What Is Medical Aid in Dying?

Medical aid in dying (also known as death with dignity) is when a terminally ill, mentally capable person who has a prognosis of six months or less to live requests, obtains and—if his or her suffering becomes unbearable—self-ingests medication that brings about a peaceful death.

Prior to providing a prescription for such medication, doctors must confirm that the person is fully informed and provide the person with information about additional end-of-life options, including comfort care, hospice and pain control.

Why Is Medical Aid in Dying a Safe Practice?

Medical aid in dying is a safe and trusted medical practice because the eligibility requirements ensure that only mentally capable, terminally ill adults with a prognosis of six months or less who want the choice of a peaceful death are able to request and obtain aid-in-dying medication. And the prestigious and peer-reviewed Journal of Palliative Medicine published clinical criteria for medical aid in dying which physicians use to ensure that the practice meets the highest standards of medical care.  

The states that authorized aid in dying through legislation modeled their bills after Oregon’s Death With Dignity Act. In those states, medical aid in dying is available to adults who are terminally ill, with six months or less to live. They must be mentally capable of making their own healthcare decisions and health providers, family and friends must not influence their decisions.

Where Is Medical Aid in Dying Authorized?

Medical aid in dying is currently authorized in five states, either through statute or court decision:

- Oregon (1994, ballot initiative)
- Washington (2008, ballot initiative)
- Montana (2009, state Supreme Court decision)
- Vermont (2013, legislation)
- California (2015, legislation)

Each state’s regulatory and procedural requirements are slightly different, but all the legislation includes the following provisions, among others:

- The person must be fully informed of all their options
- The person must request the prescription from a physician and be free from undue influence or coercion
- The person must be able to take and ingest the medication by themselves
- The physician must offer the person multiple opportunities to take back the request for aid-in-dying medication
- Two witnesses must sign the request form confirming that the request is voluntary
- Wills, contracts, insurance and annuity policies are not affected by a person choosing aid in dying
- Aid in dying is not considered suicide or assisted suicide

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How Well Has Medical Aid in Dying Worked in the States That Have Authorized It?

In the more than 30 combined years of medical aid in dying in the authorized states, there has not been a single instance of documented abuse. Almost two decades of rigorously observed and documented experience in Oregon shows us the law has worked as intended, with none of the problems opponents had predicted.

In Oregon:

- End-of-life care has improved overall since the law’s implementation, in large part due to the dialogue the Death With Dignity Act encourages between people and their doctors.7
- Hospice use is high and referrals are up, as is other use of palliative care. Some hospice programs in Oregon reported a 20 percent increase in referrals since the medical aid in dying was authorized.8
- In-hospital death rates are the lowest in the nation and at-home death rates are the highest in the nation, and violent suicide among hospice patients has virtually disappeared.7

Where Does the American Public Stand on Medical Aid in Dying?

The American public consistently supports medical aid in dying by large majorities and is of great importance to voters, as measured by national independent polling outlets such as Gallup (68 percent support in May 2015)10 and The Harris Poll (74 percent support in November 2014)11. State-by-state polling also indicates majority support that cuts across demographics.

Why Is It Wrong to Equate Medical Aid in Dying With Euthanasia?

Euthanasia is commonly given as a lethal injection by a third party. It is often performed on somebody who does not have a terminal diagnoses and is illegal throughout the United States. Compassion & Choices doesn’t support euthanasia because someone else – not the dying person – chooses and acts to cause death.

Why Is It Wrong to Equate Medical Aid in Dying With Assisted Suicide?

Factually, legally and medically speaking, it is inaccurate to equate aid in dying with assisted suicide. People who consider aid in dying find the suggestion that they are committing suicide deeply offensive, stigmatizing and inaccurate. The Oregon1, Washington2, Vermont4 and California5 laws emphasize that:

“Actions taken in accordance with [the Act] shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law.”

This is because a person who is choosing medical aid in dying already has a terminal prognosis of six months or less to live. They are not choosing to die; the disease is taking their life. The terminally ill person who chooses aid in dying is simply choosing not to prolong a difficult and painful dying process.

Which Organizations Support Medical Aid in Dying?

In addition to Compassion & Choices, national public health and medical organizations such as the American Public Health Association, American Medical Women’s Association and American Medical Student Association have adopted supportive positions on medical aid in dying at the national level.

In California, the End of Life Option Act (signed into law in October 2015) was endorsed by more than 75 organizations including the American Nurses Association/California, California Psychological Association and California Primary Care Association.
The California Medical Association dropped its 28-year opposition to medical aid in dying and adopted a neutral position on the legislation, concluding: “As physicians, we want to provide the best care possible for our patients. However, despite the remarkable medical breakthroughs we’ve made and the world-class hospice or palliative care we can provide, it isn’t always enough … it’s up to the patient and their physician to choose the course of treatment best suited for the situation.”

**Resources**

8. Ibid., p.775.