

Spring 2018

On My Own Terms: Effectiveness of Death with Dignity Legislation in Oregon

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On My Own Terms:

Effectiveness of Death with Dignity Legislation in Oregon

Megan E. Russell

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DEATH WITH DIGNITY

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Today, the elderly represents a growing segment of the population. This has resulted in a number of different controversies, including rising medical costs and end-of-life issues. In recent years, multiple states have passed legislation to provide guidance to the terminally ill regarding end-of-life issues. This paper will address the social issue of a terminally ill patient's right to dignity and self-determination at end-of-life to hasten death through the use of legally prescribed medication, and how that decision will affect the others involved in the process, including the family members and medical professionals. This issue of a 'death with dignity' has been a controversial topic on which individuals have a variety of strongly held views, and we have only just begun to come to a new consensus. This paper will begin with a literature review and continue with a review of the current Death with Dignity legislation in the state of Oregon. The paper will also compare and contrast three separate models of policy analysis and one policy framework will be selected for a detailed analysis. The paper will then conclude with comments concerning the impact of the legislation on issues of social and economic justice, and implications for social work practice.

Literature Review

This literature review will examine the literature that has been published concerning the causes of the increasing interest in Death with Dignity legislation, as well as a brief history of the social issues and key historical movements which would lead to the birth of the legislation. A summary of the varying points of view addressing the social issue and implications for social work practice in working with clients facing end-of-life issues. Finally, a discussion of current policy and legislative agenda being undertaken today will be included.

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Causes and Consequences

There are several changes which have occurred which have resulted in this recent discussion in end-of-life issues. One such change is that the United States expects see to significant growth in the elderly population between 2012 and 2050 (Ortman, Velkoff, & Hogan, 2014). According to the United States Census Bureau, “in 2050, the population aged 65 and over is projected to be 83.7 million, almost double its estimated population of 43.1 million in 2012” (Ortman, Velkoff, & Hogan, 2014). This increase in the aging population may also mean the needs of our country could shift, with greater shares of our resources being allocated to health and caregiving. Authors Keegan and Drick (2011) tell us, advances in medicine have improved the lives of patients, but have resulted in many more chronic diseases (Keegan & Drick, 2011). Correlated with the rise in chronic disease is where individuals are receiving treatment. Author and registered nurse Mary Friend (2011) explains, “the lack of quality comfort hospital-based programs is significant because most Americans continue to die in hospital settings” (Friend, 2011). This may aggravate feelings of isolation and increases a sense of burden on the family because of financial costs involved. The costs of treating chronic conditions are disproportionately expensive and can be seen as a significant portion of medical expenses at end-of-life.

According to authors Cubanski, Neuman, Griffin, and Damico (2016), Medicare is the largest insurer of medical care provided at the end of life, with 55 million beneficiaries. In 2014, 2.1 million Medicare beneficiaries died. Their Medicare benefits accounted for roughly 25 percent of total Medicare spending that year (Cubanski et al., 2016). Medical spending appears to be disproportionately higher during the final year of life. A group of researchers from the University of Michigan looked at the spending patterns of medical costs during the last year of

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life. These researchers found four particular spending profiles, however, for almost nearly 50 percent of aging Americans it was determined they followed a high persistent profile which had a high spending rate throughout their final year (Gavin, 2016). In this report, it was found that costs were driven by, “multiple chronic health conditions, including many doctor visits and regular hospital stays over year, not just in their final days” (Gavin, 2016). In response to the challenging emotional and monetary costs of end-of-life care, individuals have begun to consider alternatives.

History of the Social Issue

Attitudes and beliefs about end-of-life issues have been evolving over the past hundred years. The United States laws were derived from English common-law, which included attitudes about suicide and the assistance of suicide. According to Katherine Chamberlain (2009), the English condemned suicide as “self-murder” and ranked the act among the highest of crimes (Chamberlain, 2009). The first explicit law banning assisted suicide would not be passed until 1828, by the New York legislature. By the 1870’s all states would have passed legislation prohibiting the act of assisted suicide. In the 1990’s the U.S. Supreme Court made a statement on the subject of assisted suicide in the case of *Cruzan v. Director, Missouri Department of Health*, and there is evidence of a long-term trend of “opposition to and condemnation of both suicide and assisting suicide” (Chamberlain, 2009). In the opinion of the U.S. Supreme Court, suicide is so universally abhorrent that it could not be tolerated in the norms of the American society. The Supreme Court opinion reflects their understanding of legal precedent and society’s thoughts and feelings; however, Cruzan’s case would be seen as a turning point in the recognition for a patient's right to refuse life-sustaining measures.

