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Death with Dignity: The Legislative Wave of the Future

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Death with Dignity: The Legislative Wave of the Future
by

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BA English Literature, Benedictine College 1995

A Thesis

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University of Missouri-St. Louis

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In

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Abstract:

The objective of this paper is to determine whether the United States will experience a significant increase in the passage of Death with Dignity legislation. The methods used to predict future legislation was a comparative examination of the history of the legislation politically and socially within the United States. The historical trends of the legislation were compared with global trends as well as current societal factors that may influence legislation. The results will indicate that societal factors such as global influence, social media and the Baby Boom generation will have a dramatic affect in the rapid increase in Death with Dignity legislation soon to come. The paper will conclude that due to the historical trends of the legislation and the current societal factors involved in the issue; the Supreme Court should expand the original ruling allowing the option of Death with Dignity to be available in all 50 states.

Thesis:

The Supreme Court of the United States should amend the 1997 *Vacco V Quill* and *Washington V Glucksberg* Supreme Court rulings which deal with assisted dyeing by nationalizing the law and making physician aid in dying, or commonly known as physician-assisted suicide, an option in all 50 states. The Supreme Court should also look into expanding the current law legalizing voluntary euthanasia in extreme medical cases. The Supreme Court has

determined that no right exists for physician-aid in dying. However, states are free to enact laws to permit it under due process. It would be difficult for Congress to enact a law allowing nationwide PAD because it is not considered a protected liberty. The current statute discriminates against individuals who live outside of the Death with Dignity states and have no financial means to relocate so it would. On October 27, 1997; Oregon became the first state to permit physician-assisted suicide (Law Digest 2016). The current law also discriminates a segment of society that suffers from incapacitating diseases such as ALS and Alzheimer's disease. Under the present criteria people who suffer from those present conditions may suffer side effects on their illness that prevent them from qualifying. Furthermore, the Supreme Court of the United States should permit the Oregon Health Department to combine certain aspects of the Netherlands public administration of the law with current policy in effort to develop a rubric which can be implemented in all 50 states.

Interest Groups:

At the 2016 American Medical Association (AMA) Convention, the organization reaffirmed their stance opposing PAD and euthanasia which appears in their Code of Medical Ethics. The Code of Medical Ethics offers guidance to help physicians meet the ethical challenges of medical practice. The AMA argues that PAD and euthanasia is a violation of the Hippocratic Oath. The AMA is very

powerful organization and is very influential because it contains the largest association of medical doctors and medical students in the U.S. They have the numbers and resources to hire an unlimited number of powerful lobbyist to influence legislators. Other powerful organizations which oppose PAD and euthanasia are powerful religious organizations such as the Catholic Church. The Roman Catholic Church strongly opposes physician-assisted suicide and euthanasia. The largest lobbying group for the Catholic Church is The United States Conference of Catholic Bishops which continually publishes links to articles, newsletters, and statements about their opposition regarding this issue. The Roman Catholic Church possesses wealth and political influence throughout the nation. Despite the efforts of power religious lobbying groups, the first Death with Dignity law was passed in Oregon in 1997. Nearly twenty years later only five states have adopted similar legislation. Successful lobbying by the religious organizations has played a significant role (Pew Research Center 2016).

The Death with Dignity National Center is the largest and most active organization advocating for the passage of Death with Dignity laws. The Death with Dignity National Center was founded in Portland, Oregon in 1993 to promote and fight for legislation that allows dying people to hasten their deaths. The Death with Dignity National Center and the interest group which is now known as Compassionate Choices have been successful in expanding legislation

over the 19 year span but have fought numerous challenges to the legality of the law. (Death with Dignity National Center 2016)

Introduction:

The worldwide aging of the Baby Boomer generation and continued advances in life sustaining medicine have brought to the surface the public policy debate regarding the legalization of physician aid in dying to all 50 states. Also at the heart of this debate is the potential legality of voluntary euthanasia in extreme medical cases. The current debate focuses on the legal rights of terminally-ill patients who wish to discontinue medical treatment, including the removal of life support, or enlisting the aid of a physician in acquiring a lethal dosage of medicines for the hastening of an individual's death. The practice of physician-aid in dying is legal in several countries, including Belgium, Netherlands, Luxembourg and Switzerland (CNN Library 2016).

Several core arguments at the heart of this debate. The core arguments on both sides of the issue are as follows:

Respect for autonomy:

Decisions about time and circumstances of death are personal. Competent people should have the right to choose the timing and manner of and location of their death, at home rather than a hospital.

Justice:

Justice requires that we "treat like cases alike." Competent, terminally ill patients have the legal right to refuse treatment that will prolong their deaths. For patients who are suffering but who are not dependent on life support, such as respirators or dialysis, refusing treatment will not suffice to hasten death. Thus, to treat these patients equitably, we should allow assisted death as it is their only option to hasten death.

Compassion:

Suffering means more than pain; there are other physical, existential, social and psychological burdens such as the loss of independence, loss of sense of self, and functional capacities that some patients feel jeopardize their dignity. It is not always possible to relieve suffering. Thus PAD may be a compassionate response to unremitting suffering.

Individual liberty vs. state interest:

Though society has strong interest in preserving life, that interest lessens when a person is terminally ill and has strong desire to end life. A complete prohibition against PAD excessively limits personal liberty. Therefore PAD should be allowed in certain cases.

Honesty & transparency:

It is naive not to acknowledge that assisted death already occurs, albeit in secret. The fact that PAD is illegal in most states prevents open discussion between patients and physicians and in public discourse. Legalization of PAD would promote open discussion and may promote better end-of-life care as patients and physicians could more directly address concerns and options (Death With Dignity National Center 2016),

What are the arguments against physician aid-in-dying (PAD)?

Those who argue that PAD is ethically impermissible often offer arguments such as:

Sanctity of life:

Religious and secular traditions upholding the sanctity of human life have historically prohibited suicide or assistance in dying. PAD is morally wrong because it is viewed as diminishing the sanctity of life.

Passive vs. Active distinction:

There is an important difference between passively "letting die" and actively "killing." Treatment refusal or withholding treatment equates to letting die (passive) and is justifiable, whereas PAD equates to killing (active) and is not justifiable.

Potential for abuse:

Vulnerable populations, lacking access to quality care and support, may be pushed into assisted death. Furthermore, assisted death may become a cost-containment strategy. Burdened family members and health care providers may encourage loved ones to opt for assisted death and the protections in legislation can never catch all instances of such coercion or exploitation. To protect against these abuses, PAD should remain illegal.

Professional integrity:

Historical ethical traditions in medicine are strongly opposed to taking life. The Hippocratic Oath states, "I will not administer poison to anyone where asked," and I will "be of benefit, or at least do no harm." Furthermore, some major professional groups such as the American Medical Association and the

American Geriatrics Society oppose assisted death. The overall concern is that linking PAD to the practice of medicine could harm both the integrity and the public's image of the profession.

