The Facts: Medical Aid in Dying in the United States

What Is Medical Aid in Dying?

Medical aid in dying is a safe and trusted medical practice in which a terminally ill, mentally capable adult with a prognosis of six months or less to live may request from his or her doctor a prescription for medication which they can choose to self-ingest to bring about a peaceful death. Prior to providing a prescription for such medication, doctors must confirm that the person is fully informed and provide the person with information about additional end-of-life options, including comfort care, hospice and pain control.

Medical Aid in Dying Is a Safe and Trusted Medical Practice

Medical aid in dying is a safe and trusted medical practice because the eligibility requirements ensure that only mentally capable, terminally ill adults with a prognosis of six months or less who want the choice of a peaceful death are able to request and obtain aid-in-dying medication. And the prestigious and peer-reviewed Journal of Palliative Medicine published clinical criteria for medical aid in dying that physicians use to ensure that the practice meets the highest standards of medical care.

Proven Safety Record

In the more than 30 combined years of medical aid in dying in the authorized states, there has not been a single instance of abuse or coercion. Almost two decades of experience in Oregon shows us the law has worked as intended, with none of the problems opponents had predicted.

Compassion & Choices is the leading nonprofit organization working to improve care and expand choice at the end of life. For more than 30 years we have worked to change attitudes, practices and policies so that everyone can access the information and options they need to have more control and comfort at the end of life.

In Oregon:

- End-of-life care has improved overall since the law's implementation, in large part due to the dialogue the Death with Dignity Act encourages between people and their doctors.[1]
- Hospice use is high and referrals are up[2], as is other use of palliative care. Some hospice programs in Oregon reported a 20 percent increase in referrals since medical aid in dying was authorized.[3]
- In-hospital death rates are the lowest in the nation, at-home death rates are the highest in the nation, and violent suicide among hospice patients has virtually disappeared.[4]

The American Public Supports Medical Aid in Dying

The American public consistently supports medical aid in dying by large majorities and is of great importance to voters, as measured by national independent polling outlets such as Gallup (69 percent support in May 2016) and The Harris Poll (74 percent support in November 2014). State-by-state polling also indicates that majority support cuts across demographics.

Healthcare Professionals Support Medical Aid in Dying

A growing number of national and state organizations representing healthcare professionals have endorsed or accepted medical aid in dying as an end-of-life option for terminally ill, mentally capable adults. A 2014 Medscape survey of 17,000 U.S. doctors representing 28 medical specialties agreed by a 23 percent margin (54% vs. 31%) that medical aid in dying should be available as an end-of-life option.[5]

People with Disabilities Support Medical Aid in Dying

State polls show a strong majority of voters living with disabilities support death with dignity in Connecticut (65%), Massachusetts (74%) and New Jersey (63%). And their average support level is nearly identical to all voters in these three states (Connecticut: 66%[6]; Massachusetts: 71%[7]; New Jersey: 62%[8]).

Medical Aid in Dying Refuting Myths and False Claims

It is our goal to educate the public and refute unfounded claims about end-of-life choice in the United States. This document addresses common myths about medical aid in dying and provides independent research and other resources for fact checking. Compassion & Choices seeks to address questions and concerns about the practice of medical aid in dying with transparency and a mutual interest in the truth. Ultimately, we hope an ongoing discussion will build stronger compassion for those facing the end of life.

Medical Aid-in-Dying Is Not Euthanasia.

Myth: Medical aid in dying is a slippery slope to euthanasia.

Facts: Medical aid in dying and euthanasia are two fundamentally different practices, the chief differentiator between the two being who makes the choice to end a terminally ill person's life. Medical aid in dying is a medical practice by which a terminally ill, mentally capable adult who has a prognosis of six months or less requests, obtains and— if his or her suffering becomes unbearable — self-administers medication that brings about a peaceful death. Euthanasia, sometimes called "mercy killing," is an intentional act by which another person (not the terminally ill or dying person) chooses and acts to cause death. Medical aid-in dying laws expressly prohibit euthanasia.[9]

Euthanasia is illegal in the United States, whereas medical aid in dying is currently authorized in six states. Compassion & Choices does not support euthanasia.

Compassion & Choices stands with the disability rights movement and shares important core values of self-determination and autonomy.

Myth: Medical aid in dying will target people with disabilities.

