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Oregon State Ballot Measure 51: Repeal of 1994 Assisted Suicide Ballot Measure

City Club of Portland (Portland, Or.)

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Oregon State Ballot Measure 51: Repeal of 1994 Assisted Suicide Ballot Measure

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Your Committee Found:

The Oregon Legislature's decision to send 1994 Measure 16 back to voters—without changes or amendments—is unprecedented in the history of Oregon's initiative system. Doctor assisted suicide is a complex and controversial issue over which citizens, religious organizations, and medical professionals are divided and hold very strong and passionate opinions. While many base their opposition to doctor-assisted suicide on ethical and moral grounds, the legislature referred Measure 51 to voters on claims that the Oregon Death With Dignity Act contains "significant flaws" that cannot be amended to make the Act workable. Your Committee examined these claims and found that no fundamental flaws exist in the law that would prevent its effective implementation.

Voters made the policy decision that mentally competent people who are terminally ill should have the option of obtaining life-ending drugs. Many question the appropriateness of the legislature's referral of the measure back to voters. Problems in implementing the law can be directly addressed by the legislature, which has the power to amend the law. Your Committee unanimously recommends a "No" vote on Measure 51.

NOTE: Voters should be aware that a "No" vote would retain the doctor-assisted suicide law enacted by 1994 Measure 16, while a "Yes" vote would repeal the law.

The City Club membership will vote on this report on Friday, October 17, 1997. Until the membership vote, the City Club of Portland does not have an official position on this report. The outcome of this vote will be reported in the City Club Bulletin dated October 31, 1997.
I. INTRODUCTION

Ballot Measure 51 will appear on the ballot as follows:

Caption: Repeals law allowing terminally ill adults to obtain lethal prescription.

Result of "Yes" Vote: "Yes" vote repeals law allowing terminally ill adults to obtain physician's lethal prescription for lethal drugs.

Result of "No" Vote: "No" vote retains law allowing terminally ill adults to obtain physician's prescription for lethal drugs.

Summary: Repeals Measure 16, adopted by voters in 1994. That law:

- Allows terminally ill adult Oregon residents voluntary informed choice to obtain physician's prescription for lethal drugs when physicians predict patient's death within 6 months.
- Requires 15-day waiting period; 2 oral, 1 written request; second physician's opinion; counseling for patients with impaired judgment from depression.
- Gives health care providers immunity from civil, criminal liability for good faith compliance.
- Permits person choice whether to notify next of kin.
- Allows health care providers to refuse to participate.

(The language of the caption, result of vote, and summary was prepared by the Oregon State Attorney General.)

Ballot Measure 51 is a legislative referral to repeal the Oregon Death With Dignity Act. This act, a citizen initiative, was passed by voters in 1994 as Ballot Measure 16. The City Club did not study Measure 16 because of the great number of measures in that election and because it was felt at that time that a study could shed little light on what was primarily a values-based decision. The Club now believes that the added dimension of the political process used to refer Measure 51, and the assertion that new information is available, warrants a study and recommendations.

Study committee members were screened prior to appointment to ensure that no member had an economic interest in the outcome of the study or had taken a public position on the measure. All committee members affirmed that, if they had a position on Measure 16, they could arrive at a different conclusion if new information and the committee's
deliberations were persuasive toward a different point of view. Your Committee met for six weeks, reviewed relevant articles and reports, and interviewed proponents and opponents of Measure 51. (See Appendix B: Witness List, and Appendix C: Resource Materials.)

Your Committee found that most of the information available concerning assisted suicide is anecdotally. No studies are available that evaluate the likely impacts of physician-assisted suicide as outlined in Measure 16.

II. BACKGROUND

In 1994, proponents of physician-assisted suicide initiated and Oregon voters passed, by 51 percent to 49 percent, Ballot Measure 16—"The Death with Dignity Act." Measure 16 grants persons diagnosed with terminal illnesses and having six months or less to live the right to obtain a lethal prescription. Ballot Measure 16 banned the use of lethal injection as a method for ending the life of a terminally ill patient.

During the 1994 campaign, proponents based their campaign for the measure on an individual's right to choose the quality of his or her life and dying. Opponents raised issues including religious and ethical values against suicide, a concern that physician-assisted suicide would negatively change the role of the physician, and a belief that hospice care and better pain medication—short of assisted suicide—would more effectively ensure death with dignity.

