



Aid in Dying

Colorado Confronts a Difficult Policy Question

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About This Report

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Doctor-assisted suicide. Death with dignity. Physician-aided dying. Right to die. Even the words used to describe aid in dying are fraught with emotion and controversy.

In the 15 months following Brittany Maynard's death, more policymakers, advocates and health care providers have started having difficult conversations on this end-of-life option.

More legislation is being passed as well. On January 1, California joined Oregon, Montana, Vermont and Washington to become the fifth state to legalize the practice, effectively making this option available to one in six Americans.

Colorado's state legislature is set to once again confront the issue in 2016 after voting down a bill in support of aid in dying during the 2015 session.

This analysis by the Colorado Health Institute offers historical context, both national and international, that is essential to understanding the debate. It highlights perspectives on both sides of this issue.

Support for legal aid in dying comes from concerns that palliative care, while effective in the majority of cases, does not always sufficiently alleviate suffering at the end of life. Supporters believe patients should have autonomy over their own death. Objections are mostly rooted in religious convictions or fears that the practice

is discriminatory toward vulnerable populations such as elderly or disabled people.

Debate will only intensify as the issue returns to the Golden Dome this session.

Aid in Dying: Historic Context

Aid in dying is not always practiced in the same way. In U.S. states that allow aid in dying, a request for life-ending medication must come from a terminally ill adult patient with six months or less to live. Other countries allow aid in dying under more liberal circumstances. In some European nations, requests can even be based on physical disability or psychiatric distress.

Belgium extended its law in 2013 to cover terminally ill children as well as adults. Some aid-in-dying opponents view this as a "slippery slope" and worry it could follow legalization in the U.S. Today, however, terminal illness remains the only basis for a lethal prescription in states where the practice is permitted.

Other distinctions involve the exact definition of aid in dying and related terms. Historically, much of the discussion in the U.S. has focused on euthanasia.

Finding the Words

There is no consensus on the best term for this discussion. Supporters use phrases like “death with dignity” while opponents favor “physician-assisted suicide.” “Aid in dying,” the term used in this brief, tends to be the most neutral description because it avoids words such as “suicide” and “dignity,” which are associated with advocacy efforts.

Despite a few bursts of support during the Great Depression and patients’ rights movements of the 1970s, America has generally opposed this practice.¹

In the late 20th century, the work of Dr. Jack Kevorkian in Michigan reignited the assisted death debate. Dr. Kevorkian was a prominent euthanasia and aid-in-dying advocate who was convicted of second-degree murder after administering a voluntary lethal injection in 1998.

It is important to distinguish euthanasia, which was administered by Dr. Kevorkian and debated throughout most of America’s history, from the aid-in-dying methods being considered today by state legislators.

In voluntary euthanasia, a physician actively administers life-ending medication, usually intravenously. Aid in dying, however, requires patients to self-administer the medication. A doctor or family member cannot do it for them.

This is no small distinction. For many proponents of aid in dying, self-administration is key to ensuring patient consent.

Dr. Kevorkian’s actions in the late 1990s, while polarizing, brought the issue to dinner tables across the nation. More Americans began to favor legalizing the practice of aid in dying.²

The state of Washington’s assisted suicide ban was challenged in the Supreme Court in 1997. The court upheld the ban, but later that year Oregon became the first state to legalize aid in dying. In the years since, Oregon’s Death with Dignity Act has served as model legislation for advocates in other states.

Recently, there has been a new wave of interest in aid in dying in the U.S. The aging Baby Boomer generation and advocacy of groups such as Compassion & Choices and the Death with Dignity National Center have contributed to this. But the debate reached a fever pitch when one woman’s story became a nationwide discussion.

Brittany Maynard moved from California to Oregon in 2014 to take advantage of the latter’s Death with Dignity Act after being diagnosed with terminal brain cancer. In the months to follow, the 29-year-old Maynard became a prominent advocate for the cause. Since her death on November 1, 2014, 26 states and the District of Columbia have introduced aid in dying legislation.³

These new legislative pushes have refocused the spotlight on state experiences with aid in dying.

States that permit the practice tend to lean Democratic. One exception is Montana, a politically mixed state, where legalization came by a court order rather than by legislation or ballot initiative. Nationally, the Democratic Party has remained silent on the matter while the Republican Party opposes aid in dying as part of its official platform.

In Oregon, 859 patients have died from ingesting medication since the law passed 19 years ago, a small percentage of the population. But that number is increasing, with 32 more patients receiving prescriptions in 2014 than the year before. The option is most often used by those with terminal cancer diagnoses. Patients also tend to be well-educated and older – the median age at death is 71.