Fallibility of the profession:

The concern here is that physicians will make mistakes. The mistakes may be uncertainty in diagnosis and prognosis. There may be errors in diagnosis and treatment of depression, or inadequate treatment of pain. Thus both any state and federal legislative body has an obligation to protect lives from these inevitable mistakes and to improve the quality of pain and symptom management at the end of life (Death with Dignity National Center 2016).

Words matter! Stigma kills! The degree to which an adjective is twisted can determine the level of stigma. The use of stigma, describing the act as suicide is harmful to the Death with Dignity cause. The policy protocol has changed within the fields. Mental health professionals understand describing the choice as assisted suicide results in stigma. The reason being- it increases bias and fear. (Orentlicher, MD JD et al 2016)

There is a neutral description that has been adopted which accurately describes the choice called physician aid in dying. This description is an effort to

eradicate some of the negative stigma concerning the issue and to sway public opinion. This description will be used throughout the remainder of the paper.

Problem Statement:

Currently only five U.S. states allow physician aid in dying: Oregon, Vermont, Washington, Montana and most recently California. Of the five states, Montana is the only state which legalized it via court ruling. The other four states have legalized physician-aid in dying through legislation. The federal government has left the issue of physician-aid in dying in the hands of the states with no over-arching federal laws governing the practice (Law Digest, 2016). As of today, there is not a federal law, nor is there a law in any of the 50 states, including the District of Columbia, which legalizes any form of euthanasia, classifying it under general homicide (Law Digest, 2016). Figure 1 examines states currently considering DWD laws. The states that have successfully passed DWDA are states that are primarily more progressive, politically “blue” states. Politically “red states “which have a strongly influenced by religious organizations are not considering any DWD legislation.



Source, (DWD Nat.

Center 2016) **Figure 1**

According to the advocacy group Compassion & Choices they cited that bills on aid-in-dying have been introduced this year in Alaska, California, Colorado, Connecticut, the District of Columbia, Hawaii, Iowa, Kansas, Maryland, Massachusetts, Missouri, New Jersey, New York, Oklahoma, Wisconsin, Wyoming and Utah. Court cases have surfaced in New York and California. The advocacy group credits the increase in this type of legislation due to a more progressive political environment. Evidence of this progressive switch in attitude is demonstrated in a number of national and state polls, such as by the Eagleton Institute at Rutgers University in New Jersey, that show significant

majorities of Americans support giving terminally ill patients the option of ending their own lives peacefully (Ollove, 2015)

Legally speaking, physician-aid in dying is not considered euthanasia. The Supreme Court has determined that no right exists for physician-assisted suicide, yet the individual states are free to enact laws to permit it (Law Digest, 2016). This paper will address the current states considering Death with Dignity legislation, how the definitions vary between the countries who allow the practice, how forces such as the Baby Boomer Generation and social media will affect policy implementations as well as the legal implications involved in this issue.

Definitions:

In the United States the debate over euthanasia distinguishes between the definition of active and passive euthanasia. *Euthanasia* is from the Greek - 'eu' and 'thanatos,' which together mean a good or gentle death. The definition has come to refer to methods of inducing death, or more precisely, quicker methods of bringing about death which involve less pain and suffering (Smith 2002). In the United States a common definition of euthanasia refers to the intentional killing of a dependent human being through either an overt act or through omission (Smith 2002). Several descriptions of euthanasia have emerged: voluntary and involuntary active euthanasia, physician-assisted suicide and voluntary and

involuntary passive euthanasia. Let it be noted that not all experts agree on the descriptions.

The debate about euthanasia in the United States is commonly referred to as the “Right to die” debate. It has been expanded to include the question of whether a competent, terminally ill patient has the right to physician-aid in dying. The distinction between the two actions, euthanasia and physician-aid in dying is a heated debate.

Right to die refers to various issues related to the decisions involved in end of life matters and whether an individual should be allowed to die or continue to live with the aid of life support, or in a diminished or enfeebled capacity. It also refers to the idea that a person with a terminal illness should be allowed to hasten his/her own death through the administration of a lethal dose of medications or should have the right to refuse to have his/her life extended by artificial or heroic means. This may be done by withdrawal of feeding tubes and other artificial means of life support from a terminally ill person. The concept of “right to die” is often referred to as a “good death or dying with dignity” (Death with Dignity National Center, 2016).

Physician-Assisted Suicide or (PAS) *Physician aid in dying*(PAD) is described as the request from a terminally ill, adequately informed, competent

person who plans to hasten their death, to a physician who knowingly provides the patient with the medical means to hasten their death and the person uses those means to end their life (Smith 2002). In the United States, the legal practice of physician aid in dying is strictly limited to patients in the terminal stage of an illness. There are proponents of expanding the current law to be appropriate in some cases of non-terminal patients. For example, a patient in the latter stages of amyotrophic lateral sclerosis (ALS; a degenerative neurologic condition commonly known as Lou Gehrig's disease) is physically unable to self-administer the medicine; therefore, a physician who aids in such a person's suicide would technically be performing euthanasia. A person suffering from Alzheimer's disease suffers the same restriction because their mental competency is in question (Death with Dignity National Center, 2016).

This exact scenario is what prompted the arrest and eventual imprisonment of Dr. Jack Kevorkian. Dr. Jack Kevorkian was a medical pathologist who assisted dozens of terminally ill individuals in hastening their death. He was described as Doctor Death by the media for his claim that he assisted up to 130 people hasten their death. Dr. Jack Kevorkian was one of the first public figures to argue for the right of terminally ill and how they choose to die. He was arrested and sentenced to second-degree murder for aiding a person with ALS hasten death. Currently

this practice is still illegal universally throughout the United States (Johnson 1999).

Voluntary Passive Euthanasia (VPE) or omission is when a physician abides by the valid and rational request of a terminally ill, adequately informed, competent person's wishes to refuse treatment, with full knowledge that in doing so this refusal will result in the death of the person. Two examples: Abiding by a person's wishes that has terminal motor neuron disease and is ventilator-dependent to be removed from further mechanical ventilator support. Another example is a patient's refusal of hydration and nutrition (PRHN). This is when a person is incompetent at the time of treatment and a physician abides by a person's advance directives in a living will or through the durable power of attorney for healthcare to refuse any and all methods of hydration and nutrition (Smith, 2002).

Physician aid in dying is described as a form of active euthanasia. The reason is because it involves the hastening of death through the administration of lethal drugs, as requested by the patient or another competent individual who represents the patient's wishes. By contrast, passive euthanasia involves forgoing medical treatment, knowing that such a decision will result in death. This action is not considered illegal because the underlying illness, which is permitted to run its natural course, will ultimately cause death. It is generally accepted in the

United States that terminally ill individuals have a right to refuse medical treatment, as do those who are sick but not terminally ill. However, some people think that allowing patients to forgo medical treatment is a practice paramount to enabling suicide and is therefore morally reprehensible (Smith 2002)

The terms voluntary active euthanasia and physician-aid in dying sometimes are used interchangeably and incorrectly. The main difference between the two acts is that voluntary active euthanasia is a deliberate intervention by someone other than the suffering person and requires a third party to administer the lethal dosage. Physician-aid in dying, the person is required by law that they must be able to administer the dosage themselves. The physician either provides the means to commit the act or provides sufficient information on how to do it. Presently, VAE and IAE are illegal in every state in the United States of America (Law Digest 2016).

