



STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES
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The Honorable John Carney
Governor

John McNeal
SCPD Director

MEMORANDUM

DATE: June 6, 2017

TO: All Members of the Delaware State Senate
and House of Representatives

FROM: Ms. Jamie Wolfe, Chairperson
State Council for Persons with Disabilities

RE: H.B. 160 (End of Life Options)

This legislation was introduced on May 2, 2017. As of May 30, 2017, it awaited action by the House Health & Human Development Committee. A previous version of the legislation (H.B. No. 150) was introduced in 2015. The SCPD issued June 26, 2015 and June 6, 2016 comments generally opposing the prior bill and the concept of assisted suicide legislation.

Background on H.B. No. 160 is provided in the attached May 4, 2017 News Journal article, "Doctor-assisted suicide bill offered". The bill would authorize a competent individual with a terminal illness to obtain and self-administer a drug to end life. There are many safeguards, including waiting periods, review by both an attending and consulting physician, assessment by a psychiatrist or psychologist if either physician questions the patient's capacity/judgment, and attestation of 2 independent witnesses that the patient's written consent is voluntary and free of coercion.

There are currently six (6) states which have adopted similar legislation. See attached summary, "Death with Dignity' Laws by State. Most of the laws adopt a variation of the model reflected in the Oregon law which was passed more than twenty (20) years ago. Legislation is pending in other states. See attached March 6, 2017 article, "Death with Dignity Wins and Losses in

Several States”.

Arguments in support of assisted suicide legislation are compiled at www.deathwithdignity.org.

Proponents posit that implementation in other states has been without major problems, it offers a humane option for patients in intractable pain, safeguards deter abuse, and polls demonstrate widespread support for the concept. There may be some recent support for the latter proposition.

The attached May 21, 2017 USA Today article describes an end-of-life survey which found that only 23% of respondents characterized “living as long as possible” as extremely important while 42% opined that “being comfortable and without pain” was extremely important. The results of other polls are summarized in the attached January 18, 2017 document, “Polling on Voter Support for Medical Aid in Dying for Terminally Ill Adults”.

Arguments against assisted suicide are compiled at www.notdeadyet.org and

<https://dredf.org/public-policy/assisted-suicide/>. See also the attached Delaware Developmental Disabilities Council position statement. Opponents posit that diagnoses of terminal illness can be wrong, the safeguards are hollow with no enforcement or investigation authority, vulnerable patients in poor health are subject to undue influence from caregivers or heirs, financial and emotional pressures may prompt individuals to choose death, and such legislation is a first step towards involuntary euthanasia of the elderly and persons with disabilities.

SCPD has the following specific observations on H.B. No. 160.

First, since a patient wishing to take advantage of the bill may have to pay for the services of an attending physician, a consulting physician, a counseling psychiatrist/psychologist, and the cost of both ancillary and “end of life” drugs, the legislation may only provide an option to the affluent.

Second, the term “counseling” in lines 17-19 is a misnomer. Counseling implies that the mental health practitioner is providing guidance and advice. In contrast, the mental health practitioner is only conducting an assessment of function, not “counseling” the individual (lines 17-19 and 102-106).

Third, the Delaware residency standard (lines 146-150) is not difficult to meet and may invite non-residents to seek qualification. The sponsors could consider more robust standards to deter “suicide tourism”. See attached article, “Canada legalizes physician-assisted suicide”. One option would be to require “domicile” rather than “residence”. See attached article discussing distinctions. Another option would be to require that the patient be a Delaware resident at the time the terminal condition was diagnosed. See analogous provision in Delaware’s cancer treatment program regulations, 16 DE Reg. 4203.4.1.3.

Fourth, although the most compelling rationale for this type of legislation is to obviate protracted pain and suffering, actual or predicted pain and suffering are not required to take advantage of the law. In contrast, comparable Canadian law requires an “irremedial” condition that causes

“enduring and intolerable suffering”. *Id.* Assisted suicide legislation might garner more support if it only covered this narrower group.

Fifth, there is no statutory definition of “disease” (line 41). The medical literature has various definitions of the term. Depending on which definition is chosen, it may or may not cover conditions such as traumatic brain injury. The following definition would be encompassing:

Disease is an abnormal process affecting the structure or function of a part, organ or system of the body. It is typically manifested by signs and symptoms, but the etiology may or may not be known. Disease is a response to a specific infective agent (a microorganism or a poison), to environmental factors (e.g. malnutrition, injury, industrial hazards), to congenital or hereditary defects, or to a combination of all these factors.

See <http://medical-dictionary.thefreedictionary.com/disease> and <https://en.wikipedia.org/wiki/Disease> for this and other definitions of “disease”.

Sixth, the safeguards in lines 56-57 against witnesses lacking impartiality are limited to persons who may be entitled to a portion of the patient’s estate by “will” or “operation of law” (e.g. intestate entitlement). The safeguards could be enhanced by including beneficiaries of trusts, annuities, and life insurance. *Cf.* 16 Del.C. §2503(b) (barring trust beneficiary from witnessing advance health care directive).

Seventh, the “witness” section (line 60) bars the “attending physician” from serving as a witness. The California law (§443.3) logically also bars the consulting physician and the mental health specialist (psychiatrist/psychologist) from serving as a witness.

Eighth, the “witness” section (lines 50-60) would allow a minor to serve as a witness. *Contrast* the advance health care directive law [16 Del.C. §2503(b)] which requires the witnesses to be adults.

Ninth, Delaware law requires a State Ombudsman to be a witness to an advance health care directive of a resident of a long-term care facility. *See* 16 Del.C. 2511(b). Other state assisted suicide initiatives contain similar safeguards. *See* Oregon law, 127.810 §2.02; pending Hawaii legislation, SB 1129/2017, §3; and pending Nevada legislation, S.B. No. 261, §12. This requirement has been omitted from H.B. No. 160. The Ombudsman could be required as a third witness for residents of long-term care facilities.

Tenth, the legislation does not include any special provisions for pregnant patients seeking assisted suicide. The Delaware advance health care directive law (16 Del.C. §2503) contains the following provision:

(j) A life-sustaining procedure may not be withheld or withdrawn from a patient known to

be pregnant, so long as it is probable that the fetus will develop to be viable outside the uterus with the continued application of a life-sustaining procedure.

Eleventh, the California law (§443.5) includes the safeguard of the attending physician interviewing the patient “outside the presence of any other persons, except for an interpreter”. This deters implicit coercion and pressure from third parties. H.B. No. 160 omits this safeguard.

Twelfth, there is some “tension” between lines 86 and 91. The former contemplates a 72-hour period prior to directly dispensing end-of-life drugs while the latter has no 72-hour period if dispensed by a pharmacist.

Thirteenth, Lines 95-96 recite as follows:

(b) The attending physician may sign the qualified patient’s death certificate. The death certificate must list the underlying terminal illness as the cause of death.

Literally, this provision allows other physicians to sign the death certificate. Since the second sentence uses passive voice, it is somewhat unclear if the other physicians would be required to list the underlying terminal illness as the cause of death.

Fourteenth, H.B. No. 162 contains no definition of “impaired judgment” (line 106). Pending Maine legislation (LD 347, §2908) includes the following definition:

E. “Impaired judgment” means the inability of a person to sufficiently understand or appreciate the relevant facts necessary to make an informed decision.

Fifteenth, Lines 131-143, using passive voice, describes documentation to be filed in the patient’s medical record produced by the patient, the attending physician, the psychologist/psychiatrist, and the consulting physician. It’s not clear who is responsible for ensuring that all of the required documentation is actually filed in the record.

Sixteenth, in line 143, it would be more inclusive to specify that the identity of both the end-of-life drug(s) and ancillary drugs (line 87) should be included in the medical record. For clarity, a reference to the ancillary drugs could also be included in the “request for medication” form (line 269).

Seventeenth, Lines 170-180 could be interpreted to mean that a pre-existing life insurance policy which bars benefits for suicide would not be affected by H.B. No. 160. Lines 181-183 would apply to existing life insurance policies but query whether Delaware can affect out-of-state life insurance policies which typically recite that the laws of a specific state apply. Moreover, there may be financial consequences to assisted suicide as described in lines 256-258. The bill does not contemplate disclosure of such potentially significant negative consequences to the patient.

