The Oregon Death with Dignity Act: Twenty Years Experience

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What is the Oregon Death with Dignity Act?

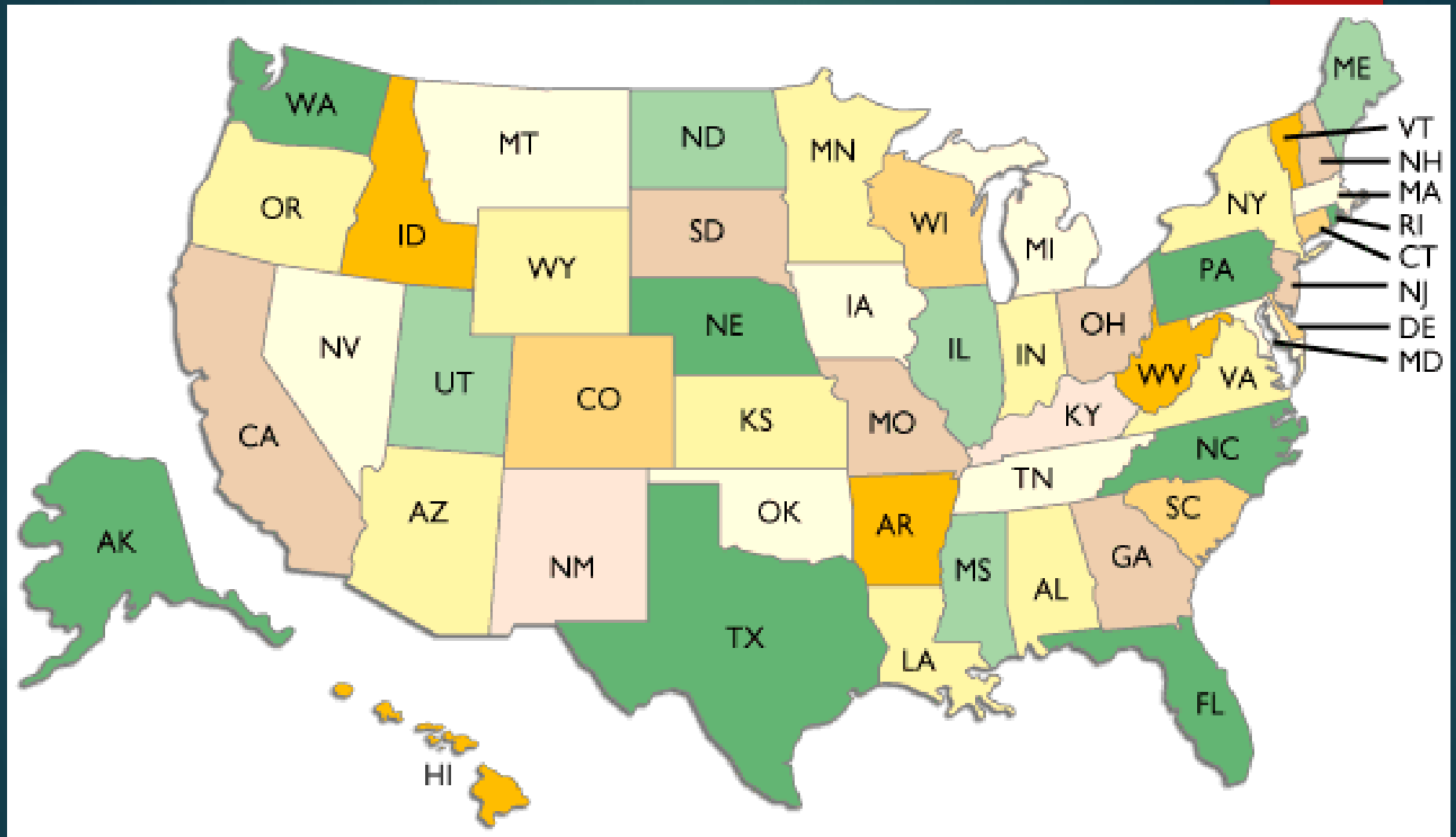
- Allows a physician to prescribe a lethal dosage of medication for a competent, terminally-ill patient for the purposes of self-administration
- Patient must be 18 years or older
- Patient must be a resident of the state of Oregon
- Patient must make two oral requests and one written request over 15 days, the latter signed by two witnesses

Roles of Attending and Consulting Physician

- Attending and second physician consultant must confirm:
  - Patient has a disease that, within reasonable judgment, will cause death within six months.
  - Patient is capable of making and communicating health care decisions.
  - Decision is voluntary.
  - Patient must be informed of all feasible alternatives including hospice and comfort care.
  - Must request (but not require) that patient notify family of request.
  - If the physician or consultant is concerned that the request is influenced by a mental disorder or depression, the patient must be evaluated by a psychiatrist or psychologist

Legal Requirements of ODDA

- All physicians who prescribe under the ODDA are required to notify the Oregon Health Division and provide documentation that legal requirements are met.
- If legal requirements not met, reported to the state licensing board.
- Not considered suicide under the law.
- 1127 deaths between 1998-2016
- Washington (2008), Vermont (2013), Colorado (2016) and California (2016) laws are almost identical
- Data from Washington state very similar.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Why Oregon?

