



DEATH WITH DIGNITY in MARYLAND Support? Oppose? Neutral?

1. LWVMD DEATH WITH DIGNITY POSITION AND BACKGROUND FOR THE STUDY*

Humans have wrestled with questions of how to handle the imminent approach of death for as long as we have had medical tools to postpone or hasten death. Modern medical advances have increased the urgency of these questions as we have gained the ability to extend life, but often with the result of prolonged periods of disability and/or pain.

At its biennial convention in June 2017, the League of Women Voters of Maryland chose Death with Dignity¹ as one of its study topics to determine an appropriate position - - ethically, morally and legally – with which to deal with end of life issues of the terminally ill.

This topic is of critical importance whatever the League's final stand may be. End-of-life issues, including DWD, are very prevalent conversations in today's society. The subject is frequently discussed and/or alluded to in many news and magazine articles, movies, television shows and radio talk shows.

2. WHAT IS DEATH WITH DIGNITY?

Death with Dignity (DWD) refers to laws that allow a terminally ill, mentally competent adult with a prognosis of six months or less to live to request a prescription for a lethal medication which can be self-ingested at the time of their own choosing to bring about a peaceful death. Most state laws provide that two doctors must confirm the terminal diagnosis, prognosis, and that the person requesting the prescription make multiple requests, is fully informed and making the choice of their own volition. The doctors must also provide the requesting person with information about additional end-of-life options, including palliative and hospice care.

Participation in Death with Dignity is completely voluntary for patients, doctors, and pharmacists. No patient is required to apply for it and no doctor or pharmacist is mandated to provide it. Forcing someone to use DWD is illegal and subject to criminal prosecution. The DWD laws only offer an additional option to terminally ill patients. If someone does not want to avail themselves of it, they do not have to. Where legal, it is a choice that people must make for themselves.

¹ Note that "Death with Dignity" (DWD) is often referred to by the names: Medical Aid in Dying (MAID), Physician Assisted Dying (PAD), Aid in Dying (AID), Physician Assisted Suicide (PAS), and Lawful Physician-Hastened Death (LPHD).

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3. WHAT DEATH WITH DIGNITY IS NOT

Death with Dignity is not suicide despite often being referred to as “Physician Assisted Suicide”. The people who opt to use DWD laws want desperately to continue to live, but do not have that option available. Death is unquestionably imminent for them, potentially with a lot of pain, discomfort, lack of dignity, and loss of quality of life. People exercising DWD generally are surrounded by loved ones when they ingest the medication and almost always die a very quick and peaceful death. People who die by suicide are usually alone and often experience a very violent death. In 2017, the American Association of Suicidology released a position paper and the following statement²:

“The American Association of Suicidology (AAS) recognizes that the practice of physician aid in dying, Death with Dignity, and medical aid in dying is distinct from the behavior that has been traditionally and ordinarily described as “suicide”. Although there may be overlap between the two categories, legal physician assisted deaths should not be considered to be cases of suicides.”

Death with Dignity is not euthanasia. Euthanasia is defined as “the painless killing of a patient suffering from an incurable and painful disease or an irreversible coma.” It is an intentional act by which another person chooses and acts to cause death and is illegal throughout the United States. Individuals qualifying and opting for DWD must self-ingest the requested medication; no one can administer the medication to him or her. Forcing someone to use DWD by administering the drug is illegal and subject to criminal prosecution. All DWD laws expressly prohibit euthanasia.

4. OTHER NON-VIOLENT END-OF-LIFE OPTIONS

Terminally ill patients have options other than DWD while they are awaiting death (usually in Hospice):

- Palliative care utilizes medication and other modalities to control symptoms while keeping patients conscious and comfortable during the progression of their disease. For those who consider DWD, this treatment is insufficient. They are still suffering physically and/or existentially.
- Palliative sedation utilizes medication to keep terminally ill patients comfortable via unconscious sedation during the progression of their disease. Those who consider DWD do not wish to end their lives by being in a coma for an indeterminate amount of time.
- Any individual may shorten their dying process by Voluntarily Stopping Eating and Drinking (VSED). By intentionally refusing to eat or drink, death will take place between 7 and 21 days. Patients opting for VSED often also utilize palliative care in an attempt to keep them comfortable during this very difficult and drawn-out process. For those wanting DWD this is an unacceptable option.

² <http://www.suicidology.org/Portals/14/docs/Press%20Release/AAS%20PAD%20Statement%20Approved%2010.30.17%20ed%2010-30-17.pdf>

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- Patients always have the right to refuse medical treatment, including those that sustain life (i.e. ventilators, feeding tubes, pacemakers). Depending on the immediate outcome of the treatment refused, patients could end up using one of the options above.

5. CHANGING SOCIAL ATTITUDES

The Hemlock Society was the first right-to-die organization in America. It was founded in 1980 by Derek Humphry, who had helped his wife dying from breast cancer take her own life. The name, *Hemlock Society*, was chosen to honor Socrates' choice to drink hemlock rather than face the execution that was awaiting him. Within 12 years, 80 Chapters had been established nationwide with the mission of helping terminally ill people die peacefully and to advocate for laws backing medical aid in dying (MAID). In 1991 Humphry self-published his book, *Final Exit*, after failing to find a publisher. The book soared to the best-seller list and an updated 3rd edition was published in 2010.

