Chapter

Leaving Early: The Reality of Assisted Suicide and Euthanasia in 2022

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Abstract

If cancer becomes a terminal illness, cancer patients may want to consider their options for managing the end of life. Palliative care and hospice give patients control over pain and symptoms at the end of life, but patients may want to know how to pursue more direct actions to end a life that feels too burdensome. This chapter provides a nonjudgmental look at legal ways to end one's own life in 2022. Where is assisted suicide legal in the world, including a detailed look at laws in those United States of America (USA) states that protect it? Where can a doctor provide and administer lethal drugs, providing euthanasia? What restrictions to access exist? What help and guidance are available? What options realistically exist beyond prescribed drugs, without turning to firearms and leaping from buildings? This chapter is not a how-to-end-it guide, but a brief survey of the options a patient might feel impelled to explore.

Keywords: physician-assisted suicide, euthanasia, hospice, palliative care, end-of-life

1. Introduction

"Can't the doctor just give me a pill to end it all now?" Some patients diagnosed with a terminal illness will feel unwilling to await natural death from their disease, especially if they anticipate that such waiting will lead to suffering, loss of control, loss of dignity, or a burden on loved ones. This chapter explores the options open to those who want to end life on their own schedule in 2022. Is there a pill? Does the doctor have it? How would that work? Is geography a factor? What choices are available to the reader today? This chapter addresses the choices available to cancer patients seeking "release" in 2022. Though the ethical issues involved in suicide and euthanasia generate rich, complex debate [1], this chapter reluctantly leaves that for another discussion, focusing instead on choices that a cancer patient can explore in 2022. Options involving a doctor are severely limited by geography and by the limitations inherent in medical practice, as we will discuss. Some readers may find that they have come here to choose a method of ending their lives, only to discover that choices are not limited to selecting a method of dying. Though we intend complete presentation

of every method of dying reasonably available, the authors confess that we will be pleased every time readers make choices other than dying by their own hands.

2. Definitions

Clear definition facilitates discussion. All humans die. Most will experience *natural death*, death that occurs because of old age, disease, accident, or catastrophe. Though natural death is one of the choices for a cancer patient, this chapter focuses on those deaths hastened by human intervention. We set aside euphemisms increasingly used to obscure human intervention (Medical Assistance in Dying, Death with Dignity, and so forth) in favor of straightforward language and clear meaning. We define as *suicide* any death caused by injuring oneself with the intent to die. *Homicide* is the term used when one human takes the life of another. We examine *assisted suicide*, suicide undertaken with the aid of another person, and focus here primarily on the special circumstance termed *physician-assisted suicide (PAS)*, in which a physician assists a person seeking death, usually by writing a prescription for a lethal dose of drugs that the patient takes without assistance.

Euthanasia (literally, good dying) is the circumstance in which an action by one person produces the intentional death of another. In contrast with suicide, in which the person who takes the action is the one who dies, with euthanasia the person who takes the action (usually a doctor) performs this action on another person, who dies. *Passive euthanasia*, which is not our primary concern in this chapter, refers to removal of life-supporting medication or technical support, not often an issue for cancer patients. *Active euthanasia* involves one person taking an action that causes another to die (often by injection of a lethal preparation by a doctor). *Euthanasia* is *voluntary* when the person dying has requested it. Euthanasia on request is legal in some countries under limited conditions and is the only euthanasia to be considered in this chapter. *Involuntary euthanasia*, in which the person who dies has neither requested nor given consent to being killed, is never legal. In most of the world, involuntary euthanasia is considered homicide, or murder. Euthanasia without consent does occur, despite being illegal, and this is a source of intense concern and debate in countries that permit euthanasia.

In summary, *suicide* means I do something, and I die. *Physician assisted suicide* means I ask a doctor to prescribe lethal medication, and I take it by myself and die. *Voluntary euthanasia* means I ask a doctor to administer lethal medication, by drink or by injection, after which I die.

3. Why seek an end of life?

Many presume that patients with terminal illness endure great suffering without access to relief. This sad, desperate, and incomplete picture is commonly presented in lobbying campaigns that seek to legalize physician-assisted suicide. Actual reports from existing programs create a different picture. Oregon's 2020 report [2] on its PAS program, which presents the statistics for 2020, shows that 27% of patients were either in pain or worried that they would be in the future. Far more common reasons for seeking assisted suicide were loss of autonomy (93%), decreasing ability to participate in the activities that make life enjoyable (92%), and loss of dignity (68%). Ironically, even patients concerned about autonomy are required to sacrifice some of

it to participate in a state's assisted suicide program. Participation usually requires pleading one's case to two separate doctors who will make the final judgment about whether to write a lethal prescription. The doctor—not the patient—decides whether a request for PAS will be honored. Use of the prescription itself remains autonomous; however, as no USA state exerts significant control over the prescribed lethal dose once it has been dispensed. Many patients inquire about assisted suicide but make other choices; many do not use the lethal prescription even when they have it in hand. In 2021, 383 people in Oregon received prescriptions for lethal medication, but only 219 are known to have died from ingesting the medication. One patient awoke after taking medication, 58 died without taking medication, and information on 106 patients is unclear, with 69 lost to follow-up [3].

4. Asking the doctor: it seems like a natural response

Facing the question of whether and how to seek an early end of life, some will fall back on their own resources, and others will seek help from the doctor. Why seek help from a doctor? Though ending one's life requires no collaboration with anyone at all, much less with a physician, the reality for most cancer patients is that they have been deeply involved in the medical care system for some time, from initial symptoms and diagnosis through rounds of chemotherapy, surgery, and radiation, or through rejection of those therapies as no longer valuable. Most cancer patients, therefore, have a close relationship with a physician, perhaps several, and are familiar with the medical care system. Thus, it follows that an initial search for relief might begin in that very system.

4.1 The limits of the doctor's power

Can a doctor simply prescribe a pill to end it all? No, not actually. A doctor is a surprisingly limited source of help in ending life early. Not only is there not a single pill that will instantly and painlessly end life, but also a doctor who assists with an intended suicide faces potential charges of homicide unless laws protect that participation. Though ending one's own life is not illegal, it is illegal to assist another person's suicide. The law views assistance in dying as helping kill the person. Only in the relatively few states or countries that have passed laws protecting doctors, pharmacists, and other professionals will doctors be able to help end life on request. At the present, doctors can help in 11 of the 50 states or districts in the USA, states with about one-sixth of the country's population. Nowhere in the USA can physicians perform euthanasia, legally administering lethal medication to end life. However, in those states with laws permitting PAS doctors can prescribe lethal medication for patients who can take it themselves. Elsewhere in the world, the Netherlands and Belgium have considerable experience in permitting physicians to produce death for patients by euthanasia or assisted suicide. Twelve countries around the world have passed laws protecting doctors who participate in assisted suicide or euthanasia; those countries are discussed extensively at the end of this chapter.

4.2 Doctors dealing death: a new phenomenon

Turning to a doctor as an agent of death is a relatively new phenomenon. In fact, doctors from the time of Hippocrates have given allegiance to an oath [4] in which they promise not to give poison to anybody when asked to do so, nor to suggest such a

course. Doctors have portrayed themselves as healers, not dealers in death, and two thousand years of Hippocratic humility have consistently rejected the immense power inherent in allowing one human to cause the death of another [5]. Until relatively recently, physicians and society have agreed on the importance of keeping the power of death separate from the powers and privileges granted to physicians. In the past century, however, society has been willing in various locations to experiment with granting physicians the power to cause death. We are still early in a societal experiment, still recording the effects of unleashing that power.

