

**FACTUAL RESPONSES  
REFUTING CLAIMS MADE BY OPPONENTS  
OF THE DEATH WITH DIGNITY LAW**

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**Submitted to the Vermont Legislative Council by:**

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## **I. Introduction and Overview**

We are Vermont doctors supportive of comprehensive improvements to Vermont's end-of-life care systems and laws, including enactment of the Death with Dignity Act that would grant terminally-ill Vermonters more autonomy, choice and control over the timing and manner of their death.

We've spoken at countless public forums in dozens of communities around the state. This experience has been rewarding and most informative. For us, this matter is simply about respecting our patients' right to self-determination and compassionately responding to their suffering.

While we anticipate and understand that the Legislative Council will develop an independent resolution of the matters disputed about the Oregon experience with the Death with Dignity law, we are submitting the following factual observations in response to opponents' claims. This is a compilation of material we've previously submitted to lawmakers. We want to provide you with this initial resource. We do not aim to provide an answer or counterpoint to every allegation made by those opposed to the act. We welcome the opportunity to follow up to provide further information on any of these or the other matters being researched.

The general topics where we present specific information on contested matters are:

- 1) The Oregon Death with Dignity Act's Impact on End-of-Life Care
- 2) Patient Utilization of the Oregon Death with Dignity Act
- 3) Safeguards Govern the Proper Application of the Act
- 4) Patients' Right to Select A Medical Care Provider
- 5) Government and Independent Monitoring of the Act's Application
- 6) Legal Issues Related to the Death with Dignity Law
- 7) Opponents' Unsubstantiated Innuendos About Specific Oregonians

## II. FACTUAL RESPONSES TO OPPONENTS= CLAIMS

### 1) The Oregon Death with Dignity Act's Impact on End-of-Life Care

- *Opponents= Claims:*

Legalizing assisted suicide will reduce efforts to improve palliative care.<sup>1</sup> Laws for assisted suicide might discourage continued efforts to provide good palliative care.<sup>2</sup>

℞ *Factual Response:*

The Act has served as a catalyst for improving end-of-life care; Oregon is a universally recognized leader in end-of-life care across the entire continuum of options and the Death with Dignity Act is a part of that success.<sup>3</sup> In fact, since the debate concerning death with dignity began in 1994, care for the terminally ill has improved in substantial and quantifiable ways.<sup>4</sup>

In Oregon:

- Hospice utilization is double the national average;<sup>5</sup>
- More people die at home than in hospitals or care facilities;<sup>6</sup>
- Oregon consistently ranks in the top three for the medical use of morphine to control pain.<sup>7</sup>

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- *Opponents= Claims:*

A physician assisted suicide isn't compassion. It is abandonment.<sup>8</sup> Palliative care must trump the lethal failure of the Oregon medical establishment.<sup>9</sup> While acknowledging that suffering is not the equivalent of evil, Christian compassion calls us to >suffer with= those who are suffering, using Christ as our model, ever mindful of the redemptive element of suffering.<sup>10</sup>

℞ *Factual Responses:*

Abandoning a patient would be a serious violation of a doctor=s professional conduct standards. Over the course of the six-plus years since Oregon=s law was enacted, no claim of abandonment has ever been filed by family members of patients who died under the law.<sup>11</sup>

99 percent of the patients who utilized the law had access to hospice care (85% were enrolled and 14% declined)<sup>12</sup>.

## 2) Patient Utilization of the Oregon Death with Dignity Act

- ***Opponents= Claims:***

Physician-assisted suicide is not needed. The need for PAS is small. Few patients ask for it and even fewer use it when it is available.<sup>13</sup> The national Christian Medical Association Executive Director, David Stevens, M.D., along with Board Trustee and CMA Ethics Committee Chair Robert Orr, M.D., are leading grass roots campaign to defeat [the] legislation because it is not needed.<sup>14</sup>

However, while the need is small, utilization in Oregon has increased by huge percentages. From 1998 to 2003, # of PAS deaths is up 279% and # of lethal Rx written is up 263%.<sup>15</sup>

℞ ***Factual Response:***

The Act benefits more than just the terminally-ill Oregonians who have acquired a prescription or actually taken the prescribed drug. The experience in Oregon indicates that, for most people, simply knowing that the option exists is enough. Each year, hundreds of Oregonians explore the death with dignity option and most of them find the comfort they need without using Oregon's law.<sup>16</sup> The law benefits all mentally competent, terminally-ill Oregonians who know that, should their suffering become more than they can bear, they can control the timing and manner of their imminent death. The same will be true in Vermont where 1300 Vermonters were expected to die from cancer in 2003.<sup>17</sup>

In the six years during which the Oregon law has been in effect, there have been approximately 180,000 deaths in that state. During this same period of time, 265 prescriptions for life-ending medication were written under the law, and 171 patients died thereby. Physician-assisted deaths have accounted for approximately one-tenth of one percent of all Oregon deaths between 1998 and 2003.<sup>18</sup> To cite percentages without citing the actual numbers distorts the significance of these percentages, and is meaningless.

