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Death and Dignity: Approaches to Medical Aid-in-Dying and Recommendations for Nevada

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Death and Dignity:

Approaches to Medical Aid-in-Dying and Recommendations for
Nevada

Cecilia Winchell
December 2022

Abstract

Advancements in medicine, surgery, and treatment have prolonged life spans in a way that presents new considerations for death and dying. When it comes to terminal illnesses, all of these innovations increase life expectancy but cannot do the same for a patient's quality of life. In fact, many people with terminal illnesses lose their autonomy and dignity, leading to the emergence of assisted dying as a way to provide terminally ill patients with an alternative to palliative care. This report takes a look at how assisted dying has developed within the US over the past two and a half decades, including the formal procedure as well as legal battles and public perception. Central to these considerations is the Oregon model of medical aid in dying that began assisted dying policy in the US and has influenced policy implementation in the states that have followed. Qualitative analysis is used to show how the policy balances personal autonomy with barriers to access. By evaluating the results of its implementation in eleven jurisdictions around the country, this report will conclude with recommendations for the future of the policy both within Nevada as well as the broader US.

Table of Contents

Introduction	2
Background	3
Historical Developments	3
Introduction to the United States.....	4
International Precedence.....	7
Present Use.....	10
Nevada Action.....	15
Contextualization	16
Attitudes and Stigma.....	16
Policy Concerns	17
The Case for MAID.....	20
Policy Recommendations	21
References	24

I. Introduction

Innovations in the medical field have given people more autonomy than ever in choosing how they can mitigate pain and fight diseases. This has been no less the case in end-of-life scenarios, where advancements in both public health and private treatment have dramatically prolonged lifespans. Over the course of the twentieth century, life expectancy in the United States increased by 28 years, and the changes in sanitation and public health that fueled such trends during the first half of the century would eventually lead to the dominance of more personal ailments such as heart disease, cancer, and stroke during the second half of the century (Cassel, 1992). Though the elimination of these diseases is not possible, prolonging the rate at which they kill is and has been the major driver in increasing life expectancy in recent decades. Palliative care has seen great success in mitigating pain and managing symptoms associated with terminal illnesses; however, it has also fueled a wide and ongoing discussion regarding the complexities between increased life expectancy and decreased quality of life.

In the midst of these discussions, the past few decades have seen the emergence of medical aid in dying (MAID), a procedure by which patients have the option to expedite the dying process. While MAID is sometimes associated with euthanasia, a process by which a medical official administers the fatal medication, it need not be. Most US iterations of assisted dying have been modeled after Oregon's policy, where MAID procedure emphasizes the patient's autonomy in choosing to end their own life through the requirement of self-administration. This means that a patient must be the one to ingest their medicine rather than a doctor injecting a patient.

Though policies vary from place to place, general guidelines require potential candidates to be mentally capable adults with a prognosis of six months or less to live. There is also an important distinction to be made with suicide as candidates who look to MAID consider themselves as having a rational desire to die as a consequence of fateful circumstances beyond reconciliation.

Federal outlook on MAID has chosen to leave each state to make its own decision on the matter. As of this writing, there are currently eleven jurisdictions including Oregon, Washington, Montana, Vermont, California, Colorado, Hawai'i, New Jersey, Maine, and New Mexico, as well as the District of Columbia that have permit MAID (Compassion and Choices, n.d.). Legislatures

in many other states continue to be in deliberation over the matter, Nevada included, but have not yet reached a consensus. As the aging US population grows over the next few decades, it is more important than ever to be able to give another option to those faced with making tough decisions at the end of their life.

The goal of this report is to take a closer look at MAID policy including everything from its origins to its current use. I will be examining both the concerns and benefits that follow, as well as comparing national and international approaches that have been enacted so far. Special attention will be paid to the Oregon model of MAID that has influenced iterations of the policy in other states and how it balances personal choice with regulative restrictions. Furthermore, annual data since 1997 depicts several trends worth noting when it comes to accessing MAID. Of these trends, the most notable is its continual rise in use each year which makes awareness of the topic ever the more pressing.

II. Background

Historical Developments

Western attitudes towards death can be most notably traced back to Ancient Greece, when dying a “good death” meant a painless exit after a flourishing life. In cases where doctors had to become involved, those from the Hippocratic School of Medicine were trusted for the oath they took as doctors to do no harm. Although the modern interpretation of the Hippocratic Oath is akin to a professional code of ethics, the ancient Greeks understood the signification of the oath as guaranteeing a reputable doctor as opposed to a criminal one (Van Hooff, 2004). In fact, in Hippocratic medicine, doctors served more as “observer than therapist,” distinguishing incurable and curable diseases from each other before deciding whether to take on a case or not (Van Hooff, 2004). Numerous Hippocratic prescriptions warned doctors of the limitations of medicine and that trying to treat incurable diseases would only prolong suffering and create false hope (Cowley, 1992). These doctors of antiquity did not put themselves in the moral position of deciding death; rather, they served as an instrument, leaving the patient to act as the ultimate agent, similar to today’s self-administration requirement (Van Hooff, 2004). This emphasis on voluntary death with the patient’s autonomy at the center of any decision would go on to become a vital component of most modern interpretations of assisted dying.