This undermines “informed judgment”. The bill (lines 66-71) exclusively limits “informed judgment” to medical considerations which is manifestly “underinclusive”.

Eighteenth, the bill does not require the patient to ingest the end-of-life drug in Delaware. The only guidance is encouragement to not take the drug in a public place (line 77). If a person travels to another state to ingest the end-of-life drug, query whether the laws of that state would apply to the death and its consequences.

Nineteenth, the bill does not contain a definition of “public place” which could result in a patient dying in public view. The California law (§443.1) contains the following definition:

(n) “Public place” means any street, alley, park, public building, any place of business or assembly open to or frequented by the public, and any other place that is open to the public view, or to which the public has access.

Parenthetically, the Washington law (RCW 70.245.210) includes a financial disincentive for patients who take an end-of-life drug in a public place:

Any government entity that incurs costs resulting from a person terminating his or her life under this chapter in a public place has a claim against the estate of the person to recover such costs and reasonable attorneys’ fees related to enforcing the claim.

Twentieth, the “request for medication” form (lines 259-282) does not include an authorization for the attending physician to contact any pharmacist to implement the request. Such an authorization is contained in the California law (§443.11) and the Washington law (§RCW70.245.220).

Twenty-first, the pending Maine bill (LD 347, §12) includes a disclaimer that its provisions may not be construed to conflict with certain provisions of federal law. The sponsors may wish to assess whether a similar disclaimer should be included in H.B. No. 160.

Twenty-second, comparable legislation in other states include a criminal penalty for exerting undue influence or interference with rescission of an end-of-life authorization. See Oregon, 127.890, §4.02; Washington, RCW 70.245.200; and pending Hawaii bill, HI SB 1129/2017, §20. Such a protection is conspicuously absent from H.B. No. 160.

Twenty-third, the California law (§443.2) includes a safeguard to explicitly disallow a surrogate requesting a prescription for an end-of-life drug:

(c) A request for a prescription for an aid-in-dying drug under this part shall be made solely and directly by the individual diagnosed with the terminal illness and shall not be made on behalf of the patient, including, but not limited to, through a power of attorney, an advance health care directive, a conservator, health care agent, surrogate, or any other

legally recognized health care decision maker.

A similar provision could be added to H.B. No. 160 to clarify that guardians and other surrogates may not invoke the law and substitute decision-making on behalf of a patient with a terminal illness.

Twenty-fourth, the California law (§443.5) requires the attending physician to counsel the patient on the importance of “maintaining the aid-in-dying drug in a safe and secure location until the time that the qualifying individual will ingest it”. This is an important consideration since it lessens the prospect for another person inadvertently taking the drug and dying. A comparable safeguard could be added to H.B. No. 160.

Twenty-fifth, the California law (§443.11) addresses “native language” and “interpreter” issues since language could easily affect “informed judgment”. This feature is absent from H.B. No. 160.

Twenty-sixth, the Washington law (RCW 70.245.140) addresses disposal of unused end-of-life drugs: “Any medication dispensed under this chapter that was not self-administered shall be disposed of by lawful means”. H.B. No. 160 does not address disposal of unused drugs.

Thank you for your consideration and please contact SCPD if you have any questions regarding our perspective on the proposed legislation, including the above observations.

cc: Mr. Brian Hartman, Esq.
Governor’s Advisory Council for Exceptional Citizens
Developmental Disabilities Council

HB 160 end of life options 6-5-17

DELAWARE

5-4-17 NJ

Doctor-assisted suicide law offered



DELAWARE LEGISLATIVE SESSION
MATTHEW ALBRIGHT

A Delaware lawmaker has proposed legislation that would allow doctors to help terminally ill people end their own lives.

"This is an issue about allowing adults facing a terminal illness to make critical decisions about their life," said Rep. Paul Baumbach, D-Newark. "Many people in the last stages of life wish to retain their dignity, including the ability to make decisions regarding their life and their suffering."

Baumbach says his "Delaware End of Life Options Act" includes numerous safeguards that would prevent someone from ending their lives "haphazardly." The option would be open only to those who have been diagnosed with an incurable and irreversible disease that has been "medically confirmed" to have six months or less to live.

"This is not a life or death decision. This is a death or death decision," Baumbach said.

A person who is considering ending their life would need to be presented with all other end-of-life options, including comfort care, hospice care and pain control. They would need medical confirmation by two physicians and psychiatric/psychological counseling when indicated.

There would be two waiting periods. First, a physician would have to wait 15 days after the patient re-

quests the lethal drugs. Then, after the patient makes a request in writing, another 48 hours would have to elapse before the prescription could be written.

Baumbach proposed similar legislation in 2015, but that bill did not make it out of committee. The new bill has four co-sponsors.

The issue of physician-assisted suicide — some supporters prefer the term "death with dignity" — is an issue of national controversy. Five states have legalized the practice, but some national organizations oppose it.

AMA's code of ethics

"Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks," the American Medical Association's code of ethics says. "Euthanasia could readily be extended to incompetent patients and other vulnerable populations."

Some religious groups, like the Catholic Church, also oppose the practice.

"A choice to take one's life is a supreme contradiction of freedom; a choice to eliminate all choices," a statement from the U.S. Conference of Catholic Bishops. "And a society that devalues some people's lives by hastening and facilitating their deaths, will ultimately lose respect for their other rights and freedoms."

Contact Matthew Albright at malbright@delawareonline.com or (302) 324-2428.

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'Death With Dignity' Laws by State

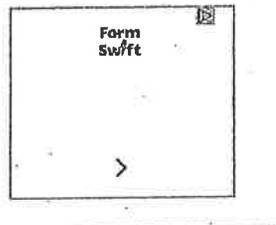
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Watching a loved one suffer through an agonizing illness or medical condition can be very difficult, especially when it's terminal. But when all hope is lost and the patient no longer has the will to live, does she have the right to end her life

(http://healthcare.findlaw.com/patient-rights/is-there-a-constitutional-right-to-physician-assisted-suicide.html)? It depends. Federal law doesn't specifically protect the act of mercy killing or *euthanasia*

(http://dictionary.findlaw.com/definition/euthanasia.html), nor does it prohibit the practice altogether. Instead, the right to assisted suicide (also sometimes known as 'death with dignity') is established by state law.



The vast majority of states do not allow patients to end their lives, either on their own or through the aid of a doctor. However, in 1990 the U.S. Supreme Court did rule (http://caselaw.lp.findlaw.com/scripts/getcase.pl?court=us&vol=497&invol=261) that patients or their designated health care agents may refuse life-preserving medical treatment, including feeding tubes. A *health care agent* is an individual named by the patient to make health care decisions on their behalf, usually through a *durable power of attorney* (http://dictionary.findlaw.com/definition/durable-power-of-attorney.html). Health care agents typically follow a patient's wishes laid out in a living will or "do not resuscitate" form.

So while all states allow patients to withhold treatment (http://estate.findlaw.com/estate-planning-help/advance-directives-and-living-wills-state-specific-forms.html), only a few states allow doctors to take an active role in assisting a patient's death. Most of these laws require the patient to:

- Be expected to die within a certain period of time
- Be a certain age
- Follow certain consent guidelines

If a patient is unable to make this request orally, they may do so through their health care agent.

The following is a breakdown of the states that allow assisted suicide or 'death with dignity':

California

Gov. Jerry Brown signed the *End of Life Option Act* (https://leginfo.ca.gov/faces/billNavCJlent.xhtml?bill_id=201520160SB128) into law in 2015, allowing physicians to prescribe lethal drugs to certain terminally ill patients. The law is modeled after similar laws in Oregon, Washington, and Vermont. Patients who are expected to die

Patient Rights

- Patient Rights Basics (http://healthcare.findlaw.com/patient-rights/patient-rights-basics.html)
- Planning Long Term Care (http://healthcare.findlaw.com/patient-rights/planning-long-term-care.html)

within the next six months, provide informed consent, have a medically confirmed diagnosis, and who request assistance three times may obtain a prescription for lethal drugs.