Following passage of the Act, assisted suicide opponents filed suit against the measure in federal District Court. A federal judge ruled that the measure violated the equal protection clause of the U.S. Constitution and issued an injunction against its implementation. Measure 16 supporters have appealed that ruling to the federal Court of Appeals for the Ninth Circuit. At the writing of this report, the injunction is still in force.

Meanwhile, the federal Ninth Circuit Court overturned a Washington State law that banned assisted suicide, and, in doing so, recognized a constitutional right to physician-assisted suicide. The U.S. Supreme Court reversed this decision in June 1997, ruling that there is no constitutional right to assisted suicide. The Supreme Court justices' opinions, however, included language that suggests that the U.S. Supreme Court would not strike down state laws permitting physician-assisted suicide. Thus, approval of Measure 51 is the only apparent obstacle to implementation of the Oregon Death With Dignity Act.

In the spring of 1997, Oregon legislative hearings were initiated to address issues related to the implementation of Measure 16. The matter was assigned to the Family Law Subcommittee, chaired by
Rep. Ron Sunseri (R-Gresham), of the House Judiciary Committee. The subcommittee held 16 hours of open public testimony with the stated intent to amend the Act, not to repeal or refer it back to the voters. Among the issues identified by these hearings and by suggestions from the opponents, proponents and Governor John Kitzhaber, were the need to better define the patient residency requirement, the need to provide pharmacists and health care facilities the right not to participate, and issues related to where an assisted suicide could take place and who should attend. (Appendix D includes a full list of the issues identified by the legislative subcommittee.) Legislators in both the House and Senate proposed bills to amend and clarify the Oregon Death with Dignity Act. In some cases, the legislation would have referred these amendments to a vote of the people.

Key testimony by assisted suicide opponents before the Family Law Subcommittee questioned the effectiveness of lethal prescriptions. The testimony was based on three studies from the Netherlands where lethal oral prescriptions are often augmented by lethal injection. Though the procedure is not formally legal, assisting physicians who follow accepted guidelines are not prosecuted. The studies showed that 75 percent of the patients died within five hours. However in 20 percent of the patients who received barbiturates, an injection of a muscular relaxant was administered to end life after five hours. Opponents of assisted suicide claimed this meant that oral medications had a “failure rate” of 25 percent. Assisted suicide opponents also presented anecdotal testimony that suggested some patients who attempted suicide without a doctor’s assistance experience complications including pain, vomiting and convulsions during the dying process.

After the hearings and several meetings to consider amendments, Rep. Sunseri declared that the testimony had persuaded him that new information on the effectiveness of lethal oral prescriptions had become available and that the measure, without amendments, should be referred back to the voters. Several groups committed to overturning the Act lobbied for such a referral. Governor Kitzhaber stated that he was opposed to delay or repeal of the Act because he believed the will of the voters should be honored. Lacking the requisite number of votes to overcome a veto, the legislature instead voted to refer the original law back to the voters. The referendum thus became the first Oregon voter-initiated measure to be returned to the electorate unchanged for a second vote.

During the late summer and early fall of 1997, assisted suicide opponents campaigned for Measure 51 primarily on the assertion that Measure 16 is “fatally flawed” and can not be safely implemented. They have identified the suggested “25-percent failure rate” for oral medication as a key flaw. Controversy over this claim increased significantly when assisted suicide supporters released two letters
contradicting this assertion—one from a physician who had participated on the Dutch study that was the source of the original information, and a second letter from the Dutch physician who had written an article reviewing the three studies mentioned above.

III. ARGUMENTS PRO AND CON

A. Arguments Advanced in Favor of the Measure by Proponents of Measure 51 (opposed to the legalization of assisted suicide under Measure 16)

1. Assisted suicide is a sign of society’s failure to address complex end of life issues. Better pain management, anxiety control, hospice care, and other forms of support are more appropriate responses to end-of-life suffering. Legalization of physician-assisted suicide will shift public attention and resources away from enhancing these alternatives.

2. The law will adversely change the doctor-patient relationship. Physician-assisted suicide is inconsistent with the ethical tradition of doctors to “do no harm.”

3. Suicide in any form is one of the worst possible sins.

4. In the Netherlands where doctor-assisted suicide and euthanasia are allowed, some physicians administer death without the patient’s consent.

