Leading the End-of-Life Movement for Thirty Years.

compassion & choices

Support. Educate. Advocate. Choice & Care at the End of Life.

Aid in Dying: Law and Experience

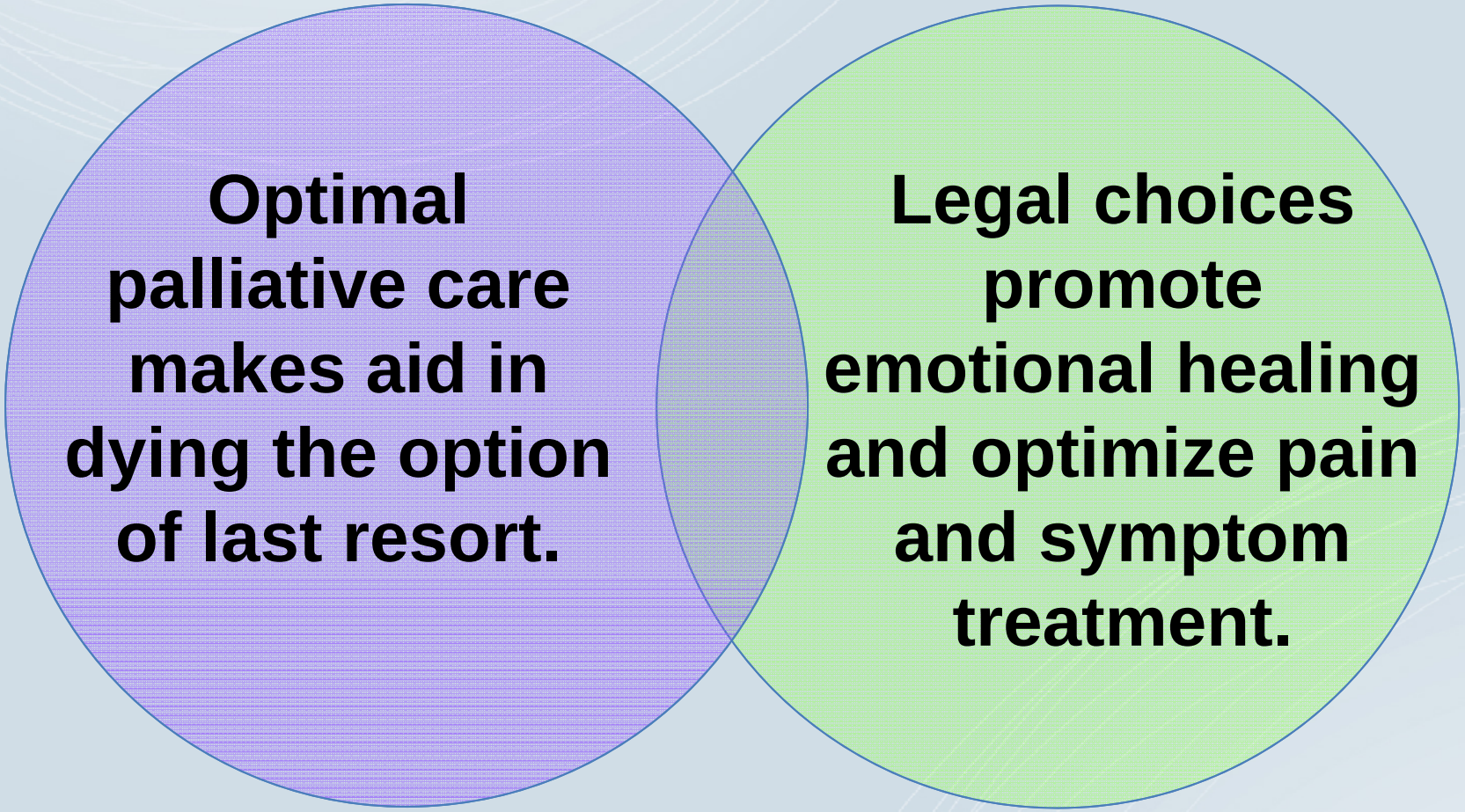
Barbara Coombs Lee, PA, FNP, JD

President

Compassion & Choices

CompassionAndChoices.org

Care and Choice Inter-Related



Charge from SCOTUS

"States are presently undertaking extensive and serious evaluation of [aid in dying]….In such circumstances, 'the challenging task of crafting appropriate procedures for safeguarding liberty interests is entrusted to the 'laboratory' of the States..."

Glucksberg 1997 O'Connor, J., concurring
Cruzan 1990 O'Connor, J., concurring

Oregon Aid In Dying Law

- Mentally competent, terminally ill adults.
- Legal resident of the state.
- 2 physicians must concur on diagnosis.
- 2 oral and 1 written request for Rx.
- Minimum 15-day waiting period between requests.

Oregon Aid In Dying Law

- 2 witnesses must certify no duress or coercion; decision is an informed one.
- Mandatory counseling about alternative treatment options.
- Patient can rescind request at anytime.
- If either physician questions the patient's decision-making ability, or suspects coercion, a psychiatric evaluation is required.


SUICIDE

Not Suicidal Ideation

"It is important to remember that the reason on which a terminally ill person (whose judgments are not impaired by mental disorders) bases a decision to end his or her life is *fundamentally different* from the reasoning a clinically depressed person uses to justify suicide."

American Psychological Association, working group. Amicus curiae brief filed in support of respondents, Gonzales v. Oregon No. 04-623.

