Unrestrictive Self-Administration in MAiD Laws

Thad Mirer
Director, Death with Dignity–Albany

December 15, 2024

An important feature of all ten medical-aid-in-dying (MAiD) laws in the U.S. is that the prescribed medication must be self-administered. While the majority of states that currently have such laws require that the method of self-administration be ingestion, three do not.

The MAiD laws in Hawaii, New Jersey, and Vermont place no restriction on the methods that can be used. Ingestion, injection, inhalation, and other methods that exist or might be developed can all be used. Laws, and provisions in these laws, that place no restriction on the methods that can be used are referred to here as "unrestrictive".

Hawaii and New Jersey have unrestrictive definitions of "self-administer". Vermont does not define "self-administer", but it uses that verb to refer to the action taken by the patient. The laws in these states do not mention ingestion or any other method that might be used. (The wording used in the laws of these three states is presented in the Appendix.)

Until recently there was a fourth state that did not require ingestion: Colorado. In 2024, an amendment to the state's MAiD law replaced the original (2016) unrestrictive definition of self-administration with one that requires ingestion. Some of the circumstances surrounding this change are explored below.

The purpose of this paper is to promote consideration of, and to advocate for, unrestrictive self-administration in medical aid in dying. The three main sections look at (1) the case for having unrestrictive self-administration, (2) the opposition that has been raised, and (3) a legal question that relates to the method of injection.

The Case for Having an Unrestrictive Definition of Self-Determination

When a MAiD law has an unrestrictive definition of self-administration, a physician can prescribe medication and determine the method (route) by which it is to be used according to the needs of the patient and the available medicine and technology. By contrast, when the law specifies ingestion as the only method that can be used, the law interferes with the physician's judgment regarding how best to help their patient.

In the practice of MAiD in the U.S. today, nearly all cases involve the ingestion of several drugs that are mixed in water or juice. Most often the medication is taken by mouth. Other times the same medication is self-administered by using a feeding tube or rectal catheter. These three ways of taking the medication are included in the legal concept of ingestion, which is simply that the route of administration is gastrointestinal.

In Switzerland today, assistance with both ingestion and intravenous injection is provided under a long-standing legal framework that requires self-administration. With intravenous administration, patients can start the flow of the medication by rotating a small wheel or by using a control mechanism that is activated by a simple bump, using their hand, arm, foot, or turn of the head.

Beyond ingestion and intravenous self-administration, other methods — including non-intravenous injection and inhalation — await further development for MAiD use. An unrestrictive definition of self-administration is open to all methods. It is forward looking.

The most important reason for not restricting methods of administration to only ingestion is to remove a barrier that prevents some qualified patients from accessing the benefits of the law. There are at least two groups of people who cannot self-administer the medication by ingestion: some people have gastrointestinal complications that make it impossible or unwise, and some people do not have sufficient strength or manual dexterity (perhaps because of a neurodegenerative disease such as ALS or Parkinson's).

To expand on this point, we present the testimony given to Oregon's Senate Judiciary Committee by Dr. Charles Blanke in favor of a bill that would have

allowed intravenous and other methods to be used by patients under the state's MAiD law. His testimony has been condensed and edited:

> Good morning. My name is Dr. Charles Blanke. I am a medical oncologist and end of life specialist. My clinic is located at Oregon Health and Science University, and I also make house calls throughout the state.
>
> My practice is composed of terminally-ill patients interested in Death with Dignity. Last year I wrote more Death-with-Dignity-related prescriptions than any physician in Oregon — about 15% of the total. What that number does not reflect, however, are all the patients I and others saw, who qualified for Death with Dignity but were unable to use the measure.
>
> Patients in my practice mirror those seen across our state. Many have swallowing difficulties and are afraid they will not be able to "ingest" the medications, as currently required by law. They are terrified they will only be able to force down a partial, non-fatal dose, and that they will then wake up, or worse, remain in a permanent coma. I am convinced some take their lives too early, because they are afraid their swallowing will only get worse.
>
> Additionally, there are many terminally ill Oregon residents who, from the outset, cannot swallow at all. Though some well-meaning but medically inexperienced proponents suggest that using a feeding tube would be a simple fix, most of those patients would be wholly unable to push the plunger of a syringe attached to the tube. They literally cannot self-administer the medication. These patients fully qualify for Death with Dignity but are being deprived of their chance to use a measure supported by 80% of Oregonians, because of a disability.
>
> No US state, including Oregon, allows euthanasia. The new wording [which would allow intravenous self-administration] does not change that position one drop, not legally or practically. While we are still developing an effective intravenous combination, whatever the practicing physicians of Oregon come up with, it will still be, in all cases,