In 1991 Oregon's Hemlock Society began working with a Senator in the Oregon State Legislature to propose an aid-in-dying bill that failed in committee. The bill's supporters, who began drafting a new law to put before the 1994 election, included a staff member, Barbara Coombs Lee, now president of *Compassion and Choices*. Colleagues in the project included members of the Hemlock Society, (later changing their name to *End of Life Choices*), which merged with *Compassion in Dying*. Eventually those two organizations merged to become today's *Compassion and Choices* (<https://www.compassionandchoices.org>). Another national organization that has continued to strongly and actively supported DWD for many years is *Death with Dignity National Center* (<https://www.deathwithdignity.org>).

Despite opposition by many religious organizations, some have begun to support DWD. An early adapter, in 1988 the Unitarian Universalist Association adopted a General Resolution in support of the Right to Die with Dignity³, a position which they continue to uphold and educate their members about. In 2009 the Central Atlantic Conference of the United Church of Christ adopted a resolution in support of the "legality of physician assistance in dying under very specific guidelines as determined by each state". In 2017 they proposed that the General Synod (UCC national organization) adopt their resolution. The resolution fell short of passing by only twelve votes. In 2013, the Society for Humanistic Judaism announced their support for Physician-assisted death.⁴

In early February 2018, the National Academies of Sciences, Engineering, and Medicine convened a very informative workshop on "Physician-Assisted Death: Scanning the Landscape and Potential Approaches" in Washington, DC to explore current practices and challenges. Experts from around the world came to share their experiences with all aspects of the subject. Announcement of the event stated:

³ <https://www.uua.org/action/statements/right-die-dignity>

⁴ <http://www.shj.org/physician-assisted-death/>

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“This National Academies of Sciences, Engineering, and Medicine workshop will explore the evidence base and research gaps relating to the implementation of the clinical practice of allowing terminally ill patients to access life-ending medications with the aid of a physician.....The workshop will examine what is known, and unknown, about how physician-assisted death is practiced and accessed in the United States; it will not be a focus of the workshop to discuss at length the moral or ethical arguments for or against the practice of physician-assisted death. The workshop will serve as a neutral space to facilitate dialogue in order to help inform ongoing discussions between patients, their providers, and other health care stakeholders. “

Videos of the speakers and copies of their presentations are available at:

<http://www.nationalacademies.org/hmd/Activities/HealthServices/PADworkshop/2018-FEB-12>. A free PDF file of the Workshop Proceedings can be found in the supporting documents folder or downloaded at: <http://nationalacademies.org/PhysicianAssistedDeath>

6. HISTORY OF DEATH WITH DIGNITY AND OTHER END-OF-LIFE LEGISLATIVE EFFORTS IN MARYLAND

Supporting Death with Dignity legislation is very likely to be introduced in the upcoming sessions of the Maryland General Assembly. Based on the trend of legislative debates over the past 30 years, bills have been introduced with opposing purposes, either prohibiting or authorizing DWD. General support for DWD has grown amongst Maryland legislators with more co-sponsors every year. Surveys show that 60%-65% of Marylanders support DWD. (See supporting document: *Compassion&ChoicesFactSheets/C&C_PollingMemo_031416*)

Bills Prohibiting DWD:

- 1987** Lawmakers considered HB 948 (introduced by Delegate Judy Toth) to outlaw assisting suicide, but the bill was defeated. This bill would have made it a felony for a person to deliberately aid or abet another person to commit suicide. Violators would have been subject to a maximum penalty of 30 years in jail.
- 1993** In response to a request from Delegate Ronald A. Guns , Attorney General Joseph Curran, Jr. issued a formal opinion (78 OAG 109, Sept. 8, 1993) ruling that current Maryland laws impose criminal sanctions on a physician or other health care provider who ... “*knowingly and intentionally supplies the means by which an individual takes his or her own life*”. (See supporting document: *PriorTo2015/1993_78OAG109.pdf*)
- 1999** Two Assisted Suicide Prohibition Bills were considered (HB 496 and SB 319). HB 496 passed the House by a vote of 78-54 and the Senate by a vote of 27-20. It was signed into law by Governor Parris N. Glendening (D). (See supporting

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document: *PriorTo2015/1999_HB496.pdf*)

- 2002** Article 27 § 416 was repealed and replaced by Acts 2002, c.26, § 2 (HB11), creating a new felony of “assisting” suicide.
- 2013** MD Code, Criminal Law, § 3-101 (Formerly cited as MD CODE Art. 27, § 416) is in effect.). (See supporting document: *PriorTo2015/2013_MD_CriminalCode_3-101.pdf*)

Bills Authorizing DWD:

- 1995** The *Terminal Illness-Physician Aid In Dying* Bill (HB 933) was introduced in the General Assembly by Delegate Dana Dembrow. A hearing was held, but the bill ultimately was rejected by the House Environmental Affairs Committee 15-4.
- 1996** Aid-in-Dying bill introduced in the General Assembly. HB 474: Failed attempt. Rejected by House Environmental Affairs Committee 16-5.
- 2015** The *Richard E. Israel and Roger “Pip” Moyer Death with Dignity Act* (based on the Oregon Death with Dignity Act) was introduced in both the Senate (SB 676)⁵ and House of Delegates (HB 1021)⁶. SB 676 was introduced by Senator Ron Young and co-sponsored by seven other Senators. HB 1021 was introduced by Delegate Shane Pendergrass and co-sponsored by thirty-seven others Delegates. Hearings were held, but both bills were withdrawn by their sponsors prior to vote as it was determined there were insufficient votes to pass them.