- *How it was Legalized:* Legislature
- *Number of Months Until Expected Death:* 6
- *Minimum Age:* 18
- *Number of Doctor Requests:* 2 oral (at least 15 days apart); 1 written

Montana

The Montana Supreme Court issued a ruling in late 2009 (http://www.patientsrightscouncil.org/site/wp-content/uploads/2011/03/Montana_Opinion_12_31_09.pdf) that broadened the state's Rights of the Terminally Ill Act (<http://codes.lp.findlaw.com/mtcode/50/9>) to include physician-assisted suicide. However, Montana statute does not provide a regulatory framework for doctor-assisted suicide. Instead, the ruling shields doctors from prosecution as long as they have the patient's request in writing. Several attempts to pass euthanasia-related bills, which would establish rules and procedures for assisted suicide, were made since the ruling, but none have passed.

- *How It was Legalized:* Montana Supreme Court decision
- *No additional regulations on assisted suicide*

New Mexico

Although New Mexico's statutes continue to list assisted suicide as a fourth-degree felony, the practice was made legal through the courts in early 2014. The 2nd District Court in Albuquerque ruled that New Mexico doctors may legally prescribe lethal drugs to assist terminally ill people with suicide. The state's attorney general declined to challenge the ruling, letting it stand. As with Montana, the ruling provides a defense for doctors who help eligible patients die but doesn't provide a regulatory framework.

- *How it was Legalized:* 2nd District Court decision
- *No additional regulations on assisted suicide*

Note: The New Mexico Court of Appeals ruled against the 2014 decision that legalized physician-assisted suicide in September of 2015. The practice is now illegal in the state, but a challenge in the New Mexico Supreme Court is likely.

Oregon

Oregon voters passed the Death with Dignity Act (<http://public.health.oregon.gov/providerpartnerresources/evaluationresearch/deathwithdignityact/Pages/index.aspx>) in 1994 with 51 percent of the vote, which allows terminally ill patients to obtain a prescription for lethal drugs. A ballot measure attempting to repeal the law lost (with 60 percent of voters opposed) in 1997, and was upheld by the U.S. Supreme Court in 2006 (<http://caselaw.lp.findlaw.com/scripts/getcase.pl?navby=cas&court=us&vol=546&page=243>). To be eligible, patients must wait 15 days after making an oral request to a doctor, and then make another oral and written request, followed by a 48-hour waiting period before medications are made available.

- *How it was Legalized:* Ballot initiative
- *Number of Months Until Expected Death:* 6
- *Minimum Age:* 18
- *Number of Doctor Requests:* 2 oral (at least 15 days apart); 1 written

Vermont

Vermont lawmakers passed the Patient Choice and Control at End of Life Act (http://healthvermont.gov/family/end_of_life_care/patient_choice.aspx) in 2013. The law protects doctors who follow the steps outlined in the Act from liability. Doctors are then able to prescribe lethal drugs to terminally ill patients. The state also requires patients to make two separate oral requests -- plus one in

writing -- separated by a 15-day waiting period before doctors are allowed to prescribe lethal drugs. The initial diagnosis must be certified by a consulting physician and the patient must be of sound mind.

- *How it was Legalized:* Legislation
- *Number of Months Until Expected Death:* 6
- *Minimum Age:* 18
- *Number of Doctor Requests:* 2 oral (at least 15 days apart); 1 written

Washington

Voters approved the [Washington Death with Dignity Act](http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct) (<http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct>) in 2008 with 58 percent of the vote. The law permits eligible patients with a terminal illness to request lethal drugs to end their lives. Individual hospitals may prohibit participation in euthanasia, but must clearly state their policy. Washington law is very similar to assisted suicide laws in Oregon and Vermont. The statute requires a series of requests and waiting periods, while requiring the patient to be of sound mind and capable of clear communication.

- *How it was Legalized:* Ballot initiative
- *Number of Months Until Expected Death:* 6
- *Minimum Age:* 18
- *Number of Doctor Requests:* 2 oral (at least 15 days apart); 1 written

This is an emerging area of the law and only a handful of states permit physician-assisted suicide. If you have additional legal questions about this issue, including euthanasia and advanced directives, contact a [health care attorney](http://lawyers.findlaw.com/lawyer/practice/health-health-care-law) (<http://lawyers.findlaw.com/lawyer/practice/health-health-care-law>) in your state.

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Next Steps

Contact a qualified health care attorney to help navigate legal issues around your health care.

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Death With Dignity Wins and Loses in Several States

A push for doctor-assisted “death with dignity” has begun in several state legislatures, as well as the District of Columbia.

NEWS (/CATEGORY/NEWS)

MELISSA BROWN ([HTTPS://REFINEDRIGHT.COM/AUTHOR/MELISSA_BROWN/](https://refinedright.com/author/melissa_brown/)) • MONDAY, MARCH 6, 2017 ([HTTPS://REFINEDRIGHT.COM/2017/03/NEWS/DEATH-DIGNITY-WINS-LOSES-SEVERAL-STATES/](https://refinedright.com/2017/03/news/death-dignity-wins-loses-several-states/))

All across the country, three words are creating a buzz that is changing the conversation on end-of-life options: Death with Dignity.

According to the 501(c)4 that shares the same name as the [term](https://www.deathwithdignity.org/terminology/) (<https://www.deathwithdignity.org/terminology/>), it is a law allowing “mentally competent, terminally ill adults to request a prescription medication from their physician for the purpose of hastening their death.” It is completely voluntary and can only happen

if the person choosing (https://www.refinedright.com)ts. These requirements include (https://www.deathwithdignity.org/learn/access/) being a legal adult, having mental competency, and being a resident of a state where death with dignity is legal. Two additional, and major requirements include being diagnosed with a terminal illness with less than six months to live, and be able to administer the prescription yourself.

Several states are currently debating on whether or not to make this an option for terminally ill adults.

In Hawaii (<http://www.hawaiinewsnow.com/story/34516905/death-with-dignity-bill-advances-in-state-legislature>), Senate Bill 1129 advanced out of the Senate Consumer Protection and Health Committee in February and is being referred to the Senate Committee on Judiciary and Labor. Three hundred people signed up to testify on the bill.

Minnesota State Senator Chris Eaton and Representative Mike Freibert introduced (<http://www.kare11.com/news/renewed-push-to-legalize-medically-assisted-death/417340892>) the End-of-Life Options Act of 2017 in both legislative chambers. The representatives do not expect the acts to get hearings in the Republican controlled legislature, but they want to continue the conversation on this issue.

Terminally ill residents (<http://www.washingtontimes.com/news/2017/feb/18/dc-physician-assisted-suicide-law-goes-effect/>) of Washington, D.C. are now able to choose death with dignity after Congressional Republican efforts to block the legislation failed. The legislation was signed into law by D.C. mayor Muriel Bowser last December.

Maryland legislators withdrew (<http://www.baltimoresun.com/news/maryland/politics/bs-md-aid-in-dying-withdrawn-20170303-story.html>) legislation for an end-of-life option act last week. The two Democratic sponsors claimed that the cross-filed bills wouldn't have enough support to pass in either chambers of the General Assembly.

Currently, six states and the District of Columbia have death with dignity laws. Twenty-four states are currently debating legislation on whether or not to enact death with dignity laws. Opponents of death with dignity claim (<http://notdeadyet.org/assisted-suicide-talking-points>) that these laws could lead to abuse of the elderly and disabled through coercion. Supporters believe (<https://www.compassionandchoices.org/who-we-are/>) that this legislation will give people more control over their lives, and possibly comfort, when they enter the final stages of their life.



DON'T BE A BURDEN
TO YOUR FAMILY.