The principle of *Double effect* has been defined in medical journals as the administration of opioids or sedative drugs with the expressed purpose of relieving pain and suffering of a terminally ill patient. The unintended consequence may be that these medications might bring about the hastening of a patient's death, or in the simple terms it means that the medication required to combat suffering cannot be given without the probable result of the patient dying (Bruce, et al 2006). This rather vague interpretation is a legal, medically accepted practice, as long as the

intention is only to relieve suffering and not to cause death. The death is attributed to the disease or complications of the disease (Bruce, et al 2006).

The principle of double effect has its roots within the Roman Catholic tradition of moral theology. The Doctrine of double effect was first introduced by Thomas Aquinas when introducing his discussion of the permissibility of self-defense in the *Summa Theologica*s (Bruce, et al 2006). Thomas Aquinas attempted to use the doctrine to morally explain the permissibility of an action that causes a serious harm, such as the death of a human being, if the side effect (double effect) is the promotion of a greater good. The example he used was self-defense. If a person is killed in the commission of self-defense - the act was morally permissible as long as the defenders intention was not to kill (Bruce, et al 2006).

Supporters of physician-aid in dying have used the rule of double effect as a means to resolve a particular type of ethical conflict in clinical cases. Double effect is often cited as a justification by clinicians who assume the risk of hastening death. A hastened death is a secondary but unintended effect of providing high-dose opiates to patients who are terminally ill and are undergoing an immense amount of suffering (Schwarz 2004). Since the intention is comfort care, this is not considered euthanasia and is legal and generally practiced throughout the United States and around the world. The act is generally performed in a low profile setting, in private and without publicity (Schwarz 2004).

The ethical and moral practice of PAD and the use of end of life opiates is currently a highly debated topic. *The Journal of Hospice and Palliative Nursing* reported that most oncology nurses openly comment on personal instances of titrating, which is defined as the gradual increase of the dosage of morphine to manage a dying patient's symptoms of pain or suffering. The medical professional readily acknowledges the possibility of secondarily hastening death. Several of these nurses wrote about instances of opiate-related hastened death on questionnaires they completed about their EOL nursing practices. The author cites that among her nursing colleagues she does not know of any who have not increased a morphine drip to increase comfort, and most likely hastened an individual's death (Schwarz 2004)."

On the other side of the argument, there are those who caution clinicians who use the principle of double effect to justify using opioids to treat pain in dying patients. It is argued that they are actually contributing to the belief in the double effect of pain medication, which in turn leads to fear of hastening death and the under treatment of pain. Palliative nurse professionals maintain that, giving a terminally ill patient who is in pain and constant suffering, sufficient opioid dosages to control the pain is quality palliative care and is not un-ethical nor does it constitute euthanasia (Schwarz 2004).

Slippery Slope

A common argument against legalizing PAD is that it will start the country on a slippery slope towards voluntary euthanasia and beyond (Schwarz, 2004). The definition of slippery slope is that if a controversial type of action, (PAD) is permitted, society will be led down a path allowing other actions that are morally wrong (Benatar 2011).

Death panel"

This negative and inflammatory political term originated during the 2009 debate about federal health care legislation. Former Republican, Governor of Alaska Sarah Palin made use of the term when she charged that proposed legislation would create a "death panel" of bureaucrats who would decide whether Americans—such as her elderly parents or children with down syndrome were worthy of medical care. This term has conveniently been associated with this slippery slope argument. A death panel of Doctors will decide if a vulnerable sector the population such as the terminally ill will have a hastened death. Though the term is highly debunked, negative, inflammatory language has been a common tool used by proponents of PAD (Leonard 2015)

As more states pass death-with-dignity legislation similar to the existing legislative and legal decisions in Oregon, Washington, Vermont and California, will federal judges, especially the Justices on the U.S. Supreme Court, enlarge the scope of liberty in the U.S. Constitution? These answers will probably be

forthcoming in this decade. The Literature Review will examine the application of the United States law and how it compares to the practice in Belgium, the Netherlands and Switzerland. "

Literature Review

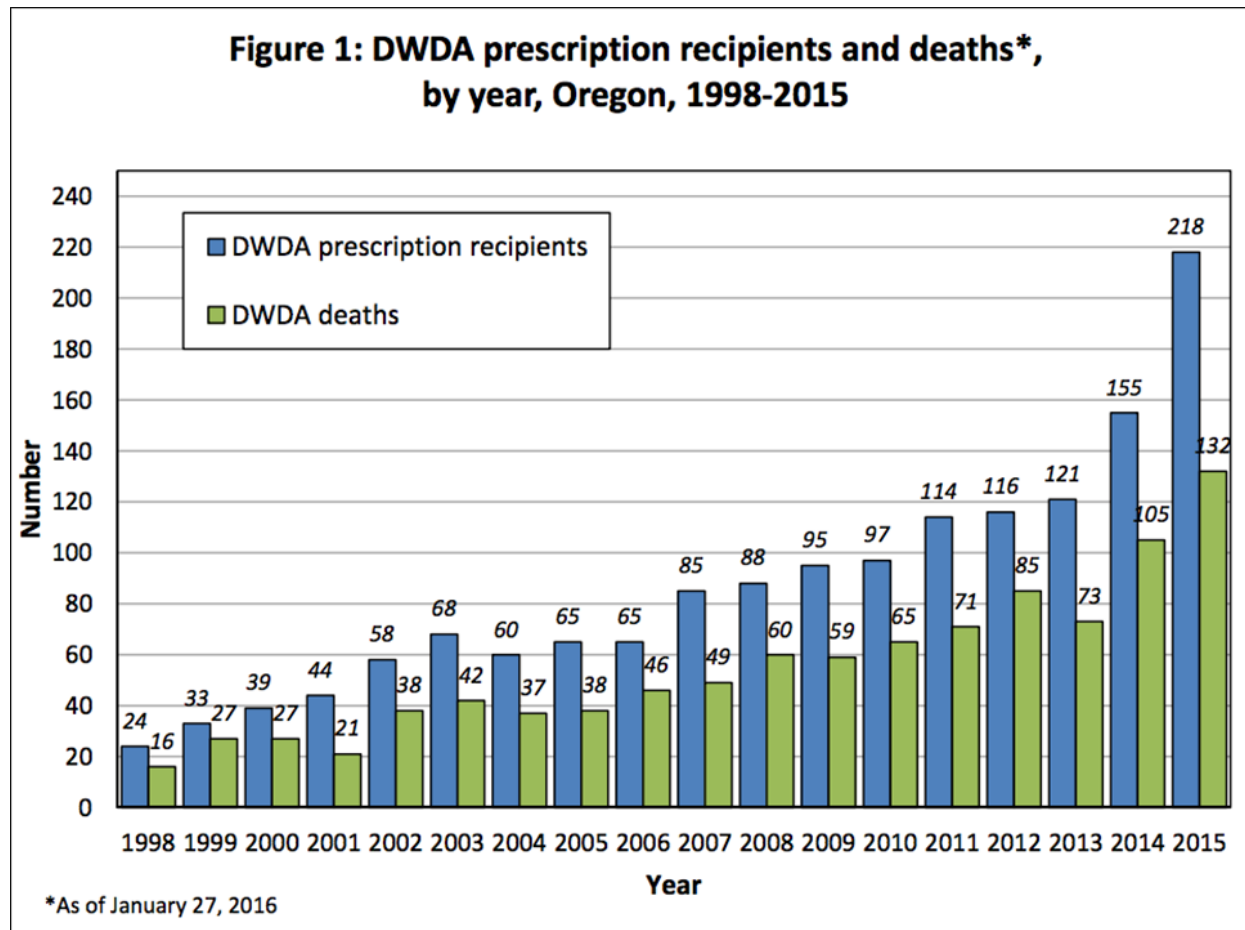
The Supreme Court has determined that no right exists for physician-aid in dying. However, states are free to enact laws to permit it. On October 27, 1997, Oregon became the first state to permit physician-assisted suicide. Two significant victories occurred on June 26 1997 when the U.S. Supreme Court reverses the decisions of the Ninth and Second Circuit Courts of Appeals in *Washington v. Glucksberg* and *Quill v. Vacco*, respectively. In *Vacco v. Quill* the Supreme Court ruled that New York's prohibition on physician-assisted dying does not violate the Equal Protection Clause. In *Washington v. Glucksberg* the Supreme Court ruled that the asserted "right" to assistance in committing suicide is not a fundamental liberty interest protected by the Constitution's Due Process Clause. The Court also instructed that the issue would be best addressed in the "laboratory of the states," which are free to prohibit or legalize physician-assisted dying. However, the court also validated the concept of "double effect," openly acknowledging that death hastened by increased palliative measures does not constitute prohibited conduct so long as the intent is the relief of pain and suffering (Law Digest 2016).

