Testimony of Geoff Sugerman
Death with Dignity National Center

RE: Opposition to HB 2217

Chair Prozanski, members of the Senate Judiciary Committee,

My name is Geoff Sugerman. I represent the Death with Dignity National Center and formerly served as campaign manager for the original Death with Dignity Act in 1994 and worked on this issue through all the ensuing court challenges and the second Oregon vote in 1997 which reaffirmed the law. Other members of the DDNC include Eli Stutsman, the author of the Death with Dignity law and our current Board President, former State Rep. George Eighmey. Today I am a national political consultant for the DDNC. I have lived in Oregon for 29 years.

The Death with Dignity National Center comes to you today to oppose HB 2217 in the amended form in which it passed the Oregon House. While we had for a short time withdrawn our opposition to the bill based on an amendment proposed by Compassion and Choices, subsequent events have convinced us that the sponsors of the bill believe this change allows activities we believe clearly violate the law.

Just one day after the House passed this bill, the lead witness for the Chief Sponsors, Dr. Charles Blanke, sent the following email to a group of doctors outlining a protocol he intends to use should the bill pass. The text of that email appears below:

From: ***Charles Blanke*** *<blankec@ohsu.edu>*
Date: Tue, Apr 23, 2019 at 12:12 PM
Subject: Re: IV self administration

Dear colleagues,

OR House Bill 2217 passed last night. It still has to go to the D controlled Senate and the (D)governor, but the voting was strictly across party lines, and the Senate has a 32 -18 split (D). So, it looks likely.

Allowing a patient to self-administer IV is tricky. And we have to be SURE things go smoothly, or we could set MAiD itself back significantly. I was thinking about the following protocol (developed of course with an anesthesiologist) and I would love your input. I realize not everyone supports this venture, but it should be a done-deal soon. And other states may follow.

Few things to remember:
The patient cannot administer drugs sequentially. Thus, we cannot use the British Columbia regimen, and we must use a multi-channel infusion pump.

We need to be 1000% sure the patient is anesthetized before any paralytics kick in. We can't delay things if they are not out.

We can't modify the administration once it is started by the patient. I assume we can stop the pump if something goes wrong.

Device: Multi-channel Oleris pump with variable rates

Induction propofol 500 mg (50 ml) at rapid rate.
Guaranteed coma in one or so minutes
Might itself abrogate breathing

2nd channel
Pancuronium 30 mg 1 mg/ml 2 mg/min
Takes about 6-12 minutes to kick in. Lasts 5 hours

3rd channel
roPpofol 2 grams (200 ml) 500 ugrams per kilo per minute
To maintain unconciousness

Thanks!

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The Death with Dignity National Center opposes HB 2217 for the following reasons:

1. The procedure outlined by Dr. Blanke constitutes lethal injection in the minds of every health care professional we have consulted with, as well our legal advisors and those who wrote the original law. The procedure violates the following provision of the Oregon Death with Dignity Act:

127.880 s.3.14. Construction of Act.

Nothing in ORS 127.800 to 127.897 shall be construed to authorize a physician or any other person to end a patient's life by ***lethal injection****, mercy killing or active euthanasia. Actions taken in accordance with ORS 127.800 to 127.897 shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law. [1995 c.3 s.3.14]*

Thus, passage of this bill would immediately set up a conflict within the law, with sponsors claiming it allows lethal injection and a provision in the law prohibiting that activity.

2. The proposed procedure is flawed according to medical experts we have contacted. This untested protocol described by Dr. Blanke could require the insertion of a PICC line, requires the use of a specialized three channel infusion pump which costs $2900, and could lead to a person awakening during the use of the paralytic which could cause significant distress and seizures as the body tries to consume air. Experts we have consulted with believe it is not a valid or safe approach even if it were legal under the law.

3. The bill fails to include any additional physician responsibilities or patient safeguards. Under current law, once the prescription is written, the doctor is under no further obligation other than reporting requirements. Thus, if this activity were permitted, a patient or family member could arguably receive the three syringes, and attempt to

complete the procedure themselves which again could lead to disastrous results. Even the prescribing physician may not have the expertise to set up the pump, install a PICC line if needed, and deal with mechanical issues should they arise. None of these very important process issues are dealt with in the bill.

Even if we supported this proposed protocol, we would oppose this law for its lack of process to protect the patient and clearly delineate physician responsibilities.