> the terminally-ill patient who directly administers the medication — not the doctor.
>
> There is no extra protection or particular dignity, offered to patients by requiring the lethal medications be taken by mouth, feeding tube, or rectum — all currently legal but often unfeasible routes. Thank you.

Dr. Blanke's testimony is a plea to let physicians help their patients by practicing medicine freely, within the framework of the law's eligibility requirements and safeguards.

Opposition to Unrestrictive Definitions

Oregon's Death with Dignity Act was written and approved thirty years ago, just a few years after a Portland resident became the first patient to die with the assistance of Dr. Jack Kevorkian in Michigan. He had developed an apparatus by which a patient could self-administer three drugs intravenously, in sequence, by pressing a button once. Kevorkian's actions sparked national controversy, and the authors of Oregon's law wanted to stay clear of that in order to get the measure approved by the voters. Advocates in favor of the measure touted that it would not allow "suicide machines". Medical aid in dying by ingestion was born.

The law in Oregon does not contain the term "self-administer". Early in 2019, a bill (HB2217) was introduced in the House that would have created a definition of "self-administer" that explicitly allowed methods other than ingestion to be used. Proponents of making this change, it seems, wanted to allow intravenous self-administration.

The bill met with substantial opposition. In testimony to a House committee, Compassion & Choices said it would support the bill only if the definition of "self-administer" originally in the bill were replaced by one it proposed. This substitute definition was accepted by the committee, and the bill was approved by the House on April 22 with the support of Compassion & Choices and Death with Dignity National Center.

Soon after the bill was approved, however, the two national groups realized that they had misunderstood what the definition actually allowed. The definition, whose key wording was essentially the same as that in Hawaii's 2018 MAiD law, did not specify or restrict the methods of self-administration that could be used. The definition was unrestrictive.

The two groups opposed the bill when it was considered on May 9 by the Senate Judiciary Committee. (It was at this hearing that Dr. Blanke testified.) They argued strongly against allowing intravenous self-administration, saying that it would be very dangerous, that it could result in botched deaths, and that it could set the movement for MAiD back in Oregon and nationally. Also, they said that a feeding tube or rectal catheter could be used by patients who could not take the medication orally. The bill died in committee.

The Oregon legislature's consideration of bill HB2217 marked a turning point in the development of MAiD laws in the U.S. It seems to have served as a wake-up call for the national groups. In previous years they had fostered and supported the approval of MAiD laws in Colorado, Hawaii, and New Jersey, all of which had unrestrictive definitions of self-administration. Similarly, in 2019 they were fostering and supporting pending bills in various states to enact new laws, many of which had unrestrictive definitions.

For reasons the groups have not explained, they embarked on a quiet but effective campaign to eliminate unrestrictive self-administration in the U.S. They have been especially focused on eliminating the possibility that intravenous self-administration could be used.

This can be seen, first, in changes that were made to MAiD bills that had been previously introduced in various states. For example, 13 states considered bills to enact new MAiD laws both in 2019 and again in 2023. In 7 of the 13 states, the 2019 version of the bills had unrestrictive definitions of self-administration. By 2023, only one of these seven retained the original definition. In six, the unrestrictive definition had been replaced by an ingestion-only definition.