A Joint Legislative Workgroup on Death with Dignity was created in the Fall 2015 and jointly chaired by Senator Victor Ramirez and Delegate Shane Pendergrass. Three meetings were held (September 8, October 6, and December 8). The purpose of the workgroup was to garner further research on Death with Dignity and come up with suggestions to improve the proposed bill. (See supporting documents in: 2015 folder)

- 2016** The *Richard E. Israel and Roger “Pip” Moyer Death with Dignity Act* (based on the Oregon Death with Dignity Act) was introduced in both the Senate (SB 418)⁷ and House of Delegates (HB 404)⁸. SB 418 was introduced by Senator Ron Young and co-sponsored by twelve other Senators. HB 404 was introduced by Delegate Shane Pendergrass and co-sponsored by forty other Delegates. Hearings were held, but both bills were withdrawn by their sponsors prior to vote as it was determined there were insufficient votes to

⁵ <http://mgaleg.maryland.gov/webmga/frmMain.aspx?id=sb0676&stab=01&pid=billpage&tab=subject3&ys=2015rs>

⁶ <http://mgaleg.maryland.gov/webmga/frmMain.aspx?pid=billpage&tab=subject3&id=hb1021&stab=01&ys=2015RS>

⁷ <http://mgaleg.maryland.gov/webmga/frmMain.aspx?id=sb0418&stab=01&pid=billpage&tab=subject3&ys=2016rs>

⁸ <http://mgaleg.maryland.gov/webmga/frmMain.aspx?pid=billpage&tab=subject3&id=hb0404&stab=01&ys=2016RS>

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pass them.

- 2017** The *Richard E. Israel and Roger "Pip" Moyer Death with Dignity Act* (based on the Oregon Death with Dignity Act) was introduced in both the Senate (SB 354)⁹ and House of Delegates (HB 370)¹⁰. SB 354 was introduced by Senator Guy Guzzone and co-sponsored by thirteen other Senators. HB 370 was introduced by Delegate Shane Pendergrass and co-sponsored by forty-two other Delegates. Both bills were withdrawn by their sponsors prior to the Senate Hearing or any votes as it was determined there were insufficient votes to pass them.

There is an excellent chance that DWD bills will be introduced in both houses of the Maryland General Assembly in the 2019 session. It is very important that the LWVMD weigh in on this significant issue and have their voices heard.

7. STATE LAWS AUTHORIZING DWD

The election of November 1994 made Oregon the first State in the Union to legalize medical aid in dying when voters approved an initiative measure to enact the Death With Dignity Act. The Oregon Death with Dignity Act allows mentally competent terminally ill adults, likely to die within six months, to obtain a prescription for lethal medication from a doctor. Patients must be at least 18, a resident of the State, and able to demonstrate that they are capable of making their own decisions. The measure faced legal appeals for several years, which kept the law from taking effect until it was enacted on 27 October 1997. The Oregon law requires the Oregon Health Authority to collect information about the usage of the Act and publish an annual report. Current and past annual reports along with relevant forms, FAQs, and additional information are available at:

<http://www.oregon.gov/oha/PH/ProviderPartnerResources/Evaluationresearch/deathwithdignityact/Pages/index.aspx>

Some DWD advocates sought to achieve their goal through litigation rather than adopting legislation. In 1997, the U.S. Supreme Court unanimously held that a right to assisted suicide in the United States was not protected by the Due Process Clause (*Washington v. Glucksberg*).

Resistance and litigation culminated in 2006 with the U.S. Supreme Court upholding Oregon Law by a 6 to 3 margin. By then the voters of Oregon had already voted in 1994 and 1997 in support and were beginning to compile a body of data that confirmed that the law was not being abused.

As of April 2018, six states and the District of Columbia have adopted Death with Dignity-like statutes: California (2015), Colorado (2015), District of Columbia (2016), Hawaii (2018),

⁹ <http://mgaleg.maryland.gov/webmga/frmMain.aspx?id=sb0354&stab=01&pid=billpage&tab=subject3&ys=2017rs>

¹⁰ <http://mgaleg.maryland.gov/webmga/frmMain.aspx?pid=billpage&tab=subject3&id=hb0370&stab=01&ys=2017RS>

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Oregon (1997), Vermont (2013), and Washington State (2008). All of these are based on the Oregon Death with Dignity Act, often with additional caveats added. In Montana, physician-assisted dying was upheld by State Supreme Court ruling (2010).

8. ACTION BY OTHER LEAGUES

In January 2016, the League of Women Voters of Utah conducted a study on Death with Dignity¹¹ and subsequently released a consensus position statement¹² based on that study:

1. The League of Women Voters of Utah believes state laws should grant the option for a terminally ill person to request medical assistance from a relevant, licensed physician to end one's life.
2. The League of Women Voters of Utah believes such legislation should include safeguards against abuse for the dying and/or medical personnel.

During the 2017 League of Women Voters of New York State convention, a proposal to consider concurrence with the LWV Utah's position on Death with Dignity was approved by convention delegates. In March 2018, the LWVNYS Board approved the following concurrence position regarding Death with Dignity¹³ :

1. The League of Women Voters of New York State believes state laws should grant the option for a terminally ill person to request medical assistance from a relevant, licensed physician to end one's life.
2. The League of Women Voters believes such legislation should include safeguards against abuse of the dying and protections for medical personnel who act in good faith compliance with the law.