The Death with Dignity Act allows terminally-ill adult, state residents to end their lives through the voluntary self-administration of lethal medications, expressly prescribed by a physician for that purpose. The Oregon Death with Dignity Act requires the Oregon State Health Authority to collect information about the patients and physicians who participate in the Act. The Oregon State Health Authority is required by law to publish an annual statistical report (Law Digest 2016). Currently, three states have enacted Death with Dignity laws: Oregon, Washington, and Vermont and California. These laws allow terminally-ill, adult state residents who are mentally competent, to voluntarily request and receive a lethal dose of prescription medication to be self-administered in hastening of their death. Oregon's law went into effect in 1997. The voters of Washington passed their law in 2008 (Law Digest 2016).

The voters in Oregon passed the Death with Dignity Act (DWDA) in 1994 by a narrow margin of 51% (Death with Dignity National Center 2016). The measure legalized physician-assisted suicide under certain circumstances. Physicians must not be forced to participate in the DWDA. People who sought to employ the law needed to show that they were a state resident, at least 18 years of age. The patient had to be diagnosed terminally ill with a life expectancy of six months or less. The patient must make two oral requests for assistance in dying and one written request for assistance. A minimum of two physicians must be

convinced that the patient is sincere, not acting on a whim, influenced by depression and that the decision is voluntary. The patient must be informed of "feasible alternatives" such as hospice care and pain control and must wait 15 days between the verbal requests (Death with Dignity National Center 2016).

Oregon was the pioneer of Death with Dignity legislation. One major component of all of the Death with Dignity states is that they must produce a yearly report from the Department of Health concerning participation in the act. The following figure is Oregon's comprehensive report from 1998 -2015: The Oregon law requires the Oregon State Health Authority to collect information about the patients and physicians who participate and to publish an annual statistical report.



Source (Oregon Department of Health 2016).

Figure 2

The 2016 report compares statistics over several years. As of January 27, 2016 - 218 qualified terminally-ill adult Oregonians received a prescription for medications under the provisions of the Oregon Death with Dignity Act. A Participation Summary and Trends published by the Oregon health department: During 2015, 218 people received prescriptions for lethal medications under the provisions of the Oregon DWDA, compared to 155 during 2014 (Figure 1,

above). As of January 27, 2016, the Oregon Public Health Division had received reports of 132 people who had died during 2015 from ingesting the medications prescribed under DWDA. Since the law was passed in 1997, a total of 1,545 people have had prescriptions written under the DWDA, and 991 patients have died from ingesting the medications. From 1998 through 2013, the number of prescriptions written annually increased at an average of 12.1%. Of the 218 patients for whom prescriptions were written during 2015, 125 (57.3%) ingested the medication; all 125 patients died from ingesting the medication without regaining consciousness. Fifty of the 218 patients who received DWDA prescriptions during 2015 did not take the medications and subsequently died of other causes. Ingestion status is unknown for 43 patients prescribed DWDA medications in 2015. Five of these patients died, but they were lost to follow-up or the follow-up questionnaires have not yet been received. For the remaining 38 patients, both death and ingestion status are pending.

The manner in which the law is publically administered clearly refutes any concern of a slippery slope to voluntary euthanasia. There are administrative safeguards in place to ensure that patients are making a voluntary and informed decision. A physician is required by the law to educate the patient about all options, including palliative care, pain management and hospice. The patient must make three separate requests (two oral and one written). The oral requests

must be separated by at least 15 days, and the written request must be independently witnessed by two people. The patient can rescind these requests at any time. Finally, to further ensure that patients remain in full control of the process, they must administer the medication themselves without assistance from any one. (Oregon Department of Health, 2016).

Comparable statistics local and world wide

Robert Pearlman, MD, MPH, Professor of Medicine at the Departments of Medicine, Medical History and Ethics, and Health Services, University of Washington conducted a study seeking explanations for requests for physician-assisted death. The most cited loss of autonomy, inadequate treatment for pain or other symptoms, depression, hopelessness, and socioeconomic stressors, such as concerns about the burden of increasing dependency on other members of the family and the economic hardship associated with the costs of health care.

The study conducted interviews with thirty-five families, the interviews asked questions about the history of the patient's illness, the patient's stated reasons for seeking aid in dying, and other factors influencing the pursuit of physician-assisted on its own ever accounted for a serious interest in a hastened death.

Rather, interest usually arose out of an interactive process involving multiple factors in three broad categories.

Illness-related experiences

Feeling weak, tired and uncomfortable 24 (69%)
Loss of function 23 (66%)
Pain or unacceptable side effects of pain medication 14 (40%)

(Pearlman 2004)

Figure

3

Fears about the future

Fears about future quality of life and dying 21 (60%)
Negative past experiences with dying 17 (49%)
Fear of being a burden on others 3 (9%).