5. Oregon’s Death With Dignity Act has serious flaws, which outweigh any potential relief the law might provide for the terminally ill. Measure 51 proponents state that these flaws include:
   - Lethal prescriptions of oral medications are ineffective 25 percent of the time. Patients may experience a lingering death. Lethal injection is the only reliable method to bring about death, but Measure 16 prohibits lethal injection. Without it, family members may face the need to suffocate the patient to “complete” a lingering suicide.
   - Mental health counseling is not required for all patients. The 15-day waiting period may not be sufficient time for a patient to adjust to a diagnosis of terminal illness.
   - The physician who prescribes the medication is not required to be present at the time of the suicide attempt.
   - Family notification is not required.
   - Physicians are not able to accurately determine when a patient will die, particularly six months in advance. The definition of “terminal illness” in Measure 16 is vague.
   - The Oregon residency requirement for patients is not defined. Oregon could become a national center for assisted suicide.
• Measure 16 lacks strong reporting requirements. Tracking abuses under the law will be nearly impossible.

• Pharmacists are not provided legal protection and are not given the right to refuse to participate in assisted suicides—a right given to physicians under Measure 16.

6. “Right to die” could become a “duty to die,” particularly for seniors. Rising health care costs coupled with dwindling resources could pressure seniors to end their lives rather than become an economic burden on their family.

7. The combination of capitation programs and health maintenance organizations and the legalization of assisted suicide will create a profit incentive for doctors, hospital managers, and stockholders to seek the earlier death of expensive patients.

B. Arguments Advanced Against the Measure by Opponents of Measure 51 (opposed to the repeal of 1994 Measure 16)

1. The Oregon Death With Dignity Act places the decision about assistance in dying with the terminally ill person rather than with health care persons or society. The Act affords personal choice and death with dignity.

2. The Act makes legal a practice that is now done covertly and informally. Explicit safeguards and procedures are provided in the Act.

3. Religious and ethical beliefs of opponents of the Act should not infringe upon the choice of others for assistance in dying. There are circumstances where involuntary prolonged biological existence is a less ethical alternative than a consciously chosen and merciful termination of life.

4. The Act prohibits euthanasia and lethal injection. There are adequate safeguards to assure that the suicide is voluntary. The individual always retains the choice of whether or not to take the lethal prescription.

5. The Act is entirely voluntary. Doctors are not required to participate if they choose not to, and may decline to respond to a patient’s request for a lethal prescription.

6. Lethal prescriptions are 100 percent effective. Every patient will die. After ingesting a prescription, nearly all patients go into a deep coma without awareness or suffering.

7. Ballot Measure 16 enacted a law rather than a constitutional amendment. If there are problems in implementing the law, a responsible and responsive legislature can and should amend it.
8. Referring assisted suicide back to the voters for a second vote in three years is a waste of resources. It is insulting to suggest that Oregonians did not know what they were doing when they approved Ballot Measure 16.

9. Experience with assisted suicide in the Netherlands has not shown significant shortcomings, and repealing The Oregon Death With Dignity Act will prevent development of experience in the United States under controlled circumstances.

IV. DISCUSSION

Ballot Measure 51 brings back to Oregon voters a social policy issue of great magnitude. Because no other state has a similar law, Oregon would be the nation's pioneer if the assisted suicide law, already approved by voters, is retained by voters and not overturned by the courts.

Your Committee heard testimony on three separate issues: (a) the underlying pros and cons of providing lethal prescriptions to terminally ill patients, (b) the perceived "flaws" in Measure 16, and (c) the legislature's referral of the measure to the voters.

Proponents of Measure 51 claim there are clinical and ethical/moral problems in implementing the Oregon Death With Dignity Act. They raise concerns about procedures and about the efficacy of pills in ending life as well as the underlying ethical/moral issues.

Opponents of Measure 51 favor the individual's choice of a physician's assistance in the dying process, and object to referral back to the voters without change a question previously approved by the voters.

A. The Basic Question of Whether to Legalize Assisted Suicide

Because the issue is again before the voters, your Committee finds it appropriate to consider the basic question: Do Oregonians wish to keep physician-assisted suicide legal? A discussion of key elements of this question follows.

Self determination and death with dignity /Improved care and pain management

Terminally ill patients and those close to them remain fearful of a painful, lingering death.

Proponents of legalized assistance in dying argue the law provides assurance to terminally ill patients that they can find relief from the pain and indignities of their illness. Important decisions about medical care and death can be shifted from the physician to the patient. Those who support physician assistance in dying believe it allows self determination
and death with dignity. From this perspective, respect for individual choice is a fundamental concept in improved care for terminally ill patients. There is wide acknowledgment of and support for the idea that patients have the right to refuse life-sustaining treatments, and this right should be extended.