Facts: The Disabilities Rights Legal Center, which has a successful track record of litigating on behalf of disabled Americans, is an active supporter of medical aid in dying. It has declared that medical aid in dying "poses no threat to people with disabilities." Furthermore, it has an End of Life Liberty Project that has litigated on behalf of disabled Americans to secure their right to determine the way in which they die, including medical aid in dying. In addition, Disability Rights Oregon, whose mission is to protect Oregonians with disabilities, has never received a complaint of abuse or attempted abuse under the Oregon Death with Dignity Act. Compassion & Choices supports medical aid-in-dying laws with core safeguards that protect vulnerable populations from abuse or coercion. Finally, medical aid-in-dying laws specifically mandate that a person is not qualified to use the law solely because of age or disability.[10]

Dustin Hankinson

At age three, Dustin was diagnosed with a genetic disorder called Duchenne muscular dystrophy. A lifelong disability rights activist, he has diligently advocated for passage of medical aid-in-dying legislation.

"Like others, we want the freedom to enjoy life. This freedom should include the full range of options at the end of life, including hospice, palliative care and aid in dying. If you have a terminal illness and are in great pain, I think you should have the right to end your life ... It is discrimination against the disabled to deny them the right ... that able-bodied people have ... We should not take away the freedom of the individual to choose to die. I believe one should have control of one's life, including its ending."

There is no financial incentive to pressure patients.

Myth: Profit-driven health insurers and HMOs will encourage medical aid in dying to save money.

Facts: Independent research published in the New England Journal of Medicine concluded that insurers have no financial incentive to pressure patients to accelerate their deaths because there are no substantial cost savings. The authors state, "savings can be predicted to be very small — less than 0.1 percent of both total healthcare spending in the United States and an individual managed-care plan's budget."[11]

This myth is further dispelled by the fact that 92 percent of people in Oregon who choose medical aid in dying are enrolled in hospice care12 and not receiving expensive or intensive treatment. Therefore, there is no financial incentive to encourage people to accelerate their deaths.

No one has accidentally ingested the medication.

Myth: It's dangerous to keep the medication around. Someone might take it accidentally.

Facts: In over 30 combined years of medical aid in dying in authorized states there has never been an accidental ingestion of the medication. Right now, millions of dangerous prescription drugs sit in medicine cabinets across the country. In the homes of terminally ill people, large quantities of controlled substances, narcotics and sedatives are commonly found and critical to good end-of-life care. Many of these potent drugs are equally hazardous and more easily ingested than aid-in-dying medication. Aid-in-dying medication is extremely bitter and unlikely to be accidentally ingested — it cannot be confused with sweet cough syrup, and ingesting a large dosage is necessary to cause death. Keeping these medications secure falls under accepted protocols already established by hospice, pharmacies, medical providers and state agencies. The federal government and state and local governments have also established take-back programs for all unused medications.

Real Stories. Real Facts. Medical Aid in Dying in the United States.

In the more than 30 combined years of medical aid in dying in the authorized states, there has not been a single instance of abuse or coercion. Below are the real stories and real facts behind the most commonly cited claims circulated to generate uncertainty and fear. Oregon shows us the law works as intended, with none of the problems opponents had predicted.

1. The Story of Linda Fleming

False claim: Linda died to prevent financial hardship.

Facts: Linda had terminal pancreatic cancer. A New York Times article in 2009 about Linda simply reported that some critics fear that medical aid in

dying will put financial pressure on people with low incomes as a motivation for choosing medical aid in dying, not that it happened to Linda. The story does not state nor is there any credible source to indicate that Linda chose medical aid in dying for any other reason than to shorten an "active dying process." Linda was supported by her children and her ex-husband in her decision. Not only does the Oregon data and numerous studies refute this implication, but also in a combined 30 years of medical aid in dying practice there has not been a single incidence of duress or abuse. Creating extra hurdles for low-income individuals to access end-of-life care would be discriminatory and unnecessary.

Source: Yardley, William. The New York Times. May 22, 2009. "First Death for Washington Assisted-Suicide Law." http://www.nytimes.com/2009/05/23/us/23suicide.html?_r=0

2. The Story of Kate Cheney

False claim: Death-with-dignity laws lack safeguards to protect those with dementia and other vulnerable patients from pressure and coercion.

Facts: This story actually highlights how well the law protects vulnerable people, possibly to the detriment of those who should qualify for it. Kate had terminal stomach cancer and followed all the legal requirements to qualify for a medical aid-in-dying prescription. An Oregonian article demonstrates that, for this proud and determined woman, many of the regulatory requirements actually functioned more like roadblocks than safeguards. Kate, who suffered from short-term memory loss, asked her primary care doctor for a medical aid-in-dying prescription, but her first request was "dismissively denied" by her doctor. She made a second request of another doctor who more thoughtfully requested a mental health evaluation to determine whether Kate had the mental capacity to make healthcare decisions for herself. Kate underwent several additional evaluations by other doctors, including the head of the healthcare provider's ethics committee and a psychiatric examination, before she was determined to be eligible for medical aid in dying. One doctor suggested that Kate's daughter, who was a strong advocate for her mother's choices, was pressuring her mother. But as Kate herself told a reporter at the Oregonian, "She (the daughter) makes more noise than I do, but that doesn't make me any any less serious." Kate was given a prescription after a thorough but arduous evaluation aimed to protect vulnerable patients from coercion. Such regulatory requirements must be consistently reevaluated to ensure that they don't raise unnecessary roadblocks to accessing the full range of end-of-life options.

