

Testimony of

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Subcommittee on the Constitution, Civil Rights, and Property Rights

"The Consequences of Legalized Assisted Suicide and Euthanasia"  
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Oregon's Death With Dignity Act (ODDA) allows a terminally-ill resident of the state to ask his or her doctor for a prescription of life-ending medication. "Physician-assisted suicide" is a term often used to describe the provisions of the ODDA, although actions taken within the law do not "constitute suicide, assisted suicide, mercy killing, or homicide." The law does not allow euthanasia.

A citizen's initiative, the ODDA passed by a margin of 51% to 49% in 1994. A repeal effort in 1997 was defeated 60% to 40%. The Act was effectively implemented in 1998, when the first of many federal challenges was resolved. In January, 2006, the US Supreme Court ended the most recent when it ruled that states, and not the Justice Department, have the authority to regulate medical treatment for the terminally ill.

The Oregon Hospice Association (OHA) was relieved by the Supreme Court's decision. Not because we support--or oppose--Oregon's Death With Dignity Act, but because the repercussions of a decision in favor of the Justice Department would have added to the chilling impact regulatory scrutiny has on pain management.

And because a decision against Oregon would have curtailed the contributions Oregon's health care community is making in our "laboratory of the states".

In its first eight years, the ODDA has been responsibly implemented with none of the predicted dire consequences. Reports issued by the State of Oregon, as required by the Act, and peer-reviewed and published research studies, confirming and adding to state data, are closing the void that existed because assisted dying had never before been practiced in a legal environment. We are learning from that body of knowledge, applying it to improve end of life care in Oregon. It is knowledge that has application well beyond our borders.

Physician-assisted dying is not disproportionately selected, as was predicted, by those who lack financial resources, health insurance, family support, or an education. These individuals tend to be more highly educated, have as much or more social support, and adequate financial resources. Only two have not had health insurance. While fearing pain is a concern of those who ask for a prescription, experiencing pain is not an important factor. Physician-assisted dying is not used by people without access to hospice and palliative care: every Oregonian has access, even in the most remote and rural areas of the state. Oregon's hospices strongly support a dying Oregonian's right to choose from among all end-of-life options.

Hospice nurses, social workers, and chaplains rank depression and financial concerns among the least important reasons an individual will ask for or use a prescription. A mental health consultation is required if an individual's judgment may be impaired by depression or another psychiatric disorder. Mental health referrals have declined over the past eight years, as physicians routinely refer patients to hospice where psychosocial and mental status is constantly assessed, addressed, and monitored.

Hospice workers have noted that violent suicide among hospice patients--always rare--is almost nonexistent, since the Act was implemented.

Health insurance or other resources for hospice care is not an issue. While care is provided without regard to a patient's ability to pay, Oregon's hospices can identify on admission individuals as immediately eligible for the Oregon Health Plan.

Although those individuals who asked for a prescription were concerned about being a burden to their caregivers, hospice workers ranked their caregivers as less likely to consider them a burden than caregivers of hospice patients who had not asked for a prescription.

Hospice workers' perspective is important because they visit patients and family caregivers often in the last weeks of life and can compare hospice patients who ask for a prescription with those who do not.

A palliative care consultation is not a requirement of Oregon's law, but almost all who have used physician-assisted dying have been offered hospice, and 88% were enrolled.

Patients' physicians identify autonomy, the ability to enjoy life, and loss of dignity as primary concerns of those who use physician-assisted dying in Oregon.

Hospice workers identify controlling circumstances of death, loss of dignity, and the desire to die at home as the most important reasons. Oregon's hospital death rate is the lowest in the nation and its home death rate, with Utah, the highest. 80% of Oregonians have an advance directive at the time of death, and respect for end-of-life wishes is virtually 100% when a POLST (physician orders for life-sustaining treatment) is in place. The POLST, developed in Oregon, is being adopted by states throughout the country. Hospice utilization is--and has been since the first hospices were developed in the US in the mid-1970s--among the highest in the country.

In fact, Oregon was declared a national leader in end-of-life care in 1998, before the Death With Dignity Act was implemented, and maintains its position as a leader today. It is not true that the quality of hospice and palliative care in Oregon has suffered.

Only 246 individuals--not thousands, as was predicted--have ended their lives under provisions of the ODDA. Research supports our observation that many more Oregonians take comfort in the law. A study published in 2004 revealed that 1 of 200 individuals who consider assisted suicide and 1 of 25 who make a formal request will use a prescription. Oregon's hospices describe as typical an individual who asks for a prescription on day 1, becomes qualified on day 15, and, because he or she has a plan to alleviate his or her worst fears, is able to get on with life. That the Oregon law is available, regardless of whether it is used, offers comfort.

It no longer matters whether assisted dying is right or wrong because it is a legal option in Oregon. No dying Oregonian must choose between hospice and physician-assisted dying. Oregon hospices encourage a referral to hospice of anyone who considers a request, if they aren't already enrolled. 240,000 Oregonians died in the first eight years. 246 individuals used a prescription to end their lives. One explanation for the very low rate may be the high quality of hospice and palliative care provided in Oregon.

Oregon's hospices recognized early in the public debate that hospice support, or the lack of it, would be a determining factor in whether a patient would, in fact, choose to hasten his or her death. Hospice addresses well the fears most often identified by the public as reasons for supporting the legalization of physician-assisted dying.

But autonomy and control--not uncontrolled symptoms--are the reasons people use a prescription. One question hospice and palliative care communities and all health care providers must address is how well they respond to the needs of individuals who value most autonomy and control--and how seriously they are willing to consider such needs.

Ironically, it is those individuals who personally direct their care that get the care they need--and get it in a timely manner. Oregon's hospices agree that it's much easier to have open and honest conversations about end-of-life care when all end-of-life options are on the table.

The Oregon Hospice Association would like to think that Congress will consider carefully the potential repercussions on pain management and end-of-life care of any action it might take against Oregon. Even a proposed law can have an immediate effect of undermining physician willingness to prescribe controlled substances, as we saw in its previous attempts to compromise Oregon's law.

The Oregon Hospice Association would prefer to think that Congress will recognize--and respect the Supreme Court's belief in--the value offered in the "laboratory of the states".