These six new definitions were written in a two-sentence format that was unlike the format used in any MAiD law enacted or proposed before 2020. The

first sentence is a statement that self-administration is a patient's act of ingesting the prescribed medication. The second sentence points out that self-administration does not include taking the medication by infusion or injection (outside the digestive system). The presence of the second sentence reflects the special concern, and the considerable influence, of the two national groups. It is as though they left their calling cards.

The quiet but effective influence of the two national groups seems to have been present also in one of several amendments made to Colorado's existing End-of-life Options Act in 2024. The original (2016) definition of self-administration was unrestrictive. The new definition has the two-sentence format just discussed, which allows only ingestion. (The original and the new definitions are presented at the end of the appendix.)

On their websites and in their newsletters, the two national groups favorably describe most of the changes that Colorado made in its law. However, the groups do *not* mention the fact that the definition of self-administration was changed. If this change were important enough to be enacted, and if it were a change the groups favored, why did they not mention it?

When Oregon's Death with Dignity law was being drafted, the intention apparently was to allow only oral ingestion and to disallow lethal injection and devices. Over time, and in various states, ingestion has come to include rectal administration because this permits some patients who cannot take the medication orally to benefit from MAiD. An interesting comparison can be made between self-administered rectal ingestion and self-administered intravenous injection.

Rectal administration is not a simple procedure. Typically, a medical professional is required to insert a catheter, connect it to a large syringe, and oversee the procedure. The patient needs to depress the plunger at an appropriate rate to empty the syringe.

Intravenous administration is not a simple procedure either. Typically (as practiced in Switzerland), a medical professional is required to insert a cannula into the patient's hand, connect it to the source of the medication, and oversee

the procedure. The patient needs to use a control to begin the flow of the medication.

Both methods require the active participation of health-care professionals and involve the use of medical devices: they are quite similar in this regard. Why is rectal administration acceptable to the national organizations while intravenous self-administration is not? Is rectal administration more dignified? Is it a more familiar procedure for people at the end of life? Can it help a wider range of people?

Neither rectal nor intravenous administration need be stopping points in the development of medical aid in dying. An unrestrictive law gives doctors the freedom to apply existing methods of administering medications to this practice and also to develop new methods.

A Legal Question

Each of the three states that allow unrestrictive self-administration has a section regarding "construction" in their MAiD laws. These sections guide how the laws should be interpreted. The first sentence in each of these sections is similar to what appears in the "Construction of Act" section in Oregon's law:

> Nothing in [this law] shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia.

In this sentence, mercy killing and active euthanasia are understood to be actions taken by a physician or any other person that result in the death of a patient. These actions are said to be "prohibited" by the construction sentence in the sense that they are not authorized by this law and they remain prohibited by other laws. In the same sense, the sentence specifically prohibits a physician or any other person from administering a lethal injection to a patient.

A legal question that may be raised in connection with intravenous methods is this: "Does this sentence *also* prohibit *self-administered lethal injection*?" If so, the construction sentence would have the effect of specifying a restriction on the methods of self-administration that could be used under the law.

This question was examined by Thaddeus Pope, a leading legal scholar on MAiD law, who argues that the construction sections in various states' MAiD laws do *not* prohibit intravenous self-administration (see pgs. 46–49 in the Reference below). He concludes that there is no legal obstacle to administering MAiD by intravenous self-administration in states with unrestrictive definitions of self-administration. The gist of his analysis is straightforward.

Consider first the claim that the first sentence of the construction section prohibits *a patient* from *self-administering a lethal medication by injection*. This reading of the words depends on the notion that the patient can be referred to both as the "patient" and as an "other person" in the same sentence. This would be a tortured use of the English language. The plain meaning of the words is that the sentence prohibits a *physician or any other person* from *injecting a patient* with a lethal medication that ends the patient's life.