Opponents of assisted suicide argue that pain relief and comfort care have improved significantly in recent years. Hospice care provides pain management and also attends to the social and emotional needs of people in their final period of life. Some in the medical community acknowledge that adequate pain relief and comfort care is not always available to all dying persons, but think the focus for research and resources should be on improvement of comfort care rather than assistance in suicide.

Measure 16 would control, by law, what is now practiced covertly

Some doctors currently do assist patients who wish to die. A survey of Oregon physicians indicates that seven percent had at one time written lethal prescriptions in response to patient requests. Studies in other areas and anecdotal evidence suggest that the practice is considerably more widespread. Such practices are secretive and do not provide data for empirical analysis.

Under existing laws, physicians are specifically prohibited from any form of active euthanasia or mercy killing, such as lethal injection. Neither Ballot Measures 16 nor 51 changes that prohibition. The current law intentionally requires that the prescription be taken only by the individual wishing to die, not administered by another.

Proponents of assistance in dying argue that it is better to have a legalized, consistent law which standardizes procedures and provides adequate safeguards, thereby providing boundaries and avoiding the "slippery slope" towards wider, unauthorized practices.

Some opponents of assisted suicide think that the current, covert practice is adequate and preferable to legalization of assisted suicide which might expand the practice. Others are opposed to suicide in any form.

Risks for abuse and the "duty to die"

There is some concern about the effect on certain vulnerable populations such as the legally "incompetent" (children, and mentally or physically debilitated), elderly, poor, handicapped or socially disadvantaged.

Opponents of assisted suicide argue the Act would exacerbate the pressure for individuals in these groups to end their lives. There is the possibility that institutions, doctors or even family members wishing to avoid the financial drain of prolonged terminal care could influence a
patient to consider suicide. Even without pressure from others, dying persons may feel they are an economic burden on the family or on society. Or they may sense the emotional distress of those around them and choose to end their lives in order to not be a burden on those they love.

Proponents of assisted suicide note all of these possibilities exist at present. Proponents cite the experience of living wills and the voluntary withdrawal of life support for terminally ill patients which has not been abused.

Ethics and suicide

The issue of assisted suicide is clearly a "value-based" issue that is loaded with passion and strong emotions. Religious and other organizations and individuals hold differing views on the ethics of suicide for terminally ill persons.

A broad-based, but not unanimous, religious community is joined by the Oregon Medical Association, Oregon Hospice Association, Oregon Association of Hospitals, and other groups in supporting Measure 51. In 1994, the Legislative Committee of Ecumenical Ministries of Oregon (EMO) argued in the voter’s pamphlet that assisted suicide “attempts to disrupt the natural season and time of death.” “Death is not a problem to be hastened, rather a sacred time of living the seasons and reasons of nature.”

EMO has taken a position in favor of Measure 51, based on its previous position on Measure 16.

In contrast, a task force of the Episcopal Diocese of Newark said that “There are circumstances where involuntarily prolonged biological existence is a less ethical alternative than a consciously chosen and merciful termination of earthly life.” “In such exception cases, assisting a suffering person in accomplishing voluntary death can be morally justified as part of the healing process, because it enables a person to die well.”

B. Measure 16 and Perceived “Flaws”

A number of issues regarding implementation of Measure 16 were identified and considered in the legislative process. (See Appendix D for a description of 19 issues considered by the House Judiciary Committee.) This report highlights below two of the more salient issues, which repeal proponents claim cannot be remedied by amendment.

Depression and suicide

Many people who commit suicide are suffering from treatable depression. Depression is often not diagnosed, particularly among the elderly where it is common. Feelings of helplessness and hopelessness can lead to the request for a lethal prescription. Opponents of assisted
suicide believe that these symptoms can be treated and the resultant depression often relieved, leading a patient who might have considered suicide to change their mind.

Supporters of assistance in dying note that Measure 16 requires counseling for patients with impaired judgment from depression as determined by the attending physician. In addition, The Oregon Death With Dignity Act provides the safeguards of having the opinion of a second physician, two oral requests and one written request, a waiting period of 15 days, a required offer by the physician to rescind the request, and medical record documentation of the terminal diagnosis and the patient’s requests.

