The Estate Planner's Guide To The Right To Die

Compassionate Killing: An Inevitable Controversy?

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Clients who face terminal illness and near-death suffering situations will often be surprised to know that it's illegal in most states to assist in expediting the "natural death" process. Some jurisdictions, however, do allow physician-prescribed medications that can hasten death in certain circumstances. This dichotomy has become a recent topic of political dialogue. Proponents claim that individuals should have the freedom to choose to end their lives without the inevitable pain and suffering associated with terminal and incurable illness, while opponents argue that terminally ill individuals may be pressured into choosing this option, due to the high cost of health care. A handful of states have codified specific regulations for conducting physician related suicide. This article discusses the requirements and safeguards of these statutes, while highlighting the differences between American and International Law.

Physician-Assisted Suicide and the Freedom of Choice

Currently, physician-facilitated suicide is only available in Montana, Washington, Vermont and Oregon. It's important to note that the use of the word "facilitated"in the above sentence because this denotes something different from both active and passive euthanasia. While active euthanasia is illegal in all jurisdictions of the United States, passive euthanasia is not. Passive euthanasia occurs when "the doctor omits treatment and permits the patient to succumb to the disease"[1], while active euthanasia refers to when the doctor takes steps to end the patient's life.

In contrast to euthanasia, physician-facilitated suicide occurs "when a licensed physician supplies lethal medication to a patient so that the patient can use the medication to end his or her own life."[2] In Oregon, doctors may prescribe the medication, but they may not administer it for the purpose of ending the patient's life.

The Current State of Regulation: Too Far for Some, Not Nearly Far Enough

for Others

The Oregon legislature passed the Death with Dignity Act in 1997. Under this statute, "a capable, terminally ill adult resident may request a prescription for lethal medication from a physician."[3] In order to meet the statute's requirements, a person must prove their residency by showing a connection with the state of Oregon. For example, this can be accomplished by showing proof of:

> "(1) a state driver's license;
>
> (2) a state voter's registration card;
>
> (3) ownership or rental of real estate in the state; or
>
> (4) a recent state income tax return."[4]

These methods of proving residency consist ofonly a few of the many ways residency may be shown in Oregon, as it's been held that any connection to the state will be an acceptable form of proof. This liberal interpretation of the statute seems to create a daunting state concern, due to the ease in mobility of American citizens. As such, it's believed that the existence of such statutes will result in "domestic death tourism," a term coined by author, Browne C. Lewis.[5]

As the residency requirements currently stand, there are very limited regulations by state legislatures. Further, physicians, generally, need not have a long-standing relationship, or even a previously existing relationship, with the patient in order to administer the medication.

It seems as if the only restrictions on obtaining physician-assisted suicide relate to the patient's physical and mental health conditions. In order to meet the requirements, a patient seeking physician-aided suicide must have a terminal or incurable disease, and their condition must be irreversible. A "terminal disease" has been defined by the states of Oregon and Washington as a disease which will likely result in death within six months following the diagnosis of the patient.[6]

In addition to the health-related requirements, physicians and patients must comply with strictly implemented procedures, in order to obtain the medication. Under Oregon Statute Section 127.800(3), patients "must be able to make health care decisions and communicate them to the appropriate medical personnel."[7] As such, patients suffering from a "psychiatric or psychological disorder" must be deemed competent through counseling before they'll be able to receive the medication.[8]

In addition to the above requirements, patients must be given all material facts before distribution of the life-ending medication. This mandatory disclosure allows patients to make an informed decision after communicating with a physician about the diagnosis and prognosis, the potential risks and results of the lethal medication, as well as any other alternatives that may be available. This informed consent is similar to that required from a patient before a physician performs a medical procedure.

Additionally, under Oregon and Washington law, in the presence of the patient, "at least

two persons must attest that 'to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request.'"[9] One of the witnesses must be a disinterested party, and the doctor who's caring for the patient may not act as a witness. Further, patients residing in long-term care facilities must have a witness designated by the facility. Following this process, the patient's medical records must be examined by another doctor to confirm the diagnosis.

These comprehensive regulations are strictly enforced and allow the patient an opportunity to make an informed decision after an adequate period of reflection. So long as the statutes are followed, the treating physician is granted statutory immunity from civil or criminal liability.

Physician-assisted suicide is not entirely a new practice. European laws have provided a basis for American law on the topics of physician assisted suicide and euthanasia. The Netherlands, in particular, has made the practice of physician assisted suicide available to minors, with parental consent until the age of 16.[10] At the ages of 16 and 17, parents must be involved with the decision-making process, but parental consent isn't needed.

A Breakdown of American and International Law on Physician Assisted Suicide

The following charts highlight applicable statutes and case law in the United States:

States Where Physician-Facilitated Suicide is Legal

State	Date	What's allowed?
Oregon	Nov. 8, 1994	Death with Dignity Act–allows a capable adult resident of Oregon, who has been determined to be terminally ill, to voluntarily make a written request for medication, which will be administered by the patient, for the purpose of ending his life. Other requirements and procedures must also be followed by both patients and attending and concurring physicians.
Washington	Nov. 4, 2008	Death With Dignity Act–allows a competent adult resident of Washington, who has been determined to be suffering from a terminal illness, to voluntarily make a written request for medication, which will be administered by the patient, to end their life. Other requirements and procedures must also be followed by both patients and attending and concurring physicians.
		Act Relating to Patient Choice and Control at End of Life–prohibits civil or criminal liability for physicians

Vermont	May 20, 2013	that prescribe life-ending, self-administered medication to a terminally ill patient, and Vermont states a patient who self-administers medicine for the purpose of ending their life will not be considered exposed to grave physical harm. The statute also limits liability for those present when a patient with a terminal condition ends his life with medication, but do nothing to prevent the act. Other requirements and procedures are also present under the full statute.
Montana	Dec. 31, 2009	*Baxter v. Montana*–the Supreme Court of Montana ruled that terminally ill and competent patients have a legal right to die with dignity under the Montana Constitution, which includes the ability to have a physician prescribe medication for the patient to self-administer for the purpose of ending the patient's life. Furthermore, the ruling protects physicians who prescribe such medication. A Death with Dignity Act, introduced on Jan. 31, 2013, was tabled by the Judiciary Committee on Feb. 13, 2013.

Endnotes

[1] Browne C. Lewis, Graceful Exit: Redefining Terminal to Expand the Availability of Physician-Facilitated Suicide, 91 *Or. L. Rev.* 457, 462 (2012).

[2] *Id.* at 463.

[3] *Id.* at 468.

[4] *Id.* at 469.

[5] *Id.* at 479.

[6] Or. Rev. Stat. Section 127.800(12). (2011); Wash. Rev. Code Ann. Section 70.245.010(13). (2011)

[7] Lewis, at 469.

[8] *Id.*

[9] *Id.* at 470. Or. Rev. Stat. Section 127.810 (2011); Wash. Rev. Code. Ann. Section 70.245.030(1) (West 2011). *http://www.westlaw.com/Find/Default.wl?rs=dfa1.0&vr=2.0&DB=1000534&DocName=ORSTS127.810&FindType=Lhttp://www.westlaw.com/Find/Default.wl?rs=dfa1.0&vr=2.0&DB=1000259&DocName=WAST70.245.030&FindType=L*

[10] Euthanasia: Euthanasia, assisted suicide and non-resuscitation on

request. *http://www.government.nl/issues/euthanasia/euthanasia-assisted-suicide-and-non-resuscitation-on-request.*