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- ***Opponents= Claims:***

Only 20% of the 129 reported cases of PAS in Oregon in the first 5 years say they have unrelieved pain; the vast majority list psycho-social reasons for their suicide.<sup>19</sup> It's about physician autonomy and/or liability.<sup>20</sup>

℞ ***Factual Response:***

Pain is only one element in this complex equation. Beyond pain, for most terminally-ill people, it is the loss of autonomy, quality of life, and control of bodily functions that becomes intolerable. For an in-depth exploration of these issues, see Oregon Physicians' Perceptions of Patients who request assisted suicide and their families.<sup>21</sup>

Oregon Department of Human Services data consistently reveal that patient desire to avoid loss of autonomy is the most frequently-cited reason why terminally-ill patients have utilized the law.<sup>22</sup>

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### 3) Safeguards Govern the Proper Application of the Act

- *Opponents= Claims:*

Twenty-seven percent of Oregon MD=s willing to write Rx under the Act admit they=re not confident of 6-month prognosis.<sup>23</sup>

℞ *Factual Response:*

The Oregon statute defines Aterminal disease@ as Aan incurable and irreversible disease that has been medically confirmed, and *will, within reasonable medical judgment, produce death within six months@* (Italics added).<sup>24</sup> Predicting a six-month life expectancy is not an exact science; it is a reasoned projection of the terminal course of an incurable disease. The ability to determine a six-month prognosis is widely accepted in the medical community, and is in fact used to determine eligibility for Medicare-reimbursed hospice services.

The Oregon law requires the agreement of two physicians that the patient is within six months of death. Such a diagnosis is not arrived at casually. In this, as in other aspects of their practice, doctors are expected to meet community standards of care. The Oregon Death with Dignity law explicitly states, ANo provisionYshall be construed to allow a lower standard of care for patients in the community where the patient is treated or a similar community.@<sup>25</sup>

The law requires that the physician offer to the patient comfort, palliative and hospice care (83% of those who used the law died in hospice care; 17% declined such care). Most people cling to life as long as life is tolerable. In Oregon, A1 in 10 requests for a lethal prescription resulted in assisted suicide.@<sup>26</sup>

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- *Opponents= Claims:*

The Asafeguard@ of a psychiatric consultation is optional, rarely used, and appears to be pro forma.

℞ *Factual Response:*

The Act requires a second opinion to confirm the terminal diagnosis and six-month prognosis. It further requires that the patient be deemed capable (defined as able to make and communicate health

care decisions). If either physician determines that the patient's judgment is impaired, the patient must be referred for a psychological examination. When the Oregon Act first passed, some of the largest health care systems in the state, such as Oregon Health Sciences University and Kaiser Permanente, required a psychological consult as part of their protocols, even though it wasn't required by the law. This is no longer the case, because they realized pretty quickly that, given the other safeguards and requirements in the law, it took a very determined and capable patient to initiate and drive the process & competency is rarely a question.<sup>27</sup>

#### 4) **Patients= Right to Select A Medical Care Provider**

- ***Opponents= Claims:***

The Asafeguard@ of a second opinion is easily obtained by shopping around.<sup>28</sup>

℞ ***Factual Response:***

The second opinion, as required by law, is made by a highly qualified Oregon physician, generally an internist, pulmonologist or oncologist. 42 different physicians wrote prescriptions under the law in 2003.<sup>29</sup>

It is appropriate and common for patients to request, and in some instances for insurance companies to require, a second opinion, when a clinical situation reaches a threshold level. To demean this process claiming it is nefarious Adoctor shopping@ is disrespectful to terminally-ill people and completely misleading.

#### 5) **Government and Independent Monitoring of the Act's Application**

- ***Opponents= Claims:***

The state government=s monitoring and enforcement of the Act can be abused by doctors.<sup>30</sup>

℞ ***Factual Responses:***

Thorough reporting of actions governed by the Act is required of all doctors. The Oregon Health Division is charged with monitoring the Act and reporting any suspected noncompliance with the law to the Oregon Board of Medical Examiners.<sup>31</sup>

Doctors do not qualify for the legal safe harbor provided by the Act if they do not fully account for their actions and they face professional disciplinary action and criminal charges for failure to report.