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The 1990 case of Missouri resident Nancy Cruzan would become a pivotal legal precedent for the right-to-die movement. The parents of Ms. Cruzan, who was left in a persistent vegetative state after a car accident in 1983, filed for a court order to have artificial nutrition and hydration discontinued. Authors Wolf, Berlinger, and Jennings (2015) tell us, “the U.S. Supreme Court finally recognized a patient’s right to refuse life-sustaining treatment, although the Court noted that states could restrict the authority of surrogates to make decisions for patients lacking decisional capacity” (Wolf, Berlinger, & Jennings, 2015). Justice Sandra Day O'Connor referred to the Hastings Center guidelines to outline how a surrogate should be best utilized to ensure a patient’s wishes are carried out. The *Cruzan* case resulted in the passage of the Patient Self-Determination Act, a 1990 piece of legislation which encouraged efforts to develop advance directives (Wolf, Berlinger, & Jennings, 2015).

Oregon would take patient rights to the next level by passing the specific legislation necessary to define the process of defining physician assisted death. Voters in Oregon first approved the initial legislation in 1994. However, according to Barbara Coombs Lee (2014), “a legal challenge delayed implementation of the law, and the Oregon legislature placed its repeal on the 1997 ballot” (Coombs Lee, 2014). This legal challenge against the legislature would fail, and the Death with Dignity Act stood and would be officially be enacted in October of 1997. The Death with Dignity Act has provided eligible individuals residing in Oregon access to aid in dying under strict statutory provisions for almost 20 years.

Oregon’s passing of the Death with Dignity in 1997 would lead would lead to several other states passing legislation that would allow a terminally ill individual with six months or less to live the option to legally obtain physician prescribed medication in order to end their lives. The next few states to pass death with dignity legislation would include Washington in

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2009, Vermont in 2013, and California in 2016. Colorado would be the most recent state to pass legislation, by passing the End of Life Option Act, 2016.

Since its inception in 1997, Oregon has provided data to the public on the number of its program participants. According to the Oregon Health Authority, since 1997, “a total of 1,749 people have had prescriptions written under the DWDA [Death with Dignity Act, 1997], and 1,127 patients have died from ingesting the medications” (Oregon Health Authority, 2017, p. 5). Of those who have died from ingesting the medication, the median age is 71 years. It is interesting to note that the Oregon population is 4 million, with 18% being over 65 years of age. A rather modest percentage take advantage of the death with dignity legislation that has been enacted. The most recent annual report conducted by the state of Oregon states, “during 2016, the rate of DWDA deaths was 37.2 per 10,000 total deaths” (Oregon Health Authority, 2017, p. 5).

Various Points of View of the Social Issue

Opposing Viewpoints and Perspectives

As the data in the prior section shows, although there has been only a small percentage of those who have accessed death with dignity legislation in the state of Oregon, end-of-life issues have been a growing topic of discussion for many years. We will review the arguments of opponents and proponents at the moment this legislation was being considered.

As the constitutional right to die continues to be a controversial and major ethical issue, we have seen many opponents voice their views about the Death with Dignity Act. Author Nora Miller (2006) expresses a viewpoint of a more conservative segment of the population, arguing that physician assisted death, “qualifies as a terrible and insidious form of state-sponsored murder, along with abortion, cloning, stem-cell research, and euthanasia[...] if we let the state kill