HAVE THE TALK ABOUT END-OF-LIFE CARE NOW

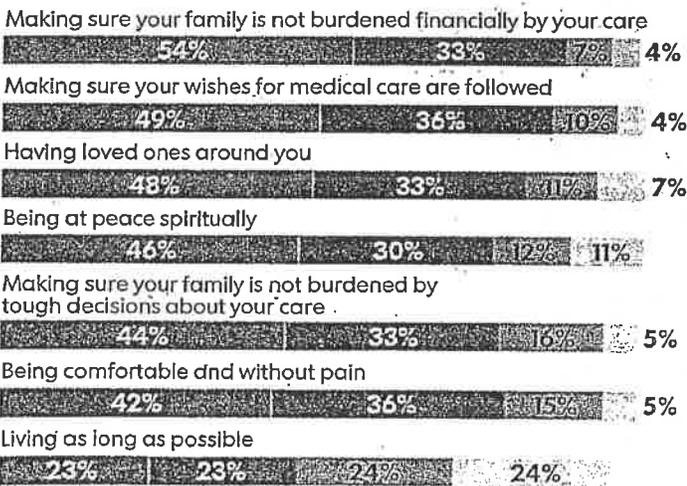
GETTY IMAGES/STOCKPHOTO

SURVEY: WHAT'S IMPORTANT AT DEATH?

The Kaiser Family Foundation did a survey in 2016 asking about end-of-life medical care. Here is the response to one question:

Thinking about your own death, how important is each of the following to you?:

Extremely important
 Very important
 Somewhat important
 Not too important



NOTE Not applicable and not sure/no answer responses are not shown
SOURCE Kaiser Family Foundation/The Economist Four-Country Survey of Aging and End of Life Medical Care (conducted March 30-May 29, 2016)

JANET LOEHRKE, USA TODAY

and communicating your values to your loved ones is a good step toward making certain your quality of life requirements are followed by your health care surrogate," McClanahan says.

A DIFFICULT TASK

Opening an end-of-life conversation is not easy, says Bob Maerterstock, author of *Passing the Torch, Critical Conversations with Your Adult Children*.

Others agree. "As a society, we are reticent to have these conversations," says Jim McCabe, president of Eldercare Resources. "What's more, don't be surprised if you're adult children don't want to discuss the topic. I have had elderly clients who wanted to talk about end of life, but it was the adult children who resisted."

FIND THE RIGHT DOCTOR

There are three kinds of doctors — paternalistic, informational and collaborative — according to Atul Gawande, author of *Being Mortal*. "The best doctor is collaborative," McClanahan says. "They take the time to understand your values and goals to help you make the choices that are right for you."

Unfortunately, there are so few of these doctors now, she says. Most doctors are informational, according to McClanahan. Given that, she provides her clients with a form to give their health care surrogate that outlines their quality of life measures.

"So, when a doctor says, 'We can do surgery, put in a feeding tube, provide antibiotics and the like' the health care surrogate says, 'Will this allow my ... to regain her ability to communicate' for whatever it is that is important?" McClanahan asks. "If the doctor says no, the surrogate does not allow the doctor to move forward and requests palliative care."

According to McCabe, end-of-life treatments such as hospice and palliative care face a good number of myths about what they do and how they operate.

"For instance, many folks don't know that they can get hospice at home," he says. "They think that they need to go to a nursing home for treatment so will not have that conversation."

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5-21-17 USA Today

Polling on Voter Support for Medical Aid in Dying for Terminally Ill Adults

National Polling

LifeWay Research online survey, Sept. 27-Oct. 1, 2016¹

- » Two thirds of Americans (67%) agree that: "When a person is facing a painful terminal disease, it is morally acceptable to ask for a physician's aid in taking his or her own life."
- » Majority support included most faith groups, including Christians (59%), Catholics (70%), Protestants (53%), those of other religions (70%) and those who identify as non-religious (84%)
- » Majority support included Americans with some college education (71%) or with graduate degrees (73%) and with high school diplomas or less (61%), Americans age 18 to 24 (77%), 35 to 44 (63%) and 55 to 64 (64%), White Americans (71%) and Hispanic Americans (69%), In addition, more than half of Black, Non-Hispanics (53%) agreed that: "Physicians should be allowed to assist terminally ill patients in ending their life."

Gallup's Poll Social Series: Values and Beliefs, May 2016²

- » Nearly 7 of out 10 Americans (69%) said they agreed that: "When a person has a disease that cannot be cured...doctors should be allowed by law to end the patient's life by some painless means if the patient and his or her family request it."
- » Gallup concluded: "Bottom Line...California, often a bellwether for change throughout the U.S., may persuade other states to consider passing legislation permitting physicians to allow terminally ill people to end their lives."

The American public consistently supports medical aid in dying by large majorities in both independent national and state surveys. Polling outlets such as Gallup and Harris both report strong support for medical aid in dying. Similarly, state-by-state polling also indicates majority support across demographic groups.

Gallup's Values and Beliefs Survey, May 2015³

- » Nearly 7 in 10 Americans (68%) agreed that "Individuals who are terminally ill, in great pain and who have no chance for recovery have the right to choose to end their own life."
- » Gallup noted that support "has risen nearly 20 points in the last two years and stands at the highest level in more than a decade," and support among young adults aged 18 to 34 "climbed 19 points this year, to 81%."

Medscape Poll, December 2016⁴

- » This online survey of more than 7500 physicians from more than 25 specialties demonstrated a significant increase in support for medical aid in dying from 2010. Today well over half (57%) of the physicians surveyed endorse the idea of medical aid in dying, agreeing that "Physician assisted death should be allowed for terminally ill patients."

Medscape Poll, December 2014⁵

- » This online survey of 17,000 U.S. doctors representing 28 medical specialties demonstrated that physicians agreed by a 23-percent margin (54% vs. 31%) that: "I believe terminal illnesses such as

metastatic cancers or degenerative neurological diseases rob a human of his/her dignity. Provided there is no shred of doubt that the disease is incurable and terminal, I would support a patient's decision to end their life, and I would also wish the same option was available in my case should the need arise."

- » The previous Medscape survey on this issue in 2010 showed physicians support medical aid in dying by a 5-percent margin (46% vs. 41%)

Harris Poll, November 2014⁶

- » Three out of 4 Americans (74%) polled after Brittany Maynard utilized Oregon's Death With Dignity Act agreed that: "Individuals who are terminally ill, in great pain and who have no chance for recovery, have the right to choose to end their own life."
- » Only 14 percent disagreed with this position.
- » Support for this position cut across all generations and educational groups, both genders, and even political affiliation: millennials (75%), Gen X (76%), baby boomers (74%), matures (68%), high school (75%), some college (74%), college grad (72%), post grad (76%), Rep. (64%), Dem. (78%), ind. (78%).

Gallup Survey, May 2014⁷

- » Nearly 7 out of 10 Americans (69%) think that doctors should be allowed by law to end the life of a patient who has a disease that cannot be cured "by some painless means if the patient and his or her family request it."

Pew Research Poll, November 2013⁸

- » Two out of 3 Americans (66%) "say there are at least some situations in which a patient should be allowed to die" and "the share saying they would stop their treatments so they could die has remained about the same over the past 23 years."

State Polling

Arizona Polling

Behavior Research Center's Rocky Mountain Poll, November 2015⁹

- » By a 25-point margin (56% vs. 31%), adult heads of households surveyed in Arizona support a "proposed law that would allow terminally ill persons to end their own lives provided that two doctors certify that the person is terminally ill and is mentally competent. The new law would also require that the ill person administer the lethal drug themselves orally or via injection. In this way the patient would be in total control of their end of life decision."
- » Adults in the 55-and-over age bracket support the legislation by more than 2-to-1 (63% vs. 25%). Younger respondents favored the plan by smaller margins.

California Polling

Journal of Palliative Medicine online survey, July-Oct. 2015: Multi-Ethnic Attitudes Toward Physician-Assisted Death in California and Hawaii¹⁰

- » "Majority of study participants in California (72.5%) were supportive of PAD [physician-assisted death]."
- » "...all ethnic groups were equally supportive of PAD."
- » "Even in the subgroups least supportive of PAD, the majority supports PAD."
- » "In California, 75.6% of non-Hispanic whites, 74.3% of Asians, and 71.6% of Hispanics were in support of PAD compared to 59.6% of African Americans."
- » "Within Asian Americans, Chinese were most favorably disposed toward PAD (82.7% in California), followed by Japanese (74.6% in California) and the Filipino Americans (67.7% in California)."