(Pearlman 2004)

Figure 4

Threats to sense of self

Loss of Sense of Self 22 (63%)
Desire for control 21 60%
Long-standing beliefs in favor of hastened death 5 (14%)

(Pearlman 2004)

Figure 5

In 2014, a total of 155 terminally-ill adult Oregonians received a prescription for medications under the provisions of the Oregon Death with Dignity Act, while 105 of them (67.7%) ingested the medications to die peacefully. This corresponds to 31 Death with Dignity Act deaths per 10,000 total deaths, or 0.31%. Since 1998, when the first person in Oregon took medication prescribed under the Death with Dignity Act, a total of 1,327 patients have received the prescription, of whom 859 (65%) ingested it and died(Oregon Health Department 2016).

In 2007 a cross-sectional survey study was conducted by the Columbia Center for the study of Chronic, Comorbid Mental and Physical Disorders, Health Services research and Development, Research Service to determine why 83 Oregon residents requested aid in dying medication. The study measured and

rated the importance of 28 possible reasons why these individuals requested PAD (Garzini, Goy, Dobsha 2007).

According to results, the most important reasons that their loved ones requested PAD, all with a median score of 4.5 or greater, the terminally ill patient wanted to control the circumstances of death and die at home. Some of the top reasons that people considered are constant concerns about autonomy, loss of dignity and future losses of independence, quality of life, and self-care ability. The least important reasons their loved ones requested PAD included depression, financial concerns, and poor social support (Garzini, Goy, Dobsha 2007).

In the most frequent reports conducted by the department of Health in both Oregon and Washington the three most frequently mentioned end-of-life concerns are loss of autonomy decreasing ability to participate in activities that made life enjoyable, and loss of dignity. These statistics are consistent with previous studies (Death with Dignity National Center 2016).

Supporting arguments:

The main argument in support of euthanasia in Holland has always been the need for more patient autonomy — that patients have the right to make their own end-of-life decisions. Yet, over the past 20 years, Dutch euthanasia practice has ultimately given doctors, not patients more and more power. The question of

whether a patient should live or die is often decided exclusively by a doctor or a team of physicians. The statistics support the notion that the chief reasons terminally ill patients choose to hasten their death is globally similar (Patients' Rights Council 2016).

U.S. opponents of the Death with Dignity Acts have voiced objections concerning the public administration of the law and that it will encompass both children and the mentally ill. The Oregon law protects children and the mentally ill. A patient must be a competent adult, minimum 18 years of age, well informed about alternative care options, not depressed, terminally ill and in proper physical health for the self-administration of the lethal dosage of medication. The Oregon law states that, in order to participate, a patient must be: 18 years of age or older, a resident of Oregon, capable of making and communicating health care decisions for him/herself, and is diagnosed with a terminal illness that will lead to death within six (6) months. It is up to the attending physician to determine whether these criteria have been met (Oregon Department of Health 2016).

Residency concerns have also entered the debate. The fear is that a person can travel from a non-death with dignity state to complete the act impulsively. The law mandates that only patients who establish that they are residents of Oregon can participate if they meet the strict criteria. A patient must provide adequate documentation to the attending physician to verify that s/he is a current

resident of Oregon. (Let it be noted that the other death with dignity states have blue printed the Oregon guidelines for administration). Factors demonstrating residency include, but are not limited to a Oregon Driver License, a lease agreement or property ownership document showing that the patient rents or owns property in Oregon, an Oregon voter registration, a recent Oregon tax return, etc. There is no minimum residency requirement. A patient must be able to establish that s/he is currently a resident of Oregon. A non-resident can move to Oregon and establish residency in order to participate in the Act. There is nothing in the law that prevents someone from doing this. However, the patient must be able to prove to the attending physician that s/he is currently a resident of Oregon, and must meet all of the terminal illness criteria. It is up to the attending physician to determine whether or not the patient has adequately established residency (Oregon Department of Health 2016). .

In effort to control false documents and corruption, the Oregon Department of Health requires all participating patients be reported to the State of Oregon by name. The State only collects the names of patients in order to cross-check residency and to issue death certificates. However, the law guarantees the confidentiality of all participating patients (as well as physicians) and the Oregon Health Authority does not release this information to the public or media. The identity of participating physicians is coded, but the identity of individual patients

is never released in any official reports. No patient's names are ever reported.

Approximately one year from the publication of the Annual Report, all source documentation is destroyed (Oregon Department of Health 2016).

Numerous concerns about how the patient is prescribed the medicine and the requirements of the all physicians in the practicing states were raised. To address these concerns the following stipulations were implemented: The patients who meet the qualifying criteria can request a prescription for lethal medication from a licensed Oregon physician. The individual must make two oral requests; there must be a 15 day separation in between the requests. The primary physician as well as a consulting physician must confirm the diagnosis and the prognosis. The physician must be a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) licensed to practice medicine by the Board of Medical Examiners for the State of Oregon. The physician must also be willing to participate in the Act. This vital piece of information has been routinely and inaccurately presented by individuals and groups who oppose the law. Physicians are not required by law to provide prescriptions to patients and participation is one hundred percent voluntary. Additionally, some health care systems (for example, a Catholic hospital or the Veterans Administration) have prohibitions against practicing the Act that physicians must abide by as terms of their employment (Oregon Department of Health 2016).

The state of Washington became the second state to Pass Death with Dignity legislation. The voters passed November 4, 2008 and it was implemented March, 5, 2009 and Vermont became the third state with a Death with Dignity law in May of 2013. The law went immediately into effect after it was signed by Governor Shumlin (Death with Dignity National Center 2016).

In December 2009, Montana's Supreme Court ruled 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. Since the ruling, several bills have been introduced to codify or ban the practice, but none of those bills have become law (Death with Dignity National Center 2016).

California

On September 11, 2015, California Governor, Jerry Brown signed in the law the End-of-Life Option Act. As of June 6, 2016, California will join the four other states that currently allow terminally ill residents the right to choose to have physician assistance in hastening their death.

The California bill is similar to the other states that have enacted death with dignity acts. All of the other states with similar legislation have virtually blue printed the original Oregon legislation. California is very similar. The major exception is that the California law will expire after 10 years and have to be re-

approved. The most controversial exception added to California law is the additional requirement that doctors will be required to consult privately with a patient seeking end-of-life medication. This measure was included in effort to ensure that no person would be coerced to end his or her life. This is a primary concern for the opponents of death with dignity legislation. Opponents of the legislation fear that low income and uninsured patients will inevitably feel pressure from family members to end their own lives to avoid the devastating cost of continual medical. On the flipside of the argument, proponents of death with dignity legislation argue that it is the family to the terminally ill patients who will ultimately convince the individual to continue medical treatment and desperate hope of discovering a cure (McGreevy 2015).

Legislation of this type has failed passage numerous times when presented in front of the California General Assembly. Death with dignity National Center credits much of the success to a grassroots effort and a social media campaign launched by Brittany Maynard, a 29-year-old, California native who was diagnosed with stage four malignant brain cancer. In recent news, a group of Doctors supported by an anti-choice filed a law suit and a temporary restraining order to prevent the End of Life Option Act. In June California judge rejected the order and allowed the implementation of the law (Death with Dignity National Center 2016).