Source: Barnett, Erin Hoover. The Oregonian. February 4, 2015. "Physician-assisted suicide: A family struggles with the question of whether mom is capable of choosing to die." http://www.oregonlive.com/health/index.ssf/2015/02/physician-assisted_suicide_a_f.html

3. The Story of Barbara Wagner

False claim: Insurers will use death-with-dignity laws to get "expensive" patients off the rolls.

Facts: This is not a story about medical aid in dying, but about the state refusing to pay for an ineffective cancer drug. Barbara had terminal lung cancer, but there is zero connection between Oregon's death-with-dignity law and Barbara's death; she never requested or received a medical aid in dying prescription. In 2005 the Oregon Medicaid program paid for chemotherapy and radiation therapy. By 2008, however, Barbara had exhausted all effective treatments. Her doctor advised Tarceva, which had no proven effectiveness against her cancer. The Oregon Medicaid program offered Barbara multiple end-of-life care options for her end-stage lung cancer, but declined to pay for what it deemed an ineffective cancer treatment that had extremely low odds of extending her life. The state explained the options it would pay for in a poorly worded form letter which included pain management, medical equipment, hospice care and all other prescriptions, including medical aid in dying. The ineffectiveness of the cancer drug, not its cost, triggered the state's decision not to pay for the drug. In the end, Barbara actually got the Tarceva, cost-free from the pharmaceutical company, but she died after her treatment began.

Source: Donaldson James, Susan. www.abcnews.com. August 6, 2008. "Death Drugs Cause Uproar in Oregon." http://abcnews.go.com/Health/story?id=5517492&page=1&singlePage=true

4. The Story of Jeanette Hall

False claim: People who are not terminally ill will get the medical aid-in-dying prescription and die.

Facts: Jeanette is actually proof that death with dignity laws work as intended. She had been diagnosed by one doctor with terminal cancer and was referred to a second doctor for radiation and chemotherapy. Jeanette requested a prescription for medical aid in dying, but the second doctor told her that her prospects with treatment were good. She undertook the treatment and became a cancer survivor. Both of her doctors followed the law, and a patient who was not eligible for aid in dying did not move through the qualification process or receive a medical aid-in-dying prescription.

Source: Donaldson James, Susan. www.ABCNews.Com. August 6, 2008. "Death Drugs Cause Uproar in Oregon." http://abcnews.go.com/Health/story?id=5517492&page=1&singlePage=true

5. The Story of Thomas Middleton

False claim: Criminals aiming to take advantage of sick people will pressure them to end their lives.

Facts: This story is also not about medical aid in dying and would have unfolded the same way with or without Oregon's Death With Dignity law. Thomas was one among 30 people that a woman named Tami Sawyer robbed or defrauded. Thomas was dying from ALS when he made Tami Sawyer trustee of his real estate holdings. Thomas requested medical aid in dying and used the drug to end his suffering. After Thomas' death, Sawyer personally pocketed the profits from selling his properties. Sawyer was not involved in Thomas' request for medical aid in dying, and her crime would have been carried out whether he died peacefully or died in pain. Tami Sawyer is serving time in jail for fraud, conspiracy and money laundering for offenses she perpetrated against Middleton and many others.

Source: Mehlhaf, Nina. Lerten, Barney. www.ktvz.com. May 1, 2013. http://www.ktvz.com/news/judgmentday-arrives-for-tami-and-kevin-sawyer/19947946

6. The Story of Randy Stroup

False claim: Insurers will use death with dignity laws to remove expensive, terminally ill patients from the rolls.

Facts: This is also not a story about medical aid in dying. Randy never asked for an aid-in-dying prescription. His death, like Barbara Wagner's, is simply unrelated to the law. Denial of payment for the chemotherapy his doctor recommended was based on its ineffectiveness, not its cost. When Randy was diagnosed with prostate cancer, he was uninsured. The treatment he sought had less than a 5 percent chance of extending Randy's life, so the state Medicaid plan would not cover it. Given his terminal prognosis, the state Medicaid plan offered to pay for multiple end-of-life care options including hospice care, pain prescriptions and aid-in-dying medication, which Randy declined. Randy appealed the decision and eventually received coverage for the chemotherapy; still, he died a year later. This story is misrepresented to somehow link a state's Medicaid policies about covering non-effective treatments with Oregon's Death With Dignity law.