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terminally ill people, what's to stop them from killing the handicapped, old, and mentally ill” (Miller, 2006). Another common argument employed by opponents is that physicians who aid individuals in suicide, [whether the act is considered legal by the state], violates the basic moral obligation of a physician to do no harm (Rosalie Ambrosino et al., 2012, p.248). Author Ronald Lindsay (2009) proposed other popular arguments discussed by opponents, including, “harms of legalization would affect certain vulnerable groups disproportionately [...] legal assisted dying could not be confined to the competent terminally ill who voluntarily request assistance [...] the practice would result in frequent abuses” (Lindsay, 2009). However, research conducted over more than a decade has provided evidence that several of their fears failed to materialize. Lindsay (2009) addresses the topic of palliative care in regard to its relationship with the Oregon Death with Dignity Act, “there is evidence that the quality of palliative care has actually improved in Oregon since adoption of the ODWDA [Oregon Death with Dignity Act]” (Lindsay, 2009). Questions often arise concerning patient competency. Lindsay (2009) also relates that the terminal illness an individual experiences should provide some assurance that a request for assistance in dying is not a product of a hasty or irrational decision (Lindsay, 2009)

Proponents of Death with Dignity legislation believe in the value of dignity and the individual's right to self-determination, as determined by state statutory eligibility requirements. Death with dignity proponents argue that an individual deemed mentally competent has the right to choose. Pamela Miller (2005) is a social worker who recalls her experience working in the hospice setting, “in all the years I worked in hospice [...] none of the many, many patients I worked with were impaired” (Miller & Hedlund, 2005). Miller’s experience helps to provide us with an understanding that often many terminally ill individuals progressing toward the end stages of their illnesses still possess the capabilities to make competent decisions about the end-

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of-life care they receive. Proponents for the Death with Dignity Act also argue that the patient will have a less traumatic and painful death when provided physician assisted death. Physician assistance will also allow for a more planned event for final goodbyes and pain reduction, this is important to advocates of the legislation because as Braun, Zir, Crocker and Seely (2005) tell us, “perhaps 50% of conscious patients die in pain” (Braun et al., 2005)

Practitioner Viewpoints and Perspectives

In Oregon, the process of physician assisted death has been in place for eligible terminally ill individuals since 1997. States have provided annual reports on their implementation of the programs that they enacted. There have also been studies performed to interview some of the medical practitioners involved in these programs. Their experiences provide insight into the current practices and issues guiding end-of-life discussions.

A study of nurses currently caring for terminally ill individuals who have elected to access physician aid in dying, was conducted in order to understand their views on the current practice (Ganzini et al., 2002). According to the nurses, their patients expressed fears about becoming a burden on their families. However, both the nurses and doctors report that the patients, “want to control the circumstances of death and maintain their independence and because they view their quality of life as poor and are ready to die” (Ganzini et al., 2002). Families of the patients provided a differing viewpoint, one in which family members were less likely to feel bothered by caretaking responsibilities, and instead were more likely to find caretaking a rewarding activity. One of the safeguards of the program is to ensure that individuals who are depressed or suffer from other psychological conditions are disqualified from receiving the lethal prescription medication. In this study, it was found that 20 percent of the patients who requested a prescription for the lethal medication would be diagnosed as

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depressed. However, none of the patients determined to be depressed would receive a prescription (Ganzini, Harvath, Jackson, Goy, Miller, & Delorit, 2002).

In 1999, over 4,000 eligible physicians were surveyed regarding their experiences with the Oregon Death with Dignity Act. The recorded response rate of respondents was 65 percent. According to Ganzini et al. (2000), the doctors reported the following: “the demographic characteristics of the patients who requested assistance with suicide in our survey were almost identical to those of members of the general population of Oregon who died” (Ganzini et al., 2000). Despite concerns of vulnerable populations being at risk, this issue does not appear to have emerged during this time period. The demographics of the individuals who applied for aid in dying and those who died in the general population are identical. The doctors reported that the patients were largely not concerned about finances, but rather far more worried about being a burden to their families. An individual’s motivation could be an economic one, however, this has not been a frequently cited reason in the database. Only four out of ten individuals who received a prescription for the lethal medication to end their lives died from ingesting these medications. This infers that six out of ten individuals who requested the medication did not carry through with their intentions. According to Ganzini et al. (2000), “eighty-one percent of those who died by assisted suicide were enrolled in a hospice program” (Ganzini et al., 2000). Overall, doctors report only granting 1 in 6 requests for a prescription, while 1 in 10 requests resulted in death (Ganzini et al., 2000). In conclusion, reviewing the results of the survey from the doctors, this is a carefully managed process in which only a few individuals are being accepted, and most who receive the prescription do not act on their intentions.

