League of Women Voters of Boulder County February, 2012
Civil Liberties Committee

Right - To - Die
The Ultimate Civil Liberty?

Should you have the right to choose when and how to die?

At the February, 2012 Unit meetings, the Civil Liberties Committee presented information on the right-to-die. The presentation included historical background, explanation of the Oregon Assisted Suicide Law and its limitations, and a survey of laws in other states and countries. End-of-life topics such as advance directives and living wills, hospice's role in dying, and the activities of other organizations involved on both sides of the issue were also covered.

The following Table of Contents provides a list of our documents and their page numbers. If you have any questions, please contact the Chair of the Civil Liberties Committee.

TABLE OF CONTENTS

League of Women Voters of Boulder County February, 2012
Civil Liberties Committee

Background to the Right-to-Die in Western Thought

Although most city-states criminalized it, there is no unified attitude toward suicide in ancient Greek or Roman philosophy. In fact, the attitudes of most philosophers are a little murky. Socrates and Plato pretty much condemn it-- ironic perhaps for Socrates, who was ordered by the state to kill himself. Aristotle vaguely writes that suicide is a wrong to the state. The individual's well-being or human rights aren't considered. The Stoics, on the other hand, held that if the individual can no longer live a flourishing life, suicide may be justified. If physical health is denied the person, ending his life is not immoral. Seneca, who like Socrates was forced to kill himself, writes that a wise person "lives as long as he ought, not as long as he can." It's the quality of life, not the quantity that matters.

Then along came the Christians. Doctrine has held that suicide is immoral although Christian scripture does not condemn it. Augustine could justify the prohibition only by the Fifth Commandment: Thou shalt not kill. Thomas Aquinas' rationale was three-part: Suicide conflicts with natural self-love, it injures the community, and it violates our duty to God. In short, our bodies and our existence do not belong to us, but to the church and state.

Protestant Reformers followed the doctrine of the church they wanted to reform, as they did in the persecution of women as witches. Renaissance thinkers generally followed the churches' lead. Sir Thomas More, however, seems to OK suicide for someone suffering a painful or incurable disease. And Montaigne treats the issue not as a religious concern, but as a personal matter. The first fully thought out defense of suicide was John Donne's *Biathanatos* (c. 1607). He uses Christian thought to conclude that suicide is not immoral. He points out that scripture does not clearly condemn suicide and that Christian doctrine permits [encourages?] martyrdom, capital punishment and wars.

The harsh attitude toward suicide of the Middle Ages was modified in the Enlightenment and through the 19th and 20th centuries by the development of the sciences and of psychology. The suspected chief cause of suicide moved from despair of God's mercy, through alienation from modern life, to clinical depression. The person who commits suicide is thought to be more a victim than a sinner. Suicide has gone from "the devil made me do it" to an unbalance of chemicals in the brain.

In our presentation we wish to consider the desire to end life as a rational decision not involving supernatural beings or requiring happy pills and as an affirmation of the individual's control over his/her existence in its most crucial moment. But how far does this right-to-die extend?

For civil libertarians, individuals enjoy an unqualified right to suicide. The concept of individualism is fundamental to democratic political theory. John Stuart Mill stated that "Over himself, over his own body and mind, the individual is sovereign." Attempts by the state or by the medical profession, including psychiatrists, to interfere with suicidal behavior are an interference with individual freedom. In extreme views this right includes a duty on the part of others to help the individual if assistance is needed.

Inherent in the claim that we enjoy a right to suicide is the belief that we own our bodies and can dispose of them as we see fit. Therefore, others may not interfere with our efforts to end our lives. In addition, we have a right to self-determination and a right to decide those matters most connected to our well-being, including the duration of our lives and circumstances of our deaths. To a civil liberties activist there is no compelling reason why another person or a government should be allowed to circumvent or to end this right.

Sources/Websites of interest:

"Highlights of Historical Thought" on http://plato.stanford.edu/entries/suicide

Definitions

Right-to-die: the idea that a person with a terminal illness should be allowed to commit suicide before death would otherwise occur.