Source: Donaldson James, Susan. www.abcnews.com. August 6, 2008. "Death Drugs Cause Uproar in Oregon." http://abcnews.go.com/Health/story?id=5517492&page=1&singlePage=true

7. The Story of David Preuitt

False claim: Medical aid-in-dying drugs fail and cause damage.

Facts: David had terminal lung cancer when he requested and obtained a medical aid-in-dying prescription to end his suffering in 2005. After taking the medication, he experienced a three-day coma and then awoke, fully alert, according to his wife. In rare cases, patients do regain consciousness. According to his wife, David said he had a religious experience during his coma and concluded that it was better to let the disease take its course than to shorten his dying process. The cancer took David's life two weeks later. Importantly, David's widow said she still supported the law after his death. Doctors, including Compassion & Choices experts, who reviewed David's case believe either an additional medication

he was taking disrupted the aid-in-dying medicine's effect, or he failed to take the entire dose. The aid-in-dying medication did not cause suffering.

Source:
http://web.archive.org/web/20051101103141/http://www.oregonlive.com/special/assisted_suicide/index.ssf?/special/oregonian/suicide/030405.html

8. The Story of Patrick Methany

False claim: Relatives will abuse the self-administration provision and administer the drug to the terminally ill person.

Facts: This story demonstrates the law works as intended. Patrick, who had ALS and a prognosis of six months or less to live, obtained a medical aid-in-dying prescription and asked his brother-in-law to be with him when he ingested the medication. The County District Attorney investigated whether Patrick, who was almost entirely paralyzed, had gotten help from his brother-in-law in ingesting the drug, but found no abuse of the law. Patrick's father said that Patrick was able to eat and swallow, so Patrick's family member held a glass for Patrick while Patrick used a straw to self-administer the medication.

Source: McMahon, Patrick. Koch, Wendy. USA Today. November 11, 1999. "Assisted Suicide: A Right or a Surrender." http://www.mult-sclerosis.org/news/Nov1999/AssistedSuicide1.html

9. The Story of Michael Freeland

False claim: A person who is not mentally capable can get a medical aid-in-dying prescription.

Facts: This story actually demonstrates that people can only receive a prescription for medical aid in dying if two doctors determine the person is mentally capable of making their own healthcare decisions. Michael was diagnosed with terminal lung cancer. After Michael requested a prescription to use if his suffering should become unbearable, two doctors determined that he was mentally capable to make his own decisions. It appears that Michael's doctors determined that a diagnosis of depression did not impair his judgment nor cause him to lose the mental capacity to make healthcare decisions, and was not the cause of his request for aid-in-dying medication. Many people are diagnosed with mental illnesses such as anxiety, phobias and depression that do not affect their ability to make decisions. Over this period of time, Michael was seen by several doctors who were all comfortable with his possessing the aid-in-dying medication. Five years after Michael's death, two doctors who actively oppose the Oregon Death With Dignity law presented an article at a conference suggesting the law had somehow failed in Michael's case because he had a mental illness, despite the fact that Michael never took the medication. In fact, the story shows that putting the person in charge of when or whether to take aid-in-dying medication is one way in which the law works so well. No one can determine how much suffering one can bear. Many patients have felt comforted by possessing the medication, giving them a sense of control and choice.

Source: Schwartz, John. The New York Times. May 7, 2004. "Opponents of Oregon Suicide Law Say Depressed Man Was Wrongly Given Drugs." http://www.nytimes.com/2004/05/07/national/07SUIC.html

Resources

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[2]Wang, S, Aldridge, MD, Gross, CP, Canavan, M, Cherlin, E, Johnson-Hurzeler, R., et al. (2015) Geographic Variation of Hospice Use Patterns at the End of Life. Journal of Palliative Medicine. 18(9), 778.
[3]Lee, M,A, & Tolle, S.W. (1996) Oregon's assisted suicide vote: The silver lining. Annals of Internal Medicine. 124(2), 267-269.
[4]Wang, S, Aldridge, MD, Gross, CP, Canavan, M, Cherlin, E, Johnson-Hurzeler, R., et al. (2015) Geographic Variation of Hospice Use Patterns at the End of Life. Journal of Palliative Medicine. 18(9), 775.
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[8]Recent Polling in NJ. Purple Insights. February 2014. Available from http://www.compassionandchoices.org/userfiles/New-Jersey-Purple-Poll-Memo-February-2014.pdf.
[9]ORS Chapter 127.880 - Oregon Death With Dignity Act.
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[11]Emanuel M.D., Ph.D, Ezekiel. Battin Ph.D., Margaret P. New England Journal of Medicine. July 16, 1998. "What Are the Potential Cost Savings from Legalizing Physician-Assisted Suicide?"
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