Aid in Dying

Prominent healthcare organizations reject the term “assisted suicide,” recognizing it as clinically and legally inaccurate:

American Academy of Hospice & Palliative Medicine

American Public Health Association

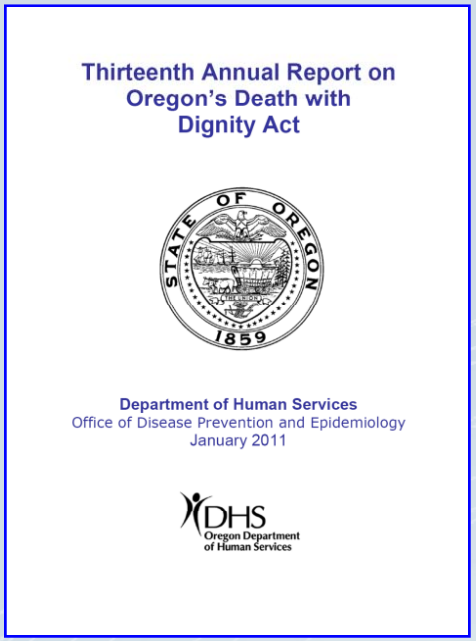
American Medical Women’s Association

Oregon Department of Human Services

14 Years Experience with Aid in Dying in Oregon

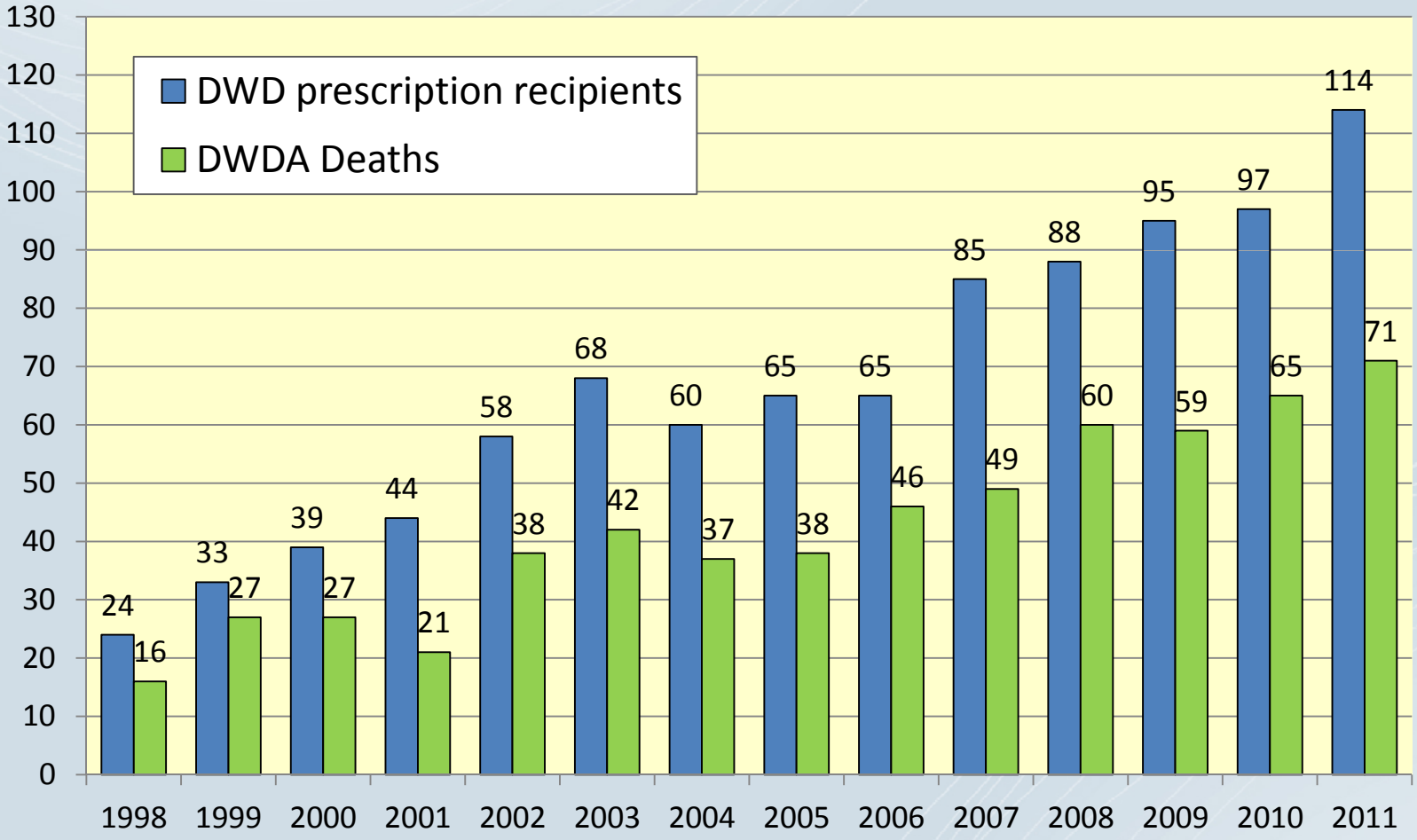
Use is limited: 596 in 14 years

- 98% white
- 70% college educated
- 90% enrolled in hospice
- 81% dying of cancer; 7% ALS
- 98% had insurance