9. SUMMARY OF MARYLAND'S 2017 PROPOSED END OF LIFE OPTION ACT

The most recently proposed Maryland END OF LIFE OPTION ACT (as well as all preceding proposed bills) was based on the Oregon Death with Dignity Act and specified:

- Only the individual may request medicine to end his/her life.
- An individual must prove he/she is a Maryland resident.
- The attending physician and consulting physician must certify:
 - That the individual has the mental capacity to make a medical decision.
 - That the prognosis for the individual is that death is likely within 6 months.
- The individual must request a life ending prescription three times:
 - Request 1 is oral;
 - Request 2 is in writing, and signed by the individual and two qualified witnesses;
 - Request 3 is oral, at least 15 days after the initial oral request; and 48 hours

¹¹ http://lwvutah.org/studies/DeathwithDignity_Final%201-19-16.pdf

¹² <http://lwvutah.org/studies/LWVUTPositiononDeathwithDignity.pdf>

¹³ <http://www.lwvny.org/programs-studies.html#death>

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- after making the written request.
- One of the witnesses to the written request may not be a relative of the individual and may not benefit from the individual's death.
- At least once, the individual must be alone with the doctor when the request for medicine to end his/her life is made.
- The prescription must be self-administered by the individual.
- The individual may withdraw the request at any time and does not have to use the prescribed medicine.
- Aid in dying by a health care provider is voluntary, but if not participating, the provider shall expeditiously transfer medical records on request.
- A health care facility may prohibit an associated health care provider from participation in this process under certain circumstances.
- Death from the self-administered medication that was prescribed shall be deemed as death from the underlying illness and recorded as such on the Death Certificate.
- There are criminal penalties for individuals who falsify a written request or coerce an individual with the intent of ending the individual's life.
- This bill does not legalize lethal injection, mercy killing, or euthanasia.
- The Department of Health and Mental Hygiene must adopt regulations to facilitate the collection of certain information and to produce and make available to the public a yearly report.

10. VIEW OF MEDICAL COMMUNITY

Despite the opposition of the **American Medical Association** (AMA) for DWD, many State Medical Associations (including the Maryland State Medical Society) are registering a neutral stance.

The American Medical Association Code of Medical Ethics Opinion states "Physician-assisted suicide is fundamentally incompatible with the physicians role as healer, would be difficult or impossible to control and would pose serious societal risks."¹⁴

2016: At its House of Delegates meeting in September 2016, **MedChi** (The Maryland State Medical Society) adopted Resolution 16-16:

"Resolved, that MedChi change its policy on physician assisted suicide (aid-in-dying) from "oppose" to a position of "neutral" on Maryland aid-in-dying legislation."

2017: **MedChi** (dedicated an entire issue of it's Quarterly Medical Journal to end-of-life issues: "What Should We Do When Cure Is Not Possible?".¹⁵

The **Massachusetts Medical Society** and **Vermont Medical Society** joined medical societies in California, Colorado, Maryland, Maine, Minnesota, Nevada,

¹⁴ <https://www.ama-assn.org/delivering-care/physician-assisted-suicide>

¹⁵ <http://www.medchi.org/Portals/18/Files/MD%20Medicine/MM-Vol17Iss4.pdf?ver=2017-07-11-104828-760>

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New York, Oregon and the District of Columbia in dropping opposition to DWD. Supporters of legislation that allows doctors to write a prescription for a lethal dose of medication that terminally ill adults can use to end their lives now prefer the term medical aid-in-dying.¹⁶

2018: The **AMA** is reevaluating its stance. In June 2018, the AMA House of Delegates voted 56 to 44 percent to reject a report by its Council on Ethical and Judicial Affairs (CEJA) that recommended the AMA maintain its Code of Medical Ethics' opposition to MAID. The House of Delegates referred the report back to the CEJA for further work.

Other Medical Associations recognizing Medical Aid in Dying:¹⁷

2007: The **American Medical Student Association (AMSA)** supports passage of aid-in-dying laws that empower terminally ill patients who have decisional capacity to hasten what might otherwise be a protracted, undignified or extremely painful death. Aid in dying should not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide.

The **American Medical Women's Association (AMWA)** supports the right of terminally ill patients to hasten what might otherwise be a protracted, undignified or extremely painful death. AMWA believes the physician should have the right to engage in practice wherein they may provide a terminally ill patient with, but not administer, a lethal dose of medication and/or medical knowledge, so that the patient can, without further assistance, hasten his/her death. This practice is known as aid in dying. AMWA supports the passage of aid-in-dying laws that empower mentally competent, terminally ill patients and protect participating physicians, such as that passed in Oregon: the Oregon Death With Dignity Act.

2008: **The American Public Health Association (APHA)** supports allowing a mentally competent, terminally ill adult to obtain a prescription for medication that the person could self-administer to control the time, place and manner of his or her impending death, where safeguards equivalent to those in the Oregon DDA are in place. Rejects the use of inaccurate terms such as "suicide" and "assisted suicide" to refer to the choice of a mentally competent, terminally ill patient to seek medications to bring about a peaceful and dignified death."