During the Middle Ages, new attitudes toward dying began to form as Christianity, the Renaissance, and the Enlightenment contributed to a reverence towards life and the ability to preserve it. While Christian faith may have dampened scientific inquiry, followers strongly believed in God to make life and death decisions, without interference from physicians (Cowley, 1992). While there was considerable diversity of thought among Enlightenment thinkers, ones such as John Locke would formulate a version of ethics based on rights—most relevant to this discussion the right to life—that is still used today as a rational justification against assisted dying policies. Arguments claim that since everyone has a right to life, assisted dying would be taking away that right and thus be illegal.

Medical advances beginning in the nineteenth century took the first steps towards improved treatment and better outcomes, but attention was still focused on curing curable illnesses rather than prolonging death from incurable illnesses, negating the need for serious ethical questions (Cowley, 1992). Doctors were still severely limited in how much they could do for a patient suffering from a terminal illness.

The modern era ushered in new drugs and treatments that have been able to successfully extend lifespans and mitigate pain. Kidney failure that would have been fatal in the nineteenth century could now be prolonged through dialysis. The success of such innovations has not gone unquestioned though, and the two major trends in history described above reflect the current debate on the subject, whether medicine should focus on what is curable or preserve life for as long as possible.

Introduction to the United States

Assisted dying has been a contentious topic within the US since the 1990s, leading to a range of ethical discussions on the sanctity of life and normative discussions on how doctors should be involved with such decisions. During the '90s, a series of high-profile public stories captured the attention of the public such as the case of Jack Kevorkian and the New York Times bestseller *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying*, a practical

guide written by Derek Humphrey for terminally ill people who wished to end their lives (Pope, 2018).

This set the stage for Oregon's ballot measure in the November 1994 election where the citizens of Oregon approved Measure 16 by a vote of 51 to 49 (Pope, 2018). Oregon would become the model as the first state to pass a statute regarding MAID entitled the Death With Dignity Act (DWDA). Though it took three more years of litigation, numerous federal challenges, and another ballot measure to repeal the law, none of the efforts were successful, and support only grew, leading to its successful implementation in 1997.

The original Oregon model had the following set of provisions:

- A. At least 18 years of age
- B. Oregon resident
- C. Terminally ill with a prognosis of six months or less
- D. Consulting physician confirmation
- E. Two oral requests 15 days apart, and a written request
- F. Psychiatric assessment if there are any signs of impaired judgment from mental illness or depression
- G. Making an informed decision with knowledge of risks and alternatives as outlined by the physician
- H. Recommendation to inform the patient's next of kin
- I. The right to rescind request
- J. Be able to self-ingest without help from a doctor or an observer

On average, the entirety of the process takes about fifty days from the first request to the ingestion of the medicine, meaning that there are some who may pass or lose their ability to self-ingest before they have the opportunity to take the prescribed medication. For others, just engaging in the process and being able to retain a sense of control over their death is enough. There is no requirement to take the medication once it has been prescribed and patients may back out at any time.

Since it was passed in 1997, Oregon's law was amended in 2019 to waive the 15-day waiting period for those expected to die within 15 days. The requirement was seen as necessary to prevent needless suffering and align with the original intention of the act. Oregon has also removed the requirement for state residency through *Gideon v. Brown*, allowing out of state patients to seek MAID within the state, although there are still a variety of legal considerations.

The rest of these state statutes also provide civil, criminal, and disciplinary immunity for assistance. In other words, doctors and other medical practitioners cannot be prosecuted for helping a patient who is freely seeking out assisted dying.

Most states also require doctors to keep detailed records on MAID use and anonymously survey those who obtain prescriptions. This data gathering not only provides quantitative figures on demographics but also qualitative ideas on why patients choose to use MAID. Each year, states will compile this data into an annual report. Information gathered from Oregon and Washington found that the top reasons patients pursue assisted dying include loss of autonomy, impaired quality of life, and inadequate pain control (Al Rabadi et al., 2019). These problems are a delicate reflection of recent advances in medical care being able to prolong individual lifespans at the expense of certain motor functions and a high quality of life. Especially with terminal illnesses, palliative care is not yet at a point where it is sufficient to ease the suffering involved and cannot be presented as a solution to those who would rather not prolong their powerlessness.

Two court cases occurred in 1997 that solidly cemented MAID's role as a state issue. Arguments in *Vacco v. Quill* tried to use the Fourteenth Amendment's Equal Protection Clause in order to establish a constitutional right to physician-assisted death (*Vacco v. Quill*). Since competently terminally ill adults could choose to withdraw their own lifesaving treatment and therefore expedite their death, the New York Attorney General argued that terminally ill individuals who were not on lifesaving treatment should also be able to expedite their death by taking medications (*Vacco v. Quill*). The Supreme Court ruled against this argument, citing the difference between an active and passive death, as well as New York's state ban on assisted dying being rationally related to their interest in protecting medical ethics and the preservation of human life (*Vacco v. Quill*).

Similar arguments were seen in *Washington v. Glucksberg*, where Glucksberg challenged Washington's state ban on assisted dying using the Fourteenth Amendment's Due Process Clause and its protection of a liberty interest where a competent and terminally ill adult could choose death over life (*Washington v. Glucksberg*). The supreme court once again ruled in favor of Washington's ban since the right to assisted dying was not a fundamental liberty interest and was in fact counter to the nation's traditions and the importance of the preservation of life (*Washington v. Glucksberg*).