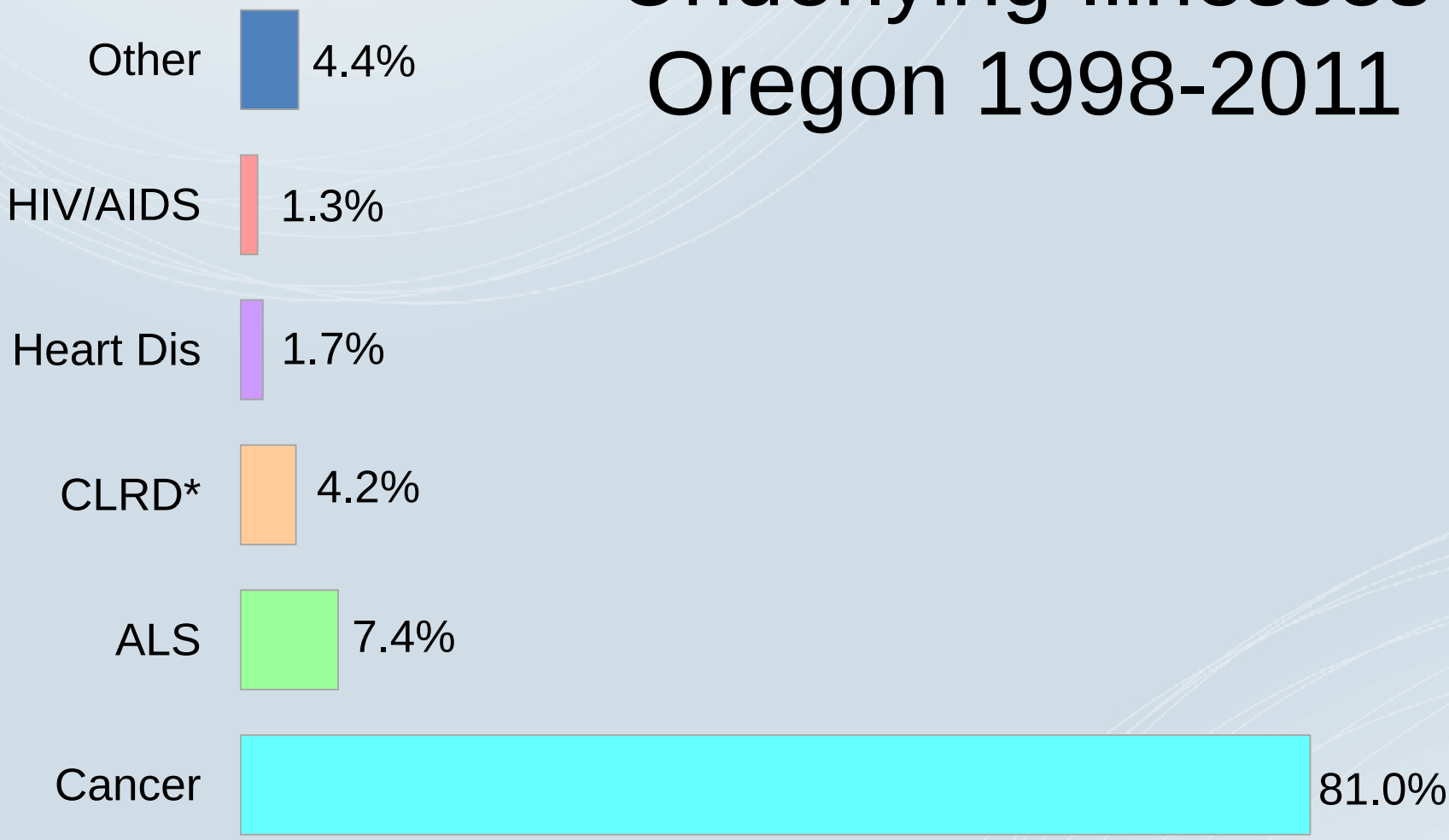
Oregon Department of Human Services February 2012