Opponents of assisted suicide, in arguing for repeal of Measure 16, state that the medical and counseling communities still cannot diagnose depression with any degree of certainty, and that requiring counseling for only some patients is not sufficient.

Will lethal prescriptions work effectively?

There are differing views on the efficacy of pills to end life.

Opponents of assisted suicide justify repeal efforts on the ground that new information on the effectiveness of lethal prescriptions taken orally came to light after passage of Measure 16. They contend that such prescriptions fail to cause death in 25 percent of cases, that the patient suffers unduly and that family members are anguished even to the point of intervening to hasten death.

However, proponents of assistance in dying note the 25-percent statistic means the lethal prescription did not cause death within three hours. Your Committee heard evidence that the rate of death is 100 percent if the period of time is extended. Those who favor legalized assistance in dying cite three studies in the Netherlands which compare the time lapse between application of the prescription and death. The time varied from a few minutes to hours, with a small percentage taking more than 24 hours. A September 17, 1997 Willamette Week article reported that a study by Dutch physician, Dr. Pieter Admiraal—the basis of the Measure 51 supporters’ claim of a 25-percent failure rate for oral medication—had shown while 75 percent of patients died after three hours, “96 percent of the 87 people he studied died within five hours of taking life-ending medication. The other 4 percent died within two days.”

Physicians have not been taught which medications to prescribe for suicide. Although doctors are trained in understanding the lethality of curative and pain relieving drugs, there is no research in professional literature about the efficacy of lethal prescriptions. Physicians who are willing to participate in assisted suicide will need to gain experience.
C. The Legislature’s Referral of Measure 16 back to Voters

A third consideration faced by the voters is the propriety of legislative referral of a recently-passed ballot measure. Measure 51 is an unprecedented event in Oregon electoral history: the legislature is asking the voters to repeal a measure recently enacted by citizen initiative. Oregonians should consider whether this is an appropriate use of the referendum.

“New information”

The issue of “new information” is put forward by opponents of assisted suicide as the major justification for referring Measure 16 back to voters. While some Dutch studies of assisted suicide and euthanasia practices have been published since the November 1994 election, other similar studies were available prior to the election. These earlier studies did not appear to receive close scrutiny in the 1994 campaign. Proponents of Measure 51 claim that new information from Dutch studies indicates that 25 percent of patients who attempt assisted suicide will either experience a lingering death or will not die. While they argue that information released since the November 1994 election reveals fundamental flaws in Measure 16’s approach to assisted suicide, the actual Dutch sources of the information have disavowed this conclusion.

Dutch physician Pieter Admiraal, M.D., Ph.D., the source of the information that led to the 25-percent failure rate claim, affirmed in a July 25, 1997 letter, that “one of four patients will die after a period longer than three hours.” He went on to say, however, that “after a[n] oral dose of 9 gram[s] of barbiturates (3 times the lethal dose), EVERY patient will die. During that time the patient is in a deep coma without awareness and so without any suffering.” “A period of 24 hours or longer will be very exceptional.”

Dutch physician, Gerrit Kimsma, M.D.,7 has been quoted as saying in his 1996 book, Drug Use in Assisted Suicide and Euthanasia, that “in 20 percent of the patients who received a barbiturate, a muscular relaxant was needed to end life after the five hour time period.” However, on July 3, 1997 Kimsma addressed a letter to The People of Oregon, in which he stated “...a particular claim has been made by the opposition to any form of legalization of physician assisted suicide that...in many cases of physician assisted suicide in the Netherlands, the established failure rate would be 25 percent. This is implied to mean that in 25 percent of the cases where physicians would assist in death through orally applied means the effect would not be death. This claim has no foundation whatsoever, is misleading and completely wrong. There are no scientific data nor hearsay to support it.”

Your Committee members believe that the claim of a 25-percent “failure rate” for lethal prescriptions is confusing and misleading. Continued research by the medical community will be needed to identify
The most effective means of providing lethal prescriptions.

Measure 16 changed Oregon statutes, not the state constitution

The Oregon Death With Dignity Act (Measure 16) changed Oregon statutes and did not amend the Oregon Constitution. As such, the legislature could have amended or repealed the Act without returning it to the voters. However, such action was subject to gubernatorial veto. The Governor identified several concerns with the Act, while stating his opposition to either delay or repeal of the Act. Supporters of the Act offered compromise amendments designed to address these problems. The refusal of the legislature to enact any of the proposed amendments, or to refer an amended bill to the voters is interpreted by opponents of Measure 51 as a strategy backed by pressure groups whose goal is to repeal the entire Act.