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Possible Solutions to the Address the Social Issue

We have examined a number of articles which have allowed us to understand the role of the social worker in various capacities in the end-of-life process. Through our research, we were able to identify instances where social workers were able to make an especially effective contribution. This has provided more insight into what is largely an undocumented role.

Norton and Miller (2012) conducted a survey which interviewed nine hospice social workers working throughout the state of Oregon. Their experiences provide guidance on the effective use of social workers in this setting. The authors report that, “while ODDA [Oregon Death with Dignity Act] provides parameters, there is a lack of clear and consistent policy for each agency and for social workers to follow” (Norton & Miller, 2012). With this, we can understand the social worker is free to adopt the most effective possible role. The authors also comment that doctors are limited in their ability to inform family members. This is because a doctor is bound a HIPAA [Health Insurance Portability and Accountability Act] laws. A participant in the study captured what they identified as the real role of the social worker, “I think sometimes it takes a fairly sophisticated negotiation to perhaps bring a patient to a point where they even would want to open a discussion about that [physician assisted death] with their families” (Norton & Miller, 2012). The social worker in these in end-of-life discussions help to build the bridge between the patient and their families.

Not only is important for the social worker to start the conversation, it is also necessary to give consideration to the types of topics to be discussed. Thomas Hack et al. (2010) conducted a study which surveyed 100 patients diagnosed with a terminal illness. The study uncovered several core values which were of greatest concern to the patients. This gives guidance to the social worker as to issues which should be addressed during engagement with the client.

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According to Hack et al. (2010), the most commonly cited value by the patients was 'family'. Hack et al. (2010) tells us that, "while not all participants reported having a strong familial bond, the existence of, or wish for, a united and supportive family was a predominant theme" (Hack et al., 2010). The second most reported common core value was 'pleasure', which was engaging in rewarding and enjoyable activities. The third common core value reported, 'caring', is identified as rewarding relationships with others. 'Sense of accomplishment' and 'rich experiences' were identified as the fourth and fifth core values. By establishing what is of concern to client, the social worker can learn to be far more effective in guiding the discussion and helping to explore the concerns of the client in order to enhance their dignity of their final hours.

Current Policy and Legislation

Previously, we have addressed some of the landmark cases which focus the attention on this social issue. There are several states still considering legislation, however, within the states that have passed legislation allowing physician assisted death, the guidelines concerning the steps to be taken are well established. Six states have codified the steps to be taken and all generally follow the steps reflected in the Oregon statute (127.800).

For a patient to exercise their rights under the Oregon Death with Dignity Act, Kathy Cerminara and Alina Perez (2000) tell us the patient must be an informed and capable adult who is terminally ill and within 6 months of death. The patient must make three requests: two oral and one written no less than 15 days after making those initial requests. Finally, the patient must orally reiterate his or her request. With this request, however, the Oregon Act imposes a waiting period of no less than 15 days between the patient's initial request and the writing of the prescription. It also imposes a waiting period of no less than 48 hours between the patient's written request and the writing of the prescription (Cerminara & Perez, 2000). These are key

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safeguards of the Death with Dignity Act which provide not only protections to the patient, but medical professionals involved in the process as well.

Discussion

The right to dignity and self-determination for a terminally ill individual at end-of-life is an important social issue that is of concern across a number of different states, and this interest continues to build. It appears that there is an important role for the social worker in the end-of-life process, however, it is a largely undocumented role. The extensive experience in those states which first implemented the laws gives guidance as to the most effective role for the social worker. The best practices help to show when the social worker should be inserted and the role to which the social worker should play.

An Outline of the Oregon Death with Dignity Act

The Oregon Revised Statute §127.800 to 127.995 outlines the provisions of the Oregon Death with Dignity Act. The Oregon Death with Dignity Act allows for terminally ill adults with six months or less to live, and who are deemed mentally competent, the option to end their lives with physician prescribed medication. This Act allows an alternative to individuals who use to feel the burden of the long, lingering nature of terminal illness, which left them with feelings of loss of autonomy, dignity, and concerns of being a burden to immediate family members. The Death with Dignity Act allows an individual more control and choice over the timing and manner of an inevitable death (Angell, 2012). The Oregon Death with Dignity Act, enacted in 1997, has been a template for other states to draft their own laws.