The **American College of Legal Medicine (ACLM)** states: "BE IT RESOLVED: That the ACLM recognizes patient autonomy and the right of a mentally

¹⁶<https://www.fiercehealthcare.com/practices/2-state-medical-societies-drop-opposition-medical-aid-dying>

¹⁷ <https://www.compassionandchoices.org/wp-content/uploads/2018/03/FS-Medical-Professional-Associations-that-Recognize-Medical-Aid-in-Dying-3.02.18-1.pdf>

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competent, though terminally ill, person to hasten what might otherwise be objectively considered a protracted, undignified or painful death, provided, however, that such person strictly complies with law specifically enacted to regulate and control such a right; and BE IT FURTHER RESOLVED: That the process initiated by a mentally competent, though terminally ill, person who wishes to end his or her suffering and hasten death according to law specifically enacted to regulate and control such a process shall not be described using the word “suicide”, but, rather, as a process intended to hasten the end of life.”¹⁸

The **Gay and Lesbian Medical Association (GLMA)**: “With the aging of the LGBT community, end-of-life concerns will continue as an important topic for the community and for GLMA’s work. Aging can be particularly difficult for members of the LGBT community due to estranged family situations, being single or not having dependents, and unequal treatment under the law. It is critical then that LGBT patients have a legal framework to discuss all healthcare options, including end-of-life options, with their physicians and healthcare providers.”¹⁹

2016: **American Academy of Hospice and Palliative Medicine (AAHPM)** adopted a position of studied neutrality²⁰:

“AAHPM takes a position of studied neutrality on the subject of whether PAD should be legally permitted or prohibited. However, as a matter of social policy, the Academy has concerns about a shift to include physician-assisted dying in routine medical practice, including palliative care. Such a change risks unintended long-range consequences that may not yet be discernable, including effects on the relationship between medicine and society, the patient and physician, and the perceived or actual integrity of the medical profession. Any statutes legalizing PAD and related regulations must include safeguards to appropriately address these concerns, such as limiting eligibility to decisionally capable individuals with a limited life expectancy.”

A December 2016 **Medscape poll** of more than 7,500 U.S. physicians from more than 25 specialties demonstrated a significant increase in support for medical aid in dying from 2010. Well over half (57%) of the physicians surveyed endorse the idea of medical aid in dying, agreeing that “Physician assisted death should be allowed for terminally ill patients.”²¹

2017: The American College of Physicians published a position paper.²² Their position

¹⁸ American Academy of Legal Medicine, Excerpted from: Policy on Aid in Dying. October 6, 2008. Available from https://aclm.memberclicks.net/assets/docs/Policy_On_Aid_In_Dying.pdf

¹⁹ GLMA Letter of Support in AB X2-15, October 2, 2015. Available from <https://drive.google.com/file/d/0B3I72uklCnvHMnQyem16SXQ3M3pKbHdHTnBjaDM0NmhjNVZv/view?usp=sharing>

²⁰ American Academy of Hospice & Palliative Medicine. Excerpted from: Statement on Physician-Assisted Death. Available from <http://aahpm.org/positions/pad>

²¹ Medscape Ethics Report 2016: Life, Death, and Pain, December 23, 2016. Available from <http://www.medscape.com/features/slideshow/ethics2016-part2-page=2>

²² <http://annals.org/aim/fullarticle/2654458/ethics-legalization-physician-assisted-suicide-american-college-physicians-position-paper>

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statement is below:

“The ACP affirms a professional responsibility to improve the care of dying patients and their families. The ACP does not support the legalization of physician-assisted suicide, the practice of which raises ethical, clinical, and other concerns. The ACP and its members, including those who might lawfully participate in the practice, should ensure that all patients can rely on high-quality care through to the end of life, with prevention or relief of suffering insofar as possible, a commitment to human dignity and management of pain and other symptoms, and support for families. Physicians and patients must continue to search together for answers to the challenges posed by living with serious illness before death.”

2018: In its February 2018, *Neurology Journal*, the **American Academy of Neurology (AAN)** reported on “Lawful physician-hastened death: AAN position statement”.²³ Below is a quote from the article:

“In consideration of the Ethics, Law and Humanities Committee recommendations, the AAN Board of Directors carefully deliberated this important issue, taking into account the evolving legal environment, all aspects of the ethical debate, the reported values of AAN members, and expectations of their adult patients dying of neurologic illness. Accordingly, the AAN has decided to retire its 1998 position on “Assisted suicide, euthanasia, and the neurologist” and to leave the decision of whether to practice or not to practice LPHD to the conscientious judgment of its members acting on behalf of their patients. The Ethics, Law and Humanities Committee and the AAN make no attempt to influence an individual member’s conscience in consideration of participation or nonparticipation in LPHD. Although the AAN endorses the belief that LPHD decisionmaking is ideally made within a well-established patient/ doctor relationship, it places no obligation on its members to identify another physician willing to participate should their conscience preclude them from participation. The AAN remains opposed to member participation in euthanasia, which remains illegal in all US jurisdictions, regardless of its legal status in the jurisdiction in which an AAN member may practice.”