- » "It is remarkable that in both states, even participants who were deeply spiritual, a majority of 52%, were still in support of PAD."
- » "The effects of gender and ethnicity did not reach statistical significance in terms of attitudes toward PAD."

Field Poll, September-October 2015¹¹

- » Two out of 3 California voters (65%) say they support "a bill [End of Life Option Act] that allows California residents who are terminally ill and declared mentally competent, and who have been evaluated by two physicians and have submitted written requests to receive a lethal prescription, which they themselves would administer to end their own lives."
- » Support for the legislation includes both Democrats and no-party-preference registrants (70%), Republicans (55%), male voters (67%), female voters (64%), "majorities of voters across all age and racial/ethnic voter segments, and spans all religious subgroups," including Protestants (58%) and Catholics (55%).
- » The survey found 71 percent of voters in favor of granting incurably ill patients this right [to medical aid in dying], "very similar to levels of support found in each of five previous polls dating back to 1995."

Institute of Governmental Studies, University of California, Berkeley, August 2015¹²

- » Three out of 4 Californians (76%) support "a bill under consideration before the California State Legislature [that] would allow terminally ill people to be able to voluntarily end their own lives by taking drugs prescribed by a physician."
- » This support includes 82 percent of Democrats, 79 percent of independents and 67 percent of Republicans.

- » Support was at least 75 percent among whites, Latinos and Asian Americans, and 52.3 percent among African Americans.
- » Support levels of at least 69 percent were registered across all other demographic categories, from gender to educational, income and age levels.

Goodwin Simon Strategic Research & Probolsky Research Poll, June 2015¹³

- » By a 49-point margin, California voters (69% vs. 20%) support "the End-of-Life Option Act [that] would allow a terminally ill adult who is mentally competent the option to request and receive aid-in-dying medication from a physician."
- » Support was significant among every voter subgroup, including: Catholics (60%), non-evangelical Protestants (65%), evangelical Christians (57%), whites (69%), African-Americans (67%), Latinos (70%), Asian-Pacific Islanders (69%), men (70%), women (67%), younger voters (69% ages 18-54), older voters (68% ages 55+), Democrats (73%), independents (80%) and Republicans (55%), particularly Republicans over the age of 55 (58%).

Goodwin Simon Strategic Research Poll, July 2014¹⁴

- » By nearly a 3-1 margin (64% vs. 24%), California voters support "giving a terminally ill person, who is mentally competent, the right to request and receive a prescription for life-ending medication from a physician."

Colorado Polling

Colorado Presidential Election, November 8, 2016¹⁵

- » By a 30-point margin (65% vs. 35%), Colorado voters approved the medical aid-in-dying ballot initiative, Prop. 106
- » Voters across a broad demographic range supported Prop 106, according to exit polling con-

ducted for the Associated Press and television networks in Colorado.

- » Both men and women, Hispanics and whites, people with and without college degrees said they backed the proposal.
- » Prop 106 received more Yes votes than any other measure or candidate on the Colorado ballot.

Colorado Mesa University, Rocky Mountain PBS, and Franklin & Marshall College, Sept. 14-18, 2016¹⁶

- » Seven out of 10 Colorado voters (70%) either "strongly favor" (46%) or "somewhat favor" (24%) medical aid in dying ballot initiative, Prop. 106, vs. only 22 percent who oppose it.

Colorado Medical Society Member Survey, February 2016¹⁷

- » Overall, 56% of CMS members are in favor of "physician-assisted suicide, where adults in Colorado could obtain and use prescriptions from their physicians for self-administered, lethal doses of medications,"
- » 31% "strongly" supported this end of life care option.

Talmey-Drake Research and Strategy Inc. omnibus poll, Jan. 2016¹⁸

- » By a 40 percent margin (65% vs. 24%), Colorado voters said they support legislation to allow "those who are terminally ill a reliable and peaceful way to end their lives if and when they want to" by self-administering aid-in-dying "medications prescribed by a doctor.

Strategies 360 Poll, May 2014¹⁹

- » By a 34 percent margin (62% vs. 28%), Colorado voters support "mentally competent, terminally ill patients with less than six months to live be able to end their life using prescription medications they can self-administer."

- » This majority support includes: 76% of Democrats, 68% of unaffiliated voters, 50% of Republican primary voters, 68% of millennial voters (18-34 years-old), 56% of seniors (65+ years old), 55% of Christians, and 52% of Catholics.

Connecticut Polling

Quinnipiac University Poll, March 2015²⁰

- » By more than a 2-1 margin (63% vs. 31%), Connecticut voters support "allowing doctors to legally prescribe lethal drugs to help terminally ill patients end their own lives."
- » All party, age and gender groups support the idea, including voters over 55 years old, who support it 59 percent to 34 percent.

Quinnipiac University Poll, March 2014²¹

- » By nearly a 2-1 margin (61% vs. 32%), Connecticut voters support death-with-dignity legislation "allowing doctors to legally prescribe lethal drugs to help terminally ill patients end their own lives" (see question 49).
- » The poll showed majority approval of a death-with-dignity bill among Republicans (51%), Democrats (66%), independents (63%), men (63%), women (58%) and all age groups (18-29: 63%, 30-49: 65%, 50-64: 62%, 65+: 54%).
- » A majority of these same groups (except Republicans and 30-39 year olds) also agreed that if death-with-dignity legislation "became law in Connecticut, and [they] were diagnosed with a terminal illness and had less than 6 months to live and were living in severe pain ... [they] would probably ask a doctor to help [them] end [their] life" (see question 51a).

Purple Insights Poll, February 2014²²

- » Two out of 3 Connecticut voters (66%) support a proposal to allow "mentally competent, terminally ill patients with less than six months to live be

able to end their life in a humane and dignified manner, using prescription medications they can self-administer.”

- » This majority support holds across all age groups (<50: 73%, 50-64: 64%, 65+: 62%), among Catholics (61%), Republicans (59%) and disabled voters (65%).

Momentum Analysis Survey, June 2012²³

- » Two out of 3 Connecticut voters (67%) favor allowing “mentally competent, terminally ill patients with less than six months to live to be able to end their life in a humane and dignified manner, using prescription medications they can self-administer.”

Hawai'i Polling

Anthology Marketing Group (formerly QMark Research) survey, Nov. 2016²⁴

- » Eight out of 10 Hawaii voters (80%) agreed that “a mentally capable adult [who] is dying of a terminal disease that cannot be cured...definitely (55%) or probably (25%) should have the legal option to request prescription medicine from their doctor, and use that medication to end their suffering in their final stages of dying.”
- » Only 12 percent of survey respondents were opposed to this legal option and 8 percent were unsure.
- » A majority of Catholics (82%) and those associated with the Christian Fellowship (83%) said terminally ill adults definitely or probably should have this legal option.

Journal of Palliative Medicine online survey, July-Oct. 2015: Multi-Ethnic Attitudes Toward Physician-Assisted Death in California and Hawaii²⁵

- » “Majority of study participants in California (72.5%) were supportive of PAD [physician-assisted death].”

- » “...all ethnic groups were equally supportive of PAD.”

- » “Even in the subgroups least supportive of PAD, the majority supports PAD.”

- » “In California, 75.6% of non-Hispanic whites, 74.3% of Asians, and 71.6% of Hispanics were in support of PAD compared to 59.6% of African Americans.”

- » “Within Asian Americans, Chinese were most favorably disposed toward PAD (82.7% in California), followed by Japanese (74.6% in California) and the Filipino Americans (67.7% in California).”

- » “It is remarkable that in both states, even participants who were deeply spiritual, a majority of 52%, were still in support of PAD.”

- » “The effects of gender and ethnicity did not reach statistical significance in terms of attitudes toward PAD.”

Qmark Research Survey, January 2012²⁶

- » Three out of 4 Hawai'i doctors (76%) support “allowing a mentally competent adult, who is dying of a terminal disease, the choice to request and receive medication from his/her physician to bring about their own peaceful death, if there were appropriate safeguards in place to protect against abuse.”