Is the legislature’s referral of Measure 16 appropriate?

Your Committee members are not in agreement over whether the legislature took appropriate action in referring Measure 16 back to voters. A majority of your Committee believes the legislative referral was inappropriate for the following reasons.

In a perfectly efficient electoral system, the voters would not be asked to vote on precisely the same question twice within a three-year period. One opponent of Measure 51 estimated the public cost of conducting the referendum election as significant. In addition, proponents and opponents incur the expense of getting their message to the voters a second time. Some believe that perhaps more significant than the dollar cost of the second election is the potential distraction from other issues of public concern.

In addition, the Committee discussed the potential misuse of the referendum process and a feeling that the legislature “took the easy way out” by referring this measure to the voters. The 1996 Ballot Measure 47 “Cut and Cap” Property Tax Limitation is a clear example of a highly-charged campaign, a large voter turnout, a slim majority, and a ballot measure with consequences far beyond the voters’ intent. The legislature decided to “fix” Measure 47, and place it, as amended, before the voters as 1997 Measure 50. The legislature considered, and rejected, that approach with Measure 16.

A minority of your Committee believes that Measure 51 appropriately brings back to the people of Oregon a matter of life and death. They believe that the passage and subsequent need to amend and clarify ballot measures passed during the last five years indicates voters often do not realize exactly what their vote would come to mean. The entire nation will be looking to Oregon if Measure 16 is implemented. This places a significant responsibility on Oregon, thus placing national public policy in our hands. This is a very serious issue. A public policy
that will become precedent for the nation deserves critical review, a second look at implementation and consequences of implementation, and medical community backing.

Closeness of Measure 16 vote in 1994

The closeness of the vote on Measure 16 in 1994 (51.3 percent to 48.7 percent) is cited as justification for a re-vote. Arguably, the voters may not have understood the action they took because Measure 16 was one of many complex measures on the ballot.

A majority of your Committee believes that in a democracy many important public issues are decided by bare majorities. Furthermore, the number of votes cast on Measure 16 was higher than on any of the other measures on the same ballot, alternately suggesting a high level of attention to the issue.

A minority of your Committee submits that when Measure 16 was passed in 1994 it was one of 23 ballot measures competing for voter attention. As the City Club noted in its 1996 report, The Initiative and Referendum in Oregon, voters are inundated with “information” about ballot measures, and voters are often unclear about the full and likely consequences of many measures. Some proponents of assisted suicide acknowledge that Measure 16 requires some amendments. As discussed previously, 19 areas of potential amendment were discussed in the House Judiciary Family Law Subcommittee. (See Appendix D.)

V. CONCLUSION

It is the unanimous conclusion of your Committee that Measure 51 does not deserve the support of the voters.

The Committee finds the issues concerning the end of life to be complex. There are many differing viewpoints about assisted suicide ranging from the ethical to the practical. Because no other state has legalized the practice, Oregon is venturing into new territory.

Notwithstanding the fact that physician-assisted suicide, as provided for under Measure 16, has not been tried elsewhere, in our nation or abroad, the Oregon Death With Dignity Act appears to be good policy and should be implemented. If problems are later identified with the law, the legislature can pass legislation to correct them.

The Committee believes the primary argument in favor of assisted suicide is that it provides individual choice in self determination about end-of-life decisions. This value of choice is strongly held in our society, and has been the basis for changes in medical practice, particularly in the area of dying. Significant legal and medical care changes allow an individual to refuse certain kinds of care or life-support measures.
Living wills and directives to physicians are common and widely used. We heard testimony that dying patients do not fear death so much as they fear the process of dying. They fear not only prolonged pain and suffering, but an undignified end of life including life support systems and a semi-conscious state.

The Committee believes a physician-assisted suicide law can have many benefits. Practices which are now covert and without regulation will be uniform, available to all, and subject to reporting guidelines and the protections of a legal system.

Concerns about the link between depression and suicide raise important questions regarding how legally assisted suicide is implemented in Oregon. However, your Committee did not find these concerns to be of such a fundamental nature that they should prevent implementation of Measure 16.

While there are clearly important questions about which medications are most effective and appropriate for assisting a terminally ill patient to end their life, claims by Measure 51 proponents that oral medications will be ineffective 25 percent of the time appear to be misleading and unsubstantiated. Your Committee did not find this so called “fatal flaw” to be a credible reason not to implement the current law as passed under Measure 16. This is a new area for the medical profession, but research and practice could improve the procedures to make such clinical problems manageable.