Assisted suicide: voluntary termination of one's own life with the direct or indirect assistance of another. If a doctor is involved, often referred to as physician-assisted suicide.

Euthanasia: action taken to end a person's life in order to relieve their suffering.

League of Women Voters of Boulder County February, 2012
Civil Liberties Committee

State Death With Dignity Legislation

OREGON
The Oregon Death With Dignity legislation (ORS 127.800 to 127.89) was adopted October 27, 1997. It was approved in the November 8, 1994, general election in a tight race with 51.3% in favor. Despite the measure's passage, implementation was tied up in courts for several years.

The Death With Dignity Act allows terminally ill Oregonians to end their lives through the voluntary self-administration of lethal medications, expressly prescribed by a physician for that purpose. Specific conditions of the ordinance are:

- Eligibility: An adult who is capable, is a resident of Oregon, and has been determined by the attending and consulting physician to be suffering from a terminal disease (with six months or less to live), and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner.

No medication to end a patient's life shall be prescribed until it is determined that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

Two witnesses must sign all written requests. One witness shall not be a relative, shall not be entitled to any portion of the person's estate upon death, and shall not own, operate or be employed at a health care facility where the person is a patient or resident.

- Residency: Only requests made by Oregon residents shall be granted. Proof of residency includes but is not limited to: (1) possession of an Oregon driver license, (2) registration to vote in Oregon, (3) evidence that the person owns or leases property in Oregon, or (4) filing of an Oregon tax return for the most recent tax year.

- Immunities for Health Care Providers: No health care provider shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with the ordinance. Any health care provider has the right to refuse to participate without penalty.

- Effect on wills, contracts, insurance or annuity policies: No provision in a contract, will, insurance of annuity policy, or the rate charged, shall be conditioned or affected by the making of a request for medication to end one's life.

As of January 7, 2011, 96 prescriptions for lethal medications had been written under the provisions of the DWDA during 2010, compared to 95 during 2009. Of the 96 patients for whom prescriptions were written during 2010, 59 died from ingesting the medications. In addition, six patients with prescriptions written during previous years ingested the medications and died during 2010 for a total of 65 known 2010 DWDA deaths. Of the 65 patients who died under DWDA in 2010, most (70.8%) were over age 65 years; the median age was 72 years. As in previous years, most were white (100%), well□educated (42.2% had a least a baccalaureate degree), and had cancer (78.5%).

Since the law was passed in 1997, 525 patients have died from ingesting medications prescribed under the Death with Dignity Act. The most frequently mentioned end□of□life concerns are consistently: loss of autonomy, decreasing ability to participate in activities that make life enjoyable, and loss of dignity.

WASHINGTON
The State of Washington's death with dignity act (RCW 70.245) was passed by voter initiative on November 4, 2008, and went into effect March 5, 2009. It is patterned after Oregon's legislation.

Between January 1, 2010, and December 31, 2010, medication was dispensed to 87 participants. Of the 87 participants in 2010, 72 individuals have died; 51 of these people died after ingesting the medication. The legislation was in effect in 2009 for less than ten months. The total number of participants in 2009 is 65.

MONTANA
In 2008, Judge Judy McCarter wrote that "the Montana constitutional rights of individual privacy and human dignity" give a mentally competent person who is terminally ill the right to "die with dignity." The ruling said that those patients had the right to obtain self-administered medications to hasten death if they found their suffering to be unbearable, and that physicians could prescribe such medication without fear of prosecution.

On December 31, the Supreme Court ruled 5-2 for the legal right to assisted suicide, making Montana the third state that gives physicians the freedom to prescribe drugs to mentally competent, terminally ill patients without fear of prosecution. No appeal is now possible. The state's supreme court did not take a stand on whether the right is a constitutional one, leaving that to lawmakers.