- <sup>1</sup> Orr, Robert. Vermont Alliance for Ethical Healthcare. March 12, 2003.
- <sup>2</sup> Vermont Medical Society Excel Committee Proposed Statement on Physician Assisted Suicide, February 21, 2003.
- <sup>3</sup> Jackson, Ann. Panel Presentation in the Vermont Statehouse, November 13, 2003.
- <sup>4</sup> Spann, Jeri. State Initiatives in End-of-Life Care: Using Qualitative and Quantitative Data to Shape Policy Change. A publication of the National Program Office for Community-State Partnerships to Improve End-of-Life Care. Issue 1. June 1998.
- <sup>5</sup> Jackson, Ann: personal communication citing Medicare data on hospice penetration (meaning access and use of hospice services): Oregon is 41%; national average 19%.
- <sup>6</sup> Jackson, Ann: personal communication citing data collected by Oregon Dept. of Human Services Center for Health Statistics and reported by Oregon Hospice Association:  
Oregon's home death rate in 1997 was 35 percent, the highest in the nation. Its hospital death rate was the lowest at 32.5 percent and nursing home death rate at 32.4 percent, among the highest. The hospital death rate in Oregon is estimated at less than 25 percent in 2001. It is estimated that 50 percent of Americans die in the hospital. It is estimated that only 24.9 percent of Americans die at home.
- <sup>7</sup> Jackson, Ann: personal communication citing data on the medical use of morphine reported by the US Drug Enforcement Agency (DEA): Oregon's rating fluctuates year to year, though has been 1, 2, or 3 for over five years.
- <sup>8</sup> Orr, Robert. Letter to Vermont Medical Society, October 1, 2003.
- <sup>9</sup> Mitchell, Ben. Oregon's Lethal Experiment: An Annual Report. CBHD. Feb 22, 2001. www.cbhd.org.
- <sup>10</sup> Charles, Daryl. Articulating a Distinctly Christian Approach to Suffering. CBHD. Feb 10, 2004. www.cbhd.org
- <sup>11</sup> Hardy Myers, Oregon Attorney General, Oregon Department of Justice.
- <sup>13</sup> Orr, Robert and Golodetz, Arnold. Critique of S-112, the Vermont Death with Dignity Act. www.vaeh.org.
- <sup>14</sup> CMA Members Fight Assisted Suicide in Vermont. Christian Medical and Dental Associations. Feb 2003. www.cmdahome.org
- <sup>15</sup> Orr, Robert. Theory vs. Practice. March 13, 2004
- <sup>16</sup> J. Schwartz and J. Estrin, In Oregon, Choosing Death Over Suffering, *The New York Times*, June 1, 2004, D1.
- <sup>17</sup> CA A Cancer Journal for Clinicians. Vol. 53 no. 1, Jan-Feb, 2003, table 3, page 10.
- <sup>18</sup> Sixth Annual Report on Oregon's Death With Dignity Act. Oregon Department of Human Services March 10, 2004.
- <sup>19</sup> Orr, Robert. Letter to Vermont Medical Society, October 1, 2003.
- <sup>20</sup> Orr, Robert. Theory vs. Practice. March 13, 2004
- <sup>21</sup> Ganzini, Linda, et al. Journal of Palliative Medicine, Vol 6, Number 2, 2003.
- <sup>22</sup> Sixth Annual Report on Oregon's Death With Dignity Act. Oregon Department of Human Services March 10, 2004.
- <sup>23</sup> Orr, Robert. Vermont Alliance for Ethical Healthcare. March 12, 2003.
- <sup>24</sup> Sixth Annual Report on Oregon's Death With Dignity Act. Oregon Department of Human Services March 10, 2004.
- <sup>25</sup> ORS 127.800 to 127.897, The Oregon Death with Dignity Act.
- <sup>26</sup> Oregon Physicians' Attitudes About and Experiences With End-of-Life Care Since Passage of the Oregon Death with Dignity Act. Linda Ganzini, M.D., et al, *JAMA*, Vol. 285, No. 18, (5/9/2001).
- <sup>27</sup> Barbara Glidewell, Director and Ombudsman, Patient Advocate, OHSU Department of Patient Relations.
- <sup>28</sup> Orr, Robert. Letter to Vermont Medical Society, October 1, 2003.
- <sup>29</sup> Sixth Annual Report on Oregon's Death With Dignity Act. Oregon Department of Human Services March 10, 2004.
- <sup>30</sup> Orr, Robert. Theory vs. Practice. March 13, 2004.
- <sup>31</sup> Sixth Annual Report on Oregon's Death With Dignity Act. Oregon Department of Human Services March 10, 2004.