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Provisions of the Legislation

The Oregon Death with Dignity Act sets forth some steps which must be followed. In order for an individual to request a prescription for lethal medication to end their lives, they must meet a set of specific criteria. The specific language of the policy and the criteria are described below:

- An adult of at least 18 years of age.
- A resident of the state of Oregon.
- Determined to be mentally competent by a physician and possess the ability to make and communicate health care decisions, including voluntarily expressing his or her wish to die.
- Possess a diagnosis of a terminal illness which will lead to death within six (6) months.

If the individual meets the prior criteria to request life-ending prescription medication from a physician, there are further criteria which must be satisfied for the individual to receive the prescription medication from a physician:

- A patient must make two (2) verbal requests to his or her physician, with a separation between each request of fifteen (15) days.
- Following the written requests, a patient must then provide a written request witnessed by two people in the presence of the patient.
- A prescribing physician and a consulting physician must confirm the diagnosis and prognosis of the terminally-ill patient
- The prescribing physician and a consulting physician must determine if the patient is mentally competent.
- The patient should be referred for counseling if either the prescribing physician or the consulting physician believes the judgement of the patient is impaired due to psychiatric or psychological disorder.
- The patient must be informed of all possible alternatives to resolve their care.
- The prescribing physician must recommend, although not require, that the patient notify the next of kin of their request to obtain life-ending medication.
- The prescribing physician and consulting physician must notify the patient that the patient may rescind their request at any time and in any manner without regard to his or her mental state.

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This criterion was put in place to protect both the patients and the medical professionals who serve them. There are other provisions put in place to protect both medical professional and the pharmacists who assists patients with these requests. The legislation helps to protect these professionals from prosecution and ensure they are under no obligation to participate.

Historical Background

The interest in what was at the time, physician assisted suicide (PAS), stemmed from controversial issues of patients' rights, specifically the right to die (Altmann & Collins, 2007). Right-to-die issues came to the forefront in the political arena when the case of Karen Ann Quinlan was brought to the attention of patient right advocates in 1976. Quinlan's parents fought to remove respiratory support, which led to a debate about whether it was ethical to terminate life support. This led to a broader discussion of patient's rights and the right to terminate treatment under certain circumstances. Controversy would again enter the media, when in 1990, Dr. Jack Kevorkian would assist a terminally-ill individual in ending their life through euthanasia (Altmann & Collins, 2007). 1990 would be a significant year for the right-to-die movement, when Nancy Cruzan would be a pivotal case for advocates. Cruzan would become the first right to refuse treatment case (Altmann & Collins, 2007), which would pave the way to the passage of the Patient Self-Determination Act (1990). At about this same time, public opinion polls began to swing in favor of legislation outlining patient's rights. According to White (as cited in Altmann & Collins, 2007), "public opinion polls were demonstrating increasing support for PAS [physician assisted suicide]; the public appeared more afraid of being kept alive in misery than of dying" (Altmann & Collins, 2007).

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Prominent Figures

The important figures who are responsible for this legislation are primarily the Oregon voters. However, Oregon State Senator Frank Roberts, who suffered from prostate cancer, introduced three separate physician-assisted dying bills during the late 1980s and early 1990s. These bills never made it out of committee, but did become templates for later bills, including the current Oregon legislation for physician aid-in-dying (Oregon Death with Dignity Act, n.d.). The President during the period was Bill Clinton. President Clinton was not involved with the initial process of enacting the Oregon Death with Dignity Act, however, in 1998, Clinton did refuse to sign the Lethal Drug Abuse Prevention Act (HR 4006/S 2151), which would have threatened to overturn the Oregon Law (Oregon Death with Dignity Act, n.d.). In this whole process the key figures were the Oregon voters who voted on the piece of legislation in 1994, ballot Measure 16. Measure 16 allowed for terminally ill adults to obtain prescription for lethal drugs. Oregon voters approved Measure 16, the Oregon Death with Dignity Act on November 8, 1994, making Oregon the first US state with a physician-assisted dying statute (Oregon Death with Dignity Act, n.d.).

As we have seen, the Oregon Revised Statute §127.800 to 127.995 outlines the provisions of the Oregon Death with Dignity Act and is a unique piece of legislation which breaks ground in providing terminally-ill individuals with greater options in dealing with end-of-life situations. This groundbreaking legislation paved the way to other similar pieces of legislation being enacted in other states. Despite initial concerns, the legislation has proven to be highly successful and has encountered very few difficulties since its enactment.