4.3 The search for understanding

Killing any person, whether oneself or another person, has profound ethical implications, even when such an act is legal. This survey chapter is too short for complete ethical discussion. We have chosen to look at the situation in existence rather than questioning whether it should exist, reserving that discussion for another time. We acknowledge ending one's life is entirely possible in these times, with or without physician assistance. We have simply compiled in one place the information needed to begin a search for one's own answers to the question of what to do. How might one choose to end one's own life, and what consequences might follow? What choices deserve mention? We hope that some who have entered these discussions to choose a method for ending their lives will find that there are other choices, not obvious when the search began.

For readers making a serious attempt to understand options as fully as possible, and to choose whether to use any of those options, we strongly recommend additional reading and contemplation. Patients who want to end their own lives have access to a variety of means other than prescribed lethal overdoses of medication from physicians. Some of the means are messy, distressing, and uncertain (firearms, hanging, jumping from high places, poisoning) and some are little known and poorly publicized (inert gas inhalation, voluntary stopping of eating and drinking—VSED).

For serious seekers after truth, we recommend two books and a website. We do not agree with all the points of view in these sites, but we do believe that by and large the information is accurate. We believe that all three of these resources try to present detailed "how-to" discussions of techniques for ending life, coupled with careful and insightful discussions of not-so-appealing consequences of choosing any method, and thoughtful discussion of alternative choices.

4.4 Resources

4.4.1 Final Exit

Derek Humphrys' Final Exit is the classical "how-to" book, with detailed instructions on such non-doctor approaches as inert gas inhalation, and a careful rundown of preparations that must be made so paperwork and finances are in order. The book is full of caveats, legally sensitive, and a good book to have read at least twice for those who are increasingly serious. Many will find their curiosity satisfied and go no further [6].

4.4.2 The Peaceful Pill

Nitschke and Stewart's The Peaceful Pill is a meticulously detailed online book that's kept up to date (also available as hard copy that can become out of date).

Written by an Australian physician who has been a pioneer in this field, it discusses medications and methods in excruciating detail. It provides copious detail on how to find Nembutal (pentobarbital)—still considered the holy grail of the "peaceful pill" search (reliable, peaceful, and available). Finding the holy grail in 2022 requires veterinary connections, foreign sources, and a willingness to abandon being completely legal. Authors rate each method of suicide they discuss on Reliability, Peacefulness, and Availability. This book does not assume that a doctor will be involved in every death. The book provides considerable detail on suicide tourism in Switzerland [7].

4.4.3 Lostallhope.com

Lostallhope.com is a website constructed and maintained by a man who survived his own suicide attempt(s) years ago. It has an excellent and detailed review of approaches to suicide, as well as ranking by lethality, time to die, and agony. The author unblinkingly contrasts methods of suicide by country (USA 50% firearms, 25% hanging, 16% poisoning; versus United Kingdom [UK] 51% hanging, 20% drug poisoning), includes his own story and the stories of other survivors, discusses helpful reading, has a "help me" section, and lists several pages of people to call in crisis.

5. Permitting assisted suicide and euthanasia: laws that protect the doctor

Many people do not realize that suicide is legal almost everywhere in the world. Patients face no legal obstacles and need no legal protection to end their own lives or ask for assistance in doing so. A physician asked to assist, however, does need legal protection, as assisting may lead to a homicide charge. Legislation that "permits" PAS or euthanasia provides that legal protection, allowing a physician to provide lethal medication or even to administer it without being prosecuted for homicide. These laws generally protect physicians and other professionals, not patients. True, most laws have specific criteria for eligibility and a number of procedural steps, but those criteria seem primarily intended to demonstrate that physicians have conducted their due diligence and deserve protection.

6. Help from the doctor: hospice and palliative care

6.1 Hospice is open to all

Any patient diagnosed with terminal cancer and worried about the possibility of a declining quality of life deserves hospice care. Hospice in the USA is a Medicare benefit open to any Medicare subscriber within 6 months of the end of life. US hospice documents [8] say, "Hospice care is to relieve pain and other symptoms related to my terminal illness and related conditions … The focus of hospice care is to provide comfort and support to both me and my family/caregivers." Mission Hospice, a typical US hospice, says that the primary goals of hospice care are to: "Relieve the physical, mental, emotional and spiritual suffering of our patients and those who care for them, promote the dignity and independence of our patients to the greatest extent possible, and support our patients and their families in finding personal fulfillment as they deal with end-of-life challenges." Palliative care—a generic term for medical care aimed at

comfort and not cure—includes hospice care, but the generic term is not specifically limited to the terminally ill.

Hospice care is provided by specially trained nurses in homes or in facilities, with assistance from certified nursing assistants, social workers, spiritual counselors, and supervising hospice physicians. Most care is provided in the home. Hospice includes access to the best and most effective pain medication and symptom relief available anywhere, and hospice patients can be confident that pain or distress will be promptly treated and kept under control.

For several decades, hospice served primarily people with cancer, though that has shifted [9] in the last decade to the point where non-cancer diagnoses outnumber cancer four to one. In 2019 slightly more than half of Medicare patients who died were enrolled in hospice at the time of death. Average length of stay was 92.6 days, with median length of stay 18 days. Most of these days were in Routine Home Care, provided in a patient's own home or an assisted living facility, nursing home, or other congregate living facility. By 2019 there were 4840 Medicare certified hospices in operation.

The American Academy of Hospice and Palliative Medicine, which does not support legalizing PAS, recommends a 5-step approach to understanding requests for PAS, ending with a commitment to the patient to work toward a mutually acceptable solution for the patient's suffering. In situations where unacceptable suffering persists, they recommend discontinuation of potentially life-prolonging treatments (steroids, insulin, oxygen, dialysis, or artificial feeding or fluids). Consider voluntary stopping of oral intake (see VSED later in chapter). Finally, consider deep sedation (sometimes called, confusingly, palliative sedation), potentially to unconsciousness, if suffering remains intractable and severe [10].

6.2 How to choose a hospice

Most people have a choice of more than one hospice. How do they know which to choose? We suggest they interview representatives before making their choices, asking especially about how the hospice approaches pain relief, loss of function, anxiety, nausea, or other things they think might be troubling. Ask what some other patients have done to keep living lives that are rewarding. Ask especially about who will come to see a patient at night or on a weekend when the patient is having trouble or in pain. Will a nurse come see the patient? Is there a doctor on call, readily available? Is there a pharmacy readily available? Does the pharmacy deliver, so the patient will not be left alone while a caregiver is picking up medications?

6.3 The hospice inpatient unit

Ask whether the hospice has an inpatient unit or a place patients can go if they are too sick to be taken care of at home. Inpatient units in the United States are generally not for permanent residence, but for access to care when control of pain or symptoms needs full-time attention. Can a patient in overwhelming pain and distress receive deep sedation, in which patients are given as much medication as it takes to make them comfortable, all the while being carefully watched? True deep sedation, also called palliative sedation, for a suffering patient may require that the patient become unconscious before suffering is relieved. If the patient's pain and symptoms continue to need deep sedation to unconsciousness, comfort at this level may have the unintended effect of reducing a patient's ability to eat or drink. A deeply sedated

patient may die painlessly of dehydration after several days of unconsciousness. Comfort, not death, is the aim of deep sedation, but death may come to a very ill patient who is comfortably sedated. Deep sedation, though rare, is best managed in an inpatient hospice unit, though unique circumstances might make it possible at home.