We heard testimony and read studies by groups who are concerned that the “right to die” may lead to the “duty to die.” The Committee believes such issues need to be widely discussed in our society. However, we do not believe that physician assistance in dying will necessarily lead to societal pressures for people to terminate their lives. The Oregon law has clear safeguards against euthanasia as well as procedures to provide that suicide is voluntary.

We also note the concern that elderly, chronically ill, and the poor may be vulnerable to assisted suicide. We share this concern. These groups do not always receive complete and compassionate care. Providing this care remains a problem in our society.

Most members of your Committee think Measure 51 is a misuse of the referendum. A majority believes the legislature should recognize that Oregonians endorsed the concept of assisted suicide. The legislature’s proper function is to amend the measure to correct flaws, not to simply refer it back for another vote. A minority of your Committee’s members believe the legislature’s referral of Measure 16 back to voters is appropriate given the seriousness of the issue and the closeness of the vote in 1994. Nevertheless they conclude that the issues raised by Measure 51 proponents concerning the implementation of Measure 16 are not so significant as to justify repeal.
VI. RECOMMENDATION

For the above reasons, your Committee unanimously recommends a "No" vote on Measure 51.

NOTE: Voters should be aware that a "No" vote would retain the doctor-assisted suicide law enacted by 1994 Measure 16, while a "Yes" vote would repeal the law.

Respectfully submitted,
Mark Anderson
Charles Landskroner
Mary Jo Morris
Joseph Nadal, M.D.
Ruth Robinson
Tamsen Wassell
Kurt Wehbring
Nickie Lynch, vice chair
Greg Macpherson, chair

Tomm Pickles, research advisor
Hillary Barbour, research assistant
Paul Leistner, research director

VII. APPENDICES

A. Endnotes


B. Witnesses Interviewed by the Committee

Ken Baker, Oregon state senator
Kate Brown, Oregon state senator
Neil Bryant, Oregon state senator
Richard Burningham, M.D.
Bob Castagna, director, Oregon Catholic Conference
Ron Cease, College of Urban and Public Affairs, Portland State University
Trish Conrad, campaign manager, Yes on 51 Campaign
Barbara Coombs Lee, executive director, Compassion in Dying; chief petitioner, 1994 Ballot Measure 16
George Eighmey, Oregon state representative
Joseph H. Eusterman, M.D.
Mark Gibson, assistant to Oregon Governor John Kitzhaber
Peter Goodwin, M.D.
Gregory Hamilton, M.D., Physicians for Compassionate Care
Grant Higginson, M.D., state health officer, Oregon Health Division
Mark Loveless, Department of Infectious Diseases, Oregon State University
Ellen Lowe, director of public policy, Ecumenical Ministries of Oregon
Emanuel Rose, rabbi, Temple Beth Israel
David Rullman, M.D.
Geoff Sugerman, Oregon Death with Dignity
Ron Sunseri, Oregon state representative
Joan Tanner, M.D.
Bill Taylor, legislative staff, Judiciary Committee, Oregon House of Representatives

Susan Tolle, M.D., Center for Ethics in Health Care, OHSU

Judith Uherbelau, Oregon state representative

Michael VanderKam, Accessibility, Information and Advocacy Council of Oregon

C. Resource Materials

Oregon Legislature


Oregon Secretary of State


Oregon Voters’ Pamphlet-November 8, 1994 Election.

Oregon Voters’ Pamphlet-November 4, 1997 Election.

Newspaper Articles

The Oregonian


Green, Ashbel S. “ Suicide law returns to voters,” June 10, 1997.


Other Newspapers


Other Documents


Statement of the National Hospice Organization Opposing the Legalization of Euthanasia and Assisted Suicide, 1997.


D. Summary of Measure 16 Amendments Considered by the Legislature

MEMO

TO: REPRESENTATIVES SUNSERI AND MINNIS
FROM: BILL TAYLOR [staff, House Judiciary Committee]
RE: HB 3362-AMENDING OREGON'S "DEATH WITH DIGNITY ACT"
DATE: MARCH 18, 1997

I have set forth below, a list of issues that pertain to Oregon's "Death with Dignity Act." Some of these issues are addressed in bills that are before the Family Law Subcommittee. Other issues are set forth, as amendments to HB 3362, or have yet to be drafted either as an amendment or as a bill.