Despite these failures to cement a constitutional right to MAID, state efforts have persisted and have followed suit in passing ballot initiatives including Washington in 2009 and Colorado in 2016. Other jurisdictions including Vermont, California, Washington D. C., Hawai'i, New Jersey, Maine, and New Mexico introduced their statutes through legislative action. Montana is unique for being the only state that has legalized assisted dying through judicial review and thus does not have a comprehensive program.

International Precedence

Cases of aided dying internationally are significant in the Netherlands, Switzerland, and Belgium and share marked differences between implementation within the US. Examining specific contrasts exposes the benefits and shortcomings of how MAID has been promulgated in the states and added considerations for implementing policy.

Switzerland

As one of the most well-known countries in the world for having an assisted dying program, Switzerland's policy actually has no specific legislation regulating or permitting MAID. Instead, assisted suicide in Switzerland has been legal since 1942 and is exempt from criminal prosecution as long as the person requesting assistance is the one to carry out the final act (Hamarat, 2021). The procedure is typically carried out by right-to-die organizations such as Exit and Dignitas that assist in acquiring the proper medication and ease patients through the process. Furthermore, there is no requirement for the patient to have a prognosis of fewer than six months; rather, the Zurich Administrative Court has stipulated "a medical indication in the sense

of a terminal illness with an inevitable progression to death” as a minimum requirement (Bosshard, 2002). This means that as long as a patient is diagnosed with a terminal illness, they are eligible for assisted dying, no matter how long they may have left to live.

One key feature regarding the Swiss use of assisted dying concerns the oral route of administration and whether that allows for those who have difficulties swallowing to introduce their lethal infusions through gastric tubes. The concern with doing so is that it turns the procedure into a form of active euthanasia, where doctors and caregivers are administering the fatal dose. On the flip side, others have indicated that the self-administration requirement could motivate patients to take their medication sooner while they still have the capacity to ingest it (Buchbinder, 2018). As swallowing and other motor functions become increasingly difficult for patients suffering from diseases such as ALS, the self-ingestion requirement can be concerningly prohibitive.

While the concerns surrounding infusion via gastric tubes are legitimate, taking away the option makes the policy too discriminatory against those whose illnesses involve the decline of motor functions. Furthermore, even among states where the self-ingestion requirement is in place, adherence seems to be lax and there are documented stories where patients were aided by being spoon fed when they lacked the ability to do so themselves (Frey, 1999). Considering the goal of assisted dying is to provide a patient with options, it seems counterintuitive to take an option away because of his or her physical limitations.

Belgium

Belgium’s assisted dying program is one of the most permissive of its kind, legalizing voluntary euthanasia in 2002. The act has extended the program from somatic illness to psychiatric illness, allowing for children without any age limit to pursue the procedure, both of which are controversial decisions (Van Zeebroeck, 2018). The one that will be examined here is the expansion to non-terminal illness and its implications.

A major concern in allowing patients who suffer from mental disorders, particularly depression, to pursue assisted dying is that there is no objective way or universal standards to measure a

person's suffering like there is for physical illnesses, making it harder to determine whether a psychiatric disorder is "incurable." Furthermore, suffering from mental illness is quite often compounded by other psychosocial factors including unemployment, financial stress, insecure housing, social isolation, or relationship turmoil (Sheehan, 2017). However, in Belgium, patients have been euthanized for every reason from autism to anorexia, chronic-fatigue syndrome, and partial paralysis (Aviv, 2015). In 2013, Wil Distelmans—one of Belgium's most outspoken advocates for euthanasia—euthanized a transgender man who was devastated by the failure of his sex-change surgeries (Aviv, 2015).

These situations all no doubt have a degree of suffering attached to them, but the philosophy behind allowing these cases is fundamentally different. In iterations that only allow terminally ill individuals with a prognosis of six months or less, the idea is that they are seeking control over an inevitable and proximate death. While other individuals who are suffering will also die eventually, their concern is to be relieved of their suffering through death, essentially utilizing death as a medical treatment. Georges Casteur, a doctor in Belgium who has performed euthanasia several times in his career for terminally ill patients, said that "There's a great difference between helping people who are already dying and helping people to die" (Aviv, 2015). This represents the exact kind of slippery slope opponents are worried about, where death is doled out to anyone interested.

What has happened in Belgium is not solely the fault of policy but rather the attitudes that have developed surrounding assisted dying. In fact, it is precisely a culture of permissiveness that has allowed for policies to extend to minors and psychiatric disorders.

Netherlands

The Netherland's bill legalizing euthanasia entitled "Termination of Life on Request and Assisted Suicide Act" was likewise passed in 2002 but had significantly different origins. Euthanasia in the Netherlands had already been established in the early 1990s, and despite being illegal, no doctors were prosecuted for the act. The primary aim of the law was to create better regulations and transparency for those who would use euthanasia. Similar to many other assisted dying laws including the Oregon model, there are a number of due care provisions that require

the patient to be experiencing unbearable suffering with no prospect of improvement, well-informed, explored other options, and making a voluntary request (Heide, 2021).

