

## Should the Right to Aid in Dying Include a Right to Euthanasia?

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Health Canada, [2nd Interim Report on Medical Assistance in Dying in Canada](#) (2017).

As more and more states legalize physician aid in dying, it appears that the acceptability of aid in dying turns on three critical requirements—that the patients be competent to make medical decisions, that they be terminally ill, and that they self-administer the lethal dose of medication. From Oregon to Hawaii, every state that has legalized aid in dying has included these three criteria for eligibility. But a report from Canada on that country's experience with aid in dying suggests that only two of the three requirements may be needed.

The three basic requirements help ensure that patients really are suffering from a serious illness that is incurable and irreversible. They also help ensure that the desire for aid in dying reflects a genuine expression of self-determination rather than the irrational choice of someone suffering from mental illness. Controversial cases of aid in dying have involved patients who were no longer able to express their wishes or who appeared to need psychiatric care.

Like Oregon and other states, Canada restricts aid in dying to adults who possess decision-making capacity and who are terminally ill, though Canada has a different definition of terminal illness (the patient's death must be "reasonably foreseeable" rather than expected within six months). But Canada allows physicians and nurse practitioners to administer the lethal dose rather than requiring self-administration. And in the government's most recent report on the country's experience with aid in dying, health practitioners administered the medication in virtually all cases. Self-administration occurred in only 5 out of the 1,382 cases that were included in the report. (The Netherlands reports similar data—in 2015, physician-administration outnumbered self-administration by 829 to 22.)

We don't know exactly why so few cases involve self-administration, but the Canadian report suggests a number of factors—many physicians and nurses "are less comfortable with self-administration due to concerns around the ability of the patient to effectively self-administer the series of medications, and the complications that may ensue." As a result, aid in dying protocols at some health institutions do not encourage self-administration. And in Quebec, the end-of-life legislation only permits provider-administered assisted dying. Also, in some communities, it can be difficult for patients to obtain the drugs needed for self-administration.

A family report from California elaborates on the concern about the ability of patients to self-administer the series of aid in dying medications. A niece described the challenges associated with emptying the contents of 100 capsules of secobarbital into her aunt's final cup.

Physician or nurse-administration also addresses another important concern with a requirement of self-administration—some mentally competent, terminally ill patients may not be physically able to self-administer their lethal dose, as in the case of patients who suffer from ALS. If the purpose of aid in dying is to provide relief from the suffering at the end of life, why should access to aid in dying turn on the ability to self-administer?

I've observed before that the requirement of a terminal illness provides a critical protection against misuse of aid in dying. When one considers the controversies over particular aid in dying cases in the Netherlands and Belgium, as well as over particular illicit aid in dying cases in the United States, they typically involve patients who were not terminally ill. Illustrative examples include [Jack Kevorkian and the woman with chronic pelvic pain](#) or the Belgian woman featured in a [New Yorker article](#) who suffered from chronic depression.

The requirement of mental capacity also is an important safeguard. It makes it much less likely that aid in dying will reflect the wishes of family members or physicians rather than of the patients themselves.

Does the requirement of self-administration add another important layer of protection against abuse? For example, by resting full control in the hands of the patients, does self-administration better ensure that the choice of aid in dying is truly the patient's choice? The patient with some ambivalence may be more likely to hesitate with self-administration than to stop the physician who is assigned to administer. It would be useful to know if there are cases in the United States or other countries where the patient had scheduled a self-administration and then called it off and how often that happens compared to cases in which the patient scheduled a physician or nurse-administration and then called it off.

In the past, proposals for physician-administration have not fared well in the United States. Ballot initiatives that included both self-administration and physician-administration failed in Washington in 1991 and California in 1992 before Oregon's successful ballot initiative for self-administration in 1994. It will be helpful to see how aid in dying plays out in Canada over the coming years and whether the Canadian experience suggests that states in the United States can feel comfortable with the administration of lethal medication by physicians or nurses.

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