7. Help from the doctor: physician assisted suicide

7.1 The approval process

The goal of the process is for a patient to persuade a doctor to write a prescription for a lethal dose of medication that the patient can take without assistance. Those states and countries that have passed laws to protect physicians who help patients die have set out eligibility requirements that are quite similar. In general patients must be 18 or over, terminally ill with 6 months or less to live, able to give their own consent, able to administer medication to themselves, and able to request lethal medication on more than one occasion, usually with an additional request in writing. Switzerland does not require that the patient be terminally ill and does accept non-residents.

After the physician makes a prescription (sometimes after a mandated delay) the medication remains in the patient's keeping until used. Most laws suggest actions for the patient (tell the family, do not use the lethal dose in a public place, and return medication for safe disposal if unused) but none of these suggestions are attached to penalties for violation. In the USA a medical person is not required to attend death, and reports are requested but not mandated.

7.2 The medications

There is no single painless completely lethal pill that doctors can prescribe. No pharmacy has such a pill—governments would immediately prohibit distribution of any pill with such a high degree of lethality. A decade ago, doctors would have prescribed barbiturates, pentobarbital or secobarbital. However, in recent years manufacturers have removed some medications from the market (no pharmaceutical manufacturer wants to be known as the provider of death medications). When barbiturates were available, a pharmacist would provide enough medication to make a lethal dose if taken all at once. That might require, say, 3 months of one-a-day capsules that would have to be opened, dumped into a slurry with something like applesauce to disguise the bitter taste, and eaten all at once to avoid falling asleep before a lethal dose is ingested, perhaps to awaken the next day still alive—with a headache. All this is simply to say that these methods are neither easy nor foolproof; many things can go wrong. Self-medication to death can be a risky, sometimes unsuccessful business.

More often now, doctors prescribe a mixture of three to five medications intended to work together to provide death. Oregon's 2021 data summary [11] shows that although barbiturates were the most common medications through about 2018, various combinations of diazepam, digoxin, morphine sulfate, and amitriptyline, with or without phenobarbital, have been introduced and evolved, with replacement of one drug by another and variations in dose of each ingredient. The law does not specify the medication, but simply permits a lethal prescription. Since there is no laboratory in which a physician can test a new lethal mixture on humans, there is a real possibility that a new mixture will not work as well as hoped when given to a real patient.

Although doctors who assist are committed to providing painless and effective death, an untested mixture might lead to an unsuccessful suicide attempt, or it might lead to an attempt marred by suffering and agony, perhaps without a doctor even present.

Assisted suicide, by definition, means that nobody but the patient is supposed to administer medications. Physically assisting by, for example, forcing more medication into a semiconscious patient, could lead to being charged with a felony. It is not possible without risking prosecution to give more medication if the patient is already unconscious and cannot take more medication unassisted. In the rare countries that permit physicians to provide euthanasia by administering lethal medications, assisted suicide becomes much less common than euthanasia. When doctors give lethal medication, they do not stop until the patient is dead. Moreover, they can give intravenous medications that work almost instantaneously, as in the operating room, rather than prescribing massive doses of oral medications that may work slowly, may produce incomplete effects if doses are too low, may be inappropriate medications in the first place, or may cause vomiting and loss of medication that cannot be replaced because the patient is already falling asleep.

7.3 Ethical issues

Ethical issues that arise with assisted suicide concern selection of appropriate candidates, protection of candidates susceptible to coercion, custody of lethal medication once dispensed, accommodation for patients incapable of self-administration, and accuracy of tracking results. Patients with mental illness are presumed to be screened out, but only two states require mental health screening. Other states only suggest it. As mentioned, not every lethal dose is consumed, and no current mechanism tracks all the medication dispensed. There is no requirement for medical attendance at death, and no firm requirement for reporting events during medication administration. As written, the laws do not accommodate patients with physical disabilities that make self-administration impossible (quadriplegia, neurodegenerative diseases).

8. Help from the doctor: euthanasia

8.1 The approval process

Countries that permit euthanasia are rare, but their criteria for eligibility for euthanasia share some elements. Patients who qualify to have doctors end their lives are generally required to be adults, capable of sound decisions, free of coercion, and suffering some sort of grievous and irreversible medical condition. In Canada, death needs to be foreseeable. Belgium requires constant and unbearable suffering that cannot be alleviated. Luxembourg requires a grave and incurable condition. Spain requires a serious or incurable illness or a chronic or incapacitating condition that causes intolerable suffering. Colombia requires a terminal illness but has expanded its reach to nonterminal illness such as chronic obstructive pulmonary disease or amyotrophic lateral sclerosis.

The Netherlands has experienced legalized euthanasia for longer than any other country and has broadened their criteria over the years. The Netherlands permits euthanasia for terminally ill children as young as 12 years old. In addition, in the Groningen Protocol [12], the Netherlands has authorized newborn euthanasia for

children born with unbearable suffering, if parents, their physician, and an independent physician agree. Dutch law requires hopeless and unbearable suffering, but a provision that would allow assisted death without a terminal illness for a person who feels they have completed life has been much discussed.

8.2 The medications

Medication given by a physician to end life can be given as a drink or can be administered intravenously. The drink is usually a strong barbiturate potion (10 grams or more), often preceded by an anti-nausea drug. Intravenous medications mirror those used to start a surgical anesthetic—a barbiturate when thiopental was easily available, and now more frequently propofol, followed by a paralyzing drug after the patient has lost consciousness. Though the medications may seem identical, the euthanasia protocol would be to give the medications and allow the patient to become unconscious, stop breathing, and die of oxygen shortage. The euthanasia patient never awakens. An operating room protocol, on the other hand, might use the same medications but would supplement the breathing and provide oxygen to keep the brain alive, monitoring every breath and every heartbeat to keep the patient stable, administering more anesthetic agent in the IV or by inhalation as needed for the patient to remain unconscious until time to awaken.

8.3 Ethical questions

Beyond those questions inherent in giving a doctor the freedom to take an action that ends a patient's life, questions around euthanasia tend to be of the "slippery slope" variety. That is, if it is permissible to end life for a 12-year-old, how about an unusually mature 10- or 11-year-old? What about a patient who asks for euthanasia when of sound mind, but now has such significant dementia that the patient can no longer confirm consent? If voluntary euthanasia is permitted, how about those cases where the patient can no longer consent but those charged with the patient's welfare are sure that the patient would have wanted life to end?

9. What can be done to shorten life? Using one's own resources

9.1 Ending life without a doctor

9.1.1 Why we die

Man is an obligate aerobe [13]. Every cell in our bodies depends on oxygen for the metabolic processes that sustain life. Although some cells such as skeletal muscles can function anaerobically (without oxygen) for a short time, accumulating an oxygen debt by forming lactic acid to be broken down when oxygen is available again, the brain cannot. The brain requires a continuing and largely uninterrupted supply of oxygen, and therefore of the blood that carries oxygen. All methods of producing death that we discuss as methods of suicide or euthanasia interrupt oxygen to the brain. Lethal doses of sedatives may stop breathing, may allow the airway to obstruct so air exchange ceases, and may themselves stop the heart. Major trauma (e.g., gunshot, car crash, and fall from a height) may destroy the brain or heart, or more likely will lead to blood loss that eventually leaves the heart running on empty, with no

oxygenated blood to send to the brain. Hanging or strangulation stops blood flow to the brain. Poisons may stop the heart. Inhaling an inert gas displaces oxygen from the lungs, leading to oxygen lack, rapid unconsciousness, and rapid death of brain and then heart.