Brittany Maynard:

On November, 3, 2014, Brittany Maynard posted her message to the world on social media bringing the policy debate surrounding Death with Dignity, euthanasia and physician assisted suicide back to the front page. In effort to bring about an amendment to the constitution, or to expand or promote passage of future Death with Dignity legislation she launched a grass roots movement on social media. Approximately six months before her death Maynard and her husband moved from California to Oregon to gain access to the state's Death with Dignity law. Maynard documented her struggle through many social media websites. She spent her final days advocating for Death with Dignity laws as her symptoms grew more severe. She decided to end her life earlier than anticipated because the Death with Dignity laws require that the person must be physically able to take the medication. She chose to end her life. She made a public farewell over social media. (Beaver, 2014).

Euthanasia/PAS Laws Switzerland, Netherlands and Belgium

On April 10, 2001 the Netherlands passed a law which permits both euthanasia and physician assisted suicide. The public administration of the law is as follows: The Dutch use the term "due care." This is defined as the physician must terminate or assist with the death of a patient in a manner that is, medically

appropriate. The reason behind this is so that it transforms the crimes of euthanasia and suicide under the scope medical treatments (Patients' Rights Council 2015).

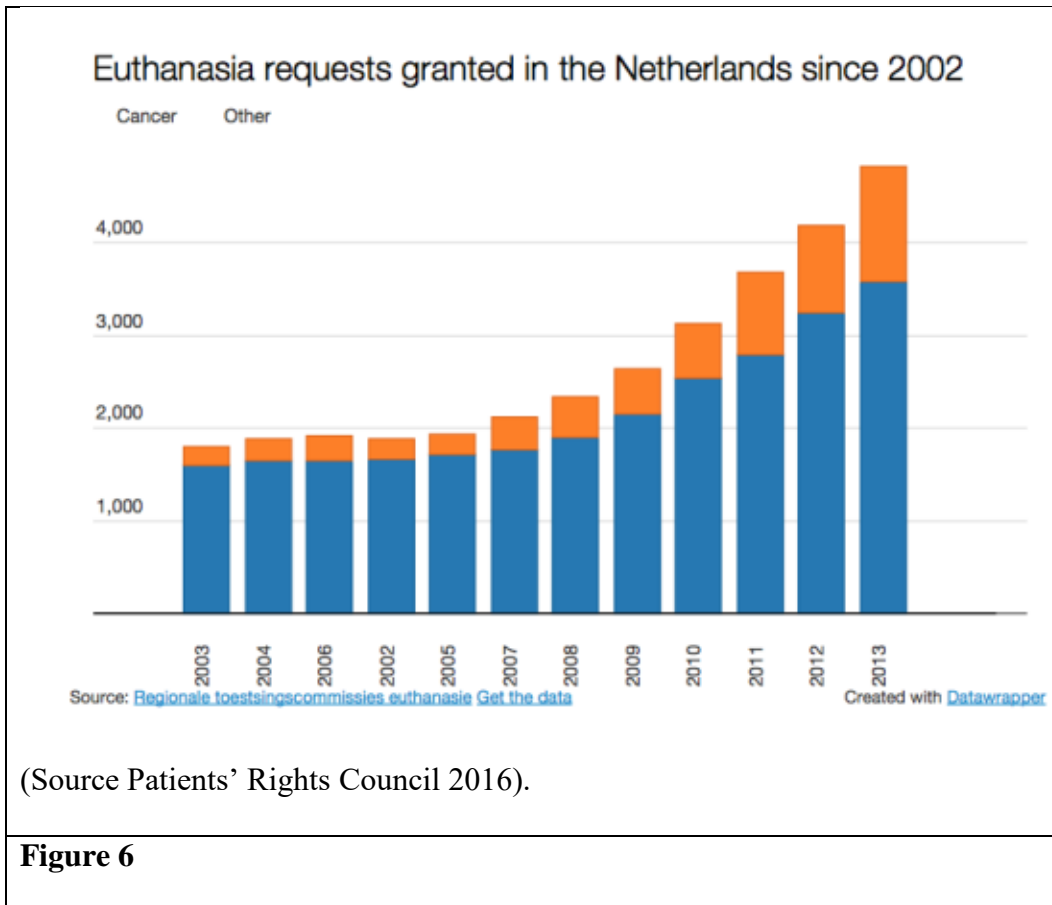
A defining difference between the law in United States and that of the Netherlands is the legality in which it is specifically allowed for minors and incompetent patients. The age requirement is 16. A 16-year-old can make an advanced directive for the termination of life in a written statement. The written request for termination of life may be honored by a physician. The physician will face no legal charges for carrying out this directive if it is deemed authentic. A medical condition is not a prerequisite for honoring the written statement. There is no timeline required for when the statement must be written. It can be 10 years old or ten minutes. The main requirement is that for patients between the ages of 16- 18, a parent or guardian must be involved in the decision process. The parent or guardians are not required to agree with the decision, just be adequately informed of the decision process. (Patients' Rights Council 2015).

Individuals between the ages of 12-16 may submit a written request to receive euthanasia or assisted suicide but a parent or guardian must agree with the termination of life. The law does not require that the condition be either physical or terminal. A person 12 and older may qualify for euthanasia or assisted suicide

if the doctor possesses the medical opinion that the patient's mental or physical suffering is constant, lasting and unbearable (Patients' Rights Council 2013).

Similar to the Oregon Department of Health, in the Netherlands an oversight committee is appointed to review all termination of life requests. The Regional Review Committee is comprised of a minimum of one physician, one legal specialist and one expert on ethics or philosophy. The burden of proof must be established through these professionals. The prior law required the burden of proof for the termination of life need only to be established through the physician. The current law mandates that the legal expert and the ethics expert must agree that the termination request satisfies the minimum requirements of due care.

Unlike the Death with Dignity Acts, there are no residency requirements. Press releases support the claim that only Dutch citizens will be able to receive euthanasia or physician-assisted suicide. The current law does not strictly forbid physicians from administering a lethal dose of medication to non-residents (Patients' Rights Council 2015).



The number of euthanasia procedures carried out in the Netherlands has risen considerably in 13 years. According to the report, the annual number of completed procedures remained constant at and around 1,900. Since 2006 it has increased by an average of 15% a year. In 2013 the number of euthanasia and assisted suicide cases stood at 4,829, nearly three times the 2002 figure.

Altogether around 38% of requests are carried out and 20% refused. Similar to the

practice in the United States, the patient either changes his or her mind or dies before euthanasia can be arranged.

When the law came in, the overwhelming majority of those who chose euthanasia – nearly 90% – were terminally ill cancer patients. Latterly the proportion has dropped to nearer 75%. Psychiatric patients, once never considered for euthanasia, are a small but growing subgroup, with 42 requests granted in 2013. Euthanasia is no longer a last resort. It was originally seen as a law that gave doctors rights rather than patients. The law is now discussed in terms of a patient's right to euthanasia (Patients' Rights Council 2016).

