

Physician Aid-in-Dying

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What is physician aid-in-dying?

Physician aid-in-dying (PAD) refers to a practice in which a physician provides a competent, terminally ill patient with a prescription for a lethal dose of medication, upon the patient's request, which the patient intends to use to end his or her own life. (For related discussion, see also [End of Life Issues](#).)

What role does language play in discussions of aid-in-dying?

A variety of terms have historically been used to describe when a terminally ill patient uses lethal medications for the purpose of ending his or her life (or having control over the timing of death). Prior to the passage of the Oregon Death with Dignity Act in 1996, the term most often used was "physician-assisted suicide" (PAS). Those who use this term feel that it is an accurate reflection of the relationship between doctor and patient and refer to the etymological roots of suicide as "auto-killing" or "self-killing." The use of this term ties the role of the physician to one that aids the patient in killing him or herself. Implicit in the understanding of the word suicide is the notion of a premature death that is being hastened out of despair, therefore when mental illness impairs judgment, intervention to stop a suicide is ethically warranted because the person seeking suicide has lost his ability to carefully weigh the benefits and burdens of continued life. Generally speaking, persons who are suicidal are treated as though their decision-making capacity is compromised and health care providers often intervene and provide life-sustaining treatments (including involuntary psychiatric treatment) over the objections of the patient. Some people, including several national professional organizations*, object to the term suicide because of the associations between suicide and mental illness. They argue that, unlike the patients with impaired judgment who request suicide, terminally ill patients who request medication under the act have the capacity to make a rational, autonomous decision to end their lives.

The term "physician aid-in-dying" is used to describe the practice authorized under the Washington and Oregon Death with Dignity Acts and is meant to reflect the requirement that eligible persons must be decisionally competent and have a limited life expectancy of about 6 months or less. In this context, the term is meant to reflect that physicians provide assistance to patients who are otherwise going to die, and who seek help to control the timing and circumstances of their death in the face of end-of-life suffering they deem intolerable. While this term evades the mental health connotations associated with the word suicide, people who object to the use of "physician aid in dying" suggest that it could include other practices that are clearly outside the legal bounds of Oregon's and Washington's Death with Dignity Act, e.g. a patient who receives assistance in ingesting the medication, which would constitute euthanasia (see below). Here we use the term physician aid-in-dying to reflect the practice that is legal under the Washington Death with Dignity Act.

It is important to note that both terms, "physician assisted suicide" and "physician aid-in-dying" are value-laden and may reflect the speaker or writer's political or ideological support for or objection to the practice. Recent research has detailed the need for open and honest discussion on end of life issues. This discussion should supercede any debate over the use of particular terms or language. Acknowledging the justification behind the early terminology, as well as acknowledging the power of both historic and contemporary terminology, will help flesh out both sides of this sensitive and powerful debate.

*The Oregon Department of Public Health, American Public Health Association, American Psychological Association, American Academy of Hospice and Palliative Care, American Medical Women's Association, and the American Medical Student Association have adopted the term patient directed dying or physician aid-in-dying and have rejected the term physician-assisted suicide.

Is physician aid-in-dying (PAD) the same as euthanasia?

No. While both physician aid-in-dying and euthanasia involve the use of lethal medications to deliberately end a patient's life, the key difference is in who acts to end the patient's life. In physician aid-in-dying, the patient must self-administer the medications; the "aid-in-dying" refers to a physician providing the medications, but the patient decides whether and when to ingest the lethal medication. Euthanasia occurs when a third party administers medication or acts directly to end the patient's life. Euthanasia is illegal in every state, including Washington.

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Some other practices that should be distinguished from physician aid-in-dying include:

- **Withholding/withdrawing life-sustaining treatments:** When a competent patient makes an informed decision to refuse life-sustaining treatment, there is virtual unanimity in state law and in the medical profession that this wish should be respected.
- **Pain medication that may hasten death:** Often a terminally ill, suffering patient may require dosages of pain medication that have side effects that may hasten death, such as impairing respiration. Using the ethical principle of double effect as the foundational argument, it is generally held by most professional societies, and supported in court decisions, that this action is justifiable. Since the primary goal and intention of administering these medications is to relieve suffering, the secondary outcome of potentially hastening death is recognized as an expected and acceptable side-effect.
- **Palliative sedation:** This refers to the practice of sedating a terminally ill patient to the point of unconsciousness, due to intractable pain and suffering that has been refractory to traditional medical management. Such patients are imminently dying, usually hours or days from death. Often other life-sustaining interventions continue to be withheld (CPR, respirator, antibiotics, artificial nutrition and hydration, etc.) while the patient is sedated. Palliative sedation may occur for a short period (respite from intractable pain) or the patient may be sedated until s/he dies. In the rare instances when pain and suffering is refractory to treatment even with expert clinical management by pain and palliative care professionals, palliative sedation may legally be employed.

Is physician aid-in-dying (PAD) ethically permissible?