9.2 Suicide in the USA: grading the methods

Suicide without physician assistance accounts for about 1.5% of deaths worldwide [14]. Rates vary by country, from as high as 53 deaths per 100,000 population in Greenland to as few as 3 per 100,000 in Peru [15]. In the USA, rates vary by state from a high of 29.6 per 100,000 in Montana to a low of 6.1 per 100,000 in the District of Columbia [16].

"lostallhope.com" has an extensive listing of methods of killing oneself, evaluated according to lethality (99% for shotgun to head, 6% for cutting wrists), time required (1.4 min for shotgun to chest, 456 min for overdose of nonprescription drugs), and agony (3.75 for explosives, 95 for setting fire to self). Those seriously evaluating methods for ending their own lives may want to examine this list of options, none of which require assistance from a physician.

Not included in this list is any accounting of the effect on bystanders, on those who find the person who has accomplished suicide, and on families. In general, some of the most effective and available methods are those frequently used, with lifelong effects on survivors and those left to clean up after a violent death.

9.3 Less easily available methods

Several methods of ending life are less violent.

9.3.1 Medications

Medications are extensively dealt with in the three references above. In general, non-prescription overdoses have a high risk of failure. However, prescription overdoses not officially provided by assisted suicide programs also fail at a high rate. Opioids (narcotics) are often used by those who want to bypass physician consultation and use materials available at home. Some cancer patients will have massive doses of opioids at home, and some will be encouraged to take huge doses of these medications as a method of inducing respiratory arrest and death. Be warned! Patients who have been taking opioids for pain relief will be refractory to the respiratory effects of even massive doses of drugs and will very likely commit themselves to several days of deep sleep and a distressing wake-up in the midst of continuing life. Worse, many will have communicated their plans to family, who may panic on discovering that the intended lethal dose is not working, taking actions to bring death to their loved one that will lead to their having committed homicide, whether charged with it or not.

Poisons, such as insecticides, are also extensively dealt with in the references. All such methods have a high risk of failure and continued life with injury and cannot be recommended for consideration.

9.3.2 Inert gas inhalation

Inhaling inert gas (helium, argon, or nitrogen) is a painless, effective, and very accessible means of dying. Both books cited above describe technique and equipment

in detail. Although doctors could recommend this setup as more effective than the medications they prescribe, they do not. Doctors prescribe medication, for the most part, and do not think of inhalation. Anesthesiologists think of inhalation but are generally not involved in assisting suicides.

"Painless" dying occurs when the brain stops functioning first, and then the heart. This can happen with drugs that abolish consciousness first, then stop breathing, then stop the heart. Eliminating oxygen from the air being breathed can also abolish consciousness first and then lead to rapid death of brain and heart, all with no poison or toxin at all. How can that happen?

In normal breathing we inhale air containing 21% oxygen, 78% nitrogen, 1% other gases, and very little carbon dioxide (0.04%). Since the body uses oxygen and produces carbon dioxide in its metabolic processes, the exhaled air after exchange in the lungs contains less oxygen (17%) and much more carbon dioxide (4%, about 100 times as much). Nitrogen is still there unchanged, but exhaled water vapor has diluted it a bit.

Breathing is automatic, generally. Our respiratory control center notices that carbon dioxide is rising and triggers a breath. Our body's breathing control mechanism is very sensitive to little rises in carbon dioxide. Too much carbon dioxide sends a loud alarm signal to the brain to defend the airway at any expense, because if carbon dioxide is rising something has gone frightfully wrong with breathing. Anybody who has breathed for even a short time into a paper bag, rebreathing carbon dioxide as it builds up, knows the desperate feeling of suffocation that shortly makes us take the bag away and breathe fresh air again.

Unlike too much carbon dioxide, the body has very weak alarms for too little oxygen. Rather, low oxygen produces primarily sleepiness and then unconsciousness. A pilot whose oxygen supply has been interrupted, or a shipyard worker who has unknowingly entered a chamber flushed with nitrogen that has displaced all the oxygen, feels no distress but keeps on breathing normally until unconsciousness sets in. Breathing is perfectly normal, even when there is no oxygen in the air, so the carbon dioxide level stays normal and the carbon dioxide alarm is never set off. A single lungful of an inert gas, such as helium, can produce rapid hypoxia (oxygen shortage) and rapid unconsciousness with no sensation of being short of breath. Anybody who has inhaled the entire content of a helium balloon and held their breath can attest to the rapid onset of light-headedness and impending loss of consciousness. Usually, the person breathing from the balloon would lose consciousness, drop the balloon, and be restored by breathing oxygen-containing room air, since breathing would not stop. If, however, an entire balloon of helium surrounded the person's head so that breathing pure helium would continue, death would rapidly follow, and the person who dies would only have been aware of falling peacefully asleep, breathing normally.

This phenomenon is the basis of a suicide technique known as "inert gas inhalation." An inert gas is one that has no toxic or anesthetic properties of its own but simply displaces oxygen in pure gas breathing. Nitrogen, argon, and helium are the commonest examples of inert gases. Breathing from a large plastic bag (think turkey bag) filled with one of these gases placed around the head and face, sealed loosely at the neck, will produce unconsciousness within one to three breaths, and death within minutes. All inert gases can be purchased or rented from gas suppliers, welding shops, or even toy stores that carry balloon supplies (though helium that has been blended with 20% oxygen would not work for this purpose). Inert gas inhalation requires some preparation and some purchase of supplies but does not require the presence of another (though recommended). Most importantly, it does not require a prescription or the participation of a doctor. It leaves no telltale signs, creates no distressing mess,

and (especially in the case of nitrogen) is generally undetectable on autopsy. These features make it the technique of choice for those looking for a painless, low-stress approach to suicide that does not require requesting a physician's participation.

9.3.3 Voluntarily stopping eating and drinking (VSED)

Since eating and drinking are essential to life, one way to control life is to control eating and drinking. Stopping eating and drinking, it can be argued, is ethically permissible in the same way that foregoing life-sustaining treatment is permissible. In fact, failing to honor a competent patient's refusal of food and drink could lead to an attempt at force feedings, with a nasogastric tube and restraints, a complete violation of a patient's dignity and autonomy. The Supreme Court of the United States of America has affirmed the right of a capable individual to refuse any unwanted treatment [17], even if that refusal results in death. Dr. Timothy Quill has written an up-to-date and complete book with answers to virtually all questions about VSED [18].

Death usually occurs within 1–3 weeks of starting a fast, depending on the patient's physical condition. Dehydrated, cachectic patients decline in a shorter time than obese, well-hydrated patients. This is not a process for a solo individual—as the fasting person declines, round-the-clock attention becomes necessary. Further, general agreement of family and caregivers gives peace and support for a process that is not easy every minute.

The first few days of fasting may find the patient awake and responsive, able to reminisce and to examine in detail the course chosen. As dehydration progresses, the patient becomes sleepier and more lethargic, eventually becoming completely unresponsive before death. Though pain and discomfort are not common, good palliative support is invaluable.

