolerable and intractable suffering of the patient resulting in death.

Aid in Dying

Aid in Dying refers to the provision by a terminal patient's physician for life ending medication to be administered by the patient so she/he may hasten death if the dying process causes unbearable suffering usually under circumstances of terminal illness.

Assisted Suicide

Suicide committed with the aid of another person, sometimes a physician. The term is often used interchangeably with physician-assisted suicide, which involves a doctor knowingly and intentionally providing a person with the knowledge or means of both required to commit suicide.

Autonomy

This is the exercise of self-determination and choice among alternatives, based on the individual's values and beliefs.

Euthanasia

This is translated literally as "good death" and refers to the act of painlessly but deliberately causing the death of another who is suffering from an incurable, painful disease or condition. It is commonly thought of as a lethal injection and it is sometimes referred to as mercy killing.

Involuntary Euthanasia

This occurs when a patient's death is hastened without the patient's consent. While generally viewed as murder, there are some instances in which the death may be viewed as a mercy killing.

Living Will

A living will is a limited type of advance directive because decisions about life sustaining procedures are made only in the event that the patient's death is potentially a terminal condition that is imminent despite the application of life sustaining procedures or is in a persistent vegetative state (permanent unconsciousness).

Non-Voluntary Euthanasia

Occurs when a legal surrogate makes the decision on the patient's behalf because the patient is unconscious or otherwise mentally unable to make a meaningful choice between living and dying.

Palliative Care

This medical specialty is often associated with hospice: however, it can also be used independently and alongside curative treatments. Palliative care is a comprehensive medical specialty focusing on quality of life services 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.

Passive Euthanasia

This is generally understood as a patient's death due to action not taken by a medical professional or layperson actions that would normally keep the patient alive.

Physician- Assisted Suicide (PAS)

PAS is defined as the introduction by a physician acting upon the request of a patient, of medicine that causes death in order to ending their unbearable suffering and intractable pain. All life sustaining treatment is discontinued.

Suicide

Generally defined as the act of taking one's own life voluntarily and intentionally.

Withholding/Withdrawing Treatment

Refers to omitting or ending life sustaining treatments such as ventilators, feeding tubes, kidney dialysis or medication that would otherwise prolong the patient's life. This legal act may be upon the patient's request, as the result of an advance directive or based upon the American Society of Internal Medicine's determination of futility.

Bibliography

1. AARP. (2015-2016). Policy Book. Health Chapter 77-129.
2. American Civil Liberty Union (ACLU). <https://www.aclu.org/news/high-court-rejects-constitutional-right-doctor-assisted-suicide>
3. American Academy of Hospice and Palliative Care Medicine (AAHPM). (n.d) [Position Statement. http://aahpm.org/uploads/PAD_for_web_site_post.pdf](http://aahpm.org/uploads/PAD_for_web_site_post.pdf)
4. American College of Physicians-American Society of Internal Medicine (ACP-ASIM). (August 2001) Position Paper, Physician Assisted Suicide, P 209. https://www.acponline.org/running_practice/ethics/issues/policy/pa_suicide.pdf
5. American Journal of Health-System Pharmacists. (2001). 58(12):1080
6. American Medical Women's Association (AMWA). (2012). Position papers for 2012 aid in dying. <http://www.amwadocs.org>
7. American Nurses Association (ANA). (04/24/13). Position Statement, Euthanasia, Assisted Suicide, and Aid in Dying. <http://www.nursingworld.org/euthanasiaanddying>
8. American Public Health Association (APHA) <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/29/13/28/patients-rights-to-self-determination-at-the-end-of-life>
9. Back, Anthony L., MD; Jeffrey I. Wallace, MD, MPH; Helene E. Starks, MPH; Robert A. Pearlman, MD, MPH. (March 27, 1996). Physician assisted Suicide and Euthanasia in Washington State-Patient Requests and Physician Responses. *JAMA*. 1996;275(12):919-925.
10. Battin, Margaret Pabst (2014). TedMed Talk: "Peggy Battin tells how and why her husband chose to die." YouTube 20 min, 22 sec.
11. Battin, Margaret Pabst (2010). The Irony of Supporting Physician assisted Suicide: A Personal Account. *Med Health Care Philos*. 2010 Nov;13(4):403-11. <http://www.ncbi.nlm.nih.gov/pubmed/20711678>
12. Battin, M.P, van der Heide, A, Ganzini, L., van der Wal, G, and Bregje Onwuteaka-Philipsen. (2007). Legal Physician assisted Dying in Oregon and the Netherlands: Evidence Concerning the Impact on Patients in "Vulnerable" Groups. *Journal of Medical Ethics*, 33:591-597.
13. Battin, Margaret Pabst (2005). *The Ethics of Suicide: Historical Sources*, Oxford University Press.
14. Battin, Margaret Pabst (2005). *Ending Life: Ethics and the Way We Die*, Oxford University Press.
15. Battin, Margaret Pabst (1994). *The Least Worst Death: Essays in Bioethics on the End of Life*. Oxford University Press.
16. The Consequences of Legalized Assisted Suicide and Euthanasia: Hearing before the Senate Committee on Judiciary Subcommittee on the Constitution, Civil Rights and Property Rights, 109th Cong., 2d Sess. (2006) (Testimony of Ann Jackson). <https://www.gpo.gov/fdsys/pkg/CHRG-109shrg45836/pdf/CHRG-109shrg45836.pdf>