Maryland Polling

Maryland State Medical Society (MedChi) survey, June-July 2016²⁷

- » Six out of 10 Maryland physicians (60%) supported changing the Maryland State Medical Society's position on Maryland's 2016 aid-in-dying legislation from opposing the bill to supporting it (47%) or adopting a neutral stance (13%).

- » Among the physicians surveyed who were current members of the Maryland State Medical Society,

65 percent supported changing the organization's position to supporting the aid in dying bill (50.2%) or adopting a neutral stance (14.6%).

Momentum Analysis poll, Feb. 2016²⁸

- » Nearly two out of three Maryland voters (65%) said they "support allowing a mentally capable adult, who is dying of a terminal disease with no hope of recovery, the option to ask for medication to bring about their own death"
- » Support for medical aid in dying included a majority of African-Americans (59%), Republicans (56%), Catholics (53%), and a plurality of voters who attend religious services weekly (46%).
- » A majority (54%) also said they would "want a legal option to end my own life," including a majority of Catholics (50%), nearly half of conservatives (48%), a plurality of seniors (47%), and about 4 in 10 frequent service-goers (39%).

Goucher Poll, February 2015²⁹

- » By a 60 to 35 percent margin, Maryland residents support death-with-dignity legislation that would allow mentally competent, terminally ill patients with less than six months to live to obtain a prescription for a fatal dose of drugs that they could self-administer.

Massachusetts Polling

Purple Insights Survey, February 2014³⁰

- » Seven out of 10 Massachusetts voters (71%) support a proposal to allow "mentally competent, terminally ill patients with less than six months to live be able to end their life in a humane and dignified manner, using prescription medications they can self-administer."
- » This majority total support holds across all age groups (<50: 73%, 50-64: 73%, 65+: 67%), among Catholics (64%), Republicans (61%) and disabled voters (74%).

Momentum Analysis Survey, May 2012³¹

- » Seven out of 10 Massachusetts voters (70%) favor allowing "mentally competent, terminally ill patients with less than six months to live to be able to end their life in a humane and dignified manner, using prescription medications they can self-administer."

Minnesota Polling

Minnesota State Senate Fair Poll, August.-September 2016³²

- » By more than a 3-1 ratio (68% vs. 22%), Minnesotans who completed the state Senate's questionnaire at the annual state fair agreed that: "When a mentally competent adult is dying from an incurable and irreversible medical condition that is expected to end the individual's life within six months...this individual should be allowed to obtain from a physician a prescription for medication that may be self-administered to end that person's life."

Minnesota House of Representatives State Fair Poll, August.-September 2016³³

- » By nearly a 3-1 ratio, (67% vs. 23%), Minnesotans who completed the state House of Representatives' questionnaire at the annual state fair agreed that: "When a mentally capable adult is dying from a terminal illness...this adult should be allowed to receive a prescription for life-ending medication they may self-administer."

Montana Polling

Global Strategy Group Survey, April 2013³⁴

- » Seven out of 10 Montana voters (69%) support allowing a mentally competent adult who is dying of a terminal disease and in extreme pain to choose to end his or her life in a humane and dignified way.

New Jersey Polling

Rutgers-Eagleton Poll, February 2015³⁵

- » By more than a 2-1 margin (63% to 29%), New Jersey residents support a state Legislature aid-in-dying bill that “would allow terminally ill patients to obtain a prescription to end their lives.”
- » “This is not really a partisan issue in New Jersey,” said Ashley Koning, manager of the Rutgers-Eagleton Poll. “Though a difficult subject for many, the issue has widespread support and acceptance here. Public opinion is mainly on the bill’s side.”
- » A majority of New Jerseyans of all denominations and levels of religiosity would prefer to relieve pain and discomfort, even if that meant shortening their life, including Protestants (73%), Catholics (64%) and other non-Protestant residents (59%).

Fairleigh Dickinson University’s PublicMind Poll, July 2014³⁶

- » A double-digit majority of New Jersey adults (51% vs. 38%) agreed that the state legislature should pass “a bill that would allow people with fewer than six months to live to end their life with a lethal dose of prescription drugs and the assistance of a doctor.”
- » The last time this question was polled, in October 2012, when the legislature considered similar legislation, 46 percent said it should pass the bill.
- » “... the consensus seems to be for personal autonomy in deciding how and when to end one’s life when a terminal illness brings the end sooner rather than later,” said Krista Jenkins, director of PublicMind and professor of political science at Fairleigh Dickinson University.

Purple Insights Survey, February 2014³⁷

- » Six out of 10 New Jersey voters (62%) support a proposal to allow “mentally competent, terminally ill patients with less than six months to live be

able to end their life in a humane and dignified manner, using prescription medications they can self-administer.”

- » This majority total support holds across all age groups (<50: 65%, 50-64: 69%, 65+: 55%), among Catholics (57%), Republicans (58%) and disabled voters (63%).

Momentum Analysis Survey, April 2013³⁸

- » Six out of 10 New Jersey voters (63%) “favor allowing a mentally competent adult, who is dying of a terminal illness with no hope of recovery, the choice to bring about their death.”

New Mexico Polling

Research & Polling Survey, April 2012³⁹

- » Two out of 3 New Mexico voters (65%) favor “allowing a mentally competent adult, who is dying of a terminal disease, with no hope of recovery, the choice to request and receive medication from his/her physician which could bring about their own death, if there were appropriate safeguards in place to protect patients against abuse.”

New York Polling

Eagle Point Strategies Survey, September 2015⁴⁰

- » Three of 4 New York voters (77%) think “when a mentally competent adult is dying from a terminal illness that cannot be cured, the adult should be allowed the option to request a prescription for life ending medication from their doctor, and decide whether and when to use that medication to end their suffering in their final stages of dying.
- » “Clear majorities extend across lines based on respondents’ religious affiliation, level of education, political party enrollment, gender, age and region of the state.”

- » When respondents learned more about New York’s medical aid-in-dying legislation, including

opponents' arguments against it, support increased to 4 out of 5 voters (81%).

Tennessee Polling

Princeton Survey Research Associates International/
Vanderbilt University, May 2015⁴¹

- » Tennessee voters agreed by a 17-point margin (55% vs. 38%) that doctors should be permitted to assist people with painful, incurable diseases to painlessly end their lives.
- » Nearly two-thirds of voters (65%) supported some sort of option for ending one's life due to health concerns.

Utah Polling

Dan Jones & Associates survey, Nov. 2015⁴²

- » Nearly six of 10 adult Utahns (58%) favor "some kind of 'right to die' law, where licensed medical personnel could help a terminally-ill, mentally-competent person die with allowed drugs if that person chooses."
- » Republicans are divided on the issue with 41% saying they favor "right-to-die" legislation and 50% opposed. Democrats and independents overwhelmingly prefer the idea with 90% of Democrats and 67% of independents supporting.
- » There was not much of a religious divide on the question: 94% of those who say they don't ascribe to any religion, self-described "not active" Latter Day Saints (LDS) Church members, 80% of Protestants, 79% of "somewhat active" Mormons, and 76% of Catholics favored the idea.
- » The only religious group opposed to the idea were "very active" LDS Church members by a 54-38% margin.

Vermont Polling

Momentum Analysis Survey, June 2012⁴³

- » Three out of 4 Vermont voters (74%) favor allowing "mentally competent, terminally ill patients with less than six months to live to be able to end their life in a humane and dignified manner, using prescription medications they can self-administer."

Washington, D.C., Polling

Lake Research Survey, July 2015⁴⁴

- » Two-thirds (67%) of District of Columbia residents support — and 51 percent strongly support — the right of terminally ill adults with less than six months to live to legally obtain medication to end their lives.

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Developmental Disabilities Council

2016 Position on Assisted Suicide

The Developmental Disabilities Council opposes the legalization of any action that legally supports medical assistance of one's death regardless of prognosis, including "medical aid in dying", "assisted suicide", "assisted death", "death with dignity", or other terms not specifically listed. Equal rights must include equal suicide prevention.

Oregon, Washington, Vermont and, recently, California have statutes legalizing assisted suicide. The Montana Supreme Court has declared that the victim's consent to assisted suicide can be a defense to homicide charges, and a New Mexico district court has declared assisted suicide a state right, but the state is appealing that ruling.