Oregon has the most robust data currently available, but drawing conclusions from its experience can be tricky. The sample is small and comes from a relatively homogenous state population. No one is sure what might happen in larger or more diverse states.

California’s End of Life Option Act, which was signed into law by Governor Jerry Brown on October 5, 2015, marks a turning point for aid-in-dying legislation. It greatly increases the number of people with the option, and many feel the law will replace Oregon’s Death with Dignity Act as a model that many states will follow. (See the breakout section: “California and Oregon: What’s the Difference?”)

The Oregon Experience



Since Oregon's Implementation in 1997...⁴

1,327 Prescriptions written

859 Patients died from ingesting prescribed pills

2014 Data*

155 prescriptions written by 83 doctors

- 94 with written prescriptions in 2014 died by ingesting lethal medication
- 37 with prescriptions in 2014 died of natural causes
- 24 with prescriptions in 2014 have "unknown" status (could still be alive)

105 people died from ingesting prescribed medication

- 94 of the 105 died from using prescriptions written in 2014
- 11 of the 105 died from using prescriptions written in 2012-2013

*Most recent report

The Average Patient



- 97% white
- 90% enrolled in hospice at time prescription was written or at time of death
- 78% had cancer
- 69% aged 65+ (median age at death was 71)
- 53% male
- 46% had at least a baccalaureate degree

The Discussion: Religion, Ethics and More

Even though aid in dying is now authorized in five states, many questions lack a clear answer.

- Do people have a "right" to die?
- What are the ethical implications of allowing a patient to take his or her own life?
- Does this law put any populations at greater risk for medical mistreatment?
- How accurate are terminal prognoses?
- How can we be sure patients don't feel pressured into this decision?

The Moral Question

Some of the most vocal opponents are religious groups, most notably the Catholic Church. Passages from scripture and statements from leadership are cited as arguments against both euthanasia and aid in dying, with the National Catholic Bioethics Center calling it a "fundamentally unreasonable act."⁵

But not all moral objections are based in theology. Many physicians believe that the practice runs contrary to their vows to uphold ethical standards of medicine. The American Medical Association and most of its state affiliates, including Colorado, oppose legalizing aid in dying.

But supporters cite moral reasoning for their beliefs as well. They say there are cases of extreme suffering when pain cannot be alleviated. They believe that in these instances, helping patients who wish to die is an act of compassion.

And while physician organizations are generally opposed to the practice, the doctors they represent don't always feel the same.

Many physicians do not see aid in dying as incompatible with medical ethics, and that number seems to be growing. More than half (54 percent) of American physicians now support legalized aid in dying, according to a recent Medscape survey, up from 46 percent in 2010.⁶

The California Medical Society changed its stance from opposed to neutral in May, stating that the decision was a personal one to be made between doctor and patient.

Vulnerable Populations

Nearly all national disability rights organizations oppose aid-in-dying legislation. They view it as a form of discrimination that creates a double standard based on health or disability status.

From their perspective, aid in dying would give seniors and people with disabilities the tools to die, while the self-inflicted deaths of young, healthy and non-disabled people would still be treated as a tragedy to be prevented. They fear that disabled patients are more likely to be approved for aid in dying because their lives are seen as less valuable.

“We think that equal rights should also mean equal rights to suicide prevention,” said Diane Coleman, president and chief executive officer of Not Dead Yet (NDY), a leading disability rights group.⁷

There are also concerns that consequences of becoming disabled may be driving the decisions of some patients. In Oregon, physicians for 91 percent of aid in dying patients said they believed fear of losing autonomy may have contributed to their patients’ decisions, and 40 percent may have been concerned about becoming a burden on family, friends or caregivers.⁸

Disability activists worry that stigma is acting as an undue influence. “This is code for ‘I’d rather die than be embarrassed by my disability,’” said Carrie Ann Lucas of NDY.

Supporters say aid in dying is not a disability issue, but an autonomy issue. They emphasize that the practice is only for cases of terminal illness, not for those with a disability.