DWDA prescription recipients and deaths* by year, 1998-2011



*As of February 29, 2012

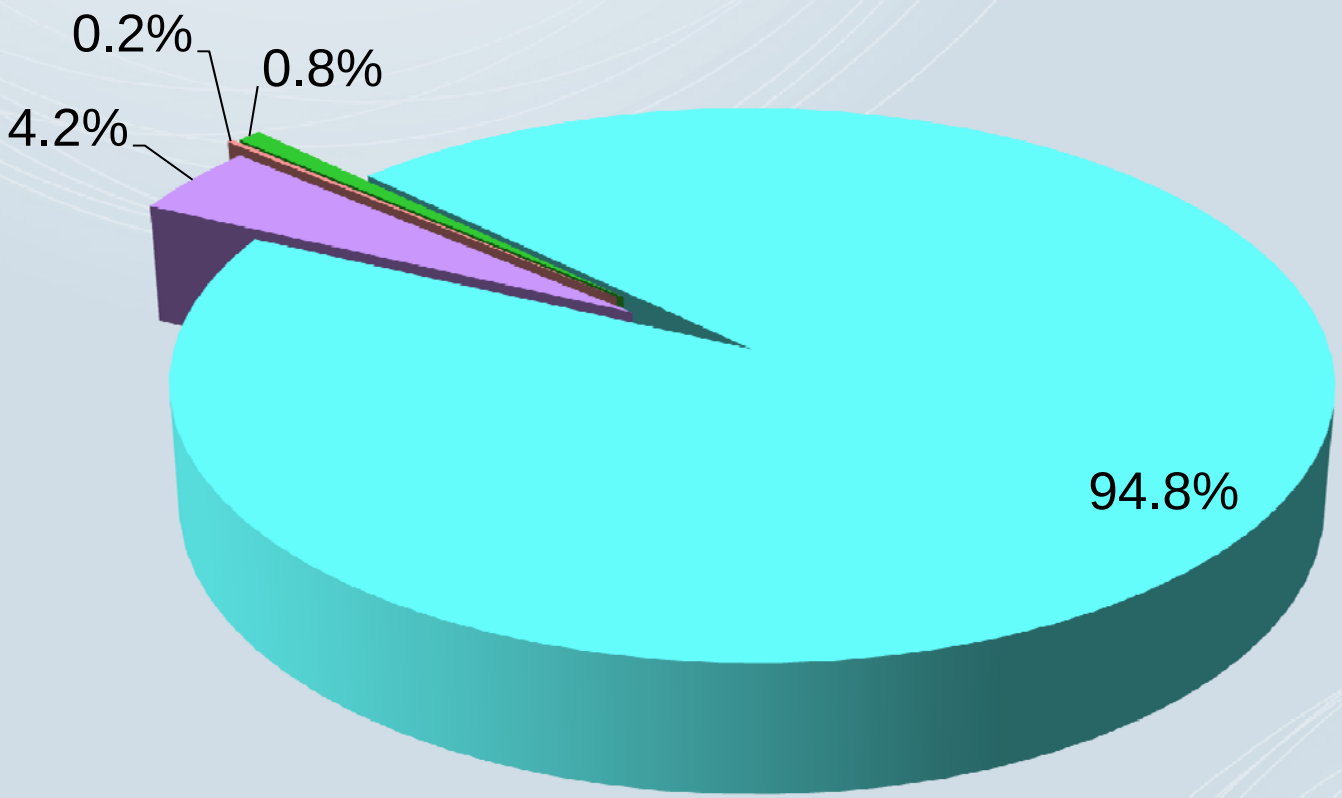
Underlying Illnesses Oregon 1998-2011



Oregon Department of Human Services, 14 Yr. Avg. - Feb. 2012

* Chronic lower respiratory disease

Place of Death



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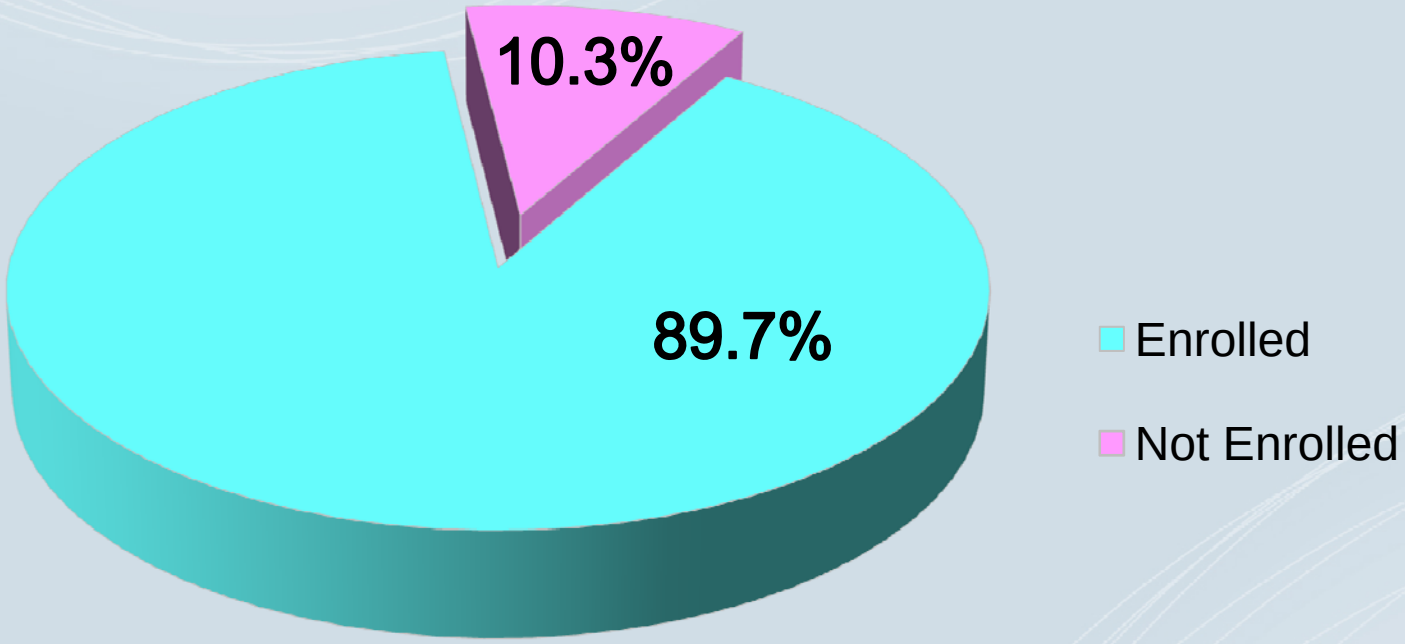
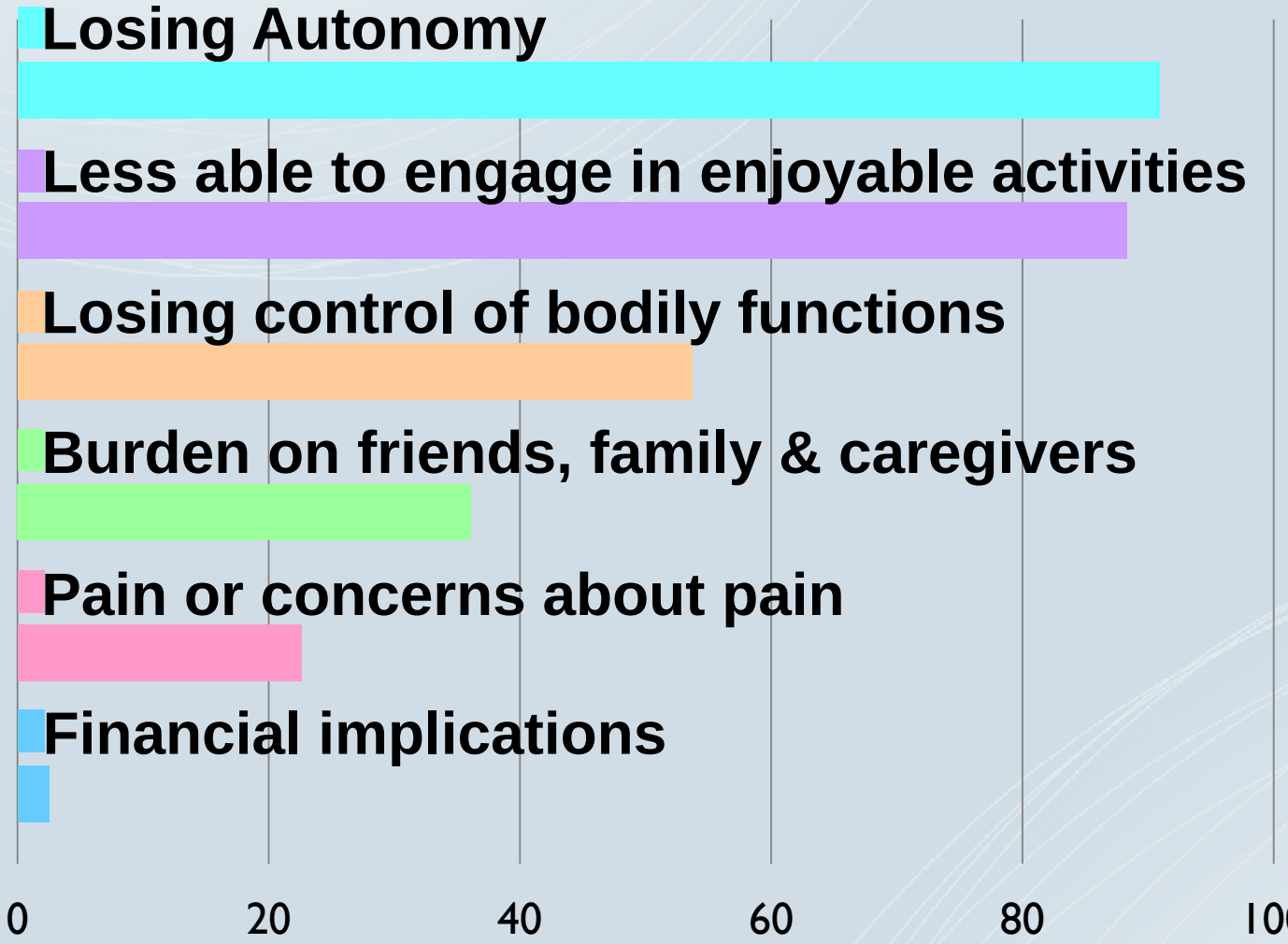
End of Life Care