In the 2011 State legislative session, two bills were introduced in the State Senate. Senate Bill 167 would have codified the bounds of the Supreme Court's 2009 decision. It was tabled by the Judiciary Committee, missed the deadline for general bill transmittal and died. Senate Bill 116 would have prohibited physician assisted suicide by banning physicians from prescribing life-ending medication to terminally ill, mentally competent

adults. The Judiciary Committee tabled the bill, and the sponsor pulled the bill to the House for a vote on February 17, 2011, where it was defeated 35-15. In the absence of any state legislation, there is no statistical data available on the number of patients using self-administered medications to hasten death.

GEORGIA

Georgia became the fourth state to legalize physician assisted suicide in a decision by the State Supreme Court in November 2011. Interpretation of the statute, section 16-5-5, by the Court says that the statute was carefully and intentionally drafted to protect the privacy of a patient' s decision, when made privately in consultation with his doctor, to end his or her life.

The State Attorney General says the law prohibits assisted suicide only in a case where the suspect publicly advertises, offers, or holds out that he will assist in a suicide. So long as a doctor does not make any public statement about his availability to participate in physician assisted suicide, the doctor has not violated the law of Georgia by writing prescriptions for lethal doses of drugs to enable patients to decide to die at the time of their own choosing.

In enacting this statute, the legislature considered banning assisted suicide in all circumstances, but ultimately determined that criminalizing all assistance of suicide would encroach upon the liberty rights of individuals to make medical decisions for themselves with their families and physicians.

VERMONT

On February 17, 2011, Representative Donna Sweaney introduced Death with Dignity legislation (House Bill 0274) to the Vermont House of Representatives for consideration during the 2011 session. Demonstrating the strong and broad base of support for the new bill, Representative Sweaney has been joined by 42 co-sponsors. Vermont's proposed legislation emulates the Oregon and Washington Death with Dignity Acts. A similar bill (Senate bill 0103) has been introduced in the Senate. Both bills are still in committee.

It is expected that the bills currently in committee will be acted on in 2012.

MASSACHUSETTS

A petition drive initiated by Dignity 2012 to pass the next death with dignity act is currently underway in Massachusetts. Petitioners must collect 68,911 voter signatures by late November. The initiative is then sent to the legislature for consideration. If the legislature chooses not to act on the proposal, additional signatures must be gathered before the question is sent to the voters in November. According to an online, non-scientific poll when the initiative proposal was filed, over 70% of the 643 respondents indicated they would vote for this initiative.

League of Women Voters of Boulder County February, 2012
Civil Liberties Committee

ASSISTED SUICIDE LAWS BY STATE
11/27/11

Two states have passed legislation permitting physician-assisted suicide:
Oregon and Washington

Two state Supreme Courts have said that citizens of their states have the right to assisted suicide:
Georgia and Montana

One state says assisted suicide is against public policy but not a crime:
Ohio

Thirty-seven states have statutes explicitly criminalizing assisted suicide:
Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Virginia, Wisconsin

Five states criminalize assisted suicide through common law:
Alabama, Massachusetts, North Carolina, Vermont, West Virginia

Three states have abolished the common law of crimes and do not have statutes criminalizing assisted suicide:
Nevada, Utah, Wyoming

Sources: www.patientsrightscouncil.org/site/assisted-suicide-state-laws/ 9/23/11
Right to Die Digest, Vol 17, Issue 176

International

Physician-assisted suicide is legal in the Netherlands, Belgium, Switzerland and Luxembourg. Except for Switzerland, the laws confine the procedure to residents only, and under strict conditions. Switzerland alone allows foreigners to come for hastened death, provided it is altruistic, not profit-making nor of evil intent.

NETHERLANDS
The Termination of Life on Request and Assisted Suicide Act took effect on April 1, 2002. It legalizes euthanasia and physician assisted suicide in very specific cases, under very specific circumstances. The procedures codified in the law had been a convention of the Dutch medical community for over twenty years.