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A Policy Analysis of the Oregon Death with Dignity Act

A thorough analysis of the Oregon Revised Statute §127.800 to 127.995, also called the Oregon Death with Dignity Act (ODWDA), will now be conducted using the McInnis-Dittrich ANALYSIS Model (1994). This model is comprised of eight elements and is particularly strong in evaluating effectiveness of service delivery on client systems. After the analysis is conducted using the selected model, this will be followed by an assessment of the importance and impact upon several areas including diverse client systems, client populations, as well as the impact on social and economic justice. The assessment will then conclude with an examination of the congruence between social work values and ethics.

Approach

The first analysis element in the McInnis-Dittrich model is Approach. It is important to understand the basic approach of the policy being evaluated to help set the stage for the remainder of the analysis. The Oregon Death with Dignity Act (ODWDA) is a piece of legislation that enables doctors to provide an additional service to their patients who are facing end-of-life decisions. The ODWDA itself is not a service; however, it spells out the rules under which doctors can provide an additional service to their patients. The program spells out eligibility requirements not through means testing, but through alternative requirements which must be met, and specific steps which must be followed for the program to be accessed. The legislation is designed to meet a specific segment of the population, those who have been diagnosed with a lingering terminal condition. The way in which the service is acquired is through patients approaching their physicians and requesting access to this service. In the legislation there are no stated goals, however, when the legislation was proposed, the intent was to create the ability for physicians to provide legal means for terminally-ill individuals to access

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prescription medication to end their lives in a dignified manner. One other primary goal of the ODWDA is to provide autonomy and self-determination to terminally-ill individuals who are facing end-of-life decisions. One of the primary concerns of the social worker is the inherent value of life, and the ODWDA has put in place provisions to ensure that both the medical professionals and the patient take the time to ensure that they are both informed and have thoroughly considered all options. Ultimately, the ODWDA places emphasis on self-determination of the patient, which is a core value of the social work profession.

Need

The second analysis element in the framework is Need. It is important to carefully assess what need or needs the policy or program is intended to meet, and if the policy or program is adequately meeting the need(s). There are several factors which have led to the creation of this social issue. The elderly segment of the population is increasing. There is also a healthcare crisis affecting the United States, which has led to higher costs in medical treatment and long-term care. Finally, in the United States, the elderly are often relatively isolated from the remainder of the family, which increases the sense of isolation, leading to depression and feelings of dysconnectivity. The matter of physician-assisted death has been considered such a controversial issue for several decades. There is well documented evidence hearings, trials, and prior bills which paved the way for the implementation of the ODWDA. However, according to Altmann and Collins (2007) there is little information provided about the phase of the policy-making process due to the law being citizen-initiated instead of a legislative process. The Oregon Health Division (OHD) was given an active role to help guide the implementation of the Oregon Revised Statute. This would then lead to the formation of the Task Force to Improve the Care of Terminally-Ill Oregonians. Together, these agencies “were enabled by the legislature to create

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and publish the rules for policy implementation” (Altmann & Collins, 2007). The need is endemic to a segment of the population. Currently, seven states have legislation that support physician-assisted death, allowing eligible residents to access prescription medication to end their lives under certain provisions that vary by state.

Assessment

The third analysis element is Assessment. This evaluative component will evaluate the demographics of the individuals who access the program and assess the effectiveness of the program or policy by identifying both the program strengths and weaknesses. Since the ODWDA was passed in 1997, an annual report is published regarding the impact of the legislation, including the effectiveness of the safeguards of the provisions put in place by the Act. These reports help researchers understand the patients who access the legislation, their situation, economic status, and other factors which drive their decision. According to the annual reports, many eligible individuals who were provided the opportunity to access the ODWDA did not carry out their intent to ingest the medication, but were able to discuss issues in a new way with their doctors and family members.