17. Church of Jesus Christ of Latter-Day Saints: Current Priesthood Handbook for the Church of Jesus Christ of Latter-Day Saints.
<https://www.lds.org/search?lang=eng&query=euthanasia>
18. Compassionate Choices Userfile.
<https://www.compassionatechoices.org/userfiles/Montana-Supreme-Court-Opinion.pdf>
19. Death with Dignity around the U.S. <https://www.deathwithdignity.org/take-action>
20. Findlaw. (n.d). Death with Dignity Laws by State.
<http://healthcare.findlaw.com/patient-rights/death-with-dignity-laws-by-state.html>
21. Death with Dignity National Center, Religion and Spirituality.
<http://www.deathwithdignity.org/historyfacts/religion>
22. Drum, Kevin. (January/February 2016). My Right to Die – Assisted Suicide, My Family, and Me. <http://www.motherjones.com/politics/2016/01/assisted-suicide-legalization-california-kevin-drum>
23. Emanuel, E.J., & Battin, M.P. (1998). What are the potential cost savings from legalizing physician assisted suicide? The New England Journal of Medicine, (339), 167-172.
24. Gallup Poll (US), May 2005
25. Ganzini, L., Nelson, H.D., Schmidt, T.A., Kraemer, D.F., Delorit, M.A. & Lee, M.A. (2000). Physicians Experiences with the Oregon Death with Dignity Act. New England Journal of Medicine (NEJM), 342(8), 557-563.
26. Ganzini, L., Nelson, H.D., Lee, M.A., Kraemer, D.F., Schmidt, T.A. & Delorit, M.A. (2001) Oregon Physicians' Attitudes About and Experiences with End-of-Life Care since Passage of the Oregon Death with Dignity Act. Journal of American Medical Association, 285.2363-2369.
27. Golden, Marilyn, policy analyst (approx. 2003). Why Assisted Suicide Must Not Be Legalized. Disability Rights Education & Defense Fund (DREDF).
(http://dredf.org/assisted_suicide/assistedsuicide.html)
28. Henig, Robin Marantz. (2013). "A Life or Death Situation," New York Times Magazine, July 17, 2013, (cover story about Peggy Battin & Brooke Hopkins' choice after the accident and living with paralysis)
http://www.nytimes.com/2013/07/21/magazine/a-life-or-death-situation.html?pagewanted=all&_r=0
29. Henig, Robin Marantz (2013). "Choosing to Die After a Struggle with Life," New York Times Magazine, August 21, 2013 (describes how Peggy Battin helped her husband Brooke die). <http://6thfloor.blogs.nytimes.com/2013/08/21/choosing-to-die-after-a-struggle-with-life/>
30. Horgan, John (May 1997). Seeking a Better Way to Die – Interviewing Kathleen Foley, M.D. of Memorial Sloan-Kettering regarding patient requests for aid in dying. Scientific American, 100-105. <http://www.scientificamerican.com/article/seeking-a-better-way-to-die/>
31. Institute of Medicine. (2015). Dying in America_Improving Quality and Honoring Individual Preferences Near the End of Life. The National Academies Press, Washington, D.C.

32. Internet - Integrated Ethics Handbook 1004.06.
https://www.google.com/?gws_rd=ssl#q=Integrated+Ethics+Handbook+1004.06++
33. Kane, Leslie, MA (December 16, 2014) Medscape Ethics Report 2014, Part 1: Life, Death & Pain.
http://www.medscape.com/features/slideshow/public/ethics2014-part1?src=wnl_edit_tpal&uac=39628CV#2
34. KRQE. (2015). New Mexico Supreme Court Hears Assisted Suicide Case.
<http://krqe.com/2015/10/26/new-mexico-supreme-court-hears-assisted-suicide-case/>
35. le.utah.gov/v2015/bills/static/ab0391.html
36. Lee, D.E. (2003). Physician assisted suicide: A Conservative Critique of Intervention. *Hastings Center Report*, 33(1), 17-19.
37. Lee, M.A. & Tolle, S.W. (1996). Oregon's Assisted Suicide Vote: The Silver Lining. *Annals of Internal Medicine*, 124(2), 267.
38. Lee, M.A., Nelson, H.D., Tilden, V.P., Ganzini, L., Schmidt, T.A. & Tiole, S.W. (1996). Legalizing Assisted Suicide-Views of Physicians in Oregon. *New England Journal of Medicine (NEJM)*, (5) 334:310-315.
39. McMurray, Richard J., MD, et al. (April 22, 1992). Decisions Near the End of Life. *JAMA*. 1992;267(16):2229-2233
40. Midred Z. Solomon, EdD, Lydia O'Donnell, EdD, Bruce Jennings, MA, Vivian Guilfooy, MA, Susan M. Wolf, JD, Kathleen Nolan, MD, Rebecca Jackson, Dieter Koch-Weser, MD, PhD, and Strachan Donnelley, PhD. (1993). Decisions Near the End of Life: Professional Views on Life-Sustaining Treatments. *American Journal of Public Health*, January 1993, Vol. 83, No. 1
41. National Hospice and Palliative Care Organization (NHPCO). Position Statement. (n.d). <http://www.nhpco.org>
42. Oregon Public Health Division. (2014). Oregon's Death with Dignity Act—2014.
<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf>
43. <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf>
44. Stutsman, Eli. (July/August 2013). Twenty Years of Living with the Oregon Death with Dignity Act. *GPSOLO*, Vol. 30 No. 4.
http://www.americanbar.org/publications/gp_solo/2013/july_august/twenty_years_living_the_oregon_death_dignity_act.html