Physician Aid-In-Dying: Lessons from Oregon’s Death with Dignity Act

George Castro, J.D., LL.M. (Health Law)
gscastro@hotmail.com

Brittany Maynard’s decision to end her own life on November 1, 2014, received broad media attention and re-ignited the debate over the right to die and physician aid-in-dying. Maynard was diagnosed with a terminal brain cancer early in 2014 and given only a few months to live. Facing such prognosis, Maynard moved to the state of Oregon to control the manner and timing of her death under Oregon’s physician aid-in-dying law. In the weeks approaching her death, Maynard became an advocate of a death-with-dignity movement, which is slowly gaining traction in several U.S. states.¹ According to the aid-in-dying advocacy group Compassion & Choices, unprecedented legislative action is currently happening in 27 states and Washington D.C. to either introduce or pass death-with-dignity legislation.²

Oregon was the first state to legalize the practice of physician aid-in-dying in the United States. In November of 1994, its citizens approved Ballot Measure 16, also called the Oregon Death with Dignity Act (DWDA), which allows a competent, adult Oregon resident, who is suffering from a terminal disease,³ to obtain prescription medications to hasten his or her death, within narrow, tightly defined circumstances. Despite the measure’s passage, opponents persuaded a federal judge to issue an injunction temporarily blocking the law. Three years later, the injunction was lifted, but Oregon’s Legislative Assembly tried to repeal the DWDA with Ballot Measure 51.

³ Terminal disease is defined as an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six (6) months. Glossary, OREGONLAWS.ORG, http://www.oregonlaws.org/glossary/definition/terminal_disease (last visited April 30, 2015).
Voters rejected it by a margin of 60% to 40%, reaffirming the nation’s first aid-in-dying law. Oregon’s DWDA took effect on October 27, 1997.

To date, DWDA remains a controversial topic across the U.S. Some faith-based opponents argue that the practice will inevitably lead to abuses, such as patients who might be pressured to take their own lives by family members and others who wish to save money or end the burden of caring for someone with a debilitating illness. Other opponents, such as advocacy groups supporting people with disabilities and the American Medical Association, argue that the Act is dangerous for vulnerable individuals, difficult or impossible to control, and that aid-in-dying is fundamentally incompatible with the physician’s role as healer, thus unethical. In addition, opponents say that aid-in-dying is an unnecessary option because excessive pain related to terminal diseases may often be manageable.

In 2008, fifty-six Oregon patients, who either requested physician aid-in-dying or contacted a physician-led aid-in-dying advocacy organization, participated in a study conducted by Dr. Ganzini, Dr. Goy, and Dr. Dobsha, which sought to explain the reasons behind requests for physician aid-in-dying. Data showed that when patients first requested DWDA medication, they did not do so because of physical symptoms or quality of life at the time of the request, but in anticipation of future limitations caused by the disease. Their desire to die was not strong, and they did not believe that their present quality of life was poor, meaningless, or worthless. Rather, they chose the DWDA option to protect against the risk of future experiences they did not believe they could endure.

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8 Id. at 492.  
9 Id.  
10 Id.
motivated to hasten death by the prospect of loss of autonomy, loss of control, quality of life, and an inability to remain at home, with looming restrictions and dependence on others.\textsuperscript{11} Research data also supported the finding that the decision to request DWDA medication did not appear to stem from lack of access to symptom management, but rather was seen by most patients as an option of last resort.\textsuperscript{12} As such, the argument that lethal prescriptions have or will substitute for competent end-of-life care is not necessarily true.

Oregon’s Health Division (OHD) has monitored compliance with the DWDA, collected information about the patients and physicians who prescribe the medications, and published annual statistical reports since the DWDA’s inception.\textsuperscript{13} The 2014 data show that only 31 deaths per 10,000 total deaths (0.3\%) last year were DWDA deaths, and that between 1998 and 2014, a total of 1,327 terminally ill patients were given written DWDA prescriptions (an average of 74 patients per year), but only 859 patients (65\% of the total) actually died from ingesting the medications prescribed under the Act.\textsuperscript{14} As in previous years, the three most frequently mentioned end-of-life concerns in 2014 were decreased ability to participate in activities that made life enjoyable (91.4\%), loss of autonomy (86.7\%), and loss of dignity (71.4\%). When analyzing data from 1998 to 2014, the number of patients concerned with loss of autonomy and decreased ability to participate in enjoyable activities has trended upward.\textsuperscript{15} Concerns about loss of autonomy increased from 75\% in 1998 to 86.7\% in 2014, and concerns about decreased ability to participate in enjoyable activities increased from 68.8\% in 1998 to 91.4\% in 2014.\textsuperscript{16} The law requires the physician to offer palliative and hospice care, and 93\% of those who died

\begin{itemize}
\item \textsuperscript{11} Id.
\item \textsuperscript{12} Id.
\item \textsuperscript{13} Annual Reports, Oregon Public Health Department, https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx.
\item \textsuperscript{15} Id. at 2.
\item \textsuperscript{16} Id.
\end{itemize}
in 2014 were enrolled in hospice care, either at the time DWDA prescription was written or at the time of death.\textsuperscript{17}

Oregon’s DWDA has strict safeguards in place to ensure protection of the terminally ill individual. Section 3 of the Act identifies twelve steps for attending physicians to follow, including procedures for ensuring informed consent, provisions for rescinding the request, and referrals to counseling.\textsuperscript{18} In addition, it mandates a referring physician to concur with the attending physician on the diagnosis of terminal illness, assess for mental competency, and ensure the patient is acting voluntarily.\textsuperscript{19} The data in Oregon do not show any evidence of patients being coerced to expedite the end of their lives. In fact, the state has procedures in place to stop the request process if there is any evidence of coercion.\textsuperscript{20}

In conclusion, for many patients, having the lethal prescription option to alleviate the suffering from symptoms that cannot be controlled even with good palliative care is the paramount reason for requesting lethal medication. As noted by Cassell in the article, “\textit{When Suffering Patients Seek Death},” it is not the absolute level of pain, but the meaning of the pain, the prospect of its worsening, and its effect on one’s sense of self that are the true components of suffering.\textsuperscript{21} Despite the debate about whether DWDA is appropriate, the data shows that its use ultimately helps terminally ill patients endure the last days of their lives with the knowledge they can control the timing and manner of their own death with dignity.

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\textsuperscript{17} Id.
\textsuperscript{18} OR. REV. STAT. §127.800 (1994).
\textsuperscript{19} Id. at §127.820 s.3.02.
\textsuperscript{20} Id. at §127.815 s.3.01.
\textsuperscript{21} \textit{Physician-Assisted Dying: The Case for Palliative Care and Patient Choice} 75-88 (Timothy E. Quill & Margaret P. Battin eds., 2004).
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