Oregon vs the Netherlands

or

Making American Physician-Assisted Death More Dutch

John Frye, PhD Candidate

Case Western Reserve University, OH, USA

American Physician-Assisted Death

- Restricted to Physician-Assisted Suicide
- Legal in 5 states (OR, WA, MT, VT, CA)
- Oregon's law served as model for others
- Requirements:
  - Terminal illness (<6 months)
  - Voluntary competent request in writing
  - Second opinion required
  - Waiting period (15 days)

Lessons from the Dutch

1 Physician Presence at the End

2 Medical Friendship

3 Trained Consultants

4 Ethics Committee Review of Cases

5 Collection and Review of Case Narratives

6 Involvement of Professional Associations

7 Public Transparency

1: Physician Presence at the End

- Physician not present in majority of cases
- Often cannot attest to other HP present
- Laws allow forbidding professional presence
- Volunteers often present (Comp & Choices)
- Presence can:
  - Show continuing support for patient
  - Confirm voluntariness of ingestion
  - Answer accusations of abandonment

2: Medical Friendship

- Request for dying changes physician-patient relationship
- Pill reception indicates that patient death is potentially imminent
- Palliative care, hospice, spiritual care, etc., should be appropriately engaged
- Collection of health professionals must help inform/respond to patient's discernment process
- An extended version of medical friendship

3: Trained Consultants

- Many doctors can confirm terminal disease and voluntary capacity
- Suffering not a criterion = no need for training
- Suffering and other concerns likely present
- Other concerns regarding ability to detect psychosocial issues that should be addressed
- Trained consultants for the hard issues and hard cases

4: Ethics Committee Review of Cases

- Dept of Public Health does not review cases with the narrative approach or ethical scrutiny
- Ethics committees could examine such cases in greater detail, before or after patient death
- Additional oversight for difficult cases (which might prompt ethics consultation)
- Uses available resources rather than creation of new committees

5: Collection & Review of Case Narratives

- In-depth review of cases beyond forms, signatures, data collection and chart review
- Further reflection on events by physicians and reviewers
- Better sense of emerging and evolving practice

6: Professional Association Involvement

- Support continuing education for such PAD
- Establish and refine professional standards that work with the law for the patient
- Connect individuals who receive requests with those who have training
- Provide support during and after filling a request
- Lobby for research funds
- Bring together opposing sides for bipartisan studies
- Does not require official sanction/support of PAD

7: Public Transparency

- Publication of more than statistics
- Case narratives and medical recommendations along with them
- Informed public, continuing debate
- Public awareness with less chance of political bias of cases and issues

Already and Not Yet

- Some physicians do stay with patients
- Hospice professionals and others can be actively involved in patient discernment
- Physicians may seek out specially experienced consultants for patients
- Ethics committees may consult on and review tough cases
- Some professional organizations are neutral/supportive of law, encourage active responses to potential issues

Already and **Not Yet**

- Too many patients use PAD w/o HP present
- Little/no training for physicians/consultants
- No provision for collecting or reviewing narratives
- Most professional organizations against practice, including 2/5 state medical associations from where it is legal
- Public receives only media narratives, not official unbiased narratives with medical responses

Conclusion

- Evolving practice of Assisted Death
- California: greatest test yet for American PAD
- Proactive engagement with issues