11. VIEW OF LEGAL COMMUNITY

The American legal system is faced with a conundrum in dealing with Death with Dignity. In the majority of states, physician participation with a patient’s desire to end his/her life is prohibited by law no matter how sympathetic the situation. Prior to enactments in Oregon and Washington, case law precedents such as the one in Montana²⁴ were the source of evidence

²³ Neurology Special Article: Lawful physician-hastened death. AAN Position statement. Available from: <http://n.neurology.org/content/90/9/420>

²⁴ <https://www.deathwithdignity.org/states/montana/>

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in defense of such actions. In that case, the Montana Supreme Court found 5-2, in *Baxter v. Montana*²⁵, that nothing in the state law prohibited a physician from honoring a terminally ill, mentally competent patient's request by prescribing medication to hasten the patient's death." The basis of the ruling was that a physician's participation by writing a prescription was not different from a physician removing life supports, which is permitted under the state's Rights of the Terminally Ill Act. Montana is the only state with such a ruling. Bills in support of the ruling and against were introduced in the state legislature in 2011, 2013, 2015, and 2017. All failed to pass, with the resolution against in 2017 failing as result of a tie.

In New Mexico, until 2014, assisting with suicide was a fourth-degree felony. In *Morris vs. New Mexico* (*Morris v. New Mexico*, 376 P.3d 8362016 NMSC 027) the Second District Court granted injunctive relief to the plaintiffs, two oncologists, and their patient by ruling that "The Defendants (state of New Mexico), their agents, employees, representatives, and all those acting in concert with them, shall be permanently enjoined from prosecuting any physician for providing aid in dying to a mentally-competent, terminally-ill individual." This ruling was upheld by the Court of Appeals, but not by the New Mexico Supreme Court²⁶. In June 2016, the Court overruled a district court that in 2014 proclaimed physician-assisted dying in the state a right, saying the matter should be resolved in the executive and legislative branches. As subsequent proposed legislative efforts have failed, physician-assisted death is NOT legal in New Mexico.

The Supreme Court has also weighed in on physician assisted end of life and has issued decisions pro and con. *Vacco v. Quill*, 521 US 793 (1997) and *Washington v. Glucksberg*, 521 US 702 (1997) were both argued that a ban on physician-assisted suicide was a violation of the due process clause of the 14th amendment. In both cases, the Supreme Court ruled that New York differentiating between withdrawal of treatment and physician-assisted suicide did not violate the Equal Protection or Due Process Clauses of the 14th amendment. In *Cruzan by Cruzan v. Director, Missouri Department of Health*, 497 US 290, the Court decided that the state of Missouri had the right to keep a patient alive in a persistent vegetative state as there was no "clear and convincing" evidence of the wishes of the patient. However, in *Gonzales v. Oregon*, 546 US 243 (2006), the Court upheld the Oregon Death with Dignity legislation and the decision was that the Controlled Substance Act did not ban the use of these substances in physician-assisted suicide. Nor could the Attorney General determine what is a violation of that Act. Since the California End of Life Option Act was only recently enacted (2016), any court challenges have not made their way through the legal system.

²⁵ <https://law.justia.com/cases/montana/supreme-court/2009/50c59956-3100-468d-b397-4ab38f6eda4d.html>

²⁶ <https://law.justia.com/cases/new-mexico/supreme-court/2016/35-478.html>

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12. OPPOSITION TO DEATH WITH DIGNITY

To the opposition, Death with Dignity is referred to as “*Assisted Suicide*” (counseling, abetting or aiding someone to kill him or herself. It is murder or homicide whether the intention is compassion, or the person has consented to be killed) or “*Euthanasia*” (the deliberate killing of someone by action or omission, with or without that person’s consent, for what are claimed to be compassionate reason).

Most censure stems from the ambiguous moral fields of defining life, cessation of life, and quality of life. Other arguments challenge the ethics of ending life and the control and influence of the people surrounding the dying. The opposition suggests there are alternatives to ending life unnaturally.

Activists offer similar arguments as Abortion Rights and Right to Life advocates. Opinions have depth and inspire deep conviction in supporters, physicians, legislators and policy makers. Religious and spiritual groups, rights of disability groups, individuals confronted with this issue, and every individual, all have a stake in the outcome.

As the leading edge of public policy working to ensure the rights of patients on this important final journey, Death with Dignity is not only a legal issue, but a cultural one.

"From the Soviet gulag to the Nazi concentration camps and the killing fields of Cambodia, history teaches that granting the state legal authority to kill innocent individuals has dreadful consequences." ... Pete Du Pont, former Delaware governor.

"My Administration is dedicated to the preservation of America as a free land, and there is no cause more important for preserving that freedom than affirming the transcendent right to life of all human beings, the right without which no other rights have any meaning." ... Ronald Reagan, former U.S. president.²⁷

Listed below are some of the most common opposition arguments:

- **Insurance and costs:** Insurance company interference with end of life choices is of primary concern. Lethal prescriptions are cheaper than chemotherapy or long-term care for patients. Experimental drugs, personalized or specialized medicine, hospitalization, and elder care are costly. There is a real fear of insurance companies defaulting on treatment costs to cause critically ill patients to seek relief by ending life. The insurance lobby is strong and well-funded, increasing concern.

