

**Written Testimony of David Grube, MD, National Medical Director,
Compassion & Choices
Regarding HB 2217, Relating to the Oregon Death with Dignity Act
Senate Judiciary Committee
Thursday May 9, 2019**

Good morning Chair and Members of the Committee. My name is Dr. David Grube, National Medical Director for Compassion & Choices, the nation's oldest and largest nonprofit organization working to improve care and expand options at the end of life.^{1,2,3,4,5} As a retired family physician from Oregon, I have almost 40 years of experience caring for patients in all stages of life through death, including those who have requested and utilized medical aid in dying, I wish to express concerns about the proposed legislation, HB 2217.

Oregon has more than 20 years of experience with medical aid in dying and a tremendous amount of data that assures us of the effectiveness and value of this option. In that time we have also come to learn that many of the well-intentioned regulatory requirements within the Death With Dignity Act are more barricades than safeguards, disincentivizing provider participation and making it very difficult for terminally ill individuals to access medical aid in dying.

The time has certainly come to re-evaluate and refine the law, and to remove those unnecessary regulatory requirements that create barriers. However it is imperative that any changes made to the Death with Dignity Act are done so thoughtfully, in a way that

¹ Compassion & Choices brought landmark federal cases establishing that dying patients have the right to aggressive pain management, including palliative sedation. *Vacco v. Quill*, 521 U.S. 793 (1997); *Washington v. Glucksberg*, 521 U.S. 702 (1997).

² Compassion & Choices drafted and sponsored introduction of legislation requiring comprehensive counseling regarding end-of-life care options. See, California Right to Know End-of-Life Options Act, CAL. HEALTH & SAFETY CODE §442.5; New York Palliative Care Information Act, N.Y. PUB. HEALTH LAW § 2997-c.

³ For example, Compassion & Choices is pursuing accountability for failure to honor a patient's wishes as documented in a POLST, *DeArmond v Kaiser*, No. 30-2011-00520263 (Superior Court, Orange County, CA). In another case, Compassion & Choices represented a family in bringing into the public eye a situation where patient wishes to forego food and fluid were obstructed. See Span, "Deciding to Die, Then Shown the Door," *The New York Times*, Aug. 24, 2011, available at

<http://newoldage.blogs.nytimes.com/2011/08/24/deciding-to-die-then-shown-the-door/?ref=health>; Uyttebrouck, "Couple Transported Out of Facility After Refusing Food," *Albuquerque Journal*, Jan. 08, 2011, available at <http://www.abqjournal.com/news/metro/08232859metro01-08-11.htm>.

⁴ Compassion & Choices brought two federal cases to the United States Supreme Court urging recognition of a federal constitutional right to choose aid in dying. *Washington v. Glucksberg*, 521 U.S. 702 (1997); *Vacco v. Quill*, 521 U.S. 793(1997). Compassion & Choices was in leadership in the campaigns to enact the Death with Dignity Acts in Oregon and Washington. OR. REV. STAT. § 127.800 (2007); WASH. REV. CODE ANN. § 70.245 (West 2011).

⁵ See supra n. 1, Bergman, Tomlinson, Tolliver, Hargett; See supra n. 3, DeArmond.

ensures access to this end-of-life care option while ensuring terminally ill residents have a compassionate death.

While I can appreciate ensuring that people who can swallow are able to access medical aid in dying, the reality is that people who can't swallow are already eligible under the law. I am concerned that the legislation as written will introduce considerable risk into the process that could result in Oregon's medical aid in dying law going from one that protects patients to one that could result in botched deaths.

Currently, under the law, qualified terminally ill individuals who receive a prescription for aid-in-dying medication are able to use various forms of self-ingestion. In addition to drinking from a cup, qualified terminally ill patients are able to ingest the medication either through a feeding tube or a Macy catheter (a rectal device). These devices are generally in place already because of some medical condition (if the patient is unable to swallow, for example), and the terminally ill individual has been trained how to properly employ it.

If and when the qualified terminally ill individual decides to self-ingest the medication, they are able to do so by a deliberate act such as pushing a plunger or syringe on the feeding tube or catheter so that the medication is ingested, just as it would be if they were to sip from a straw. So patients who are unable to swallow do still have access to other administration methods under the existing law.

While some physicians may not be aware of these modes of self-ingestion, this is an issue to be addressed through education within the medical community, not the legislature. Revising the law is not the way to address this.

Our initial understanding of the law was that the above was the intention; however, based on recent emails that we have seen and comments by the bill sponsor, we now understand that the intention of the law may in fact have been to expand the means of administering the medication to the intravenous administration (IV). We are concerned that this is a very dangerous proposition. As has even been noted by those who support the administration via the IV: it can be tricky, and if it's not done right it will set the movement back here in Oregon and nationally.

Patients do not have the medical expertise to know how to put in an IV line. We have seen with the death penalty that when a non-medical personnel attempts to insert an IV line that the result can be a botched death. If it's not done by a person with experience, the medication does not go into the vein, but under the skin, and the person does not die in a compassionate manner; they may, in fact, end up not dying but instead living in

an even more debilitated state.

As the law is written, there is no requirement for a doctor to be present and the reality is that in very few medical aid in dying deaths occur in medical facilities. Most patients who are using medical aid in dying do not have IV's set up. So this is not just a simple clarification of the law, it is opening up an entirely different way of administering this practice, that is counter to the way it was originally drafted and intended.

Since we have had good experiences with the various methods of ingestion, authorizing self-administration via IV is not worth the risk. As my colleague Sam DeWitt also stated, there is too much at stake here in Oregon, a state which is known to have produced a compassionate law that also protects patients. This bill, as written, is not the way to achieve that.

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