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Understanding Assistance in Dying: Arguments in Favor of the End of Life Option Act

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Cover Page Footnote

Sources Footnotes: *Palliative care may involve physical, spiritual, emotional or legal assistance, explains the National Cancer Institute. Pain management therapies help patients cope with symptoms and side effects, while talk therapy and support groups provide emotional care. Some palliative care programs offer practical assistance to manage health insurance issues, advanced care directives, and wills and other legal paperwork. At the end of a patient's life, palliative care may be the only treatment available. However, patients can begin palliative care as soon as they are diagnosed with a serious illness, explains the National Cancer Institute. **The list of states, and their legal document, that legalized assisted dying. California 2015 End of Life Option Act <https://www.deathwithdignity.org/states/california/> Colorado 2016 Colorado End-of-Life Options Act <https://www.uhealth.org/colorado-end-of-life-options-act/> District of Columbia 2016 District of Columbia Death with Dignity Act <https://www.deathwithdignity.org/states/district-of-columbia/> Hawaii 2018 Our Care, Our Choice Act <https://www.deathwithdignity.org/states/hawaii/> Maine 2019 Maine Death with Dignity Act <https://www.deathwithdignity.org/states/maine/> New Jersey 2019 Aid in Dying for the Terminally Ill Act <https://www.deathwithdignity.org/states/new-jersey/> Oregon 1994 Oregon's Death With Dignity Act <https://www.deathwithdignity.org/states/oregon/> Vermont 2013 Patient Choice and Control at End of Life <https://www.deathwithdignity.org/states/vermont/> Washington 2008 Washington Death with Dignity Act <https://www.deathwithdignity.org/states/washington/> References 1. Braverman, D., Marcus, B., Wakim, P., Mercurio, M., and G. Kopf. Healthcare Professional- s'Attitudes About Physician-Assisted Death: An Analysis of Their Justifications and the Roles of Terminology and Patient Competency. *Journal of Pain and Symptom Management*. 2017 Jul 14. (Epub ahead of print). 2. Brennan M: Americans' Strong Support for Euthanasia Persists. Gallup. May 31, 2018. Avail- able at <https://news.gallup.com/poll/235145/americans-strong-support-euthanasia-persists.aspx>. Accessed June 27, 2019. 3. Bruce, S. D., Hendrix, C. C., Gentry, J. H., Palliative Sedation in End-of-Life Care, *Journal of Hospice and Palliative Nursing*. 2006;8(6):320-327 <https://www.medscape.com/viewarti- cle/550666>. Accessed June 29, 2019. p.324 4. Cassell, E. J., Rich, B. A., Intractable End-of-Life Suffering and the Ethics of Palliative Se- dation, *Pain Medicine*, Volume 11, Issue 3, March 2010, Pages 435–438, <https://doi.org/10.1111/j.1526-4637.2009.00786.x> 5. Christopher, M., Role of Ethics Committees, Ethics Networks, and Ethics Centers in Improv- ing End-of-Life Care, *Pain Medicine*, Volume 2, Issue 2, June 2001, Pages 162–168, <https://doi.org/10.1046/j.1526-4637.2001.002002162.x> 6. Emanuel, E., Onwuteaka-Philipsen, B., Urwin, J., and J. Cohen. Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe. *JAMA*. 2016. 316(1):79-90 7. End of Life Option Act, California Department of Health Care Online, <https://www.cdph.- ca.gov/Programs/CHSI/ Pages/End-of-Life-Option-Act-.aspx#>. Accessed July 01,2019. 8. Mayo Clinic <https://newsnetwork.mayoclinic.org/discussion/tuesday-q-a-palliative-care-fo- cuses-on-providing-relief-from-symptoms-pain-and-stress-of-serious-illness/> 9. Oxford Textbook of Palliative Medicine, Fifth Edition, Cherny, Nathan I., Fallon, Marie T., Kaasa, Stein, Portenoy, Russel K., Currow, David C., Oxford University Press, UK, 2015. p. 314. 10. Sprung, Ch. L., Somerville, M. A., Radbruch, L., Steiner Collete, N., MD, Duttge, G., Piva, J. P., Antonelli, M., Sulmasy, D. P., Lemmens, W., Ely, W., Physician-Assisted Suicide and Euthanasia: Emerging Issues From a Global Perspective, First Published June 1, 2018 Case Report, Volume: 33 issue: 4, page(s): 197-203 Article first published online: June 1, 2018; Issue published: October 1, 2018 <https://journals.sagepub.com/doi/abs/10.1177/0825859718777325> Accessed June 30, 2019. 11. Mayo Clinic <https://newsnetwork.mayoclinic.org/discussion/tuesday-q-a-palliative-care-fo- cuses-on-providing-relief-from-symptoms-pain-and-stress-of-serious-illness/>