The law allows medical review board to suspend prosecution of doctors who performed euthanasia when each of the following conditions is fulfilled:

- The patient's suffering is unbearable with no prospect of improvement
- The patient's request for euthanasia must be voluntary and persist over time (the request cannot be granted when under the influence of others, psychological illness or drugs)
- The patient must be fully aware of his/her condition, prospects and options
- There must be consultation with at least one other independent doctor who needs to confirm the conditions mentioned above
- The death must be carried out in a medically appropriate fashion by the doctor or patient, in which case the doctor must be present
- The patient is a least 12 years old (patients between 12 and 16 years of age require the consent of their parents)

The doctor must also report the cause of death to the municipal coroner in accordance with the relevant provisions of the Burial and Cremation Act. A regional review committee assesses whether a case of termination of life on request or assisted suicide complies with the due care criteria.

In February 2010 a citizens' initial called Out of Free Will further demanded that all Dutch people over 70 who feel tired of life should have the right to professional help in ending it. They have started collecting signatures in support of this proposed change in Dutch legislation, hoping to place the matter firmly on the parliamentarian agenda.

BELGIUM
The legislation in Belgium is largely patterned on that of the Netherlands. It came into effect on September 23, 2002. When the legislation passed, Belgium became the second country after the Netherlands to vote to legalize euthanasia and assisted suicide.

The legislation states that the patient must request to die, the suffering must be unbearable, and the clinical course hopeless. An independent physician must be consulted, and a third physician must be brought in for non-terminal cases. The patient must be a resident of Belgium, though not necessarily a citizen.

LUXEMBOURG
On February 19, 2008, the Parliament of Grand Duchy of Luxembourg approved the bill Errr/Huss on de-criminalization of euthanasia. Luxembourg is the third EU country allowing doctors to help patients end their own lives.

The parliament passed the bill with only a slim majority with 30 out of 59 lawmakers voting in favor. According to the bill, euthanasia will be strictly regulated and can be mentioned in a "living will." Doctors will have to consult with a colleague to confirm that the person is suffering from a "grave and incurable condition." A national commission made up mainly of doctors and officials verifies on a case-by-case basis that all legal conditions and procedures are respected.

SWITZERLAND
Assisted suicide has been legal in Switzerland since 1941. Assisted suicide in Switzerland need not be performed by a medical doctor. It can be performed by a non-physician with no vested interest in the death. All assisted suicides in Switzerland are video-taped. Two right-to-die organizations (both called EXIT) in Switzerland help only their own members to die, but DIGNITAS will help foreign visitors to die in cases which they feel justified because of the terminal suffering. The person must be a competent adult.

Dignitas is a Swiss assisted dying group that helps those with terminal illness and severe physical and mental illnesses to die assisted by qualified doctor and nurses. Additionally, they provide assisted suicide for people provided that they are of sound judgment and submit to an in-depth medical report prepared by a psychiatrist that establishes the patient's condition as fulfilling the specifications of the Federal Court of Switzerland.

Swiss law on assisted suicide clearly states that people who assist in an assisted suicide can only be prosecuted if they are motivated by self interest, an important legal point. As a result, Dignitas ensures that it acts as an entirely neutral party by proving that aside from non-recurring fees, they have absolutely nothing whatsoever to gain from the deaths of its members.

Legally admissible proof that the person wishes to die is created including a signed affidavit, countersigned by independent witnesses. In cases where a person is physically unable to sign a document, a short video film of the person is made in which they are asked t confirm their identity, that they wish to die, and that their decision is made of their own free will, without any form of coercion.

Dignitas has been highly criticized for creating "suicide tourism." It has over time been forced to move and refused the use of facilities to conduct their business. However, while there is concern about the number of foreigners coming to Zurich to die, efforts to restrict legally assisted suicides to only Zurich residents failed in 2011.

Drugs

Netherland: Sedative sodium thiopental is intravenously administered to induce a coma. Once it is certain that the patient is in a deep come, Pancuronium is administered to stop the breathing and cause death.

Dignitas: An oral dose of an anti-emetic drug, followed approximately 30 minutes later by a lethal overdose of powdered Nembutal. Death is caused by respiratory arrest, which occurs within 30 minutes of ingesting the Nembutal.