In Oregon and Washington, data indicates that people request assisted suicide for reasons directly related to disability-based oppression, such as feelings of loss of autonomy and dignity, and feelings of being a burden on others. These factors are the direct result of both negative stereotypes and public policies that deny people the consumer-controlled long-term services and supports that they need to feel respected and valued throughout life to a natural death. Assisted suicide laws set up a double standard whereby most people who are suicidal get suicide prevention services and support while certain others get suicide assistance. For those who are old, ill, or "disabled enough", society will not only agree that suicide is appropriate but will provide the lethal means to complete the act. This form of discrimination violates the ADA and must be opposed.

During 2015, disability rights and independent living advocates were instrumental in defeating assisted suicide legislation in Alaska, Colorado, Connecticut, Delaware, Maine, Nevada, Rhode Island and Tennessee, with efforts continuing in New Jersey, Maryland and the District of Columbia. The Developmental Disabilities Council believes there is a clear danger that individuals with intellectual and developmental disabilities and other disabilities

will not be advised of other options but instead steered toward the least expensive options rather than the supports individuals may need. This is due to the current climate in a profit driven healthcare system and environment of cost containment.

Recommendations:

1. Options other than suicide need to be offered and provided to terminally ill patients and their families by medical and social work professionals. Medical interventions such as hospice, palliative care, and pain management have been shown to provide comfort while the individual is dying. In addition, these services are typically covered by medical insurances.
2. Medical professionals need to be provided information such as disability etiquette and disability rights, and demonstrate that individuals can have a quality life despite any disabling



conditions. Groups such as Not Dead Yet, the National Council on Independent Living, ADAPT, and Disability Rights and Educational Defense Fund can provide this.

3. To assure quality of life issues are valued, local Centers for Independent Living need to work on individual and systemic advocacy. Working with the individual with a disability and his/her family on how to identify supports needed so the individual and the family can have a quality life that is appropriate for him/her.

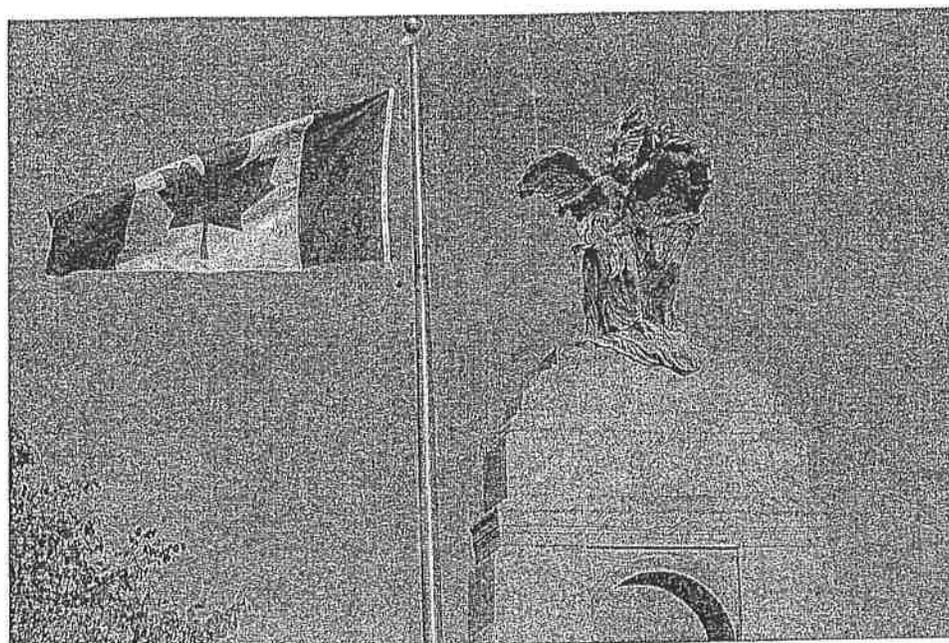
4. Groups that also oppose assisted suicide include the National Association of Nurses and several medical schools. Disability advocacy organizations and nonprofits need to work with these groups to demand that assisted suicide laws do not get passed.

Sources for this statement include: The National Council for Independent Living, The Arc of Maryland, and Not Dead Yet.

Vox

Canada legalizes physician-assisted suicide

Updated by Sarah Kliff | sarah@vox.com | Feb 6, 2015, 3:40pm EST



Mike Carroccetto/Getty Images

1. On Friday, Canada's Supreme Court legalized physician-assisted suicide.
2. This makes Canada one of a small handful of countries — the others are Belgium, the Netherlands, Luxembourg and Switzerland — that allow doctors to hasten the deaths of terminally-ill patients.
3. Canada's law will take effect in one year, after the country's provinces have had time to set up rules and regulations of how new aid-in-dying laws will work.

A huge decision for advocates of physician-assisted suicide

In a **landmark decision**, Canada's Supreme Court ruled that physicians should be allowed to aid a patient in dying so long as "the person affected clearly consents to the termination of life" and is suffering from "grievous and irremediable medical condition."

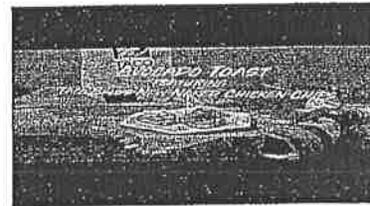
The ruling centered on the case of 89-year-old Gloria Taylor, a resident of British Columbia who suffered from late-stage Amyotrophic Lateral Sclerosis, or ALS, which causes progressive muscle weakness.

***"I DO NOT WANT TO WASTE AWAY," THE PLAINTIFF
IN THE CASE WROTE***

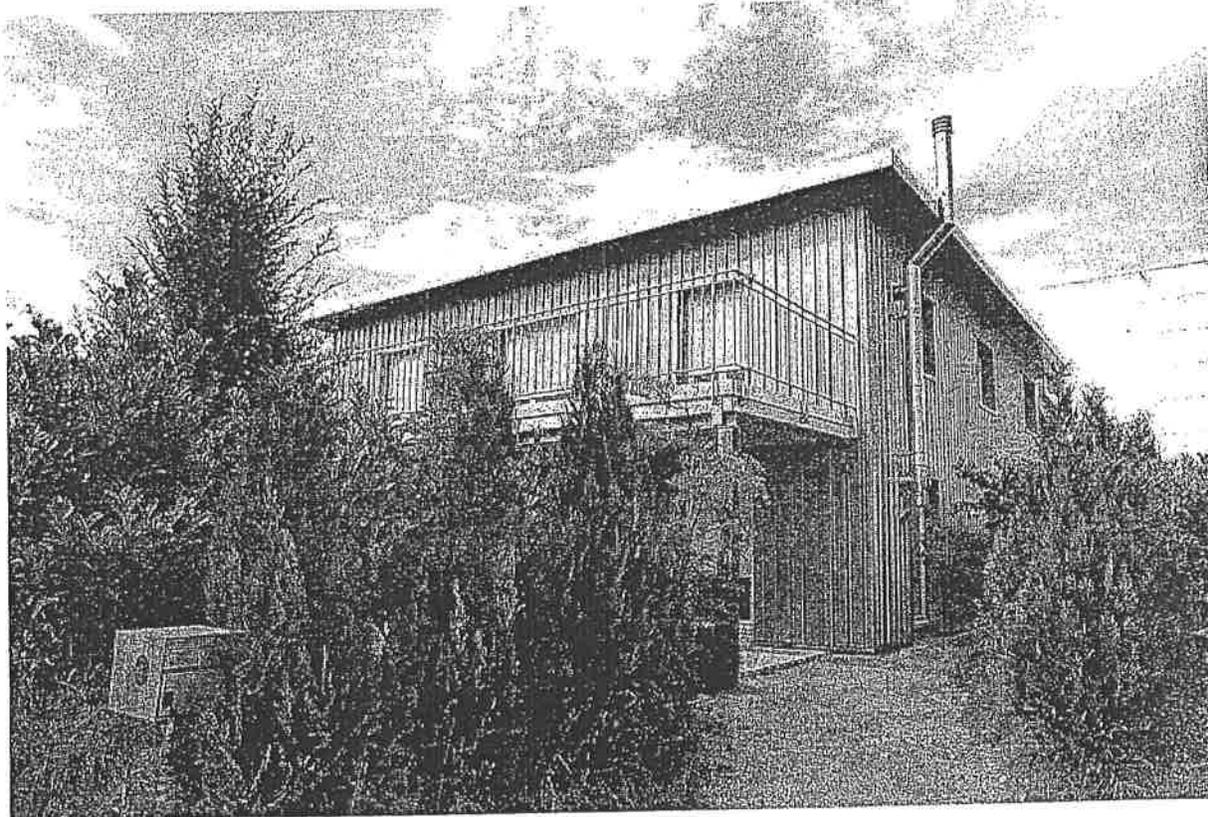
"What I fear is a death that negates, as opposed to concludes, my life," Taylor wrote of her wish for physician-assisted suicide in documents the Supreme Court quoted. "I do not want to die slowly, piece by piece. I do not want to waste away unconscious in a hospital bed. I do not want to die wracked with pain."