A 2007 study found that vulnerable populations such as physically disabled patients were no more likely to use aid in dying than the general population.⁹

For supporters, the issue is a matter of patients’ rights. Compassion & Choices, the leading aid in dying organization, says its work aims to increase patient control and reduce unwanted interventions at the end of life.¹⁰

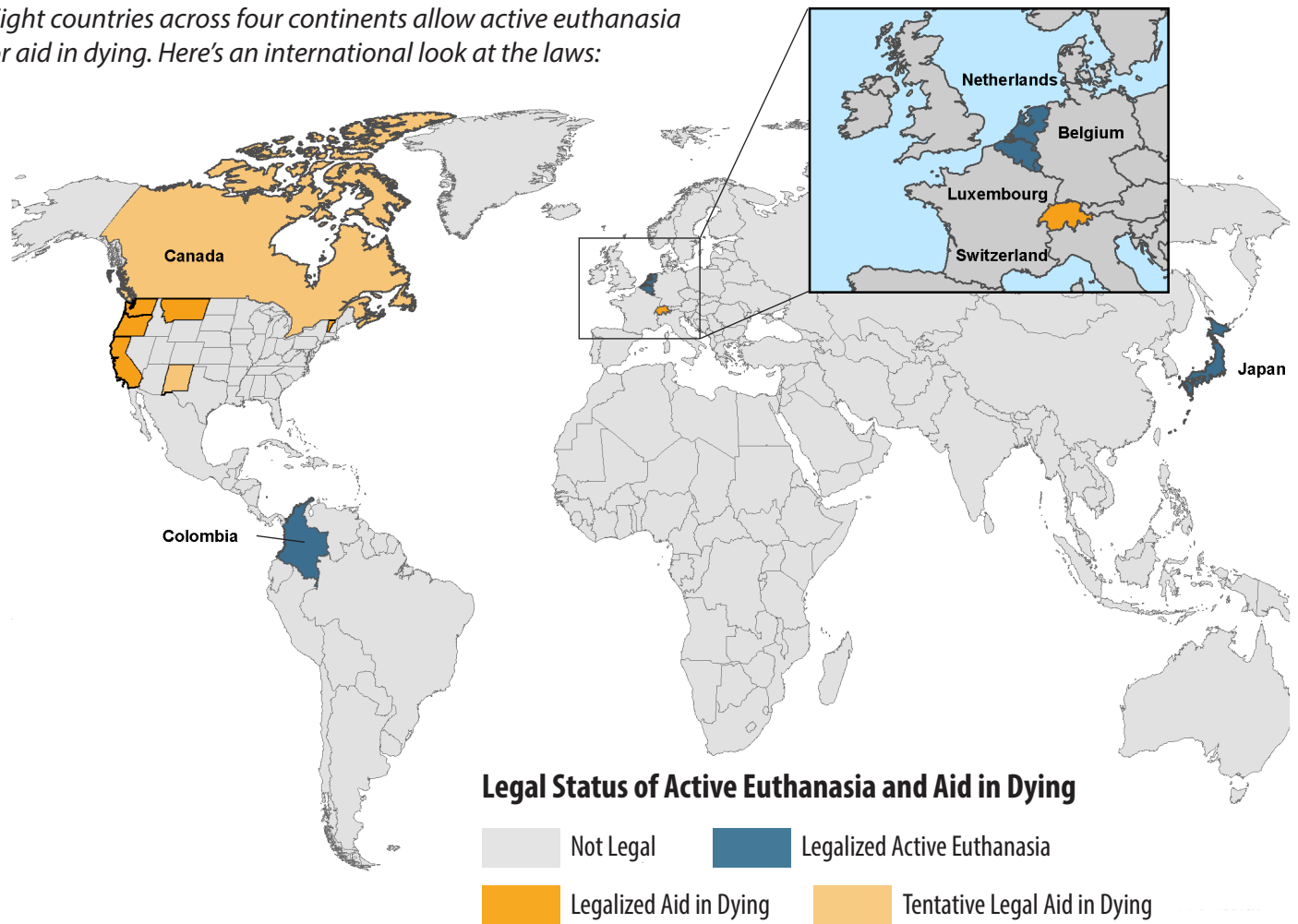
California and Oregon: What’s the Difference?

Oregon’s Death with Dignity Act has been used as the model for aid-in-dying legislation for nearly 20 years. Now, many experts believe California’s 2015 End of Life Option Act will be a better example. What makes California’s law different?

- **Tighter Terminology.** The bills are similar in their approach to patient safeguards and physician liability protections. However, California’s law tends to define terms and describe processes more explicitly. For example, California states that the attending physician, and not a designee, must directly receive all three patient requests for lethal medication. In Oregon, this is how the law is practiced – but it isn’t explicitly required.
- **Final Attestation.** California requires aid-in-dying patients to document their intent to end their life no more than 48 hours before taking the medication. This aims to ensure that the patient still consents at the time the medication is administered. Oregon’s law requires only that consent be documented at the time the medication is dispensed, even though there can be a long gap between when the medication is dispensed and when it is taken.
- **Interpretation.** California, which has a more linguistically diverse population than Oregon, outlines specific requirements for interpreter services. Oregon’s law does not address the issue of language. Federal law requires language assistance services be available to anyone with limited English proficiency who is receiving any medical service.
- **Sunset Clause.** California’s legislation will remain valid through January 1, 2026 - 10 years after its implementation. At that time, lawmakers will reevaluate the policy and can repeal it. Oregon’s law doesn’t contain that provision.