1. **Residency:** HB 3362, subsection 12 of section 1, redefines "resident of Oregon," so residency means more than just an expression of intent. Uses a facts and circumstances test rather than a durational time period test. The courts have closely scrutinized the latter. The -3 amendments require patient to prove to the Health Division that he or she is a resident. Requires patient to list name of attending physician. Prohibits physician from prescribing final dose without receiving notice that patient is a resident. Not only will the amendment help in limiting the Act to those who are residents of Oregon, it will also help law enforcement identify those who have departed pursuant to the Act.

2. **Conscience clause:** For health care facilities that do not want to participate. Currently, ORS 127.885(4) grants immunity, but (2) cuts off any remedy. HB 3362, section 6, gives the health care facility a remedy against a physician. Probably should be expanded to cover "person." Otherwise, a physician could argue that he or she issued the prescription, outside the hospital or nursing home, and gave it to the nurse.

3. **"Attending physician"**: We heard testimony that not all physicians should be attending physicians for the purposes of Act. No bill or amendments address this issue. Could require the Board of Medical Examiners to decide.

4. **Recognition of pain and suffering:** HB 3362, section 1, subsection (3), requires the consulting physician be qualified in the treatment of pain and suffering.

5. **Psychiatric or psychological disorders:** HB 3362, section 1, subsection (3), requires that the consulting physician be qualified in the recognition of psychological and psychiatric disorders. HB 2965 adds neurological disorders. The -2 amendments require an
evaluation, by a psychiatrist or psychologist, prior to the attending
physician issuing the final dose. Also, we may need to clarify
whether depression is or is not considered a mental illness for the
purposes of the Act, and whether a patient, who suffers from
depression, can still qualify, as long as the depression does not
impair judgment.

6. "Capable": HB 3362 uses the term "capable" rather than
"incapable." HB 2965 requires that the patient understand what is
meant by death. This area needs work.

7. Patient’s spouse: The -1 amendments require the physician to
notify the patients spouse.

8. Patient’s guardian: HB 3362, section 5, requires that the patient’s
guardian be notified. A person under guardianship is not presumed
to be incompetent. ORS 125.300(2). However, the guardian has
custody over the person. ORS 125.315.

9. Where the patent may take the final dose: The -4 amendments
limit the place to a health care facility, the patients home, or a private
home of someone who consents.

10. Attending physician to be present: The -4 amendments require
the attending physician be present. Also, if the attending physician
were there, he or she could sign the death certificate and thus
remove the need for the State Medical Examiner to investigate.

11. Delivery of final dose: The -4 amendments require pharmacist
to deliver medication at one of the locations listed above.

12. Conflict of Interest: The -6 amendments prohibit the attending
and consulting physician from having a financial relationship.

13. Standing: The -5 amendments, on their face, give any person,
domiciled in Oregon, standing to challenge the constitutionality of
the Act, if they do so within six months. One major question is
whether this amendment accomplishes anything. We cannot create
standing in federal court. We may not be able to create standing in
state court.

14. Prescription Marked: Pharmacists would like to have the
purpose of the prescription, for the final dose, clearly listed on the
prescription. Not in any bill. No amendments. Also, pharmacists
would like clarification that they do have a conscience clause. This is
in HB 3362, section 1(5).

15. Witness to request: ORS 127.810 requires two individuals
to witness the patient’s written request for the final dose. The -7
amendments require one of the two witnesses to have known the
patient for six months or longer.
16. **Terminal disease:** ORS 127.800 defines what a terminal disease is. Thomas Marzen, General Counsel of the National Legal Center for the Medically Dependent and Disabled, raised several issues concerning the definition of terminal disease, particularly as it relates to such diseases as diabetes — diseases that without medication or treatment are terminal but with treatment are not. Do not have amendments that address these issues. Not sure if we can answer some the questions he raises.

17. **Enforcement:** Need to clarify that the Department of Health has the right to review medical records and enforce its right. The amendments clarify that the Department has the authority to inspect and has enforcement powers.

18. **Hospice care and pain relief:** For those who are not covered by insurance and do not quality for the Oregon Health Care Plan.

19. **How effective is the medication:** According to studies from the Netherlands, 25% of all persons who attempt physician aided suicide by orally taking the fatal dose do not die immediately. Death takes from three hours to four days. What happens to those who do not immediately die?