Hospice Enrollment



Oregon Department of Human Services, 14 Yr. Avg. - Feb. 2012

End-of-Life Concerns



Oregon Department of Human Services, 14 Yr. Avg. - Feb. 2012

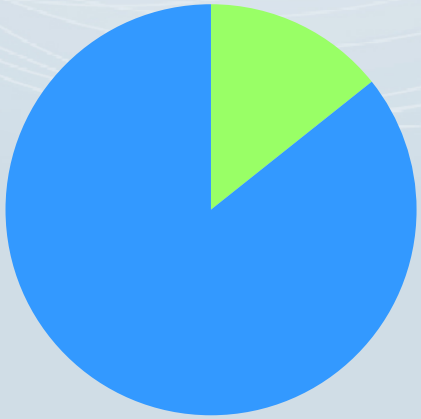
No Negative Effect on Families

- Family members better prepared for/ accepting of patient’s death.
- Diminished denial.
- Grief more resolved.
- More likely to believe patient's choices were honored.
- Less likely to have regrets about death.

Ganzini, Prigerson, et al. J Pain and Symptom Management (Sep. 2009)

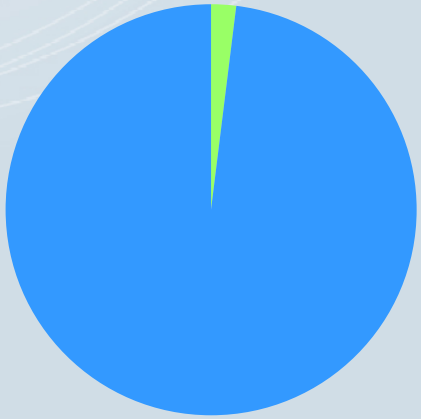
Consideration ≠ Equal Decision

1 in 6



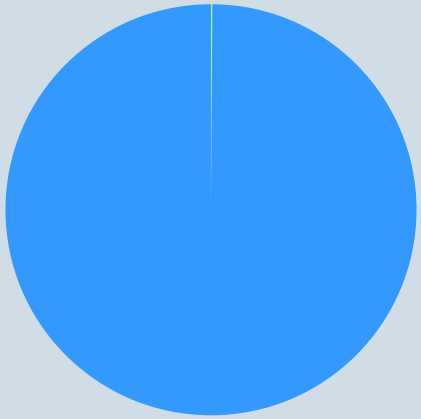
Consider Aid in Dying

1 in 50



Begin Request

1 in 1,000



Take life-ending medication

No covert practice revealed in 1,384 family interviews.

Susan Tolle et al. J. Clinical Ethics, Summer 2004

Doctors Who Receive Requests

5% Received Requests in First 21 Months

Predictors:

