OREGON SENATE BILL 893
2017 Legislative Session

PROPOSED AMENDMENT TO THE DEATH WITH DIGNITY ACT

• Patient executes a lawful advance directive;
• Designate an “expressly identified agent” (“attorney-in-fact”); 
• If person “ceases to be capable” following prescription for PAD;
• EIA can “collect” and “administer” prescribed medication

Why was such a process rejected in 1994 and in 2017?
SAFEGUARDS ... FOR WHOM?

Terminally ill patients

• Ensure informed and voluntary choices; Counseling referral for impaired judgment
• “No safeguards are in place for a patient who loses cognitive function after the prescription is written” *(K. Hedberg, C. New, Annals of Internal Medicine, 2017; 167: 579-583)*

Physicians/Pharmacists

• Immunity from prosecution or discipline for participation in good-faith compliance
• No legal duty of participation protects personal conscience or religious values

Public

• Transparency and Reporting processes a “reasonable model of regulation”
• Prohibitions of ending a patient's life by lethal injection, mercy killing or active euthanasia assure that “Dr. Death” imitators would be subject to prosecution
LEGAL SILENCE: A CATALYST for BEST PRACTICES

• “The problem with the law is that there is no implementation procedure” (Oregon participating physician)

• “... the law does not address what happens from the time the prescription is written until the patient’s death.” (K. Hedberg, C. New, 2017).

• “Unknowns” of ~50% of PAD deaths:
  • Presence of provider at time of medication ingestion
  • Duration between ingestion and unconsciousness
  • Duration between ingestion and death

  (Oregon Health Authority, 2016 Oregon Death With Dignity Act)
HOSPICE as “BEST PRACTICE” CONTEXT

% PAD PATIENTS IN HOSPICE

- Oregon: 1997-2016
- California: 6-12/2016
- Colorado: 2017

% PAD PATIENTS IN HOSPICE
RESEARCH on HOSPICE POLICIES on PHYSICIAN-ASSISTED DEATH

• 2010 study of 56 (86%) hospice programs affiliated with Oregon Hospice Association
  
  *Campbell, Cox, Hastings Center Report 40:5 (2010), 26-35*

• 2014 study of 33 (87%) hospice programs affiliated with Washington State Hospice and Palliative Care Organization
  
  *Campbell, Black, Journal of Pain and Symptom Management 47:1 (2014), 137-153*
TYPOLOGY of HOSPICE POLICIES on PAD
BY %

Oregon (n=56)
Washington (33)
PRIMARY VALUES of HOSPICE PAD POLICIES
By %

OREGON AND WASHINGTON COMBINED (n=89)

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self determination</td>
<td>80%</td>
</tr>
<tr>
<td>Relief pain and suffering</td>
<td>75%</td>
</tr>
<tr>
<td>Integritiy of P.-Pat Relationship</td>
<td>60%</td>
</tr>
<tr>
<td>Neither prolong nor hasten death</td>
<td>55%</td>
</tr>
<tr>
<td>Quality of Life</td>
<td>50%</td>
</tr>
<tr>
<td>Non-Abandonment</td>
<td>50%</td>
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LINE-DRAWING:
Can Hospice staff be present at ingestion/death?

<table>
<thead>
<tr>
<th></th>
<th>Oregon</th>
<th>Washington</th>
<th>Total</th>
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</thead>
<tbody>
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<td>Prohibit</td>
<td>31</td>
<td>24</td>
<td>55</td>
</tr>
<tr>
<td>Permit Some Staff</td>
<td>11</td>
<td>9</td>
<td>20</td>
</tr>
<tr>
<td>No Statement</td>
<td>13</td>
<td>13</td>
<td>13</td>
</tr>
</tbody>
</table>

Legend:
- Green: Prohibit
- Blue: Permit Some Staff
- Yellow: No Statement
Two Prominent Concerns about Patient Access

The Scope of Participation and Conscience

• 0.6% licensed Oregon physicians have written prescriptions (Hedberg 2017)
• The “no legal duty to participate” provision of the Oregon law (ORS 127.885.) also does not require non-participating professionals to refer.

The Costs of Medication

• The preferred secobarbitol medication has increased to ~$4000.
• The DDMP combination (diazepam, digoxin, morphine sulfate, propranolol) is ~$500 but has side-effects, longer duration of unconsciousness.
“Best Practices”: “Patient Navigator” systems

Institutional Challenges

• Complexity of the legal process

• Rare Utilization
  • “DWDA death rate of 54.6/10,000 from the same underlying diseases” (Hedberg 2017)
  • 19,000 patients admitted to hospice, 220 prescriptions written (OHA 2016 Report)

• Some physicians are not well-educated as to how to utilize the process

The “Patient Navigator” Concept