Once committed, most patients want the process to move as quickly as possible. The number one bit of advice is to take no fluids at all, including fluids taken with medication. Even a little bit of water every day may prolong the dying process by days. Most patients will complete their fasting journey in several days to a week [19]. Those who take longer are almost always taking some sort of fluids. In a Dutch study of the VSED experience of patients of 708 family physicians median time to death was 7 days; 8% had a prolonged process of 14 days or more [20].

VSED is particularly well suited to patients with gastrointestinal obstruction or difficulty swallowing, or those with sufficient control to deal with discomfort in early stages. For some, VSED has the appeal of being an entirely natural process that needs no medication or instrumentation. It is also legal and effective even in states where assisted suicide is not protected. Although patient experience is better if those in the environment are supportive, the process depends entirely on an individual decision. VSED is supported by most hospices and is an extension of the end-of-life process that many experience, with stopping eating and drinking as death approaches.

10. Get your financial house in order

Do not forget about getting your financial house in order—will, living will, POA selection, accounts in order, insurances discovered, etc. Having all the details of your accounts, beneficiaries, funeral wishes and such in one place will make things easier for your heirs and those who are tasked with planning and executing your wishes. Use a simple book where you can fill in the essential information, or you can provide your attorney's information if your trust and/or will is there.

11. Geographic limitations on physician assistance

See **Table 1**.

11.1 Countries in which euthanasia and physician-assisted suicide are legal

11.1.1 Netherlands

Euthanasia and physician-assisted suicide were legalized in the Netherlands in 2002 for Dutch citizens over 12 years old, in an act that made physicians exempt from criminal responsibility if they practiced under a set of conditions established by the law. Newborns have been eligible to be euthanized since 2004 under the Groningen Protocol if they are believed to have unbearable suffering and parents, the child's physician, and an independent physician agree to the procedure. In 2020 the Dutch announced plans to extend euthanasia to terminally ill children between the ages of one and 12. Euthanasia tourism is not possible: citizenship is not the issue. The treating physician who will vouch for the patient must be in the Netherlands. A patient cannot be treated outside the Netherlands and receive euthanasia in the Netherlands. Euthanasia rates have risen from just under 2% of all deaths in 2002 to just over 4% in 2019 [22].

11.1.2 Belgium

Belgium legalized PAS and euthanasia in 2002 for "competent" adults and emancipated minors suffering from "constant and unbearable physical or mental suffering that cannot be alleviated." Patients do NOT need to be suffering from terminal illness. The law was extended to minors in 2014. The Analysis of the 2020 Commission Report [23] asserted that 954 reported assisted deaths in 2010 had increased to 2656 by 2019, an increase of 267% in 9 years. The main conditions generating requests were cancer or polypathology unlikely to improve; no unemancipated minor euthanasia was recorded.

11.1.3 Luxembourg

Luxembourg became the third country in Europe to legalize euthanasia and physician-assisted suicide with a law that went into effect in 2009. Doctors have legal immunity from prosecution and lawsuits if they perform euthanasia or PAS for a patient with a grave and incurable condition who has asked repeatedly for the procedure. Luxembourg also requires palliative care and paid leave for relatives of terminally ill family members. In all cases, before euthanasia or assisted suicide can be performed, the doctor must fulfill certain formal and procedural conditions (e.g., conduct several interviews with the patient, etc.) [24].

Patients who live elsewhere but have a physician in Luxembourg may record end-of-life wishes and plans in their medical file. Luxembourg attaches no stipulations of residency or nationality to placing this information in one's medical file. However, the physician must have been caring for the patient for a long, uninterrupted period. Minors, persons of legal age under guardianship or protection, and legally incapable persons may not legally request euthanasia or assisted suicide, nor may their parents, guardians or trustees make such a request on their behalf.

Country	Assisted suicide?	Euthanasia
Belgium	Legal	Legal
Canada	Legal	Legal
Luxembourg	Legal	Legal
Netherlands	Legal	Legal
Spain	Legal	Legal
Australia	Legal in all states but Northern Territory and Australian Capital Territory	Legal in all states but Northern Territory and Australian Capital Territory)
Colombia	Illegal	Legal
Austria	Legal	Illegal
Finland	Legal	Illegal
Germany	Legal	Illegal
New Zealand	Legal	Illegal
Switzerland	Legal	Illegal
Japan	Unclear	Unclear
South Africa	Unclear	Unclear
United States	Illegal (legal in OR, WA, CA, HI, NM, MT, ME, VT, CO, NJ, DC)	Illegal
China	Illegal	Illegal
Denmark	Illegal	Illegal
France	Illegal	Illegal
India	Illegal	Illegal
Ireland	Illegal	Illegal
Israel	Illegal	Illegal
Italy	Illegal	Illegal
Mexico	Illegal	Illegal
Norway	Illegal	Illegal
Philippines	Illegal	Illegal
Russia	Illegal	Illegal
Sweden	Illegal	Illegal
Turkey	Illegal	Illegal
United Kingdom	Illegal	Illegal
Uruguay	Illegal	Illegal

Table 1.
Countries allowing assisted suicide or euthanasia, 2022 [21].

The sixth biennial report by the National Commission for Control and Evaluation [25], published in March 2021, records 16 cases of euthanasia in 2019 (twice the 8 cases in 2018) and 25 cases in 2020. Total cases from 2009 to 2020 were 112. Lethal

injection was the mode for all but occasional rare cases of oral ingestion of a barbiturate. In 2020 the Commission approved the first euthanasia of a 96-year-old man claiming "fatigue of life," citing the Belgian practice.

11.1.4 Canada

Canada decriminalized suicide in 1972 but retained a provision prohibiting assisted suicide until it was struck down in 2015 by the Supreme Court of Canada, which gave the Canadian Parliament 1 year to pass a law legalizing and regulating physician-assisted suicide and perhaps euthanasia. Bill C-14 [26] passed the Senate in 2016, making assisted suicide and possibly euthanasia legal. The Court was unclear about the distinction between PAS and euthanasia, but Bill C-14 states that "medical assistance in dying (MAID) means (a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes death; or (b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so, cause their own death." These provisions apply to citizens or permanent residents of Canada, at least 18 years old, who have a "grievous and irremediable medical condition." To be eligible for MAID [27] in Canada, a person must be at least 18 years of age and be eligible for publicly funded health care services in Canada. By November 2020, more than 13,000 Individuals [28] nearing the end of life had been voluntarily euthanized as a result of this bill. In 2020, 2.5% of deaths in Canada were due to MAID. In March 2023, Canada is set to become one of the few nations allowing medical aid in dying (MAID) for people with afflictions that are solely mental, such as depression, schizophrenia, bipolar disorder, personality disorder, PTSD, or other mental affliction. In March 2021, Bill C-7 [29] made changes to the eligibility criteria, removing the "reasonably foreseeable death" criterion. As of March 17, 2023, MAID will be available to capable adults whose sole underlying condition is a mental illness.

Canada's MAID law says that intolerable suffering is wholly subjective and personal. Unlike the Netherlands, a doctor does not have to agree. Suffering is what the person says it is. Under those criteria, the Council of Canadian Academies suggests that Canada could become the most permissive jurisdiction in the world with respect to MAID and mental illness [30].