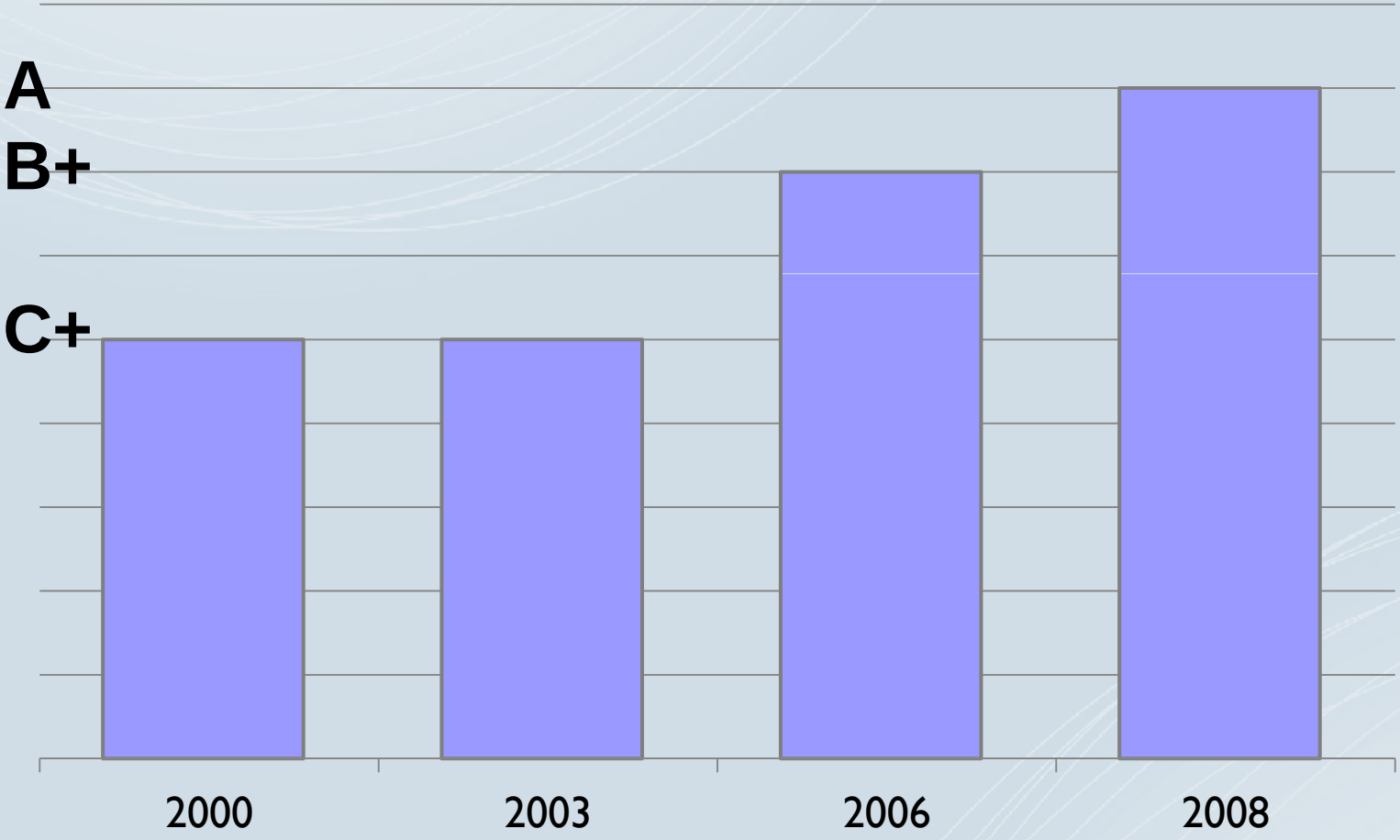
- Caring for large numbers of terminally ill.
- Willingness to write prescription.
- Finding care of the dying intellectually satisfying.
- Having sought to improve knowledge of pain medications.

Ganzini et al. JAMA, May 2001

Oregon Leads in End-of-Life Care

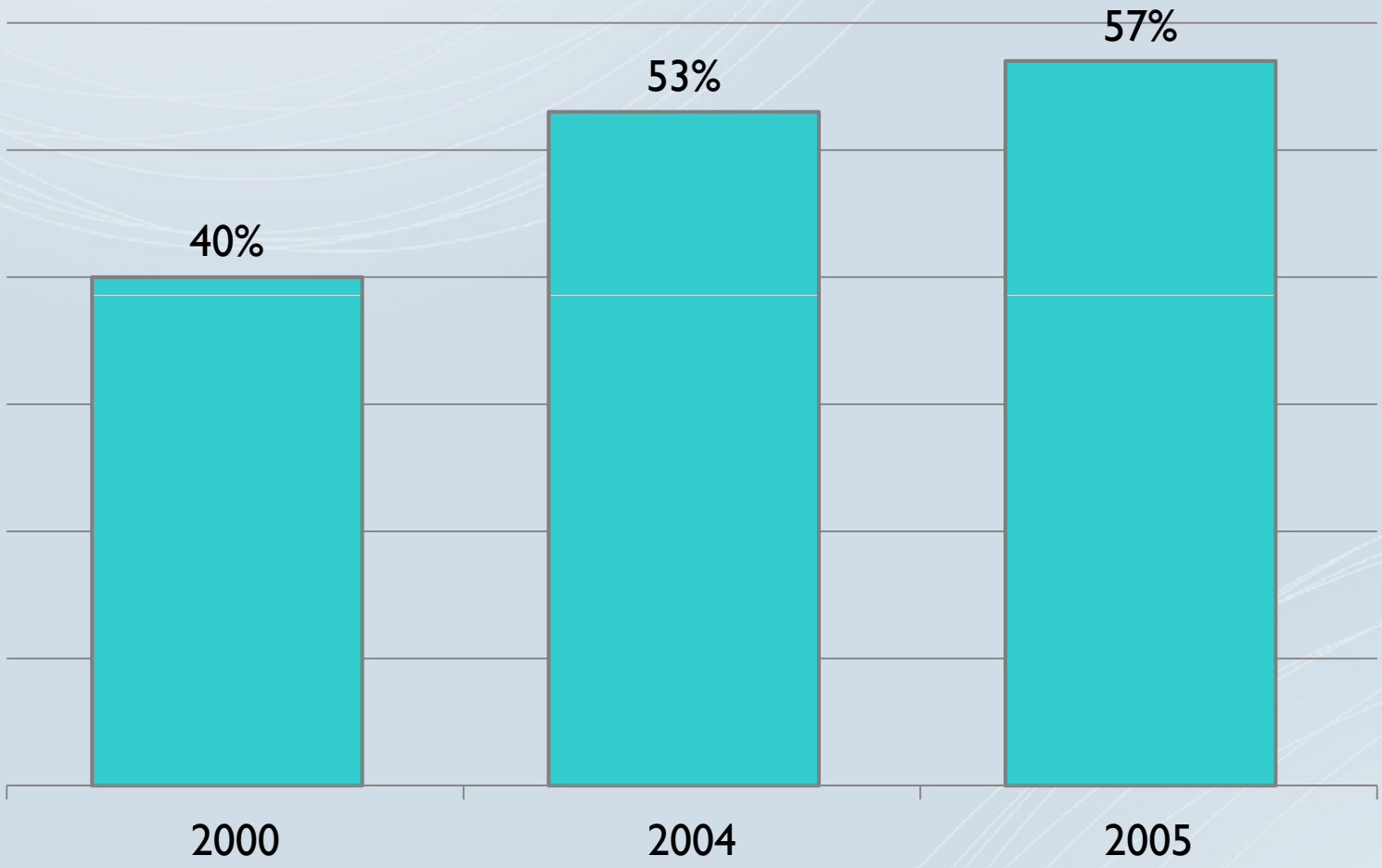
- Progressive Advance Directive Law.
- Pioneering Comfort Care Teams.
- Physician discipline for under-treating pain.
- Per capita use of medical morphine.