Since the passage of the law, three evaluation studies have been conducted to determine the effectiveness of the law in reaching the goal of preserving patient autonomy and alleviating unnecessary suffering. Part of what has made the Dutch law so effective in reaching its goals is that these studies undertaken by independent multidisciplinary officials have recognized the deficiencies of the law and made recommendations for improvement.

Current Trends

In terms of procedure, modern-day MAID utilizes a concoction of opiates in order to methodically and painlessly induce death. Prior to 2015, two barbiturates—pentobarbital and secobarbital—were considered the most effective for hastening death but have largely been unavailable since as pentobarbital was disapproved for human use and the price of secobarbital has skyrocketed from \$300 to \$3,500 for a lethal dose (Dear, 2019). Nevertheless, because there are no feasible ways to conduct direct research on the best way to induce death, several different combinations of protocols are currently being prescribed and used as seen in Figure 1.

Medication	Contents
DDMA	Digoxin 100 mg, Diazepam 1 gm, Morphine 15 gm, Amitriptyline 8 gm
DDMP/DDMP2	Digoxin 50 mg (DDMP2 100 mg), Diazepam 1 gm, Morphine 15 gm, Propranolol 2 gm
DDMA-Ph	Digoxin 100 mg, Diazepam 1 gm, Morphine 15 gm, Amitriptyline 8 gm, Phenobarbital 5 gm

Figure 1: Medicinal combinations. Adapted from End of Life Symposium (2021), “Aid in Dying Medications & the Clinical Competencies of Prescribing.”

Use of these medicinal combinations illustrates the wide variability among assisted dying practices and the unsure nature of this periphery field. Even between states where the practice has been in place for a significant amount of time, statistics on combinations vary widely from year to year as doctors continue to record their observations on what takes the least amount of

time and how certain medications can be affected by a patient’s medical history. In Oregon, the introduction of the DDMA combination in 2018 replaced DDMP as the most used prescription as seen in Figure 2. The altered formulation of DDMA-Ph beginning in 2019 can be seen as potentially recreating a similar trend, surpassing its previous iteration in net change. All of these formulations are effective in what they do. However, it is clear that significant work is still being done in figuring out how a patient’s medical history affects their reaction to certain medications.

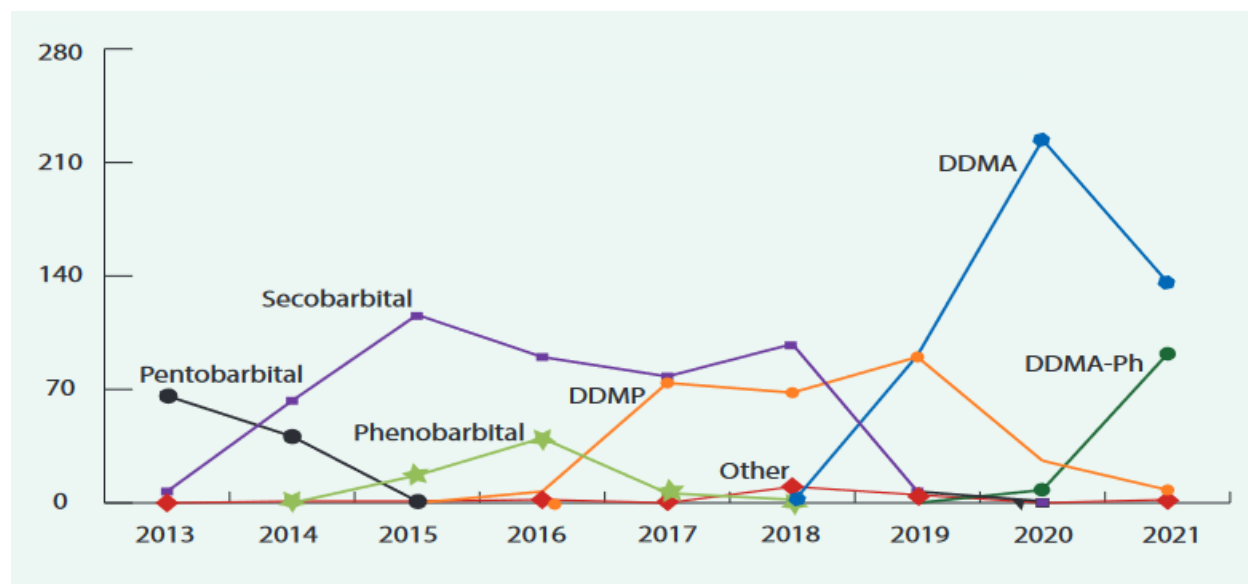


Figure 2: Medication used in DWDA ingestions. From “Oregon Death with Dignity Act 2021 Data Summary.”

Recent findings aggregating 23 years of data from nine states¹ found further trends worth noting about the demographic use of MAID that should be accounted for during policymaking. As each state establishes its own program, policy interaction has increased each successive year as more people become aware and accessibility increases as seen in Figure 3. Between 1998 and 2021, a total of 5,329 recorded patients died through MAID, while 8,451 total received prescriptions (Kozlov, 2022). This reaffirms the idea that MAID policy as outlined in most US states grants patients the capacity to opt out any point.