Impact on Diverse Client Systems

In order to examine the diversity of the population that accesses the Death with Dignity legislation, the reported demographics of the 1,127 ODWDA patients who have died from ingesting a lethal dose of medication as of January 23, 2016, were compared to the 2016 U.S. Census Bureau report for the state of Oregon for cities and towns with a population of 5,000 or more. There were four characteristics of the ODWDA population which diverged from the overall Oregon population. As expected, the ODWDA population tends to be much older than the general population. In Oregon, as stated in the U.S. Census Bureau report, the 65 and older

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population is 16.8 percent (QuickFacts, n.d.), however as we expect, according to the *2016 Annual Report* (Oregon Health Authority, 2017), the 65 and older population totals 71 percent. This provides an understanding that those who access the Death with Dignity legislation are significantly older. There tends to be a greater proportion of white individuals who access the ODWDA than in the general population. In Oregon, 87.4 percent of the population is white, while according to the *2016 Annual Report* (Oregon Health Authority, 2017), 96.5 percent of individuals who access the legislation are white.

The percentage of women that accessed the ODWDA (48.4 percent) was low when compared to the general population (50.4 percent). This provides an understanding that women are underrepresented. In the general population, there is 89.8 percent (QuickFacts, n.d.) of those who have obtained an educational background that is of high school or higher attainment, compared to that of the ODWDA participants at 94.4 percent (Oregon Health Authority, 2017). The numbers indicate some trends in the data that might bear some further research in order to understand who is accessing or avoiding this legislation.

Impact on All Client Systems

The ODWDA impacts client systems on multiple levels. Qualified individuals often involved their families in the end-of-life decision-making process. The *2016 Annual Report* (Oregon Health Authority, 2017) notes that 92.3 percent of individuals who accessed the Death with Dignity legislation had some sort of immediate family. The report also details that 93 percent of those individuals informed their families of their decision to access the ODWDA (Oregon Health Authority, 2017).

As previously noted, many individuals who accessed the legislation were enrolled in hospice care at the time of their death. In addition, eligible Oregon residents requesting access to

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the ODWDA must interact with their physician, and oftentimes will interact with nurses and social workers during their end-of-life care. With this, we are provided a better understanding of the organizations in which individuals interact with in concert to the legislation.

In the state of Oregon, those residing in the Portland metropolitan statistical area, or Portland and its surrounding suburbs, has a population of more than two million out of a total Oregon population 4.1 million as the U.S. Census Bureau figures in 2010 (QuickFacts, n.d.). This provides an understanding that Portland represents more than half of Oregon's size, and yet of the individuals who access the ODWDA, only 43 percent are from the Portland metro counties (QuickFacts, n.d.). This indicates a departure from randomness, which might indicate a trend in the preferences in the individuals who access this legislation.

Discussion of Strengths and Weaknesses

The ODWDA has a strong screening process and a well-thought-out list of eligibility requirements. The worst fears of critics, particularly regarding the abuse of the legislation, never occurred. This is due to the strong safeguards that were put in place, because individuals accessed the Act in a sensible and responsible way. The *2016 Annual Report* (Oregon Health Authority, 2017) shows the amount of prescriptions written by physicians for patients who made requests and the number of terminally-ill patients who ingested the medication, and does not demonstrate any concerns for abuse of the legislation. The *2016 Annual Report* (Oregon Health Authority, 2017) also provides insight that, where physician-assisted death is legal, an increase in hospice care is seen (Oregon Health Authority, 2017). This is viewed as a strength of the legislation because it provides a wider range of potential services for a greater scope of patients with a larger range of needs. Regarding the weaknesses of the legislation, the mandatory waiting periods embodied in legislation are working and are seen as a strength in safeguarding the

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process, although those individuals with fast-acting fatal diseases may not have adequate time to satisfy the provisions of this legislation.

Logic

The fourth analysis element of the selected model is Logic. This element addresses if the policy or program logically connects to its goals. When the ODWDA was drafted, the legislators considered the potential behaviors and motivations of all the individuals involved, including physicians, patients, and family members. Through a long series of discussions, hearings, debates, and elections the provisions were crafted to honor the wishes of the participants and to prevent the abuses of the legislation. This legislation was not designed to make people change, but was designed to help people think through their true wishes and desires.