- Demographics
  - Few Ethnic Minorities
  - Low proportion church-affiliated
- Politics
  - Opposition caught unaware—ballot measures in neighboring Washington and California failed in the early 1990s
  - Long history of political innovation through ballot measure
- Culture
  - Ethos of rugged individualism
- Medical
  - Already a well developed hospice system and low rate of deaths in hospital

Oregon end of life policy innovations--POLST

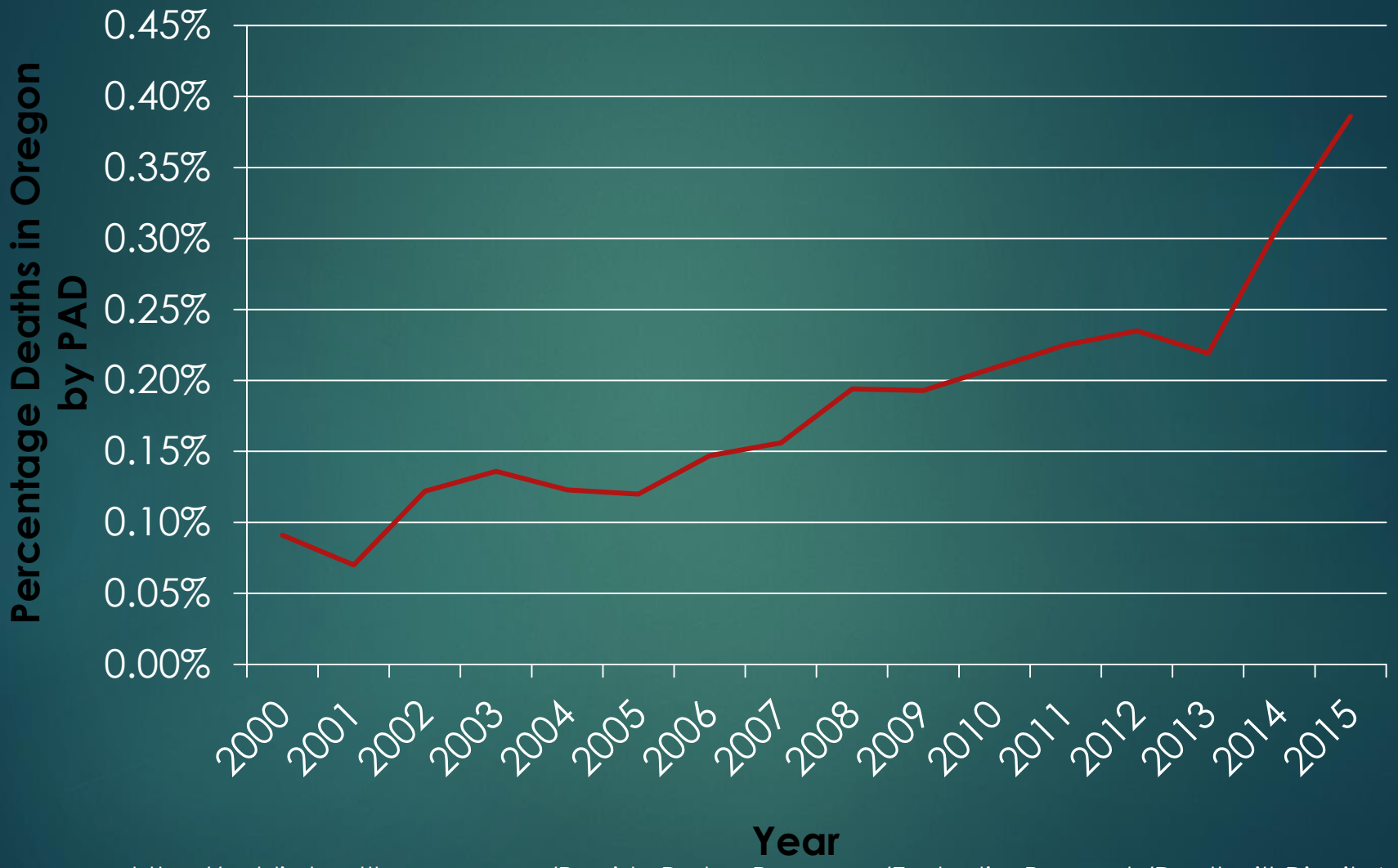
- POLST—Physician Order for Life-sustaining Treatment
- A medical order that conveys a patient's treatment preferences that can be transferred across settings
- Pioneered in Oregon in 1995, now available in 19 states
- Includes sections on resuscitation preferences, level of interventions, and specific preferences for antibiotics and nutrition

POLST—Oregon Innovations

- Order is transmitted to a large electronic data base the interacts with the EPIC Electronic health record
- Available immediately to Emergency Medical System Personnel and Emergency Department Staff
- Can be signed by a physician, nurse practitioner or physician assistant.
- Prepared by nurses and social workers in hospice and nursing facilities.
- Positively regarded by EMTs.