11.1.5 Spain

The fifth country to legalize both PAS and euthanasia, Spain wrote a "death with dignity" bill in 2011 that allowed passive euthanasia, the removal of treatment or life-sustaining machinery. Ten years later, Spain's parliament legalized both active euthanasia and PAS for Spanish citizens and legal residents who suffer from a "serious or incurable illness" or a "chronic or incapacitating condition" that causes "intolerable suffering" [31]. The person seeking death must make two requests, 15 days apart, in writing, and must be found "fully aware and conscious."

11.2 A country in which euthanasia alone is legal

11.2.1 Colombia

Though Colombia's Constitutional Court appeared to legalize euthanasia in 1997 when it ruled that physicians could not be prosecuted for assisting with suicide,

legalization awaited Health Ministry released guidelines that were not released until 2015. In 2021 the Court recognized that the procedure should be available to persons with degenerative illnesses as well as terminal illnesses. On March 9, 2018, Colombia passed a resolution permitting euthanasia for children [32]. Children under 14 require parental consent, but those over 14 may give their own consent even if parents disagree.

11.3 Countries in which physician-assisted suicide alone is legal

11.3.1 Austria

In 2020 Austria's constitutional court ruled that banning assisted suicide violated fundamental rights. Effective in January 2022, two doctors review each case (one must be a palliative care physician), and a 12-week waiting period applies unless the patient is terminal. Austria reported 1160 suicides in 2019, 68 fewer than in 2018. Of those, 907 were men, 253 were women, making suicide the leading causes of unnatural death in Austria.

11.3.2 Finland

Finland's National Advisory Board on Social Welfare and Health Care Ethics (ETENE) created a statement released in 2021 asserting that assisted suicide is not a crime in Finland [33]. This was to involve placing medication within reach of a patient but requiring the patient to take the deadly dose himself/herself. The group took no position on legalization of euthanasia but suggested that discussion should continue.

11.3.3 Germany

Germany legalized physician-assisted suicide in 2015 when performed on "an individual basis out of altruistic motives," but commercial euthanasia and suicide business were out. In 2020 a high court overturned the ban on professionally provided assisted suicide [34]. There is an ongoing debate in Germany about how to settle the issue, but regardless of that parliament cannot overturn the decision of the constitutional court. Assisted suicide will remain legal in Germany under certain, specific circumstances, but the decision for how it will be regulated now lies with the parliament.

11.3.4 New Zealand

After numerous unsuccessful legislative attempts, a nationwide vote in 2020 legalized physician-assisted suicide, effective November 7, 2021. New Zealand's Ministry of Health maintains an informative web site [35] that answers most potential questions about what it calls its Assisted Dying Service; noncitizens are not eligible to apply for the service. In the 5 months preceding March 31, 2022, 206 people applied for assisted dying. As of March 31, 66 people had already obtained an assisted death, 59 were still trying, and 81 people had not persisted (they were ineligible, they withdrew, or they died) [36].

11.3.5 Switzerland

Euthanasia is illegal. Article 114 of the Penal Code of Switzerland forbids causing the death of a person even in the face of genuine and repeated requests. Article 115 forbids assisting with suicide for "selfish motives." Assisted suicide is permissible if the person assisting has good intentions and does not actually administer the medication that leads to death. Dignitas clinic [37] in Forch performs "accompanied suicides." Dignitas provides detailed information in their brochure, which emphasizes that the process is detailed, time-consuming, and expensive. Novelist Amy Bloom has written about her husband's death in Switzerland [38] and has been interviewed on NPR about that experience [39].

11.4 Countries in which the status of PAS and euthanasia is unclear

11.4.1 Japan

Despite the absence of specific laws banning euthanasia, physician-assisted suicide is a criminal offense. A District Court in 1995 found a physician guilty of homicide for injecting lethal drugs at a patient's request and set out four conditions to be met for active euthanasia to be legal. The same court in 2005 found a physician guilty of homicide for removing an endotracheal tube and giving a muscle relaxant without the patient's permission, a conviction upheld in 2007 by a court critical of the lower court's rules but unwilling to produce new ones. The Supreme Court declined to hear the case.

11.4.2 South Africa

The South African Law Commission in 1997 produced a draft law that would have legalized both euthanasia and PAS, but the report was ignored, and a law never passed. In 2015 a terminally ill lawyer asked that his physician be allowed to assist with his suicide, but the court's supportive ruling was not read until the lawyer had already died, leaving the scope of the ruling unclear.

11.5 Countries in which individual states permit PAS or euthanasia despite country-wide bans

11.5.1 Australia

Despite previous countrywide bans on both euthanasia and PAS, the state of Victoria passed a law in 2017 that allowed doctors to prescribe lethal drugs for self-administration by terminally ill patients; the law also allowed doctors to administer the medications if the patient is unable to do so themselves. Western Australia followed in 2019, followed in 2021 by Tasmania, Queensland, and South Australia. Parliament will be under pressure to permit legalization of assisted dying in the Northern Territory and in the Australian Capital Territory.

11.5.2 United States of America

The USA holds euthanasia illegal everywhere, in every state. However, 10 of 50 states and the District of Columbia have laws protecting physicians involved in

physician-assisted suicide if procedures are followed. These states will be examined in detail in the subsequent section.

11.6 Countries in which physician-assisted suicide or euthanasia are illegal

Table 1 lists several specific countries in which PAS or euthanasia are not protected. The fact that a country is not on the list attests only to lack of information and does not imply that PAS or euthanasia might be legal in unlisted countries.

11.7 A more detailed look at USA states in which PAS is protected

USA states that permit physician assisted suicide have very similar laws, all based on the same core template espoused by advocates in Oregon. Montana is an exception, as its protection is based on a court ruling in 2009 which held that consent could be a defense against a charge of homicide in a case of PAS. No legislative or regulatory steps have been completed there (**Table 2**).

All states require that candidates be at least 18 and diagnosed with a terminal illness that limits life expectancy to 6 months or less. All states require two oral and one written request for services except for New Mexico. All states protect patients' insurance and contracts. Mental health consultation is required in Hawaii and Colorado and is left up to screening physicians elsewhere. All states require a second "consultant" physician who confirms the diagnosis and the patient's capability of giving their own consent.

Montana, on the other hand, having arrived at assisted suicide by a court decision, has no legislative framework to follow, and no reporting structure.

State	Date passed	Residency required?	Minimum age	Months until expected death	Number of requests to provider
California	2015	Yes	18	6 or fewer	2 oral, 15 d apart, one written
Colorado	2016	Yes	18	6 or fewer	2 oral, 15 d apart, one written
District of Columbia	2016	Yes	18	6 or fewer	2 oral, 15 d apart, one written
Hawaii	2018	Yes	18	6 or fewer	2 oral, 20 d apart, one written
Maine	2019	Yes	18	6 or fewer	2 oral, 20 d apart, one written
Montana	2009	Yes	No legal protocol	No legal protocol	No legal protocol
New Jersey	2019	Yes	18	6 or fewer	2 oral, 15 d apart, one written
New Mexico	2021	Yes	18	6 or fewer	One written request (state form)
Oregon	1994	No (starting 2022)	18	6 or fewer	Two oral, one written
Vermont	2013	Yes	18	6 or fewer	2 oral, 15 d apart, one written
Washington	2008	Yes	18	6 or fewer	2 oral, 15 d apart, one written

Table 2.
States of the USA in which physician-assisted suicide is protected.

A recent report, from 2019, says that 4249 prescriptions for lethal medication have been written since 1998 in US states, and that 66.3% of these patients have used the drugs to end their lives. Of note for this chapter, 63.1% of these patients had cancer [40].