²⁷ <http://www.euthanasia.com/page16.html>



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- *Miracles are possible:* Death is an inaccurate science. What was terminal in the past, is no longer terminal. Many people believe that miracles and recovery are possible at any point in a disease. Terminating life denies that hope.
- *Death by drugs, an inexact science:* Administering drugs to cause death is imprecise as shown specifically in botched lethal injections at correction facilities. Doctors are not trained to cause death; therefore, they lack the expertise and training to make death pain and stress free.
- *Coercion:* Legally, suicide is solitary and not illegal in any state. But family intervention and influence cannot be measured. The possibility of elder abuse and persuasion is prevalent. It is argued that the elderly, people in pain, the disabled and other vulnerable groups do not have the mental capacity to disagree with strong family members and make their own decisions.
- *Eliminating the disabled:* Similarly, all people, no matter what their disability are valuable to society. Fear bias and prejudice against disability may lead others toward euthanasia. But when the disabled are unable to make their own choices, they have no say in their own lives. This dehumanization leaves them vulnerable.²⁸
- *Other end of life alternatives:* There are other alternatives to ending one's life. Pain, isolation and fear should not control decisions. Hospice and palliative care are under-explored options. Pain management and care alleviates suffering and allows life to be productive again.
- *Physicians as Gatekeepers:* Physicians become suicide gatekeepers, following arbitrary laws and health care policies. Do we rely on them to judge quality of life, violate their Hippocratic oath, or predict death within six months? How do we control the unethical doctors who help for the wrong reasons? It is unreasonable to give them the power over life and death.
- *Eliminating the disadvantaged:* In this world of economic disadvantages, there is a socio-economic dimension to choosing death over life. Disadvantaged and more impoverished people will not have the options of the wealthy and will choose to end life rather than suffer. Lack of options and a depressed mentally will affect the poor adversely than the wealthy. In a Democracy this is immoral and unacceptable.

²⁸ <http://notdeadyet.org/>

*Supporting documents, background materials, and resources are available online at:
https://www.lwvmd.org/fact_sheets



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- *Slippery Slope:* This refers to the implication that once DWD is accepted, the guidelines will either be liberalized by elected officials (i.e.. expand eligibility guidelines) or disregarded by practitioners. To date, none of these fears have been realized in states where DWD has been legalized.
- *Religious Opposition:* Finally, religious opposition is extremely cohesive and expressive in opposing physician-assisted death. Often, they advocate within the medical community for increased emphasis on the caring goals of medicine that preserve the dignity and minimize the suffering of the individual and respect personal choice for end of life care. Many Christians and Jews see assisted suicide as denial of God's presence and power. The sanctity of human life is paramount, God not man should be in control; man should care, not kill. The practice of painlessly putting to death people suffering from incurable diseases contradicts Christian morals. Hindus say the separation of soul and body through assisted suicide damages karma of both doctor and patient, and that the practice goes against the teaching of doing no harm. Muslims believe all life is sacred and Allah determines how long a person will live, humans should not interfere. Sikhs also see it as man's interference with God's plan. Suffering is part of karma. However, Unitarian Universalists, Spiritualists, United Church of Christ, Methodist Church on the US West Coast, Episcopalian, Presbyterian and Quakers are more liberal, and continue to discuss the issue as well as allow individual decision making.²⁹

Several very vocal and active organizations opposing DWD are:

- Maryland Against Physician Assisted Suicide (<https://stopassistedsuicidemd.org>)
- Not Dead Yet (<http://notdeadyet.org>)
- Disability Rights Education & Defense Fund (<https://dredf.org/?s=assisted+suicide&submit=Search>)
- The Arc (<https://www.thearc.org/who-we-are/position-statements/rights/physician-assisted-suicide>)
- True Dignity (<http://www.truedignity.org>)

13. POSITIVE ASPECTS OF DEATH WITH DIGNITY

Death with Dignity acknowledges patient dignity and autonomy while protecting vulnerable patients and gives dying patients some control over their remaining life. It has been shown that having this option relieves stress and fears of dying patients and allows them to focus on the quality of the life they have remaining whether or not they use it.

²⁹ <https://www.deathwithdignity.org/learn/religion-spirituality/>

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DWD laws have more safeguards than other laws designed to ease suffering. In the proposed Maryland End of Life Option Act:

- A patient must meet privately with the physician at least once
- There is a 15-day cooling off period, where the patient must make their request three times
- A second physician must be consulted and concur with the first physician's prognosis
- A mental health evaluation is required if either physician has concern about a patient's capacity
- Two witnesses are required for the request, one which may not be an heir
- An interpreter must be provided, if required

Neither palliative sedation or "a wink & a nod" (other ways that suffering may be alleviated) require any of the above safeguards.

	Withdrawal of Life Support (Health Care Decisions Act 1993)	Palliative Sedation 1999	Aid in Dying (Proposed End-of-Life Option Act 2017)	"A Wink & A Nod"
Physician meets alone with patient	No	No	Yes	No
"Cooling Off" period	No	No	15 days	No
Consultation with a second physician	No	No	Yes	No
Two witnesses, one of whom cannot be: -an heir -a relative	Yes No	No No	Yes Yes	No No
Obtain mental health evaluation if concern about patient's capacity	No	No	Yes	No
Interpreter	No	No	Yes	No

There are many reasons to support DWD:

- A patient's death brings him or her the end of pain and suffering.
- Patients have an opportunity to die with dignity, without fear that they will lose their physical or mental capacities.
- The overall healthcare financial burden on the family is reduced.
- Patients can arrange for final goodbyes with loved ones.
- If planned for in advance, organs can be harvested and donated.
- With physician assistance, patients have a better chance of experiencing a painless and less traumatic death.
- Patients can end pain and suffering when there is no hope for relief.
- Some say assisted death with dignity is against the Hippocratic Oath, however, the statement "first do no harm" can also apply to helping a patient find the ultimate relief from suffering through death.