¹ Excluding Vermont and Montana due to lack of data collection

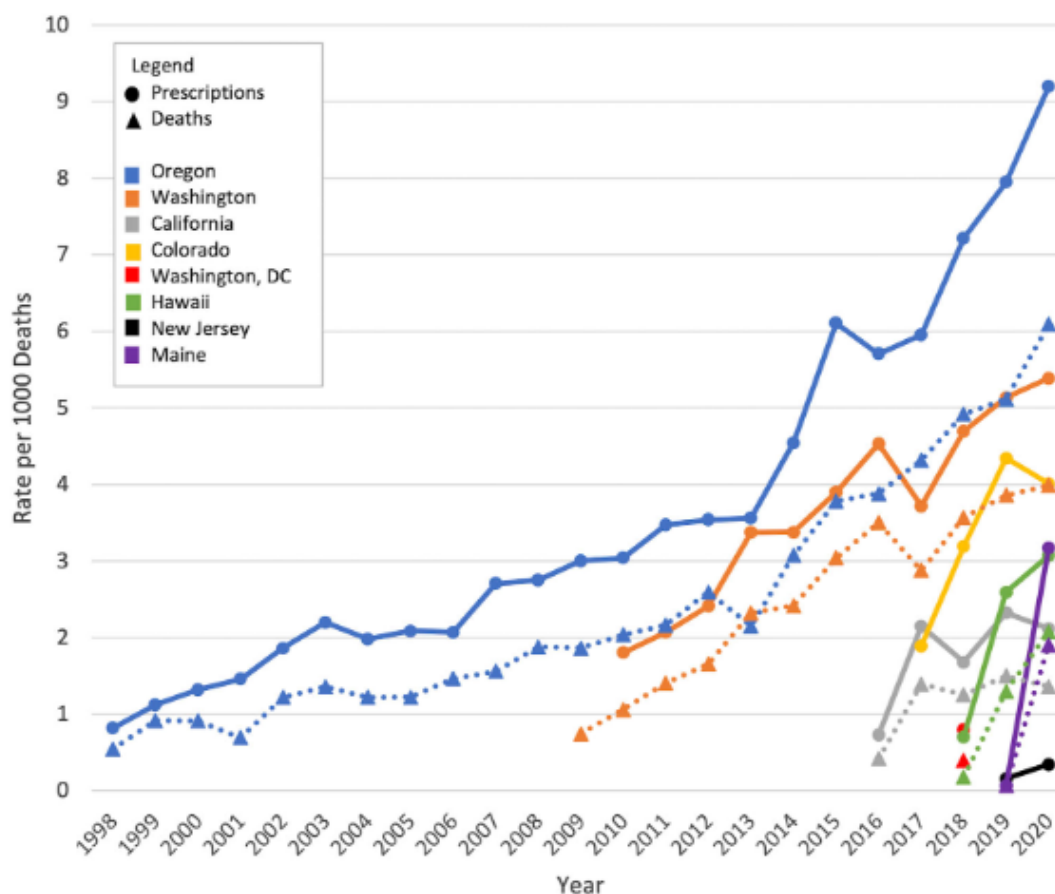


Figure 3: Rates of MAID prescription and MAID death per 1000 deaths, by state and year. From Aggregating 23 Years of Data on Medical Aid in Dying in the United States by Elissa Kozlov, 2022²

Among those who used their prescriptions, non-Hispanic white individuals comprise the largest racial and ethnic group at 95.6% and the median age at death was 74 (Kozlov, 2022).

Educational breakdowns show that 72.2% had at least some college education and the primary underlying medical condition was cancer at 74.0% (Kozlov, 2022). Conclusions from this dataset overwhelmingly show that the average MAID user tends to be nearing their life expectancy, with 74.5% being over the age of 65. They also tend to be white, educated, and diagnosed with cancer as seen in Figure 4.

² Graph excludes New Mexico as their implementation began in 2021

In one particular case, looking at Oregon’s MAID usage in comparison to total deaths offers further support of some of these trends. From Figure 5, it is apparent that there are minority populations

Characteristics	Category	MAID deaths ^a	Percentage of deaths	MAID Rx ^b	Percentage of Rx
Sex	Male	1035	53.10%	2367	49.40%
	Female	914	46.90%	2252	47.00%
	Missing	0	0.00%	172	3.60%
Race/ethnicity	Non-Hispanic white	1864	95.60%	4244	88.60%
	Non-white	85	4.40%	351	7.30%
	Missing	0	0.00%	196	4.10%
Age	18–34	155	8.00%	194	4.00%
	35–44				
	45–54				
	55–64	341	17.50%	519	10.80%
	65–74	598	30.70%		
	75–84	538	27.60%	2074	43.30%
	85+	316	16.20%		
	Missing	1	0.10%	2004	41.80%
Educational attainment	No HS	511	26.20%	1133	23.60%
	High school/GED				
	Some college	392	20.10%	3429	71.60%
	Associate’s				
	Bachelor’s	874	44.80%		
	Master’s				
	Doctorate/Professional	142	7.30%		
	Unknown	30	1.50%	34	0.70%
Missing	0	0.00%	195	4.10%	

Figure 4: Frequencies and percentages of individuals who died by MAID and individuals who received a MAID prescription. From *Aggregating 23 Years of Data on Medical Aid in Dying in the United States* by Elissa Kozlov, 2022

When comparing those who have died from MAID with overall deaths, the findings reveal that very few people utilize the procedure. In Oregon, the estimated rate of MAID deaths in 2019 was 51.9 per 10,000 total deaths (Oregon Health Authority, 2019). This means that less than one percent of all deaths were a result from MAID, and there are similar findings elsewhere. Washington data from 2019 shows that 252 patients died from MAID (Washington, 2021).