The issues at the core of the argument concerning euthanasia both worldwide and in America are inexplicably similar. There is no doubt that the laws in the Netherlands are much more liberal and expansive than in United States. The slippery slope argument is very common in the Netherlands. Despite the liberal laws in the Netherlands as the statistics demonstrate there is no slippery slope present. Both in Oregon and the Netherlands, participants are similar: the terminally ill and there is not overwhelming numbers that the law is being abused. The tight public administration of the practice in both countries is designed to prevent abuse and a slippery slope.

The debate

It is easier to assert the existence of a slippery slope because of an increase in the statistics rather than to prove one actually exists. The problem with the slippery slope argument is the assumption that the instances of euthanasia in both United States and the Netherlands are morally wrong. There are those individuals that would disagree. Proponents of both PAD and euthanasia argue that a person who is terminally ill or in chronic pain need not be the product of unnecessary suffering.

An additional argument invoked by opponents of the legal right to die is the argument that such a right will be abused and that no are legal safeguards that could be implemented to prevent abuse. An example would be if the American law is expanded to permit voluntary euthanasia -a legal requirement be that consent must be obtained through written legal documentation. Opponents would argue that that consent would not always be obtained. The problem with that argument is that, a few bad apples should not necessarily spoil the entire barrel. Abuse of a right should not automatically permit grounds for withholding the right.

Banning a constitutional right of choice will not result in the elimination of the practice in abusive or non-abusive forms. American history has direct examples of that in prohibition and the dark days of illegal abortion. It would be absolutely naïve for a person to believe that euthanasia and assisted aid in dying

does not exist all throughout the United States were the law is not permitted. That fact does not give a carte blanche to abuse the act or even a right that it exists. The right of choice is guaranteed by the United States Constitution. Expanding the act to incorporate all 50 states including voluntary euthanasia only allow the act to be carried out in a safe structured environment.

Belgium:

Laws permitting euthanasia were passed in 2002. Remarkably different from the United States, there is no distinction between euthanasia and physician assisted suicide in the law in Belgium. They do not bother with the semantics. The law states that a patient may elicit terminal medication from physician to end their lives if they suffer from a terminal condition or a condition that renders them incurable and unbearable pain. Unlike the United States law, the patient may request physician assisted terminal sedation prior to entering a coma or vegetative state. They do enlist an additional requirement that the physician must be present at bedside when the patient self-administers the medicine. The United States law only requires the doctor prescribed medication (Guardian 2014).

In March of 2014, The King of Belgium signed the world's first child euthanasia law. This law permits terminally ill children to request euthanasia. There is no age minimum for minors seeking lethal injection if they meet acceptable

criteria. The decision must be informed; the child must understand the scope and meaning of euthanasia. The child must request on multiple occasions the right to die. The child must be suffering from a terminal illness and must be in the final stages of the illness. The child must suffer from unbearable pain with no expected treatment to alleviate it. A team of medical experts along with the child's parents must agree upon the severity of the child's condition and approve of the decision to allow a lethal injection. Similar legislation exists in the Netherlands, though only for children 12 and over (Gerlin 2014).

Switzerland

The term euthanasia, because of its association with the abuses of the Nazis, is not recognized. Switzerland has an unusual position on assisted suicide. It is legally condoned and can be performed by non-physicians. The practice of assisted suicide in Switzerland has led many people to believe that the practice is state sanctioned through legislation. That is not the case. The main difference between the Swiss practice and that of Oregon, the Netherlands and Belgium is it does not require a physician to perform it or administer the lethal medication. Instead it decriminalizes the practice of the act. Thus, in Switzerland, there is no prosecution if a person who assists another with a suicide, as long as their intentions were altruistic. While this results in *de facto* legalization, assisted suicide is not legal, only unpunishable, unless a selfish motive is proven. It should also be noted that

there is no illusion that assisted suicide is a medical practice. The person assisting a suicide need not be a medical professional to escape prosecution (Hurst and Mauron 2003).

The particulars of the Swiss law are somewhat vague. The law states nothing about residency. The law specifically notes that a terminal or a painfully debilitating medical condition is not a prerequisite for requesting terminal assistance and a physician does not need be involved. Ultimately this vague interpretation gave rise to a number of non-profit assisted suicide agencies. Some attempts have been made to regulate the growth of the assisted suicide industry, but they have largely failed.

With the law phrased so loosely, the only certain criterion is that the person requesting help must be mentally competent. Evidence of this comes from a 2009 situation in which a psychiatrist was convicted for being reckless in assisting two people with mental illness to commit suicide. In 2011 the Swiss government decided that further regulation was not an option because it was politically impossible. It was concluded that amending the law might make the situation worse by giving legitimacy to the suicide organizations. So instead, the government has decided to promote palliative care and to campaign against suicide (Cook 2013).

Palliative care is a wonderful thing. Some argue that euthanasia and PAD should be minimized or eliminated through palliative care. The belief is that there are always alternative ways to alleviate suffering. This is a very naïve statement because who determines what is intolerable suffering? Only the individual who is experiencing the suffering can define what is intolerable. Quality of life determined by the individual and their families

Recommendations:

The aspect of the law in the Netherland that pertains to The Regional Review Committee is a brilliant piece of checks and balances. The United States could incorporate this public administrative tool within the current administration of the law. This could increase the ethical efficiency of not only the current Death with Dignity Acts but future acts as well. The Netherlands committee is comprised of at least one physician, one legal specialist and one expert on ethics or philosophy. The burden of proof must be established through these professionals. The United States could easily apply this extra measure of checks and balances with relative ease to the current system in effort to expand it.

The issue of the U.S. Supreme Court and its ruling that physician-assisted suicide is not a protected liberty interest under the Constitution needs to be re-

examined. There are many arguments including a Washington law that argues that criminalizing physician assisted suicide is a violation of the 14 amendment specifically the Due Process. Due Process prohibits the states from taking away citizens' rights, except for good reason and with due process of law. The Supreme should include physician-assisted suicide as a protected liberty of choice under due process, allowing it to be publicly administered in every state. The narrow scope in which the ruling allows the practice to be administered actually promotes discrimination based on geography, specificity of illness and intelligence. The strength of the public administration within the United States and the blueprint of success illustrated in Oregon make expanding the parameters of the law to include a population that is currently restricted both possible and necessary (Death with Dignity National Center, 2016).

The ruling could be amended to incorporate certain aspects of the Belgium and Netherlands laws, primarily, increasing the scope of qualified applicants. Currently, terminal sedation is not illegal in any of the 50 states. ***Terminal Sedation*** is a procedure where the terminally ill patients do not respond to pain medications or may be suffering in other ways that make comfort impossible. In this situation the patient will be given medications that induce sleep or unconsciousness until such time as death occurs as a result of the underlying illness or disease. How is not the same as voluntary passive euthanasia, which is

illegal? (Delden, 2007) These interpretations of the rule of “do no harm” or double effect can easily be seen within the Swiss law. When an individual assists a terminal ill or a person who suffers from a debilitating, painful medical condition with the hastening of their own death for the reasons of ending their suffering, would that not be considered acting altruistic? The United States could learn a lesson in legislative linguistics from the Swiss.