4. In both his House testimony and a recent article in the Bend Bullletin, Dr. Blanke is quoted as saying:

"Blanke said most of the critics of the bill are opposed to the concept of assisted suicide, not the specific changes in language included in the bill. "I just can't believe the route was that important to the people who wrote the law and that they intended people to not be able to use it because they can't swallow," he said."

Actually, the route of administration was vitally important to us, back then and now. In fact, as I attended every single meeting for well over a year as we wrote this law during 1993 and 1994, administration was usually at the center of the debate. We grappled over how to ensure the patient stay in control of the process, and how we could ensure the delicate balance between allowing this right and ensuring no one could harm the patient against their will. In the end, we determined oral administration was the only way to guarantee patient control.

The late Dr. Peter Goodwin, a chief petitioner of Measure 16, was a leader in the effort to insist the bill not allow for lethal injection and only allow the use of pills requiring oral ingestion. It is characterized this way in the book, "Freedom to Die:"

"One person with influential views was Dr. Peter Goodwin, who argued trenchantly that doctors instinctively opposed inducing deaths by injection because this act too closely resembled killing."

We did care about administration. It was a key decision that was central to the theme of our campaign and one that, in my mind, was largely responsible for its passage. We intentionally left out the use of lethal injection and devices, and to suggest otherwise is simply an untruth.

5. To further underscore that point, remember that in 1994 the country was grappling with the actions of Dr. Jack Kevorkian who used a machine or device to administer a lethal dose of CO2 to patients. We intentionally and very frequently said the law prohibited the use of lethal injection and devices. Quoting from the Voter Pamphlet argument provided by the drafters of the bill:

"Under Measure 16, only the dying person may self-administer the medication: Measure 16 does not allow lethal injection, mercy killing, or "suicide machines."

We again very intentionally made the decision to not allow devices or lethal injection, and our organization has never wavered from that conviction.

We understand that the sponsors of this legislation may have proposed this bill with the best of intentions. But this "technical fix" is wholly deficient in laying out a safe, well-defined process that will lead to a peaceful and dignified death. It conflicts with the current law and it fails to include the necessary safeguards. For all of those reasons we urge this committee to reject HB 2217.

Thank you.

127.815 s.3.01.Attending physician responsibilities.

(1) The attending physician shall:

(a) Make the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily;

(b) Request that the patient demonstrate Oregon residency pursuant to ORS 127.860;

(c) To ensure that the patient is making an informed decision, inform the patient of:

(A) His or her medical diagnosis;

(B) His or her prognosis;

(C) The potential risks associated with taking the medication to be prescribed;

(D) The probable result of taking the medication to be prescribed; and

(E) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control;

(d) Refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily;

(e) Refer the patient for counseling if appropriate pursuant to ORS 127.825;

(f) Recommend that the patient notify next of kin;

(g) Counsel the patient about the importance of having another person present when the patient takes the medication prescribed pursuant to ORS 127.800 to 127.897 and of not taking the medication in a public place;

(h) Inform the patient that he or she has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the end of the 15 day waiting period pursuant to ORS 127.840;

(i) Verify, immediately prior to writing the prescription for medication under ORS 127.800 to 127.897, that the patient is making an informed decision;

(j) Fulfill the medical record documentation requirements of ORS 127.855;

(k) Ensure that all appropriate steps are carried out in accordance with ORS 127.800 to 127.897 prior to writing a prescription for medication to enable a qualified patient to end his or her life in a humane and dignified manner; and

(L)(A) Dispense medications directly, including ancillary medications intended to facilitate the desired effect to minimize the patient's discomfort, provided the attending physician is registered as a dispensing physician with the Board of Medical Examiners, has a current Drug Enforcement Administration certificate and complies with any applicable administrative rule; or

(B) With the patient's written consent:

(i) Contact a pharmacist and inform the pharmacist of the prescription; and

(ii) Deliver the written prescription personally or by mail to the pharmacist, who will dispense the medications to either the patient, the attending physician or an expressly identified agent of the patient.

(2) Notwithstanding any other provision of law, the attending physician may sign the patient's death certificate. [1995 c.3 s.3.01; 1999 c.423 s.3]

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Nothing in ORS 127.800 to 127.897 shall be construed to authorize a physician or any other person to end a patient's life by ***lethal injection****, mercy killing or active euthanasia. Actions taken in accordance with ORS 127.800 to 127.897 shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law. [1995 c.3 s.3.14]*