Understanding Assistance in Dying: Arguments in Favor of the End of Life Option Act

Malgorzata Hausdorff

The California End of Life Option Act took effect on June 9, 2016, allowing the terminally ill to ask doctors for assistance in dying. It is a legal document, clearly defining and regulating the safeguards and procedures involved in physician-assisted dying. At the same time there are many people in our society--27% of the US population (Brenan, 2018)--who are profoundly uncomfortable with the legalization of physician assistance in dying, previously known as physician-assisted suicide. They argue that it is a slippery slope, that anyone will be able to “pull the plug” on them. They say that we should invest in end of life care and good pain management rather than end lives due to discomfort. Some are concerned that whoever suffers from depression will commit suicide instead of receiving treatment for their disorder. (Cherny, Fallon, Kaasa, Portenoy, & Currow, 2015; Braverman, Marcus, Wakim, Mercurio, & Kopf, 2017; Emanuel, Onwuteaka-Philipsen, Urwin, & Cohen, 2016) These are real concerns that, unfortunately, come from misconceptions. The End of Life Option Act is designed to help people who are dying, who have no realistic chance for meaningful improvement of their health, and who are senselessly suffering from their condition. (“End of Life Option Act,” n.d.)

The most common misconception regarding assisting in dying is the terminology itself. The mass media bears a lot of responsibility for this, for they sometimes use the terms “Assisted Suicide” and “Euthanasia” interchangeably. These are two different things, even though they both have to do with

ending life. According to a leading palliative medicine* textbook, *The Oxford Textbook of Palliative Medicine, Fifth Edition* (2015), “euthanasia is defined as medical administration of life-ending drugs at the patient’s explicit request” (p. 314). The result is the patient’s death. The textbook goes on to clearly define the difference between these two entities. “Physician-assisted suicide (PAS): in contrast to in euthanasia, the doctor is not the final actor in PAS but instead provides medication for the patient to self-administer and overdose of barbiturates that suppress respiration” (p. 314).

In accordance with the law, you are the only person who can request assistance in dying. It cannot be a sudden emotional decision. Firstly, the law only pertains to terminally ill patients deemed, by two physicians, to have a prognosis of less than six months. Your physicians are obligated to determine your ability to think clearly and rule out any treatable causes of your desire to end your life. Undergoing psychological assessment is a prerequisite to further conversation, if there is evidence of a “mental disorder” that may be affecting judgment. Your request has to be made, and documented by your doctor, at least three times on separate occasions: twice made verbally, at least 15 days apart, and the third request must be made in writing. There is the requirement of a private conference between the patient and physician to establish that no one is trying to influence or put any pressure on the patient to make the decision. Furthermore, there are witnesses to be present for the

Culture, Society, and Praxis

written request, and the witnesses must not be involved in the patient's medical care, and at least one of them must not be a relative of the patient. The above is to assure that witnesses do not have an inappropriate interest in the patient's death. It is designed to protect the patient's independence and safety. ("End of Life Option Act," n.d.; Christopher, 2001)

End of life care is an important topic. Palliative care, a type of medical treatment that focuses on improving the patient's quality of life by lessening pain and discomfort (Sprung, Somerville, Radbruch, Steiner Collete, Duttge, Piva, Antonelli, Sulmasy, Lemmens, & Ely, 2018), is without a doubt the least developed field in our country's health care. Pain management, despite the endless array of drugs available, does not work out perfectly for everybody. Physicians can control pain for the majority of people and provide reasonable and acceptable comfort. Yet, there is a group of patients (most often the cancer victims) for whom the pain cannot be controlled fully while they are conscious; therefore, physicians may have to resort to palliative sedation. Palliative sedation is defined as "the monitored use of medications to relieve refractory and unendurable symptoms by inducing varying degrees of unconsciousness-but not death-in patients who, given their disease state, progression, and symptom constellation, are expected to die within hours or days" (Bruce, Hendrix, & Gentry, 2006, p. 324; Cassell & Rich, 2010). Hence, this differs in a very important way from both euthanasia and physician assistance in dying, in that the intent is symptom management, and not death. Death often follows in this situation, but not always, and it is not the goal.