Consider now the claim that the first sentence of the construction section prohibits *a physician or any other person* from *writing a prescription* for a medication that the patient could self-administer by injection. This would not be a plain reading of the words either. Writing the prescription is not the action that ends the patient's life: it is the self-administration of the medication that ends the patient's life.

It is important to note that this legal question relates only to self-administration by injection. Other methods that could be used under an unrestrictive MAiD law are not in question.

Conclusion

The medical-aid-in-dying laws in Hawaii, New Jersey, and Vermont do not specify or restrict the methods of self-administration that may be used. As a result, a physician can prescribe medication and determine the method by which it is to be used according to the needs of the patient and the available medicine and technology. Physicians are free to make the best choice.

By contrast, MAiD laws that specify ingestion to be the only allowable method of self-administration put legislative fiat in place of professional medical

judgment. As a result, patients who cannot ingest the medication are denied the benefit of the law.

Ingestion-only requirements are barriers to access, which hark back to the earliest days in the development of MAiD in Oregon, 30 years ago. What was path-breaking then now stands in the way of realizing the full potential of medical aid in dying. Instead of looking backward, states should look forward.

Notes and References

• The wording used regarding self-administration and related features of MAiD laws was carefully examined by Thaddeus Pope, a leading legal scholar of MAiD law. See: Thaddeus Mason Pope, "Medical Aid in Dying: Key Variations Among U.S. State Laws", Journal of Health and Life Sciences Law, October 2020, Vol. 14, No. 1, pgs. 25–59. A reprint is available at:

https://www.thaddeuspope.com/images/Pope_-_J_HEALTH_LIFE_SCI_LAW_2020_MAID.pdf
(The relevant section is journal page numbers 43–49, which appear as pages 22–28 of the pdf file in this article reprint.)

• The public record of the Oregon legislature's consideration of HB2217 in 2019 is available at:
https://olis.oregonlegislature.gov/liz/2019R1/Measures/Overview/HB2217
(This provides access to the text, legislative history, and testimony for the bill.)

Appendix: States in which Self-Administration is Unrestrictive

Hawaii, "Our Care, Our Choice Act", Approved April 5, 2018. Effective January 1, 2019. Hawaii Revised Statutes, Chapter 327L.

• §327L-1 Definitions.

> "Self-administer" means an individual performing an affirmative, conscious, voluntary act to take into the individual's body prescription medication to end the individual's life pursuant to this chapter.

• There is no use of the word "ingest" or its variants (ingesting, ingestion, etc.) anywhere in the law.

New Jersey, "Medical Aid in Dying for the Terminally Ill Act", Approved April 12, 2019. Effective August 1, 2019. P.L.2019, c.59 (C.26:16-1 et seq.).

• C.26:16-3 Definitions

> "Self-administer" means a qualified terminally ill patient's act of physically administering, to the patient's own self, medication that has been prescribed pursuant to [this law].

• There is no use of the word "ingest" or its variants anywhere in the law.

Vermont, "Patient Choice at End of Life Law" (Act 39), Approved May 20, 2013. Effective May 20, 2013. Vermont Statutes Annotated, Title 18, Chapter 113.

• There is no definition of "self-administer".

• There are repeated uses of the phrases "medication to be self-administered for the purpose of hastening the patient's death", "self-administer a lethal dose of medication", and their variants.

• There is no use of the word "ingest" or its variants anywhere in the law.

Colorado, "Colorado End-of-life Options Act", Colorado Revised Statutes, Title 25, Article 48.

25-48-102. Definitions.

Approved by Initiative November 8, 2016. Effective December 16, 2016:

(15) “Self-administer” means a qualified individual’s affirmative, conscious, and physical act of administering the medical aid-in-dying medication to himself or herself to bring about his or her own death.

Amended. Approved June 5, 2024. Effective August 7, 2024:

(15) (a) "Self-administer" means when a qualified individual performs an affirmative, conscious, voluntary act to ingest medication prescribed pursuant to [this article] to bring about the individual's death.

(b) "Self-administer" does not include administration by parenteral injection or infusion.

☐