End-of-Life Laws Around the World

Eight countries across four continents allow active euthanasia or aid in dying. Here's an international look at the laws:



The Denver Medical Society testified in support of HB15-1135, the proposed aid-in-dying bill considered by the Colorado legislature in 2015, stating that it felt the bill protected vulnerable groups from abuse.

Timelines for Terminal Illness

In the United States, all aid-in-dying laws require the diagnosis of a terminal illness that is expected to cause death within six months.

But doctors aren't infallible. So how can they be sure someone only has six months to live? Aid-in-dying opponents point out that they can't. And there is no shortage of patients whose disease progressed in much less than six months, while it has taken longer than

expected for others.

In 2014, about 10 percent of Oregon's aid-in-dying patients used medication they were initially prescribed in 2012 or 2013, indicating that some outlived a six-month prognosis. Brittany Maynard herself lived beyond the six-month prognosis she received in April 2014.

Supporters point out that the attending physician's prognosis must be certified by a consulting physician. While this doesn't guarantee an accurate timeline, supporters feel that agreement between professionals improves the likelihood of one. They also feel that the probable time of death is not all that significant, since patients themselves decide whether and when to take the medication.

Coercion and Consent

A patient’s ability to make an informed decision lies at the core of aid-in-dying discussions. Regardless of their position on this issue, all sides acknowledge how important it is to prevent any form of coercion, overt or indirect.

Opponents worry that too few safeguards exist at numerous points in the process. Insurance companies may cover aid-in-dying counseling and medication yet deny requests for coverage of more expensive treatment options. This could pressure patients to make a decision based on finances, not suffering, they argue.

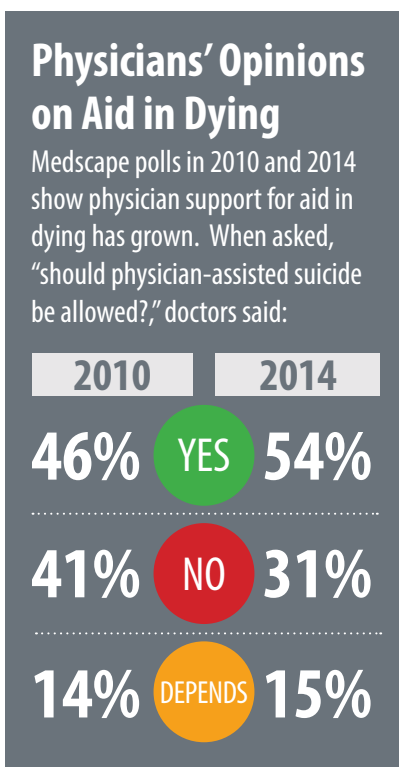
There is also the risk of more direct coercion. Colorado records more than 11,000 cases of adult abuse annually,¹¹ and abused seniors may be more susceptible to outside influence in making this decision.

In addition, medication is not well monitored after it is dispensed. Many patients who receive a prescription choose not to use it. But if they keep the medication, it might be accessible to others. This makes it hard to guarantee consent. Opponents argue that family members or parties who stand to benefit from a patient’s death could put the medication in a patient’s food or otherwise trick them into taking it.

Supporters cite the protections written into aid-in-dying legislation. The patient must request the medication a minimum of three times. One of these requests must be made in the presence of two witnesses, one of whom is not related to the patient and doesn’t stand to gain financially from the patient’s death.

A private conversation must take place between the physician and the patient during which all available options are reviewed. And if there is any concern about the patient’s decision-making process, the doctor must request a mental health evaluation.

California’s law requires dying patients to sign an affidavit no more than 48 hours prior to self-



administering the drug. The purpose is twofold. First, it confirms a patient consents at the time the medication is administered as well as when it was dispensed. Second, it helps track aid-in-dying medication. When a patient dies, whether from aid-in-dying methods or from the underlying illness, either the health care provider must file the completed affidavit or the person in custody of the unused medication must return it to a designated disposal facility.

Finally, supporters note that altering, concealing or destroying any document during the process is a felony. Likewise, it is a felony to coerce someone into making a request for the medication. There has yet to be a report of aid-in-dying coercion from any state where it is legal.