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- Medical advances have enabled life beyond what nature might have allowed, but that is not always in the best interest of the suffering patient with no hope of recovery.

The most important, but not obvious, positive aspect of DWD is that overall it improves care at the end of life. Compassion & Choices reports that “Medical aid in dying expands choice, and improves care at the end of life. Multiple studies demonstrate that when states authorize medical aid in dying, palliative care and hospice systems grow stronger, improving care.”³⁰

Before providing a prescription, physicians are required to inform their patients of all options available to them including palliative care and hospice care. “Palliative care physicians report that a patient’s questions about medical aid in dying prompt in- depth conversations between doctors and patients about the full-range of end-of-life care options, including hospice, pain management and emotional support in addition to aid in dying.”³¹

Numerous studies in Oregon and Washington, along with a host of national surveys, link the availability of medical aid in dying as a palliative care option to a number of positive outcomes for end-of-life care³²:

- Research conducted in Oregon suggests that having medical aid in dying as an option relieves worries about future discomfort, pain and loss of control.
- Medical aid in dying promotes appropriate hospice use.
- Medical aid in dying helps family caregivers prepare for and accept a terminally ill person’s death.
- Medical aid in dying has resulted in better physician palliative care training.
- Terminally ill people who choose medical aid in dying are overwhelmingly in hospice care and able to die at home.
- Since the authorization of aid in dying, Oregon hospitals have expanded palliative care for individuals with terminal and life-threatening illnesses.
- Adults in Oregon and Washington, where medical aid in dying is authorized, are more knowledgeable about palliative, end-of-life and hospice care.

According to Compassion & Choices, “A number of prominent thought leaders and public influencers including religious figures, actors, authors and other notable people have spoken out — in touching, profound and highly personal ways — in favor of the full range of end-of-life options.”³³

10. CONCLUSION

³⁰ Medical Aid in Dying Improves Care at the End of Life: <https://www.compassionandchoices.org/wp-content/uploads/2016/07/FS-Medical-Aid-in-Dying-Improves-Care-at-the-End-of-Life-FINAL-2.2.16-Approved-for-Public-Distribution.pdf>

³¹ <https://www.compassionandchoices.org/wp-content/uploads/2016/07/FS-Medical-Aid-in-Dying-Improves-Care-at-the-End-of-Life-FINAL-2.2.16-Approved-for-Public-Distribution.pdf>

³² Ibid

³³ <https://www.compassionandchoices.org/wp-content/uploads/2016/02/FS-Medical-Aid-in-Dying-Thought-Leaders-FINAL-2.2.16-Approved-for-Public-Distribution.pdf>

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The League of Women Voters of Maryland Death with Dignity Study Group has reviewed the history as well as much of the pro and con literature about DWD. We propose a concurrence process for this significant topic so that when a bill is introduced in the 2019 Legislative Session we can have a statement.

*Supporting documents, background materials, and resources are available online at:

https://www.lwvmd.org/fact_sheets

Concurrence Form



Death With Dignity Study 2018

The League of Women Voters of Maryland Death with Dignity Study Group has reviewed the history as well as much of the pro and con literature about DWD from its inception to the current day and summarized it in the DWD Study Fact Sheet.

We propose a concurrence process with the League of Women Voters of Utah who completed an in-depth study in 2016 and formed a position on this important topic.

Having a position on DWD would enable the League of Women Voters of Maryland to speak on the topic when a bill is introduced in the 2019 Maryland General Assembly legislative session.

The League of Women Voters of Utah released a two-point consensus position statement based on their 2016 Death with Dignity study. The study provided information about laws in the five states that were currently allowing terminally ill persons to request physician aid in dying, as well as a detailed history of death with dignity through the ages.

CONCURRENCE QUESTION

League members throughout Maryland are involved in this study and may respond to the question differently from your local League. Concurrence is Yes or No as written. Please give us your opinion on the question so statewide consensus can be determined.

CONCURRENCE QUESTION: Should the League of Women Voters of Maryland concur with the Death with Dignity consensus position as written?

League of Women Voters of Utah (LWVUT) position states:

1. The League of Women Voters of Utah believes state laws should grant the option for a terminally ill person to request medical assistance from a relevant, licensed physician to end one's life.
2. The League of Women Voters of Utah believes such legislation should include safeguards against abuse for the dying and/or medical personnel.

Support concurrence with LWVUT Death with Dignity position statement
 Oppose concurrence with LWVUT Death with Dignity position statement

The complete LWVUT Death with Dignity study can be found: http://lwvutah.org/studies/DeathwithDignity_Final%201-19-16.pdf

LWVMD Death with Dignity supporting documents, background materials, and resources are available online at: <https://drive.google.com/open?id=1okQctR0Fjn6HWG4sCrWTqSnT5QqA8QmH>

The LWVMD committee that prepared this study were Erin Brandt, Elizabeth Demulling, Marti Hawkins, Dick Hawkins, Carolyn Hetterick, Sally Hunt, Cathy Keech, Sharalyn Luciani, Peggy Markman, Elaine Naper, Linda Silversmith, and chair, Sandra Bjork