League of Women Voters of Boulder County February, 2012
Civil Liberties Committee

Advance Health Directives

If you want a say in your medical care, even when you are incapacitated, in a coma etc, you should put your wishes down on paper. Karen Ann Quinlan (1975) and Terri Schiavo (1998) were both young women in comas, a "persistent vegetative state". When Karen's parents and Schiavo's husband wanted to remove them from life support, the legal battles that ensued lasted for years. These cases highlight the need for "advance health directives" especially since, in Colorado, the spouse is not automatically presumed to have the right to make medical decisions for an incapacitated spouse.

In 1990 the US Supreme Court ruled that competent persons have the constitutional right to refuse heroic medical treatment. However states can require clear and convincing proof of a patient's intent before allowing life-support systems to be removed.

Advance Health Directives are usually Living Wills and Durable Medical Power of Attorney forms but also include Do-Not-Resuscitate orders and can translate into a new Colorado form "MOST - Medical Orders for Scope of Treatment". All of these forms are available from your attorney, the Internet, health care providers, and stores that sell legal forms. If you are religious, you may want to consult with your priest or minister to see what end-of-life choices are compatible with your denomination.

A Living Will is a legal document that a person uses to make known his or her wishes regarding life prolonging medical treatments. It is important to have a living will as it informs your health care providers and your family about your desires for medical treatment in the event you are not able to speak for yourself. In the Living Will, you indicate which treatments you do or do not want applied to you in the event you either suffer from a terminal illness or are in a permanent vegetative state. A living will does not become effective unless you are incapacitated; until then you'll be able to say what treatments you do or don't want. They usually require a certification by your doctor and another doctor that you are either suffering from a terminal illness or permanently unconscious before they become effective as well. This means that if you suffer a heart attack, for example, but otherwise do not have any terminal illness and are not permanently unconscious, a living will does not have any effect. You would still be resuscitated, even if you had a living will indicating that you don't want life prolonging procedures. A living will is only used when your ultimate recovery is hopeless. (based on article by Rebecca Berlin on www.allLaw.com)

A Durable Medical Power of Attorney appoints someone else to make health care decisions for you when you are incapacitated. This document could prevent a legal fight like that, which occurred in the Terri Schiavo case. It is important to discuss your health care wishes with the person to whom you grant the power-of-attorney. Also it is

recommended that you tell all your family who you have appointed as power-of-attorney and why.

A Do-Not-Resuscitate (DNR) order is another kind of advance directive. A DNR is a request not to have cardiopulmonary resuscitation (CPR) if your heart stops or if you stop breathing. (Unless given other instructions, hospital staff will try to help all patients whose heart has stopped or who have stopped breathing.)

MOST - Medical Orders for Scope of Treatment is a Doctor's order that accompanies patients as they go through different healthcare services (hospital, nursing home, etc.). The MOST form is completed by the Doctor, the patient, and (if applicable) the person with the medical power-of-attorney. The form is designed to be used by people who already have a life-limiting condition and are in frequent contact with healthcare services. MOST will overrule prior directives when they specifically conflict.

Religious hospitals follow church directives. You may be in a religious hospital even if you are not a member of that faith (i.e. if you have Kaiser health insurance in Boulder County you will go to a Catholic hospital). Depending on your condition and how the hospital interprets the church directives, your living will and the wishes of the person granted your medical power-of-attorney may not be followed. Under Colorado law you have the right to be moved to a hospital that will honor your end-of-life-wishes.

Sources/Websites of interest:

"A Catholic Guide to End-of-Life Decisions",
www.ncbcenter.org/NetCommunity/Page.aspx?pid=347

League of Women Voters of Boulder County February, 2012
Civil Liberties Committee

Hospice

Hospice provides end-of-life care for those who are no longer seeking a cure or treatment for their underlying disease. Hospice care services are provided by a team of health care professionals who maximize comfort for a terminally ill person by reducing pain and addressing physical, psychological, social and spiritual needs.

Generally to use Hospice, a Doctor must state that you have 6 months or less to live. You can receive hospice care for as long as you need it. Some hospices have a palliative care program for those with less than a year to live (whether it's illness or age-related) who are homebound and require skilled nursing.