House Bill 3337/ALS

ALS, or amyotrophic lateral sclerosis, (Lou Gehrig’s disease) is a progressive neurodegenerative disease that affects nerve cells in the brain and the spinal cord. When a muscle has no nourishment, it deteriorates. The progressive degeneration of the motor neurons in ALS eventually leads to their demise. When the motor neurons die, the ability of the brain to initiate and control muscle movement is lost. With voluntary muscle action progressively affected, people may lose the ability to speak, eat, move and breathe. The motor nerves that are affected when you have ALS are the motor neurons that provide voluntary movements and muscle control. Examples of voluntary movements are making the effort to reach for a glass of water or step off a small incline. These actions are controlled by the muscles in the arms and legs (Sabatier 2015).

The current Death with dignity laws clearly discriminate those individuals who suffer with ALS. The law clearly states that a person must be able to administer the medicine themselves and they must be six months terminal. By the time a person who suffers from this disease becomes six months terminal in many instances is too late. By that time, the disease has progressed to the point where there muscles are incapable of completing the act without assistance (Sabatier 2015).

House Bill 3337

Democratic Representative Mitch Greenlick sponsored the failed house Bill 3337 which would have expanded the current law to include extreme medical cases. If it was passed the law would have allowed terminally ill Oregonians to get a lethal prescription when they have a life expectancy of 12 months rather than the six months specified under current law. The law was specifically designed to assist ALS suffers who may not have the motor dexterity necessary n to complete the act under the current time frame. In addition to ALS patients, Greenlick was hopeful that the expanded timeframe would allow some Alzheimer's patients to use the law, since patients must be of sound mind to invoke it (Mapes 2015).

Autonomy

The advances in life sustaining medicine have not compensated for quality of life issues. Two claims involving both the chronically and terminally ill population are as follows, a life without quality escalates into a life without dignity. Nationwide, all terminally ill and certain chronically ill people should have the choice to hasten their death. The terminally ill and the chronically ill should be allowed to make the choices necessary to have a death with dignity (Death with Dignity 2016).

A death with dignity should respect a person's autonomy, use of human reason, and the removal of barriers. The number one cited reason for chronically ill and terminally ill people seeking alternative ways to in their life is loss of autonomy and the feeling that they are a burden on their families. For example, the presence of pain is a barrier to a dignified life; it hinders a person's ability to have a substantial quality of life. By an individual choosing to end their life, they are removing the barrier of pain (or loss of autonomy, depression, etc.).

Opposition to Death with Dignity include physicians arguing that medications can alleviate the suffering of terminally ill patients, that fully allowing physician-assisted suicide or euthanasia will take the country down a convoluted path, and that too many grey areas are involved in the process. However, allowing a person to partake in a chosen dignified death respects an individual's autonomy and overall wishes.

The United States of America prides itself on the reputation that the government respects and defends the civil liberties of choice for all of its citizens. The debate over physician-aid in dying, while once widely rejected is receiving and surely will continue to receive increased recognition as an appropriate alternative for terminally ill citizens. The increasing numbers of the Baby Boomer population is partly responsible for this shift in policy attitude. The shift is due largely in part to Oregon's proven safe and effective public administration of the law. In chapter 12 of David Rosenbloom, Robert Kravchuk's book: Public Administration: Understanding Management, Politics, and Law in the Public Sector Seventh (7th) Edition, the authors cited that the modern public administrators play an active role in the creation and implementation of public policy. The execution of this policy relies heavily on the individual style, pace and tone of public administrators. On a global scale, the American public administration system is considered exceptionally honest. The high level of efficiency in which the public officials in Oregon have administered the law, opens the door not only for expanding the current law throughout the United States, but expanding it to also include individuals who suffer from ALS or survive in a persistent vegetative state. The states of Oregon, Vermont, and Washington are demonstrating to the nation and to the world that this law can be successively administered under the present system.

Despite the fact that on a global scale, the American public administration system is considered exceptionally honest, it is still susceptible to corruption. Due to the limited availability of Death with Dignity states, individuals who wish to participate are limited to the strict public administration of the law. Unless an individual who lives outside of those three states has the means, time and physical ability to relocate and establish permanent residence, they are unable to participate. It makes it a law of opportunity and geography rather than that of choice. This puts pressure on the public administrators in the non-death with dignity states to abide strictly by their states law, regardless of conviction. The risks of ethical violations are more common in non-dignity states rather than the states that permit the practice. The resulting conundrum is that a law becomes so heavily ethically scrutinized, many of the efforts to apply the necessary scrutiny violates a portion of the population's individual, ethical rights (Bascom &Johnston, 2004).

Conclusion:

The individuals and organizations that present arguments opposing all forms of euthanasia including physician aid in dying use reasoning that varies from the moral components of suicide to ethical medical concerns of do no harm.

Opponents present arguments which are absolute not considering the many grey areas throughout this issue. A major flaw in the present proponent's arguments is the ability to clearly define what the 'final stages' of a terminal illness and the definition of quality of life.

Physicians opposing the law argue that modern medicine can alleviate the suffering of terminally ill patients. Oppositionists, especially in the United States worry that expanding the current legislation will contribute to the trivialization of euthanasia and will take the country down an ethically perilous, convoluted path; A slippery slope.

As the growing wave of older adults progresses into society, they will be changing health-care (American Hospital Association 2007). A generation of innovators, they will be searching to find new ways to live, and die. In a society that promotes free-thinking and freedom of choice, Death with Dignity and euthanasia are viable options that should be legalized throughout the United States. Chronic pain and terminal illnesses will not disappear, but new ways of ending the suffering have entered the world. Seeing Belgium, and Oregon's Acts as successes, Oregon's Death with Dignity should be changed to resemble Belgium's, and then spread across the United States. Simply because something is legalized, does not mean that everyone has to partake, it is just an option. There will always be people who refuse to acknowledge assisted-dying, but those who prefer that way of death should be allowed to make that decision for themselves.

If the matter is ever going to reach the Supreme Court in hopes of nationalization of Death with Dignity legislation, grassroots campaigns similar to the one Maynard convened must take place. Social media is the medium to promote such a movement. Brittany Maynard may be just a single person on a long list of participants and advocates for Death with Dignity but her statement reached millions on social media. A grass roots movement in every state promoting the Death with Dignity mission, using the Oregon law as a blueprint for future legislation will start a potential ripple effect of real change. It's time for brave people to stand up and start pushing back on issues that involve human suffering and injustice.

Brittany Maynard may have changed the face and the progression of Death with Dignity legislation throughout the United States. She has become a force, a poster child if you will for the passage of this legislation nationwide. Her message inspired a new form of grassroots recruitment, that being social media.

It is time the United States end the war of semantics when debating this issue. The states have the power to allow and regulate assisted suicide or to prohibit it. The public administration system of the United States is efficient enough to handle any social and legislative riffs this type of law may bring. The Death with Dignity movement, along with sufficient pressure from critical thinkers and lobbyist will allow all Americans, regardless of state residence,

especially the elderly and terminally ill the freedom of choice to live and end their lives with dignity.

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