Oregon Pain Management Grades



Pain and Policies Study Group – Unv. of Wisc.

Oregon Hospice Penetration



Ann Jackson, former ED/CEO Oregon Hospice Assoc.

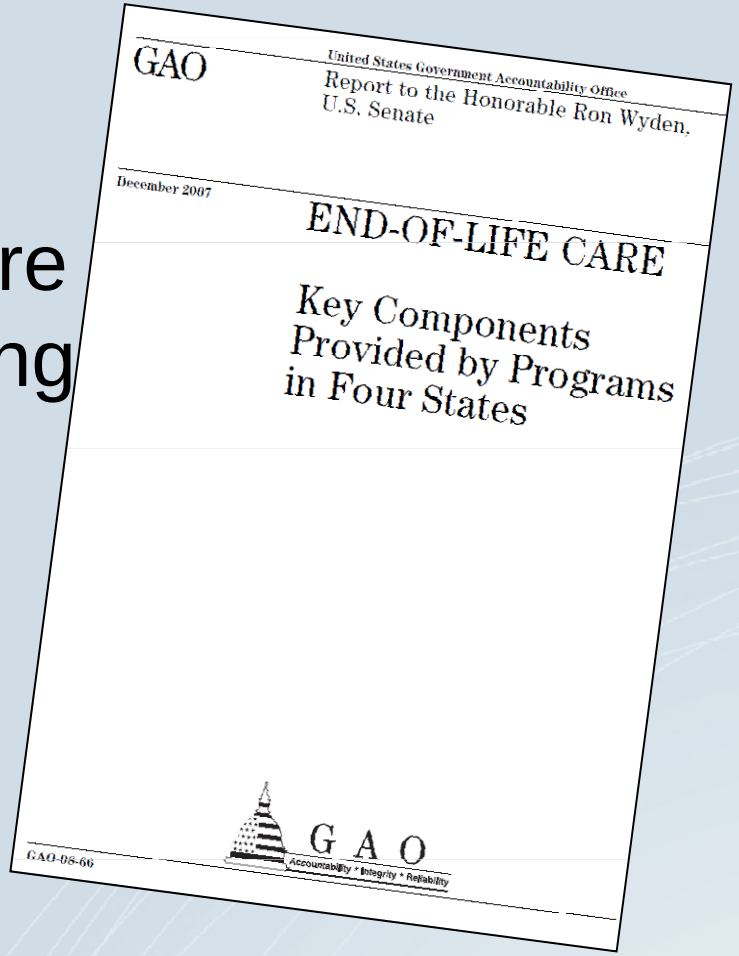
Objective Evaluation

"It is [quite] apparent from credible sources in and out of Oregon that the Death with Dignity Act has not had an adverse impact on end-of-life care and in all probability has enhanced the other options."

-Legislative Counsel of Vermont 2004

Objective Evaluation

2007 - U.S. GAO, the watchdog of Congress, compared Oregon with 3 other states. “Physicians are more comfortable discussing end-of-life issues…since… the Dignity Act… focused attention…and helped create an environment where options are discussed more openly.”



APHA Two-Year Study

2008 – APHA House of Delegates Supports Aid in Dying

Recommendations

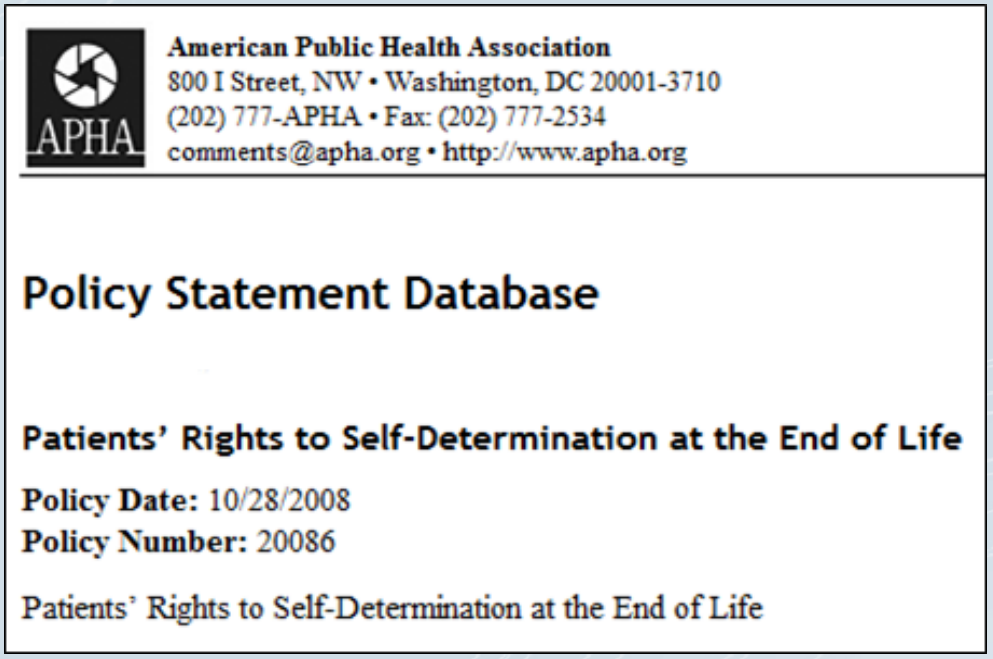
Accordingly, the American Public Health Association—

• Supports allowing a mentally competent, terminally ill adult to obtain a prescription for medication that the person could self-administer to control the time, place, and manner of his or her impending death, where safeguards equivalent to those in the Oregon DDA are in place.