The ethics of physician aid-in-dying continue to be debated. Some argue that PAD is ethically permissible (see [arguments in favor](#)). Often this is argued on the grounds that PAD may be a rational choice for a dying person who is choosing to escape unbearable suffering at the end of life. Furthermore, the physician's duty to alleviate suffering may, at times, justify providing aid-in-dying. These arguments rely a great deal on respect for individual autonomy, recognizing the right of competent people to choose the timing and manner of death in the face of a terminal illness.

Others have argued that PAD is not ethically permissible because PAD runs directly counter to the traditional duty of the physician to preserve life and to do no harm (see [arguments against](#)). Furthermore, many argue if PAD were legal, abuses would take place, as the social forces that condone the practice are a slippery slope that could lead to euthanasia. For instance, the disabled, poor or elderly might be covertly pressured to choose PAD over more complex and expensive palliative care options.

For more information on the debate around PAD please see <http://euthanasia.procon.org/>

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

Those who argue that PAD is ethically justifiable offer the following sorts of arguments:

1. **Respect for autonomy:** Decisions about time and circumstances of death are personal. Competent people should have right to choose the timing and manner of death.
2. **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 quickly. Thus, to treat these patients equitably, we should allow assisted death as it is their only option to hasten death.
3. **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.
4. **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.
5. **Honesty & Transparency:** Some acknowledge that assisted death already occurs, albeit in secret. The fact that PAD is illegal in most states prevents open discussion, in which patients and physicians could engage. 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.

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

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

1. **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 seems to diminish the sanctity of life.
2. **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.
3. **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.
4. **Professional integrity:** Historical ethical traditions in medicine are strongly opposed to taking life. For instance, 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 ([American Medical Association](#), [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.

5. **Fallibility of the profession:** The concern is that physicians will make mistakes. For instance there may be uncertainty in diagnosis and prognosis. There may be errors in diagnosis and treatment of depression, or inadequate treatment of pain. Thus the State 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.

Is physician aid-in-dying (PAD) illegal?

Physician aid-in-dying is legal in Oregon and Washington, where voter approved initiatives have legalized aid-in-dying under very specific circumstances. A Montana lower court has also determined that physician aid-in-dying is permitted under Montana's State Constitution. The Montana case is expected to be appealed to the Montana State Supreme Court, but the lower court's decision recognizing aid-in-dying remains in full force and effect.

In other states, without specific legislative authority, or a court decision, physician aid-in-dying would most likely be considered illegal, and in many states is explicitly illegal.

The citizens of Oregon passed Measure 16, the Oregon Death with Dignity Act, on November 16, 1994 by a margin of 51.3% to 48.7%. Opponents immediately challenged the law and it was not enacted. In response, the Oregon Legislature referred Measure 51 (a law to repeal Measure 16) for a public vote. That measure was defeated by 60% of the votes in 1997. Thus, physician-assisted dying has been legal in the state of Oregon since 1997. In November 2008, the citizens of Washington state passed I-1000, The Washington State Death with Dignity Act (DwDA) by a margin of 57.8% to 42.2%, and it went into effect on March 5th, 2009. ([Click here](#) for a link to a fact sheet on the Washington DwDA)

In both states, the Death with Dignity Act has strict patient eligibility criteria, limiting access to competent, legal residents of the state over age 18, with a terminal illness (defined as an estimated life expectancy of 6 months or less) that is confirmed by two independent physicians. There is a requirement for two oral requests with a 15-day waiting period in between, as well as a written request that must be witnessed. Prescriptions may be written no less than 48 hours after the receipt of the written request. Patients must be able to self-administer the medications (i.e., have the mental and physical capacity to take the medications on their own). Providers may decline to prescribe medication under the Act.

Several major court decisions have been made regarding this issue. In the case of [Washington v. Glucksberg](#), the plaintiffs argued that prohibitions against suicide impinged on an individual's right to liberty, as stated in the due process clause of the 14th Amendment. The Ninth US Circuit Court of Appeals upheld this argument, but this decision was later overturned by the United States Supreme Court. In another case, [Vacco v. Quill](#), the Second Circuit Court found a New York law on prohibiting assisted suicide was in conflict with the equal protections clause of the 14th amendment, which says that no state shall "deny to any person within its jurisdiction the equal protection of the laws." The Court held that competent patients were being treated differently than incompetent patients. The US Supreme Court declined to find a federal constitutional right to "assisted suicide", and made a legal distinction between refusal of treatment and PAS. The Court also left the decision of whether to legalize PAS up to each individual state.

There have several high-profile cases related to specific incidents of aid-in-dying. The first was Dr. Timothy Quill (of [Vacco v. Quill](#)) who was investigated but not indicted for his participation in the suicide of a patient after he published his account of the incident. The second was Dr. Jack Kevorkian who claimed to have assisted over 100 patients in death. He was tried and acquitted for his role in the death of 3 persons. In November 1998, he and his patient, 52 year-old Thomas Youk, who suffered from Amyotrophic Lateral Sclerosis (ALS—otherwise known as Lou Gehrig's Disease) appeared on the TV show 60 Minutes where Dr. Kevorkian administered a lethal injection. As a result of the show, Kevorkian was tried for first degree murder in Oakland County, Michigan. Prosecutors argued that, in administering a lethal injection to Youk, his actions constituted euthanasia rather than PAD. Kevorkian was convicted of second degree murder in 1998, sentenced to a 15-25 year term of which he served 8 years, and was released in 2007.

