## End of Life Liberty in DC

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JURIST Guest Columnist [Kathryn L. Tucker](http://www.cascadianow.org/end-of-life-liberty-project/) Executive Director of End of Life Liberty Project (ELLP) discusses the Death with Dignity Act adopted by DC...



© *[WikiMedia (U.S. Navy photo by Photographer’s Mate 2nd Class Timothy Comerford)](https://commons.wikimedia.org/wiki/File%3AUS_Navy_030117-N-5996C-003_One_of_four_intensive_care_units_%28ICU%29_aboard_Comfort.jpg%22%20%5Ct%20%22_new)*

The Death with Dignity Act adopted by the DC City Council in November 2016, establishes statutory permission for [aid in dying (AID)](https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/29/13/28/patients-rights-to-self-determination-at-the-end-of-life), the practice whereby a physician provides a mentally competent terminally ill patient with a prescription for medication that the patient can ingest to achieve a peaceful death. DC is the sixth jurisdiction to adopt such a law, following [Oregon](https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ors.aspx), [Washington](http://apps.leg.wa.gov/rcw/default.aspx?cite=70.245), [Vermont](http://legislature.vermont.gov/statutes/fullchapter/18/113), California, and Colorado. Montana permits the practice by decision of the Montana Supreme Court, in [*Baxter v. Montana*](https://scholar.google.com/scholar_case?case=1689304237166933790). Thus, with the DC enactment, a total of 7 US jurisdictions openly permit the practice of AID.

Because bills proposing permitting AID routinely face arguments of insufficient "safeguards", proponents of these measure embrace a 'throw in the kitchen sink' approach: drafting measures thick with "safeguards". The many burdens and restrictions imposed by these statutes include, among others:

* Patients electing AID must make at least three requests, two oral and one written.
* The requests must be witnessed.
* A second opinion confirming diagnosis and prognosis is required.
* A mental health specialist must be consulted if the attending or consulting physician has concerns regarding the patient's ability to make an informed decision.
* A minimum fifteen-day waiting period must elapse between the two oral requests.
* Physicians must collect and report a vast amount of demographic data on who chooses AID and why.

While in some ways these enactments are a step toward expanding end of life liberty, they impose heavy governmental intrusion into the practice of medicine, which is concerning because it creates barriers to patient access and to physician participation. Oregon's experience as the first state with an AID statute has been closely watched and studied. The State collects and publishes data in an annual report about aid in dying, and a [plethora of articles](http://heinonline.org/HOL/LandingPage?handle=hein.journals/whitlr33&div=8&id=&page=) examining and discussing the data have been published in journals of law, medicine, and health policy. In light of nearly 20 years of practice in Oregon demonstrating that no harm arises when AID is openly available, it would be appropriate for the practice to evolve to a more normalized status within the practice of medicine. This was contemplated in the Vermont Statute enacted in 2013, the third state to adopt an AID statute—and the first to do so via the traditional legislative process. As initially adopted, Vermont's law would have modeled Oregon's for a period of three years, after which nearly all regulation would sunset, leaving a [clear safe harbor](http://lawreview.vermontlaw.edu/wp-content/uploads/2014/05/05-TuckerG.pdf) for physicians to practice aid in dying in conformity with standard of care. This reflected a positive step in the direction of normalizing AID within the practice of medicine. Medicine is not routinely governed by statute but, rather, by the [type of care that a competent health care professional would render in similar circumstances](http://www.sciencedirect.com/science/article/pii/S0012369212604085)—referred to as [standard of care or best practice](http://www.suffolk.edu/documents/Law%20Journal%20of%20H%20and%20B/Tucker-2-19.pdf). This progressive aspect of Vermont's law was short-lived: it was [repealed](http://legislature.vermont.gov/bill/status/2016/S.108) in 2015. Accordingly, Vermont's statute remains nearly identical to those in other states and, most recently, DC. In Montana, where AID is practiced not subject to statute but, in the wake of the Baxter decision, has been practiced subject to standard of care, no untoward result has occurred.

It is unfortunate that modern enactments, including the DC Death with Dignity Act, are not moving in the direction of normalizing AID within the practice of medicine, and allowing best practices to determine what makes sense for waiting periods and other aspects relating to patient access.

Take for example the fifteen-day waiting period in the statutory permissions. This is unreasonably long. A shorter period could ensure that a patient's choice is reflective, carefully considered and enduring. For example, consider the plight of [Angie Bloomquist](http://www.latimes.com/local/great-reads/la-me-c1-assisted-death-20150519-story.html), dying of ALS. Her illness had progressed to the point where she had lost the ability to move any part of her body other than her eyeballs. She communicated by eye gaze computer, and expressed her desire for a more peaceful death through aid in dying. Patients choosing AID do so because they find themselves in an unbearable dying process, concluding that the cumulative burden of suffering imposed by their end stage terminal illness is overwhelming. Forcing them to suffer longer seems unjustifiable. Moreover, some of these patients will be forever denied the right to choose aid in dying due to a rigid statutorily imposed fifteen-day waiting period, as they will die or become incapable of self-administration of the medication during that long period. If the practice of AID were to evolve subject to best practices, it is likely that a much shorter period for reflection would become standard of care.

Other elements of the statutory permissions for AID are problematic. For instance, they require patients seeking AID to make a written request in addition to two oral requests separated by a fifteen-day waiting period before the prescription can be provided. Patients must also see a consulting physician who must confirm a patient's diagnosis, prognosis, and mental competence. These provisions delay when a patient can access AID. Delays operate to either deter some patients from seeking AID or prevent them from using it given the terminal and progressive nature of their illnesses. Fewer requests in order to access AID, as well as allowing the assessment of an attending physician to be sufficient in determining the diagnosis, prognosis, and mental competence of a patient, might well be appropriate and should be considered in future enactments. Ideally, future enactments ought leave such to evolving standard of care and best practices.

Those who believe it is the individual who ought be vested with the autonomy to make their own informed decisions about profoundly personal matters involving their own body, life course and medical treatment will applaud such evolution.

Kathryn L. Tucker, a graduate of Georgetown University Law School and Hampshire College, is Executive Director of the End of Life Liberty Project (ELLP), which she founded during her tenure as Executive Director of the Disability Rights Legal Center (DRLC), the nation’s oldest disability rights advocacy organization. Ms. Tucker also handles state constitutional litigation asserting claims of a similar nature, including Baxter v. Montana that established the right to choose aid in dying as a matter of state law. She currently is handling similar cases in New York and California.

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