Hickam JAGS, 2015; Zive J Med Syst, 2016

Deaths in Oregon by PAD



https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/index.aspx

Comparison of Laws in Canada and Oregon

Oregon

- Life expectancy of less than six months
- Mental disorder that is impacting decision may result in exclusion
- Only oral self administration
- Physician must prescribe
- No requirement to facilitate finding a willing provider.
- 15 day wait period
- No requirement for suffering
- Must be competent when lethal medication prescribed

Canada

- Natural death is reasonably forseeable
- Psychological suffering is one type of suffering that is a requirement
- Both self administration and clinician administration
- Physician or nurse practitioner may prescribe or administer.
- Some provinces require transfer of care if clinician has objection.
- 10 day reflection period
- Physical or psychological suffering
- Must be competent when MAID provided

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Debra Malina, Ph.D., *Editor*

Medical Assistance in Dying — Implementing a Hospital-Based Program in Canada

Madeline Li, M.D., Ph.D., Sarah Watt, Marnie Escaf, H.B.B.A., M.H.A., Michael Gardam, M.D., Ann Heesters, M.A., Gerald O'Leary, M.B., and Gary Rodin, M.D.

Oregon Surveys

- 418 Oregon psychiatrists (Ganzini, et al, Am J Psych, 1995)
- 625 Oregon psychologists (Fenn and Ganzini, 1996)
- 4000 eligible physicians (Ganzini et al, NEJM, 1999)
  - 5% had received a request
- 545 hospice nurses and social workers (Ganzini et al, NEJM 2001)
  - 45% had cared for a requesting client
  - 30% had cared for a client who had received a lethal prescription
- 58 Oregonians in process of requesting PAD (Ganzini Arch Intern Med, 20098; Ganzini et al BMJ, 2008
- 83 family members of patients who requested PAD (Ganzini et al, JPSM, 2009)

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Oregon Health Care Practitioners' Attitudes Toward ODDA

Attitude toward ODDA or PAD	Generalist Physicians N=2641	Hospice Nurses N=307	Hospice Social Workers N=90	Hospice Chaplains N=50
Support	51%	48%	70%	40%
Neutral	17%	16%	16%	18%
Oppose	31%	36%	13%	42%

Actions of Health Care Practitioners

- 34% of physicians willing to prescribe
- Only 3% of hospice nurses and 14% of chaplains would actively oppose a client's choice for PAD (62% of nurses neither support nor oppose, 34% of nurses support)
- 12% of hospice nurses and no chaplains would transfer a patient who received a lethal prescription

Data from Oregon Health Division

- 1127 deaths by Physician assisted death (PAD) 1998-2016
  - 97% white, 1% Asian, 1% Hispanic
  - 52% men
  - Terminal diseases—77% cancer, 8% ALS
  - 90% hospice enrolled
  - 93% died at home (increased numbers in LTC or hospital)
  - 1 % lacked health insurance
  - Median 56 days between first request and death
- Risk factors for dying by PAD
  - B.A college degree or higher— RR 8.3 (5.0-13.7)
  - ALS—RR 31 (14.4-73.5), Cancer RR 4.6 (2.5-8.4)
  - Younger age and being unmarried

https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx

Requesting Patients (N=56): Physical Symptoms as Reasons for Requests

	Current symptoms median (IQR)	Future Symptoms median (IQR)
Pain	1 (1,3)	5 (4,5)
Dyspnea	1 (1,2)	3 (1,5)
Fatigue		3 (1,5)
Loss of bowel/ bladder control	1 (1,1)	3 (1,5)
Confusion	1 (1,1)	3.5 (1,5)

1= not important, 5 = very important

Were these patients receiving adequate palliative care?

- Physicians implemented a substantive intervention in half of requesting patients
- 46% of requesting patients who received a substantive intervention changed their mind about PAD compared to 15% who did not ($P < .001$)
- 90% in hospice
- Only 15% of patients had more pain than average hospice patient, 43% had less

Requesting Patients' (N=56) Reasons: Independence, Control, Self-sufficiency

	Current State median (IQR)	Future State median (IQR)
Loss of independence		5 (3,5)
Inability to care for self	1 (1,2)	5 (3,5)
Control circumstances of death		5 (4,5)
Not wanting to be cared for by others		3 (1,5)
Wanting to die at home		3 (1,5)

1 = not important, 5 = very important

Role of Depression in Requests for PAD

	Physician Study[1]	Hospice Practitioners Survey[2]		Requesting Patients Study[3]
		Nurses	Social Workers	
	N=143	N=82	N=38	N=58
	Prevalence	Median (IRQ)	Median (IRQ)	No. (%)
Depression	20%	2 (1,3)	1 (1,2)	15 (24)

[1] Patients who requested PAD

[2] Hospice clients who received a lethal prescription. Score 1=not important, 5=very important

[3] Patients who made an actual request. 1=not important, 5=very important

Summary

- Potentially important differences between Canadian and American laws on PAD
  - may render Oregon data on PAD not generalizable to Canada
  - Canadian law has fewer barriers to PAD
- Oregon law invites persons who want control and independence at the end of life
- Most Oregonians do not have substantial suffering at the time they begin the process of obtaining PAD.