What does the medical profession think of physician aid-in-dying (PAD)?

Surveys of individual physicians show that half believe that PAD is ethically justifiable in certain cases (Cohen et al, 1994). However, professional organizations such as the American Medical Association have generally argued against PAD on the grounds that it undermines the integrity of the profession.

Surveys of physicians in practice show that about 1 in 5 will receive a request for PAD sometime in their career (Back et al, 1996; Meier et al, 1998). Qualitative research has shown that requests for PAD bring up sensitive issues and emotions. Physicians stated that the discussion around these issues took a large time investment and brought up patient and physician concerns about depression, pain and symptom management, issues of control, and exploration of the fear of abandonment (Back et al, 2001; Dobscha et al, 2004; Ganzini et al, 2000, 2001).

What should I do if a patient asks me for physician aid-in-dying (PAD)?

One of the most important aspects of responding to a request for PAD is to be respectful and caring. Virtually every request represents a profound event for the patient, who may have agonized over his situation. The patient's request should be explored, to better understand its origin and to determine if there are other interventions that may help ameliorate the motive for the request. In states where PAD is illegal, it is important to evaluate the reasons behind the request, because in most cases, there are alternatives in palliative and hospice care that likely will address most of the patient's concerns. Palliative care physicians recommend the following process for evaluating and responding to requests (Emanuel 1998; Quill

and Arnold 2008a, 2008b).

1. Wait to directly respond to the request until you have explored the reasons for the patient's request. Discuss various ways of addressing the patient's pain, suffering, hopes, and fears. If time permits, tell the patient that you would like to talk more about this at a subsequent appointment. That gives both you and the patient time to prepare for a fuller exploration of PAD as well as other palliative treatments, hospice, etc.
2. Evaluate for depression or other psychiatric conditions and treat appropriately.
3. Assess the patient's decision-making competence.
4. Engage in discussion surrounding the patient's diagnosis, prognosis, and goals for care. Make sure to assess patient understanding.
5. Evaluate patient's physical, mental, social, and spiritual suffering. Be sure to take into account the patient's support system as well as personal and professional pressures and stressors.
6. Discuss all alternative options like palliative care and hospice.
7. Consult with professional colleagues regarding the patient's situation. Where appropriate, ask for help from a palliative care specialist to assure that all options have been explored.
8. Help the patient complete advance directives, DNR orders and POLST forms, as appropriate and ensure that preferences are followed.

What if the request for physician aid-in-dying persists?

If a patient's request for aid-in-dying persists, each individual clinician must decide his or her own position and choose a course of action that is ethically justifiable and legally permissible. It is useful to carefully reflect on and think through where you stand on the issue and be prepared to openly discuss your position with the patient, acknowledging and respecting difference of opinion when it occurs. Patients who ask for PAD – in states where it is legal or illegal – understand that physicians will have different opinions about what they can and should do. The most important thing is to be clear and transparent about your position. Even in states where it is illegal, some physicians will decide to help their patients, particularly when patients are enduring unbearable suffering. While we cannot condone this practice, we must recognize its occurrence and the reasoning behind it. No physician, however, should feel forced to provide assistance if he or she is morally opposed to PAD.

What are the attending physician's duties and responsibilities under the Washington Death with Dignity Act?

([Click here](#) for a link to a slide show reviewing these responsibilities on the Washington DwDA)

1. Confirm the following eligibility criteria:
 - o Washington State resident
 - o Age 18 and older
 - o Competent (able to make and communicate an informed decision to health care providers)
 - o Terminally ill (incurable, irreversible disease expected to cause death within six months, as determined by the attending physician and a consulting physician)
 - o Able to voluntarily express his or her wish to die
2. Assure that it is an informed decision, which means the patient has an appreciation of the relevant facts, after being fully informed about the following:
 - o Medical diagnosis
 - o Prognosis
 - o Potential risks associated with taking the prescribed medication
 - o Probable result of taking the prescribed medication
 - o Feasible alternatives including, but not limited to, comfort care, hospice care, and pain control
3. Evaluate the patient's request
 - o Assess reasons
 - o Explore and recommend alternatives (palliative care, hospice, pain/symptom management, psychosocial and/or spiritual counseling, palliative sedation)
4. Counsel patient about the following:
 - o Opportunities to rescind request at any time
 - o Recommend notifying next of kin
 - o Importance of having another person present and not taking medications in a public place
5. Refer to a consulting physician, who reviews the medical record and interviews the patient to confirm the diagnosis, and confirm that the patient is competent and is making a voluntary request
6. Refer to a counselor if concerned about a psychiatric or psychological disorder or depression causing impaired judgment
7. Work with pharmacists to prescribe/get medications
8. Medical record documentation of all steps
9. Sign the death certificate
 - o List the underlying terminal disease as the cause of death

10. Send a copy of the dispensing record to DOH within 30 days

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