Medicare and insurance companies will often cover hospice care. There are 15 hospice organizations in Boulder County and over 40 in the Denver metropolitan area. Their philosophy, level of care and resources vary.

Compassion and Choices of Boulder County (www.choicesboulder.org) and HospiceCare of Boulder and Broomfield Counties (www.HospiceCareOnline.org) have information on choosing a hospice.

Sources/Websites of interest: www.HospiceCareOnline.org

League of Women Voters of Boulder County February, 2012
Civil Liberties Committee

Compassion and Choices

Compassion and Choices (C&C) is a non-profit organization dedicated to education regarding end-of-life issues and choices in dying.

Compassion and Choices says "We believe that "in a free society it is a fundamental right to choose the time and manner of one's death. The right to choose the course of one's death is as fundamental as the right to choose the course of one's life. Our vision, therefore, in a free society, is to support choices in dying, including physician aid in dying."

C&C believes that only the individual, not the government, religious institutions or medical associations, has the right to choose the course and manner of one's death. They feel that no one should be forced to go through a long, painful death. C&C supports hospice programs which provide support to dying patients.

They discourage suicide for emotional reasons in the absence of terminal illness and support the work of suicide prevention organizations.

In 2006 the Colorado Compassion and Choices helped get legislation passed that grants immunity to medical caregivers who unintentionally cause the death of a terminally ill patent as a result of efforts to relieve the patient's pain.

In addition to political activism, C&C, will assist in end-of-life decision-making. This includes information on advance directives, help in navigating the health care system, education on pain and symptom management, patient advocacy and information about aid in dying.

C&C believes that at the end of life, you have choices including: staying home or moving to a healthcare facility, receiving hospice care, stopping all life-sustaining treatments, understanding and accepting the "double effect" of pain medication, and stopping eating and drinking.

Sources/Websites of interest:

www.choicesboulder.org
www.compassionandchoices.org

League of Women Voters of Boulder County February, 2012
Civil Liberties Committee

Final Exit Network

In 1980 the Hemlock Society was founded by Derek Humphry. The society fought for voluntary euthanasia and physician-assisted suicide to be made legal for terminally and hopelessly ill adults. In 2004 organizational differences within the Hemlock Society caused the group to split into two different organizations, Final Exit Network (FEN), and Compassion and Choices.

Final Exit's guiding principle states that, "Mentally competent adults have a basic human right to end their lives when they suffer from a fatal or irreversible illness or intractable pain, when their quality of life is personally unacceptable, and the future holds only hopelessness and misery. Such a right shall be an individual choice, including the timing and companion, free of any restrictions by the law, clergy, medical profession, even friends and relatives no matter how well intentioned. We do not encourage anyone to end their life, do not provide the means to do so, and do not actively assist in a person's death. We do, however, support any member who requests it when medical circumstances warrant their decision."

Final Exit provides information, counseling and home visits for individuals who are suffering from incurable conditions which cause intolerable suffering. For qualified people, they will assign a counselor who will advise on methods of suicide. If desired, this counselor will be present at the suicide (but will not assist).

Final Exit Network will help individuals who are not "terminally ill", that is, they have more than 6 months to live. They will serve many that have neurological diseases such as ALS, Parkinson's, Huntington's, MS, respiratory diseases and so on. Because the law requires that FEN must work with a mentally competent adult who is capable of providing the means for self-deliverance and carrying out the act, they can only help Alzheimer's patients in the early stages of dementia. There may still be quality of life left at that point but when competence is lost the Network would not be able to provide the information and support necessary for the member to carry out self-deliverance.

FEN supports research into other peaceful means for self-deliverance, and are committed to advocate for members whose advance directives are not being honored.

Sources/Websites of interest:

Humphry, Derek: *Final Exit: The Practicalities of Self-Deliverance & Assisted Suicide for the Dying.*

www.finalexitnetwork.org

League of Women Voters of Boulder County February, 2012
Civil Liberties Committee

End of Life Choices with Alzheimer's

Currently, in this country, there are about 100,000 individuals in the advanced stages of Alzheimer's. Some would not have wanted to live to that point. These are things that can be done:

1. Give thought to the conditions under which you would want your life to continue. Write these down in your advance directive, discuss them in detail with your loved ones to make sure they understand, discuss them with your doctors.

