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VIEWPOINT

The Changing Legal Climate for Physician Aid in Dying

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While once widely rejected as a health care option, physician aid in dying is receiving increased recognition as a response to the suffering of patients at the end of life. With aid in dying, a physician writes a prescription for life-ending medication for an eligible patient. Following the recommendation of the American Public Health Association, the term *aid in dying* rather than "assisted suicide" is used to describe the practice.¹ In this Viewpoint, we describe the changing legal climate for physician aid in dying occurring in several states (Table).

Voters in Oregon and Washington have legalized aid in dying by public referendum, legislators in Vermont have done so by statutory enactment, and courts in Montana and New Mexico have done so by judicial rulings. Support for aid in dying is increasing, and it would not be surprising to see voters, legislators, or courts in other states approve the practice. Indeed, in their 2014 sessions, at least 6 state legislatures considered proposals similar to the Vermont statute.

Although different states have authorized aid in dying through different legal routes, they all have extended the right to the same class of patients—mentally competent adults who are terminally ill. Even

an advance directive statute in California,⁵ courts and legislatures concluded that patients may reject their physicians' treatment recommendations even when treatment is necessary to prolong life.

Recognition of the right to refuse life-sustaining care reflected a societal consensus that people should be able to decline treatment when they are suffering greatly from irreversible and severe illness. In such cases, the burdens of continued treatment may easily outweigh the benefits, and people should not be forced to endure a prolonged and undignified dying process.⁶ What is critical about the right is the desire to protect seriously ill people from intolerable suffering.

How is it possible to decide when someone's illness is serious enough that treatment can be refused? The *Quinlan* case concluded that the right to refuse life-sustaining treatment should exist when the patient's prognosis becomes very grim.⁴

However, this approach raises serious problems. If judges must decide when a patient is so sick that the patient can refuse life-sustaining treatment, then the government ends up deciding who must live and who may die based on judgments about a person's quality of life. This approach would possibly lead to "death panels." Accordingly, later courts concluded that decisions whether to accept or refuse treatment "must ultimately belong to the one whose life is in issue."⁷

Although it is possible that someone will refuse life-sustaining treatment in the absence of a serious illness, that rarely happens. Moreover, when such refusals occur, they typically reflect important religious beliefs, as when a Jehovah's Witness refuses a blood transfusion. In short, it is possible

to avoid having the government make quality-of-life decisions and still be confident that life-sustaining treatment will be refused by patients only in situations in which that option is warranted.

Although a right to refuse treatment did not go too far in allowing death-causing actions, many people felt it did not go far enough. For instance, some patients are seriously ill and suffering greatly from widely metastatic cancer or other advanced diseases, but are not dependent on life-sustaining treatment. For those patients, aid in dying can be an important option.

However, there are real risks if patients are allowed to receive a prescription for a lethal dose of medication. Not all patients who would ask for a prescription would be suffering from an irreversible and severe illness. Some might have become tired of life, depressed, or feel that their life has insufficient meaning. Accordingly, a right to aid in dying could be recognized only

By restricting aid in dying to competent and terminally ill adults, the law can ease the dying process for patients, and their families, and avoid the potential for the mistreatment of patients.

though patients can suffer greatly from disease before their final days, the 5 states have limited recognition of aid in dying to patients with an incurable condition that will likely result in death within 6 months² or within a "relatively short time."³

This convergence on a right only for terminally ill persons to aid in dying is no coincidence. Indeed, it reflects a long-standing progression in end-of-life law. Society limits aid in dying to terminally ill patients to ensure that the practice is available only for individuals whose conditions might justify this option of last resort. The history of end-of-life law is instructive.

At one time, it was not clear whether patients could hasten death by refusing life-sustaining medical treatment. In the view of many people, turning off a ventilator, stopping dialysis, or discontinuing artificial feeding was an act of killing and should be unlawful. But beginning in 1976 with the *Quinlan* case in New Jersey⁴ and

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Table. States Currently Legalizing Aid in Dying for Mentally Competent, Terminally Ill Adults

State	Year of Legalization	Path of Recognition	Eligibility Criteria	Citation for Statute or Court Decision
Oregon	1994 and 1997	Public referenda	Mentally competent, terminally ill adults	Or Rev Stat §§127.800-127.897
Washington	2008	Public referendum	Mentally competent, terminally ill adults	Rev Code Wash § 70.245
Montana	2009	State supreme court decision	Mentally competent, terminally ill adults	<i>Baxter v State of Montana</i> , 224 P3d 1211 (Mont 2009)
Vermont	2013	Legislation	Mentally competent, terminally ill adults	18 Vt Stat §§5281-5292
New Mexico	2014	State trial court decision (subject to reversal on appeal)	Mentally competent, terminally ill adults	<i>Morris v Brandenburg</i> , No. D-202-CV 2012-02909 (Bernalillo County, NM, January 13, 2014)

with assurances that access would be limited to patients who are truly seriously ill. In addition, as with the withdrawal of treatment, the government could not impose limits by making quality-of-life judgments.

The terminal illness requirement provides the right kind of limit for aid in dying. It does not empower the government to make quality-of-life judgments, and it restricts the practice to patients who are suffering from irreversible and severe disease.⁸

This is not just a matter of theory. Oregon has had more than 15 years of experience with aid in dying limited to the terminally ill, and the state's experience has been reassuring. Aid in dying is used rarely by dying patients—less than one-half of 1% of deaths result from the practice (less than 100 patients annually). Approximately 80% of aid-in-dying patients are terminally ill from cancer,

and aid-in-dying patients are similar to other dying patients in terms of sex, race, health insurance coverage, and hospice enrollment. Moreover, aid-in-dying patients tend to have higher levels of education than other dying patients.⁹ Vulnerable patients are not succumbing to aid in dying. It is not surprising that once Oregon's experience with aid in dying was reassuring, other states were willing to consider authorizing aid in dying.

Although many critics of aid in dying have been concerned that legal recognition of the practice would result in a slippery slope to abuse, those fears have not materialized in Oregon, Washington, or the other states that have given formal recognition to aid in dying. By restricting aid in dying to competent and terminally ill adults, the law can ease the dying process for patients, and their families,¹⁰ and avoid the potential for the mistreatment of patients.

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