Canada's law will take effect in one year, after the country's provinces have had time to set up rules and regulations of how new aid-in-dying laws will work.

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Canada joins a handful of European countries with legal physician-assisted suicide



An assisted suicide clinic in Switzerland run by Zurich-based group Dignitas (AFP via Getty News Images) Three countries have passed legislation that allows doctors to hasten the deaths of terminally-ill patients: Belgium, the Netherlands, and Luxembourg. Switzerland has an even more liberal aid-in-dying policy, which allows non-doctors to assist suicide, that stems from the country's **criminal code**.

The Netherlands was the first country to legalize physician-assisted suicide with a 2002 law, although the country has informally permitted such activities for approximately three decades. The Dutch law also legalized euthanasia, which the country defines as death from a medication administered by a physician to

hasten death (whereas physician-assisted suicide includes cases where the patient gets a prescription for a deadly dosage, but administers it him or herself).

1.8 PERCENT OF ALL DEATHS IN THE NETHERLANDS ARE THE RESULT OF PHYSICIAN AID-IN-DYING

A **2007 study** found that, in 2005, 1.8 percent of all deaths in the country were the result of euthanasia or physician-assisted suicide.

Belgium also **passed** its aid-in-dying law in 2002, and it also permits both euthanasia and physician-assisted suicide. In 2014, Belgium **extended** its law to apply to children of any age living with terminal illness (the Netherlands' law is not available to children under 12 and, for teens using it, requires parental consent). **Luxembourg** was the third country to legalize euthanasia in 2009.

In Switzerland, physician-assisted suicide is legal so long as the doctor is not motivated by "selfish" interests. Euthanasia, however, is not allowed. Switzerland is **unique** in that it allows non-doctors to assist in suicides as well and does not limit access to life-ending drugs to patients with terminal illness.

The ruling from the Canadian Supreme Court says that provinces there cannot "prohibit physician-assisted death." Whether this means they will allow physician-assisted suicide (where doctors prescribe fatal drugs for patients to take) or euthanasia (where the doctor himself administers the deadly medication).

Five states in America have right-to-die laws





Protesters rally at the Supreme Court before arguments in *Gonzalez v. Oregon*, a 2005 decision that allowed Oregon's aid-in-dying law to continue (The Washington Post via Getty News Images)

No states in America allow for euthanasia. The five states with right-to-die laws — Oregon, Washington, New Mexico, Montana, and Vermont — all require the patient to administer their own deadly medications.

In Oregon, which passed its Death with Dignity law in 1997, patients must make their request for a lethal medication in writing and then, 15 days later, make an oral request. Another 15 days must pass before the patient can fill the prescription — and they could decide never to fill it at all.

"If a doctor is allowed to give a patient a lethal injection, the doctor is the last actor," says Alan Meisel, a bioethicist at the University of Pittsburgh who has written extensively on right-to-die laws. "In Oregon and Washington, the patient is the last actor. And that lets them reserve the right not to act at all."

Will Canada's new law lead to suicide tourism in North America?

Switzerland's law is best known for attracting suicide tourism: those who travel from abroad to end their own lives, because they cannot do where they live.

Suicide tourism to Switzerland, particularly among those who are not terminally-ill, appears to have increased in recent years. **One study** found that 611 non-Swiss citizens from 31 countries used the country's aid-in-dying laws between 2008 and 2012.

There are two reasons to think Canada will not have nearly as much suicide tourism as Switzerland. First, Canada's law is much more restrictive than Switzerland's. While Switzerland allows those who are not terminally ill to end their lives, Canada's laws will restrict access to those who have an "irremediable" condition that causes "enduring and intolerable suffering."

Second, aid-in-dying has been available in the United States since 1997, when Oregon passed its death with dignity law. The Oregon law does require those wishing to end their lives to be residents of the state. This is certainly an obstacle, but not an impossible one: 29-year-old **Brittany Maynard** famously moved to Oregon in 2014 to end her life after being diagnosed with terminal brain cancer.

It's unclear, at this point, whether the Canadian law will have residency requirements — that's up to the provinces there as they interpret the new court ruling. If it does, that will likely be a significant deterrent to Americans traveling there seeking to end their lives.



Brittany Maynard ended her life on November 1 (Courtesy of Compassion and Choices)

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Distinctions Between Domicile and Residence

Distinctions Between Domicile and Residence

Domicile is a person's permanent place of dwelling. It is a legal relationship between a person and a locality. It may or may not be of same meaning as the term 'residence'.

The concept of domicile has different meanings in different context. For purposes of jurisdiction, "domicile" means a legal residence which is the place where a person has fixed dwelling with an intention of making it his/her permanent home[i].

Domicile is a combination of two factors namely, residence and intent to remain. As the term domicile includes residence, the scope and significance of the term domicile is larger than the term residence. An individual may have several residences whereas; s/he will have only one domicile. Domicile is more used in reference to personal rights, duties and obligations[ii].

Generally residence is referred to a place, where one person lives. It is also a building used as home. Residence is of a more temporary nature compared to domicile. An individual's present physical location of stay is residence [iii]. It may be one among several places where a person may be present. Residence can also be referred to a person's fixed place of stay without any intention to move from there.

Domicile involves intent of an individual whereas, residence is something objective. A person may have his/her residence in one place and his/her domicile in another[iv].

Whether the term 'residence' used in a statute will be construed as having the meaning of 'domicile', or vice versa, depends on the purpose of the statute. Also, the nature of the subject matter as well as the context in which the term is used would be taken into consideration[v].

The terms are given equivalent meaning when used in connection with subjects of domestic policy. These terms are given equal meaning where a statute stipulates residence as a qualification for the enjoyment of a privilege or the right of voting in an election[vi].

Residency is a more flexible concept than domicile, and permanency is not a requirement for residency. Even a temporary and transient place of dwelling can qualify as residence. In addition, a minor is legally unable to establish a residence separate and apart from their parents[vii].

Residence takes meaning from the context in the term is found. A definition which fits one situation will not be apt

when used in another context or in a different sense[viii].

[i] *Snyder v. McLeod*, 971 So. 2d 166 (Fla. Dist. Ct. App. 5th Dist. 2007).

[ii] *McIntosh v. Maricopa County*, 73 Ariz. 366 (Ariz. 1952).

[iii] *George Zulakis, Personal Representative of the Estate of Charles M. Decker v. Auto-owners ins. Co.*, 2001 Mich. App. LEXIS 1874 (Mich. Ct. App. Nov. 20, 2001).

[iv] *Missouri Pacific R. Co. v. Lawrence*, 215 Ark. 718, 223 S.W.2d 823, 12 A.L.R.2d 748 (1949).

[v] *McIntosh v. Maricopa County*, 73 Ariz. 366 (Ariz. 1952).

[vi] *Id.*

[vii] *McLeod v. Allstate Ins. Co.*, 789 So. 2d 806 (Miss. 2001).

[viii] *State v. Tustin*, 322 S.W.2d 179, 180 (Mo. App. 1959).

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