When compared to a total of 58,297 deaths, it similarly results in less than one percent of deaths (Washington, n.d.).

In one particular case, looking at Oregon's MAID usage in comparison to total deaths offers further support of some of these trends. From Figure 5, it is apparent that there are minority populations such as Black Americans, American Indians, and Pacific Islanders who have completely chosen not to use MAID. Whether this is due to lack of awareness or historical distrust of medical systems among minority communities is a question that should be asked in further research. Nevertheless, considering the small group of people that choose to use MAID, it is important to note how this group is disproportionately White.

Another trend worth noting is when looking at age breakdowns, while the 65-74 and 75-84 range both feature MAID with a larger percentage of deaths, the 85+ sees a significant decrease when compared to overall deaths. This could likely be attributed to terminal illnesses primarily affecting people around the time of their life expectancy, with fewer cases lasting into one's 80s. Furthermore, it is likely that MAID requirements in general contribute to this trend. Although they are set up to be protective, the arduous requirements can deter those who have increasingly hindered mobility and cognitive abilities. In particular, cognitive decline can prevent competent decision-making capabilities thus disqualifying them.

Characteristic	Category	Total Deaths	MAID Deaths
Race	White	91.3%	96.3%
	Black	1.4%	0.0%
	American Indian	0.8%	0.0%
	Asian	1.9%	1.1%
	Pacific Islander	0.3%	0.0%
	Hispanic	3.0%	2.1%
Age	35-44	2.3%	2.1%
	34-54	4.7%	5.9%
	55-64	12.3%	17.0%
	65-74	20.5%	29.3%

	75-84	24.5%	28.7%
	85+	32.2%	16.5%

Figure 5: Comparison of MAID deaths to total deaths in Oregon, broken down between characteristics

In summation, even though MAID has become more accessible with each successive year, it is limited in scope and used by a very small proportion of the population. This is partially because as a policy it purposefully pertains to a very niche group of people. However, there are still significant gaps in knowledge on the subject complicated by the inability to conduct official research, organize national efforts, and the program's recent introduction in several states. The goal is that as more and more states are able to push through their own legislation, more data can be made available in order to improve the overall quality of care.

Nevada Action

Potential MAID legislation was first introduced in Nevada in 2017 by Nevada State Senator David Parks in SB261 (NELIS, 2017). After passing both the Senate Health and Human Services Committee and the senate floor, it stalled in the Assembly HHS Committee and was never voted on before the session ended. A similar situation occurred during the 2019 legislative session, when SB165, still sponsored by Senator Parks made it through the Senate HHS Committee but missed deadlines and did not advance (NELIS, 2019). Even less progress was made in 2021 when AB351 was introduced by Assemblyman Edgar Flores and only heard in the Assembly HHS Committee (NELIS, 2021).

All versions of the bill presented so far including the most recent iteration, AB351, have been modeled after Oregon's Death with Dignity Act (DWDA). Its eligibility criteria include being at least aged 18, being terminally ill with a prognosis of six months or less given by two different physicians, being a resident, and being mentally capable of making an informed healthcare decision (NELIS, 2021). Key provisions include two verbal requests fifteen days apart, awareness of self-administering the medication, and that the patient may change their mind at any point (NELIS, 2021).

Having attempted passage in three consecutive legislative sessions to more meager success each time indicates that there is a lack of interest and will on the issue. Despite three out of four Nevadans supporting MAID across all ages, races, and gender, this has not translated into significant legislative action (Nevada Coalition for Death with Dignity, 2021). Although the reason for this problem is multi-faceted, it is likely a combination of proximity and uncertainty. Previous hearings have drawn large public attention and featured both supporters as well as opponents offering their public comments (Marier, 2021). Those who oppose the bill have a standard list of concerns and misunderstandings surrounding it and its potential for abuse, and the easy perpetuation of these harmful judgments about what MAID is can generate aversion to showing support for the bill (Marier, 2021).

Furthermore, even though people have died from terminal illnesses for a long time and will continue to do so for a long time, the concept of just exactly what it is like to live out those final days is distant and remote for most people. Typically, only those with close friends or family members suffering from terminal illnesses will be able to grasp the scope of the issue. For those unaffected, the status quo has seemingly always worked and is thus acceptable.

III. Contextualization

Attitudes and stigma

Official attitudes surrounding MAID from the medical community remain in a sort of limbo, with major organizations such as the American Medical Association (AMA) leaving such decisions up to the individual and their physician. The AMA considered both the for and against perspectives on MAID, acknowledging that they both originate from the principle of “compassion and respect for human dignity and rights” (*Physician-Assisted Suicide*). Both patients and physicians need to be upfront with what their personal beliefs and boundaries are before entering into a physician-patient relationship. Many other organizations such as the American Academy of Family Physicians and the American Academy of Hospice and Palliative Medicine have also taken neutral positions on the matter (*New AMA Position on Medical Aid in Dying*).