Your Reaction as a Practitioner

The fifth element of the framework is Your Reaction as a Practitioner. This element helps a professional social worker get in-touch with their own judgement and intuition to have a better understanding of the clients and the underlying issues. I feel that the ODWDA is a competent policy with well-prepared safeguards that provide terminally-ill individuals access to a peaceful, humane, and dignified end-of-life option. I have seen the difficulties that the aging population faces, the needs they have, as well as the lack of resources they have available. I have also experienced a close friend who has suffered terminal-illness and have witnessed the impact of end-of-life issues on both the individual and the family. This legislation has strong provisions that focus carefully on the rights of the target population and do an exceptional job at protecting their interests. This area provides fertile ground for the involvement of the social worker to help fulfill the needs of this population. As previously discussed, individuals facing end-of-life issues have often expressed several core values that were of great concern to the patients. Social

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workers would most effectively work with the client to identify these core values of concern, as well as to bridge the conversations between the individuals, the family members, and the physicians to enhance their dignity and quality of life.

Support

The sixth element is Support. This element of the framework evaluates how the program or policy is being funded. The ODWDA was written by the Oregon legislature, and its provisions are maintained by the court system, both of which are paid for by taxes. Individuals exercise their rights under this legislation through the services of their own private physicians. The physician and prescription fees would be covered by patient's private insurance. The number of individuals who access the Act is limited, however, this is likely due to eligibility of the legislation, rather than the health care costs. The cost of the treatment is not the issue, the only condition that money becomes an issue in this process is in the individuals considering the burden of long-term suffering and the costs of ongoing medical care.

Innovation

The seventh analysis element is Innovation. This element guides the researcher in understanding the channels through which changes can be achieved in the policy or program. It should be considered to change the law to encourage or require that a social worker or therapist lead the discussion with the patients to help them explore their motivations in accessing the Act. A physician does not possess the background to conduct such a discussion with the completeness and thoroughness that the patient deserves. An expansion of Death with Dignity legislation to other states should be seriously considered, due to the empirical evidence tracking the success of the ODWDA and other similar statutes that have been enacted in six other states. State oversight

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will be necessary to monitor the practitioners utilizing this process to ensure the provisions are being followed in a consistent and careful manner.

Social Justice

The eighth and final analysis element is Social Justice. This element reviews how the policy or program is consistent with the social work profession's commitment to social justice. The ODWDA is consistent with social work values, including the professions commitment to social justice. The Act emphasizes the individual's right to autonomy and self-determination, while also focusing on enhancing dignity and worth of the individual. The policy provides safeguards that ensure public accountability: provides that the decision will be reviewed, that participants will be held accountable, and ensures that patients are free from coercive influences (Campbell, 2008). Most importantly, the strict provisions of the ODWDA help to draw a line between assisted-physician death and euthanasia in the United States, allowing those with lingering terminal illness the opportunity to choose a compassionate and dignified end-of-life option to ease both mental and physical suffering.

Congruence with Social Work Values

The ODWDA aligns with several core social work values. According to the NASW Code of Ethics (2008), social workers must enhance "dignity and worth of the person" (Workers, 2008). The ODWDA provides an individual a greater range of options when faced with a terminal condition by providing access to a dignified and peaceful end-of-life option. This legislation provides the social worker with greater tools and resources to work with the client and their family unit to help discuss difficult issues at a time of crisis and stress in their relationships. The social work value of importance of human relationships is empathized by helping to bridge the relationship between the terminally-ill individual and their loved ones. The process helps to

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provide a gateway to discuss and deal in greater depth about their end-of-life situation. This aids candidates in identifying in what ways they can best provide resources and information to these clients, and can be tied to the social work value of service.

Conclusion

Attitudes concerning end-of-life issues have been evolving over the past hundred years. The voters of Oregon have paved the way in creating options for terminally ill individuals. The Oregon Death with Dignity Act is an effective piece of legislation that has been enacted in the state of Oregon by Oregon voters since 1997. The analysis conducted using the McInnis-Dittrich ANALYSIS model framework helped to provide a better understanding of some of the strengths and weaknesses of the policy. The analysis shows that the safeguards and provisions of the act have been effective based on several years careful preparation and implementation. The analysis of the data seems to indicate that there could be trends in the usage within the population which accessed the ODWDA. This could call for a further analysis of the data to provide some further insights about the population which accesses or is avoiding the legislation, as well as in the selection mechanisms that are at work within these populations. This could also provide further insights to the practitioner who is working with the client who is facing end-of-life issues.

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