There is another kind of pain that cannot be satisfactorily controlled with medication - psychological pain. Can you imagine being comfortable with no control over your own deteriorating body, with no reasonable chance for recovery, or even temporary

improvement? We do not realize that it actually happens until we experience it first-hand. For example, imagine how you would feel having no control over bodily functions. Imagine urinating or defecating in bed in the middle of the night, and waiting for a caregiver (frequently a complete stranger) to come and clean you up. How would it feel to be aware of the smell and burning of your skin, while lying in a warm sticky mess, imprisoned in your own body, and not being able to clean up? How would it feel to have a stranger change your bed and wipe your most intimate parts clean? How would it feel to experience it day after day until you die? Might it cause legitimate psychological pain? Should one have no choice but to accept it? We should have the basic human right to dignity and independence. We should have the right to end painful humiliation and discomfort if we are of clear mind, and choose to end it by the only way that would achieve it: ending our own life.

Suicide is a word many associate with depression. Depression is a mood disorder manifested in a persistent feeling of sadness and loss of interest. There are ways to treat it, and the End of Life Option Act is not intended for individuals who are suicidal due to depression. People who decide to commit suicide do not seek assistance. They are not concerned with the legal aspects of their act. They will find a way to commit suicide: jump off a bridge, hang themselves, take sleeping pills, cut their wrists, or legally buy a gun and shoot themselves. Suicidal people would not generally come to a doctor and ask for help. If they do, doctors can evaluate their state and provide help. Doctors are trained for this kind of intervention and can forcefully, if necessary, admit suicidal people to a hospital for treatment. The End of Life Option Act is clear on who can seek help from the physician, and people suicidal in the heat of the moment are not eligible ("End of Life Option Act," n.d.).

Culture, Society, and Praxis

The law includes many safeguards against coercion. It obligates physicians to fully inform patients of their treatment options, and it not only gives the patient an ample amount of time and flexibility to make an informed decision, but it specifically requires 15 days between the oral requests to warrant time for rethinking. It allows for a change of heart at any time (“End of Life Option Act,” n.d.). It is not the law’s intent to challenge the religious beliefs of those for whom suicide is a “sin;” they will continue to be free to reject this option. Furthermore, they will never be offered it as an option. To exercise the right to assistance in dying one has to voluntarily,

by one’s own request, initiate the process. Assistance in dying is help in ending unnecessary suffering at the end of life. Assistance in dying harms no one who has no use for it, and it aids the few who otherwise have no better option.

It is an undeniable fact that 100% of us will face our own death. There is no knowing how and when. The End of Life Option Act (see Table 1) is designed to provide a choice for terminally ill who experience unbearable suffering, without a chance of a meaningful recovery, to end life on their terms. It is a purely personal decision.

Footnotes:

*Palliative care may involve physical, spiritual, emotional or legal assistance (“Palliative care,” n.d.). Pain management therapies help patients cope with symptoms and side effects, while talk therapy and support groups provide emotional care. Some palliative care programs offer practical assistance to manage health insurance issues, advanced care directives, and wills and other legal paperwork. At the end of a patient's life, palliative care may be the only treatment available. However, patients can begin palliative care as soon as they are diagnosed with a serious illness.

Table 1: States and their legal documents that legalized assisted dying.

California	2015	End of Life Option Act	https://www.deathwithdignity.org/states/california/
Colorado	2016	Colorado End-of-Life Options Act	https://www.uchealth.org/colorado-end-life-options-act/
District of Columbia	2016	District of Columbia Death with Dignity Act	https://www.deathwithdignity.org/states/district-of-columbia/
Hawaii	2018	Our Care, Our Choice Act	https://www.deathwithdignity.org/states/hawaii/
Maine	2019	Maine Death with Dignity Act	https://www.deathwithdignity.org/states/maine/
New Jersey	2019	Aid in Dying for the Terminally Ill Act	https://www.deathwithdignity.org/states/new-jersey/
Oregon	1994	Oregon's Death with Dignity Act	https://www.deathwithdignity.org/states/oregon/

Vermont	2013	Patient Choice and Control at the End of Life	https://www.deathwithdignity.org/states/vermont/
Washington	2008	Washington Death with Dignity Act	https://www.deathwithdignity.org/states/washington/

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