APHA's Data Review and Analysis Concluded:

No Adverse Impact

No Risk to People with Disabilities



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comments@apha.org • http://www.apha.org

Policy Statement Database

Patients' Rights to Self-Determination at the End of Life

Policy Date: 10/28/2008
Policy Number: 20086

Patients' Rights to Self-Determination at the End of Life

Conclusion of Leading Bioethicist

"I worried about people being pressured to do this. But … the policy in Oregon is working. There is no evidence of abuse or coercion, or misuse of the policy."

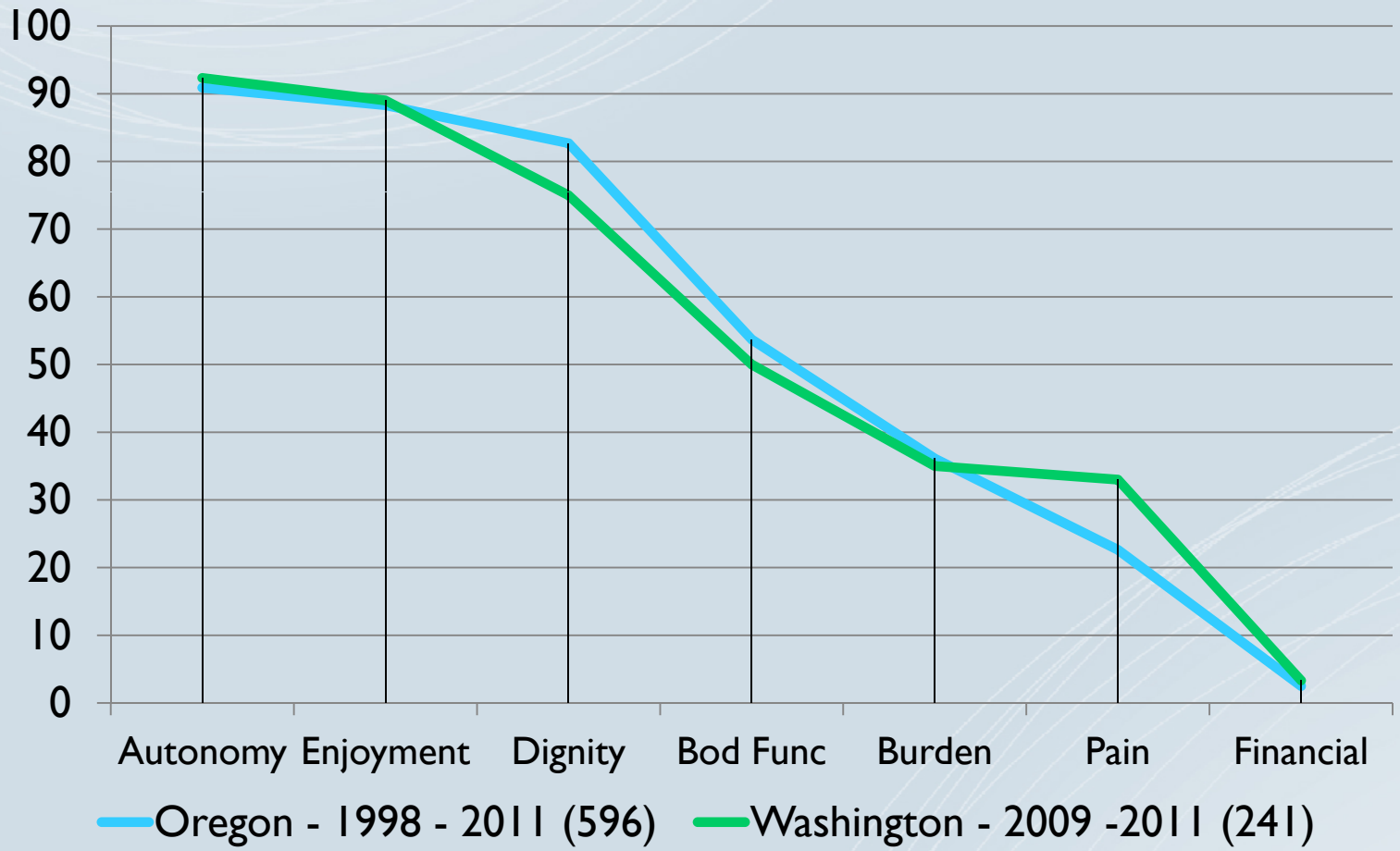
Arthur Caplan, Director of the Center for Bioethics at the University of Pennsylvania School of Medicine.

The Oregon Experience
The “laboratory” has served its function

Rather than posing a risk to patients or the medical profession, the DWDA has galvanized improvements in EOL care:

- Increased physician enrollment in CME courses on pain/symptom management;
- Increased physician enrollment in CME courses on recognizing depression and other psychiatric disorders;
- Increased referrals to hospice programs.

Washington State
Three Years of Replicating Data



Does Decriminalization Reduce Aid in Dying?

Consideration Rate = Other States

(Jacobson et. al. J. Clinical Ethics Summer 1995)

National Assisted Deaths = 1 in 250

(E.S. Emanual Lancet 1996)

National Study Found 6% of Physicians Admit to Having Helped at Least One Patient End Life

(Medical Economics 2002)

Neither the Tolle 2004 family survey, nor the Ganzini 2000 physician survey, found Oregon unreported cases. (Reported = 1/1000)

How Might Legalization Reduce Aid in Dying?

1. Doctors won't act outside safe harbor.
2. Hospice referrals ameliorate need.
3. Open conversation invites careful deliberation and symptom management.

Ganzini, J. Clinical Ethics, Summer 2004

Out of the Laboratory

And Into Medical Practice


Montana

Baxter, et al. v. Montana

On December 31, 2009, the Montana Supreme Court ruled that Montanans may choose aid in dying under state law. “We find no indication in Montana law that physician aid in dying provided to terminally ill, mentally competent adult patients is against public policy.”

Under Montana's Ruling Patient:

- Must be an adult
- Must be mentally competent
- Must initiate request for the medication
- Must be a resident of Montana
- Must be terminally ill
- Must self-administer medication

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