11.7.1 California

ABX2-12 End of Life Option Act [41], was signed into Law Oct. 5, 2015, and became effective June 9, 2016.

Contact California Department of Health, **Phone:** 916-558-1784.

Patient eligibility: As with other states, candidates must be 18 or older, residents of the state, and able to make their own decisions and communicate them. A patient must have a terminal illness with a life expectancy of 6 months or less but must still be physically and mentally capable of self-administering the prescribed lethal medication without assistance. **Physician requirements:** The doctor must diagnose a terminal illness with a life expectancy of 6 months or less. This must be confirmed by a second consulting doctor, who is also expected to certify that the patient can make and communicate health care decisions. If either doctor questions the patient's ability to make judgments, the patient must be referred for a psychological examination. The attending doctor must inform the patient of alternatives, including hospice, palliative care, and pain management options. **Patient request timeline:** First oral request to doctor, 15-day waiting period, second oral request to doctor along with written request. **Other:** Patient's insurance is protected from being affected by patient's decision to "use law." Doctors and health care systems have choice about whether to participate. Non-English speakers are to have translators available. Pharmacists cannot be prosecuted for filling lethal prescriptions.

11.7.2 Colorado

Proposition 106: End of Life Options Act [42], came from voters Nov. 8, 2016 (65% in favor), became **Effective:** Jan. 2017.

Colorado Department of Public Health & Environment **Phone:** 303-692-2000; **Email:** cdphe.information@state.co.us

Patient eligibility: As with other states, candidates must be 18 or older, residents of the state, and able to make their own decisions and communicate them. They must have made requests voluntarily. A patient must have a terminal illness with a life expectancy of 6 months or less. **Physician requirements:** The doctor must diagnose a terminal illness with a life expectancy of 6 months or less, confirm the patient's capacity to make and communicate medical decisions, and confirm residency. Diagnosis must be confirmed by a second consulting doctor, who is also expected to confirm competency. The doctor must refer the patient to a licensed mental health professional. The doctor must discuss diagnosis, prognosis, feasible alternatives, and risks of taking lethal medication, as well as possibility of choosing not to use it. The doctor should tell the patient to notify next of kin, and request that medication not be taken in a public place. **Patient request timeline:** First oral request to doctor, 15-day waiting period, second oral request to doctor along with written request. **Other:** Patient's insurance is protected from being affected by patient's decision to "use law." Doctors and health care systems have choice about whether to participate.

11.7.3 District of Columbia

DC ACT 21-577 *Death with Dignity Act of 2016* [43], **Signed into Law** Dec. 19, 2016, **Effective Date:** Feb. 18, 2017.

DC Department of Health **Phone:** 202-442-5955 **Email:** doh@dc.gov

Patient eligibility: As with other states, candidates must be 18 or older, residents of the District, and able to make their own decisions and communicate them. A patient must have a terminal illness with a life expectancy of 6 months or less. **Physician requirements:** The doctor must diagnose a terminal illness with a life expectancy of 6 months or less. This must be confirmed by a second consulting doctor, who is also expected to certify that the patient can make and communicate health care decisions. If either doctor questions the patient's ability to make judgments, the patient must be referred for a psychological examination. The attending doctor must inform the patient of alternatives, including palliative care, hospice, and pain management options. **patient request Timeline:** First oral request to doctor, 15-day waiting period, second oral request to doctor along with written request before second request, then 48-hour waiting period before drugs dispensed. **Other:** Patient's insurance is protected from being affected by patient's decision to "use law."

11.7.4 Hawaii

HB 2739, Hawai'i Our Care, Our Choice Act [44] **signed into Law** Apr. 5, 2018, **effective Date** January 1, 2019.

Hawaii Department of Health **Phone:** 808-586-4400, **Email:** webmail@doh.hawaii.gov

Highlights of the law (use Hyperlink to see entire law):

Patient eligibility: As with other states, candidates must be 18 or older, residents of the state, and able to make their own decisions and communicate them. A patient must have a terminal illness with a life expectancy of 6 months or less. **Physician requirements:** The doctor must diagnose a terminal illness with a life expectancy of 6 months or less. This must be confirmed by a second consulting doctor, who is also expected to certify that the patient can make and communicate health care decisions. A counselor must confirm that the patient is capable and not suffering from depression or impaired decision-making ability. The attending doctor must inform the patient of alternatives, including palliative care, hospice, and pain management options. **Patient request timeline:** First oral request to doctor, 20-day waiting period, second oral request to doctor along with witnessed written request before second request; 48 h to prescription. **Other:** The patient can withdraw request at any time and is not required to fill the prescription. Patient's insurance is protected from being affected by patient's decision to "use law."

11.7.5 Maine

HP 948, An Act to Enact the Maine Death with Dignity Act [45] **signed into Law** June 12, 2019, **effective Date** September 19, 2019.

Note: Maine's law indicates that it does not legalize "assisted suicide," but states that the act must be referred to as "obtaining and administering life-ending medication" in state reports. Note that this does not alter the action for which the physician is protected.

Maine Department of Health and Human Services **Phone:** 207-287-3707.

Patient eligibility: As with other states, candidates must be 18 or older, residents of the state, and able to make their own decisions and communicate them. A patient must have a terminal illness with a life expectancy of 6 months or less but must still be physically and mentally capable of self-administering the prescribed lethal medication without assistance. **Physician requirements:** The doctor must diagnose a terminal illness with a life expectancy of 6 months or less and judge the patient mentally capable of making an informed, voluntary decision. This must be confirmed by a second consulting doctor, who is also expected to certify that the patient can make and communicate health care decisions and is acting voluntarily. If either doctor questions the patient's ability to make judgments, the patient must be referred for a psychological examination. The attending doctor must discuss diagnosis and prognosis, and inform the patient of alternatives, including palliative care, hospice, and pain management options, as well as risks of taking lethal medication and possibility of not taking it. Patient is to be requested to notify next of kin, and not take medication in a public place. **Patient request timeline:** First oral request to doctor, 15-day waiting period, second oral request to doctor along with written request signed at least 15 days after first request; 48 h to prescription. **Other:** The patient may withdraw the request at any time and is not required to fill the prescription. Patient's insurance is protected from being affected by patient's decision to "use law." No will, contract, or other agreement can interfere with patient's use of law.

11.7.6 Montana

Montana First Judicial District Court: *Baxter v. Montana* [46]
Court ruling date: Dec. 5, 2008, in favor of plaintiffs.

Plaintiffs (four physicians and a dying patient) asked court to establish constitutional right "to receive and provide aid in dying." Judge ruled that a terminally ill, competent patient has a legal right to die with dignity under Article II, Sections 4 and 10 of the Montana Constitution, including a right to "use the assistance of his physician to obtain a prescription for a lethal dose of medication that the patient may take on his own if and when he decides to terminate his life." Judge further held that this right "includes protection of that patient's physician from liability under the State's homicide statutes."

State Supreme Court: **Baxter v. Montana**
Decided: Dec. 31, 2009, in favor of plaintiffs 5-4.

The Attorney General of Montana appealed the ruling above to the Montana Supreme Court, which said, "we find no indication in Montana law that physician aid in dying provided to terminally ill, mentally competent adult patients is against public policy." Therefore, the physician who assists is shielded from criminal liability *by the patient's consent*.

No legal protocol is in place.

Despite multiple legislative attempts since 2009, neither laws nor regulations dealing with assisted suicide have been put in place in Montana.