Beyond medical organizations, the public sphere continues to retain a close association between MAID with euthanasia and suicide which still contributes to many people's misconceptions about what the policy is. While 73% of Nevadans support the procedure, public comments at previous legislative sessions show that there are still some who think that legalizing MAID means suicide becomes a form of medical treatment (Marier, 2021). Others worry that legalizing MAID will incentivize insurance companies and governments to save money by encouraging MAID rather than extensive treatment (Marier, 2021).

While these claims are rooted in a common fear of abuse, they are overblown as the Oregon model precisely addresses these worries. These decisions will always be between a patient and their provider to decide if the choice is right. Furthermore, since the procedure is only available for those who already have six months or less to live, there is no sense of any kind of medical treatment that is going to be able to prolong a patient's life. By the time they are considering MAID, there are no more questions about "if," only "when" and "how."

Policy Concerns

One of the largest worries, both among the general public as well as among policymakers, is preventing a slippery slope where the qualification to use MAID is relaxed more and more giving way to its overuse. Though this has not become a problem in any of the US iterations of MAID policy, variations such as those seen in Canada and Belgium have proved to be more problematic and concerning. Nevertheless, the current policy recommendation is very distinct from those examples and already has a proven track record.

There are also issues related to the difficulty in prognosing terminal illnesses. Part of the problem is that prognostication is simply an inductive field where future predictions are best modeled on past findings. In other words, accuracy can range drastically from case to case. These uncertainties can cause more fear among those who are already concerned about the slippery slope issue, but it is key to keep in mind that physicians predict a range or the upper bound by when a patient's death is expected. Furthermore, the same prognosis of six months is also a necessary condition of being eligible for hospice care, meaning that when a patient is within this time frame, they have multiple options to choose from.

Another key component is the issue of mental health, as those who are near the end of their life may feel a sense of helplessness and depression that comes with the situation. There is a significant difference between someone seeking assisted dying to retain their autonomy and dignity versus someone who feels they are not being taken care of and has no other choice but to participate in assisted dying. For those who do seem to be suffering from a psychological disorder, counseling is required to determine whether there is impaired judgment before a patient is allowed to proceed in the process.

Among all the current state statutes, Hawai'i is currently the only state that mandates a mental health consultation for all patients. While this policy adds another requirement that can be deemed laborious, it is an important safety measure when considering the increase of depression among terminally ill patients. In one report on mental illness in palliative patients, rates of depression ranged from 3.7% to 58%, demonstrating high variability and uncertainty (Kelly, 2006). The concern comes when looking at Oregon's MAID statistics and finding that in 2020, only three out of 245 patients were referred for a psychiatric evaluation. In total since 1998, out of 1,905 patients, this number was 69, meaning only 3.6% of patients have ever been referred for psychiatric evaluations in Oregon. This percentage is below even the lowest estimates of depression, not accounting for other mental illnesses such as anxiety and delirium, raising significant concerns over whether current physician attention to mental illness is stringent enough. As most physicians do not have the same grasp on mental health as those who specialize in the area do, it is understandable as to why incidences of depression, anxiety, or delirium can slip through the cracks. Thus, creating a mandated psychiatric evaluation is likely the best way to more accurately assess a patient's mental capabilities.

Lastly, while the previous concerns centered around permissiveness, the last concern regards prohibitiveness and barriers to access. In a qualitative study on Vermont's 2013 Patient Choice and Control at End-of-Life Act, Mara Buchbinder found that the process of accessing MAID reflected broader socioeconomic inequalities in healthcare (Buchbinder, 2018). The four key access barriers she identified were safeguards, cost of medication, access to physicians, and access to information (Buchbinder, 2018). While no single step in the process by itself is

restrictive, the combination of all of them serves to nibble away at accessibility bit by bit. Several physicians in the study suggested that “[MAID] would be impossible to utilize without a robust support network” that can help terminally ill patients navigate through the great number of requirements (Buchbinder, 2018). This means that those who are most likely to be able to pursue MAID are those who are socioeconomically privileged, a trend reflected in the data on who has used the procedure.

While these factors are important to note, it is very likely that the introduction and continued presence of MAID will contribute to alleviating these barriers. Current trends already indicate an increased use per year as a result of more people becoming aware of the procedure, which will gradually eliminate informational barriers. Simultaneously, doctors will be able to have a better grasp on affordable medications to use successfully as data increases.

The most concerning barrier to access remains finding willing physicians. Although there has been no centralized study concerning physician availability, there are several trends worth noting. Most MAID statutes give not just doctors but entire healthcare systems the chance to opt-out, and in Colorado, this means that nearly one-third of their hospitals, particularly those that are faith-based, restrict their doctors from offering aid in dying (Graham). The ultimate effects of this are nuanced, first and foremost creating a heavier burden on those who live in rural and other low-density areas. In California’s Coachella Valley, the three largest hospitals have all opted out of the new state law and affiliated doctors cannot use hospital premises, resources, or systems in connection with aid in dying (Aleccia, 2017).