2. There is an advance directive for Alzheimer's. It is called "My Last Wish" and is available on the ERGO web site (www.finalexit.org/ergo-store/) The first part, stating which treatments you would not want to have, is legally enforceable but it must be discussed beforehand with the person(s) designated to be your power of attorney for health care. The second part, which asks that your life not be prolonged if you have certain symptoms which you can indicate, must also be discussed but serves more as a guideline and a statement of your wishes

3. If you feel that self-deliverance may be an option for you can contact Final Exit Network for further assistance.

4. If you do not want to end your life by self-deliverance, you might consider making a clear, written statement about the circumstances under which you would not want to be kept alive by any artificial means including antibiotics, hospitalization, artificial food and hydration, ventilation, dialysis, etc.

5. Some people who chose to hasten the dying process decide not to eat and drink. This will lead to death in about two weeks. If this is an acceptable option you should be getting care from a hospice to make sure you have access to medications and good comfort care.

6. When dementia progresses often a person cannot feed themselves. You can state in advance that you do want to be fed but with no insistence or cajoling. If you do not eat when the food is presented it should be removed. It is helpful for the facility you are in to have this policy in writing so they will not be accused of neglect if you die as a result.

The Final Exit Network strongly encourages a person to think through -- and maybe talk through with closest friends -- a personal strategy for dealing with the possible onset of dementia. The Network can only help if there is a clearly defined individual plan for dealing with this type of illness.

Sources/Websites of interest: www.finalexit.org

League of Women Voters of Boulder County February, 2012
Civil Liberties Committee

Euthanasia

Euthanasia is also known as "mercy killing". A mentally competent patient who is suffering and has no practical hope of recovery asks a Doctor for an injection that will end the patient's life. This procedure is legal in the Netherlands, Belgium and Luxembourg. Except for refusing nourishment, this is the only means of hastening death for people who are physically incapable of suicide.

With Physician Assisted Suicide, a patient must be mentally competent and physically able to take the lethal medication. In cases of degenerative diseases, like ALS, a patient has to take the drug while he or she is still able to swallow. Their lives could be prolonged if they knew they could ask a Doctor to administer the lethal medication after they became incapable of doing it themselves.

In January, 2012, the Council of Europe passed a non-binding resolution that euthanasia should be banned in Europe.

League of Women Voters of Boulder County February, 2012
Civil Liberties Committee

Arguments For and Against Assisted Suicide

Arguments in Favor:

The right-to die is a basic human right and a basic civil liberty.

Assisted suicide is a way to relieve pain and suffering.

Having physician-prescribed medication gives the terminally ill comfort in knowing that, if their condition worsens, they have the means to end their lives.

People can wait longer before ending their lives when they have legally prescribed medication on hand.

It is not all that easy to accomplish the act of committing unassisted suicide, especially in a way that does not cause your family more anguish.

Legalization of assisted suicide does not lessen the provision of good palliative care.

Legalization of assisted suicide does not increase the overall rate of suicide.

Arguments Opposed:

There is a redemptive power of suffering, it is part of God's plan.

The period of dying gives people time to make peace with their family, friends and God.

Assisted suicide for the terminally ill is on a slippery slope to assisted suicide for everyone and euthanasia.

If assisted suicide is legal, the terminally ill and elderly will feel like they have a duty to die.

Assisted suicide may be abused by those who stand to gain financially.

Health care providers may cap benefits to terminally ill patients if assisted suicide is legal.

Society may be more likely to accept assisted suicide for disabled people rather than to meet their needs for living fulfilling and meaningful lives.

A person may die prematurely with assisted suicide if underlying illness was misdiagnosed.

Sources/Websites of interest:

To sign up for newsletters on right-to-die issues:
http://lists.opn.org/mailman/listinfo/right-to-die_lists.opn.org

Organization opposed to assisted suicide:
www.nightingalealliance.org