11.7.7 New Jersey

Bill A1504 Aid in Dying for the Terminally Ill Act [47] **signed into Law** Apr. 12, 2019, e**ffective Date** Aug. 1, 2019.

State of New Jersey Department of Health **Phone:** 800-367-6543.

Patient eligibility: As with other states, candidates must be 18 or older, residents of the state, and able to make their own decisions and communicate them. A patient must have a terminal illness with a life expectancy of 6 months or less. **Physician requirements:** The doctor must diagnose a terminal illness with a life expectancy of 6 months or less. This must be confirmed by a second consulting doctor, who is also expected to certify that the patient can make and communicate health care decisions. If either doctor questions the patient's ability to make judgments, the patient must be referred for a psychological examination. The attending doctor must inform the patient of alternatives, including hospice, palliative care, and pain management options. The physician should request that the patient notify next of kin. **Patient request timeline:** First oral request to doctor, 15-day waiting period, second oral request to doctor along with written request; 48 h to dispensing. **Other:** Patient's ability to request medication cannot be restricted or stopped by contracts, wills, insurance policies, or other agreements. The Department of Human Services—Health Services requires physicians to report all prescriptions to the state. Compliance confers protection from criminal prosecution. Physicians and health care systems may choose not to participate.

11.7.8 New Mexico

Elizabeth Whitefield End of Life Options Act [48] **signed into Law** Apr. 8, 2021, **effective Date** June 18, 2021.

New Mexico Department of Health **Phone:** 800-432-2080.

Patient eligibility: As with other states, candidates must be 18 or older, residents of the state, and able to make their own decisions and communicate them. A patient must have a terminal illness with a life expectancy of 6 months or less. **Physician requirements:** The doctor must diagnose a terminal illness with a life expectancy of 6 months or less and ensure that patient is either enrolled in a hospice program, or that one other health care provider has confirmed the patient's diagnosis and 6-month life expectancy. If either doctor questions the patient's ability to make judgments, the patient must be referred for a psychological examination. Prescribing doctor confirms lack of coercion and ability to administer medication. Prescribing doctor must inform the patient of alternatives, including hospice, palliative care, and pain management options. Prescribing doctor must offer opportunity to withdraw request. **Patient request timeline:** Written request to their doctor, signed in front of two qualified, adult witnesses. Use specific form. **Other:** Patient's ability to request medication cannot be restricted or stopped by contracts, wills, insurance policies, or other agreements. Physicians and health care systems may choose not to participate.

11.7.9 Oregon

1. Ballot Measure 16**: Death With Dignity Act [49] Passed:** Nov. 8, 1994 (51% in favor), **effective Date** October 27, 1997.

2. Ballot Measure 51: **Repeals Death with Dignity Act** Passed: Nov. 4, 1997 (60% against).

3. Supreme Court of the United States: *Gonzales v. State of Oregon* Decided: Jan. 17, 2006 (6-3 in favor of the State of Oregon), upholds ***Death With Dignity Act***. Court majority opinion held that the *Controlled Substances Act* does not empower

the Attorney General of the United States to prohibit doctors from prescribing regulated drugs for use in physician-assisted suicide under state law permitting the procedure.

4. SB 579 Changes **Death with Dignity Act** [50]. Signed into law July 24, 2019, allowing patients with fewer than 15 days to live to submit the second oral request for life-ending medication at any time after the first oral request, bypassing the 15-day waiting period.

5. Mar. 29, 2022 – Oregon Ends Residency Requirement In a court settlement with Compassion & Choices, the Oregon Health Authority and the Oregon Medical Board agreed to stop enforcing the residency requirement and to ask the legislature to amend the law.

Oregon Health Authority **Phone:** 971-673-1222 **Email:** dwda.info@state.or.us

Patient eligibility: As with other states, candidates must be 18 or older, without a requirement for state residency, and able to make their own decisions and communicate them. A patient must have a terminal illness with a life expectancy of 6 months or less. **Physician requirements:** The doctor must diagnose a terminal illness with a life expectancy of 6 months or less. This must be confirmed by a second consulting doctor, who is also expected to certify that the patient can make and communicate health care decisions. If either doctor questions the patient's ability to make judgments, the patient must be referred for a psychological examination. The attending doctor must inform the patient of alternatives, including palliative care, hospice, and pain management options. The doctor must request that the patient notify next of kin. **Patient request timeline:** First oral request to physician, 15-day waiting period for patients who are expected to live more than 15 days (no waiting for patients nearer death). Second oral request to physician, written request to physician, 48-hour waiting period before picking up prescribed medications from pharmacy. **Other:** Patient's health or life insurance policies cannot be affected by use of law. The Department of Human Services—Health Services requires physicians to report all prescriptions to the state. Compliance ensures protection from criminal prosecution. Physicians and health care systems may choose not to participate.

11.7.10 Vermont

Act 39 **An Act Relating to Patient Choice and Control at End of Life [51] signed into Law** May 20, 2013 **effective Date:** May 20, 2013.

Vermont Department of Health **Phone:** 800-464-4343.

Patient eligibility: As with other states, candidates must be 18 or older, residents of the state, and able to make their own decisions and communicate them. A patient must have a terminal illness with a life expectancy of 6 months or less.

Physician requirements: The doctor must diagnose a terminal illness with a life expectancy of 6 months or less. This must be confirmed by a second consulting doctor, who is also expected to certify that the patient can make and communicate health care decisions. If either doctor questions the patient's ability to make judgments, the patient must be referred for a psychological examination. The attending doctor must inform the patient of alternatives, including palliative care, hospice, and pain management options.

Patient request timeline: First oral request to doctor, 15-day waiting period, second oral request to doctor along with written request; 48 h to dispense.

Other: Insurance policies are protected from being affected by patient's decision to use law. Physicians and health care systems may choose not to participate.

11.7.11 Washington

Ballot Initiative 1000: Death With Dignity Act [52] **voted On** Nov. 4, 2008 (58% in favor), **effective Date** March 5, 2009.

Washington State Department of Health Phone: 360-236-4030.

Patient eligibility: As with other states, candidates must be 18 or older, residents of the state, and able to make their own decisions and communicate them. A patient must have a terminal illness with a life expectancy of 6 months or less.

Physician requirements: The doctor must diagnose a terminal illness with a life expectancy of 6 months or less. This must be confirmed by a second consulting doctor, who is also expected to certify that the patient can make and communicate health care decisions. If either doctor questions the patient's ability to make judgments, the patient must be referred for a psychological examination. The attending doctor must inform the patient of alternatives, including palliative care, hospice, and pain management options. The doctor should request that the patient notify next of kin.

Patient request timeline: First oral request to doctor, 15-day waiting period, second oral request to doctor along with written request; 48 h to dispense.

Other: Patient's health or life insurance policies cannot be affected by use of law. The Department of Health requires physicians to report all prescriptions to the state. Compliance is the condition for protection from criminal prosecution. Physicians and health care systems may choose not to participate.

12. Conclusion

We set out to discuss every way a patient could deliberately shorten life in 2022. We believed that a truthful presentation of choices and the consequences that could accrue might lead a patient, after extensive reading and contemplation, to seek help with fears and suffering and make peace with living among us as long as life holds out. We made this presentation even though we have come to have increasingly grave reservations about the wisdom of allowing doctors to kill people while protected by the state.

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Conflict of interest

No conflicts of interest are identified for either author.

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