However, most patients begin to seek MAID in primary care clinics, oncology centers, and hospices rather than hospitals, concentrating the availability of the procedure in places most patients already frequent. What this ends up doing is reinforcing the trend of a small concentration of doctors who are willing and able to prescribe the medication. For example, Oregon’s 2020 data showed that 142 physicians wrote a total of 370 prescriptions, with half of those physicians practicing in the Portland metropolitan area (Oregon Health Authority, 2021). The most prescriptions written by any physician were 31 while 79% of physicians wrote one or two prescriptions (Oregon Health Authority, 2021).

In a national study, the majority of physicians (60%) agreed that physician-assisted death should be legalized, but of that number, only 13% indicated that they would actually be willing to perform the practice if it was legal (Hetzler, 2019). For the other 87% that indicated no, about half (47%) said it was because of a lack of training or outside of their scope of practice (Hetzler, 2019). The rest cited various personal or religious reasons.

It is clear that access to MAID is dependent on certain geographical, informational, and socioeconomic factors. The concentration of willing physicians nevertheless remains overwhelmingly in urban areas and generally in facilities that already cater to terminally ill patients. Thus, for those who are on the outskirts of this system—as most socioeconomically less privileged are—navigating the system is a complicated issue.

The case for MAID

While MAID relates to death, it is nevertheless a distinct and separate discussion from suicide. Anyone who is considering assisted dying as an option no longer has a choice over whether they are going to die, but rather how they are going to die. The struggle with a terminal illness is deeply personal and can be severely debilitating, no matter what kind of palliative care is available. In cases such as these, the decision for a patient to choose death over continued misery is a dignified and rational choice.

The role of MAID policies is to provide such an option for those confronting the end of their lives. Palliative care may be a viable option for many patients, but not all, and it is unnecessarily burdensome to force those who are in pain and distress to continue to suffer when there is a simple alternative. Whether this option is right for a patient is ultimately between them and their doctor to decide but having the policy in place is crucial to facilitating that conversation and process.

What the Oregon model has successfully proven to do is to offer a sense of control for those who most need it. The psychological effect of knowing that they can die whenever they want on a patient is often enough to give them the reassurance that they need. In cases such as these, there is no further external pressure to move forward with the procedure.

As an opt-in policy, even if no one chooses to use it, there is no net negative for society at large. If on the other hand, a member of the small minority of people who may be eligible for MAID does choose this option, the countless measures and protections in place ensure that patients are making an informed and positive choice.

IV. Policy Recommendations

The Oregon model for MAID has proven sufficient for the purposes it was intended for and should thus be used for Nevada implementation. These include the requirements that a patient must be 18 years old or older, have been diagnosed with a terminal illness with a prognosis of six months or less, and be mentally capable of making their own healthcare decisions. Similar to Hawai'i, all patients should be consulted by a mental health professional and be deemed capable before proceeding in the process. In cases where the patient cannot self-administer the medication, the requirement should be waived in order to allow for ingestion through gastrointestinal tube. The patient must also be a resident of Nevada and the state should also maintain and publish annual reports on statistics related to all aspects of its use.

The process itself needs to require two independent Nevadan physicians to confirm the patient's eligibility, their informed decision, and their voluntary request. The patient must also make an oral request and a written request for medication, as well as a second oral request 15 days after the first one. In cases where the patient may not have 15 days to live, this requirement can be waived, and they may make a second request within 15 days as is already being done in states such as California and Oregon. Furthermore, the act should provide immunity for healthcare providers who choose to provide this service.

It is a key component that the patient may change their mind at any time throughout this process that is built into how these requirements are structured. By providing multiple points where patients must reaffirm their choice, safeguards are put into place to ensure that they are well-informed and truly committed to their choice.

The only major hurdle left beside the policy itself is greater Nevada enthusiasm. This is a pertinent issue to the state as more and more retirees settle in the state every year. While age and

terminal illness are not necessarily related, the age group with the largest use of MAID is those 65 or older. According to the Elders Count Nevada 2021 report, between 2011 and 2018 the 65 and older population increased by 40%, and the 85 and older population increased by 25%. These growth rates are double the national rate and are expected to continue through 2030 (Aging and Disability Services Division, 2021).

The senior population comes with its own unique concerns that need to be proactively addressed, top among them including healthcare. Although MAID may only constitute a small area of healthcare within senior living options, permitting it provides assurance to everyone that it would be available if needed to alleviate suffering. Current options within terminal illness treatment may be sufficient for keeping patients alive for longer amounts of time, but they are insufficient at retaining a high quality of life and preserving dignity.

This issue surrounding an aging population is not limited to Nevada either. According to the US census, the US surpassed 50 million seniors in 2016 and will continue to see that number increase for decades to come (US Census Bureau). That means that one in five Americans is 65 years or older and more consideration will be necessary for the problems that they face. The Oregon model for MAID has proved to be a reliable option for end-of-life care, with its implementation in Washington, Colorado, and a number of other states seeing similar success. There has been no track record of abuse in the policy while offering invaluable benefits to the few parts of the population it can apply to. There is substantial evidence that enacting the Oregon model for MAID would be plausible on a national level and should be considered by national policymakers.

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