While both viewpoints are based on concern for the well-being of patients, the two sides differ in what they believe this means. There may be room for compromise in some areas. For example, increased documentation of consent may allay the fears of some opponents. In other areas, opinions seem to be irreconcilable, including the view by disability advocates that aid in dying is always a discriminatory practice.

The Debate in Colorado

New legislation, entitled the Colorado End-of-life Options Act, was introduced this year. The proposed law would legalize aid in dying for Colorado residents meeting certain conditions. (See the breakout section “The Colorado End-of-life Options Act.”)

A similar bill modeled after Oregon’s Death with Dignity Act was introduced in the 2015 session. After 11 hours of debate in the House Committee on Public Health Care & Human Services, HB15-1135 was postponed indefinitely.

A long list of physicians, disability rights activists, patients and others offered impassioned testimony during last year’s committee hearing. And while the key



The Colorado End-of-life Options Act

A new bill would legalize aid in dying in Colorado. What exactly does that look like?

- Terminally ill patients with a six-month prognosis could request to take their own life using medication prescribed by a Colorado-licensed physician.
- The prescribing physician would not be accountable for the death if all conditions of the bill were met and documented.
- Patients would need to be a Colorado resident, at least 18 and capable of making and communicating health care decisions for themselves.

provisions in the 2016 bill remain largely unchanged, some new language aims to address concerns raised in response to HB15-1135.

Opponents worry that inadequate end-of-life care, including insufficient pain management, could influence a patient's decision to end his or her life if aid in dying is legalized. To allay these fears, the 2016 bill explicitly requires health care providers to "meet or exceed the standard of care for end-of-life medical care."

The new legislation also includes more detail intended to reduce the risk of coercion. There is a more explicit requirement that attending physicians offer patients an opportunity to rescind their request at any time and for any reason. Additional phrases were also added to the patient's written request form. This new language requires the patient reiterate that he or she is not being

coerced and is aware of the right to rescind.

The 2016 proposal shares some characteristics with California's recent End of Life Option Act – most notably, the similar name. Both bills also define terminology more explicitly or in more detail than Oregon's original law.

For example, Colorado's proposal now includes a requirement that participating physicians be licensed to practice in the state. And important terms such as "self-administration" and "health care facility" are defined in more detail.

But just because the bill was changed in 2016 doesn't mean that every concern has been addressed.

During the 2015 committee debate, there was pushback on a provision requiring medical examiners to list the cause of death as the underlying illness rather than aid in dying. Opponents felt this was asking examiners to lie on the death certificate, but the provision remains in the new proposal.

A Competing Ballot Initiative

Meanwhile, a separate petition has been filed that proposes to amend the state constitution to make medical aid in dying a constitutionally protected right in Colorado.

While the language is not final, the potential ballot initiative promises to be substantially different than the bill introduced in the legislature.

It would legalize voluntary euthanasia, allowing physicians to help administer life-ending medication. Instead of requiring two physicians to approve a request for lethal medication, the amendment would require "permission of no person, governmental body or religious organization."¹² And it would allow aid in dying and euthanasia to be part of an advance planning directive, meaning that patients could designate ahead of time that under certain circumstances they should be administered the medication.

Lance Wright, the primary petitioner, said he feels that this is an issue of personal freedom. Wright, a Denver resident, has Parkinson's disease, an illness that may not be covered under the proposed legislation. He has said he wishes to have this option available to him as his

illness progresses.

Most supporters of more traditional aid-in-dying legislation staunchly oppose Wright's proposal. Representative Lois Court, a sponsor of the Colorado End-of-life Options Act, says that it goes too far. Compassion & Choices has come out in opposition, reiterating its belief that self-administration is key to preventing abuse of the law. Instead, the group will continue to advocate for the Colorado End-of-life Options Act.

A poll commissioned in 2014 by Compassion & Choices, the pro-aid in dying group, found that 62 percent of Coloradans support the principle of aid in dying.

Conclusion

With Colorado's debate on aid in dying entering its second year, both supporters and opponents are likely to increase their efforts.

Supporters believe this is an issue of patients' rights and personal autonomy. They feel that current aid-in-dying laws and the new Colorado legislation include an appropriate number of safeguards.

Opponents base their objections primarily on moral reasoning, both religious and secular, and in concerns for the rights of people with disabilities.

No matter their view, Coloradans can expect to see the bill in the headlines this session. While most major provisions from HB15-1135 will be present in this new legislation, some important details will be different.

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