

End of Life Discussion Panel

Stanford OpenXChange
May 12, 2016

Thaddeus Mason Pope, JD, PhD
Mitchell Hamline School of Law

Introduction

Death is
not always
bad

Life is
not always
good

For many, the
alternative to
death is **worse**



Avoid
unwanted
life

Even more
obviously

Avoid
unwanted
death

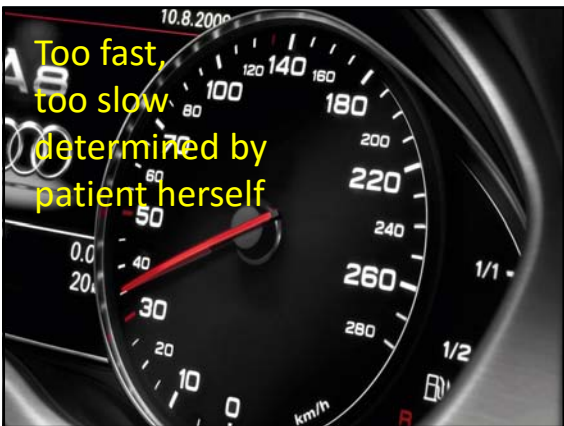


Thesis

2 risks
to avoid

Dying
too fast

Dying
too slow



Preference
sensitive
Value laden

But ...

Safeguards to
reduce one risk
increase the
other risk

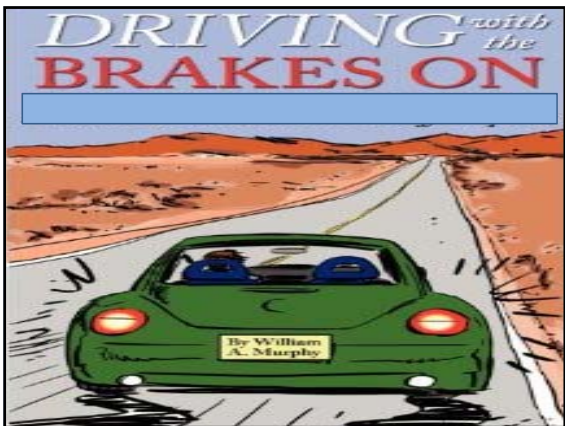


Roadmap

1. Too slow
2. Too fast

**Too
Fast**

**Smaller
risk**





Cruzan (Mo. 1988)

“we err on the side of preserving life”

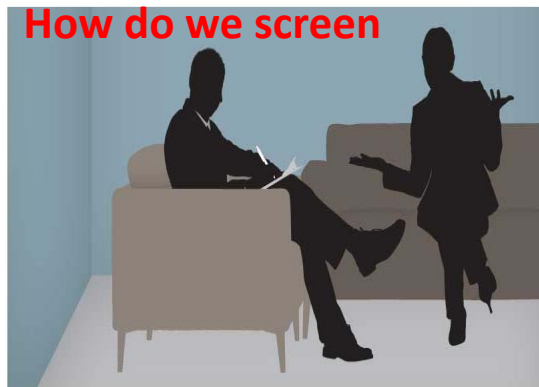
One example

MAID

CA EOLO
is **not an**
option

“impaired
judgment ...
mental
disorder”

How do we screen



Mental health specialist assessment **only if** attending or consulting physician determines “indications of a mental disorder”

Rare

OREGON DEATH WITH DIGNITY ACT:
2015 DATA SUMMARY



5/132
< 4%

QUT Law Review ISSN: (Print) 2205-0507 (Online) 2201-7275
Volume 16, Issue 1, pp 76-83. DOI: 10.5204/qutlr.v16i1.623

OHSU psychiatrist
LEGALISED PHYSICIAN-ASSISTED DEATH IN
OREGON

LINDA GANZINI*

VIEWPOINT The Challenge of New Legislation on Physician-Assisted Death

Linda Ganzini, MD, MPH
Department of Psychiatry, Oregon Health & Science University & VA Portland Health Care System, Portland.

Anthony L. Back, MD
Department of Medicine, University of Washington, Seattle.

By the end of 2016, more than 80 million people in the United States will live in a jurisdiction allowing physician-assisted death. As such, this practice can no longer be considered a quirky experiment in a few states. (1) In Oregon, a jurisdiction with physician-assisted death began in 1994, when voters in Oregon approved a ballot measure, the Death With Dignity Act, allowing physicians to provide lethal drugs to patients who are terminally ill and who have been certified that a patient voluntarily self-administers. Oregon stood alone for 14 years until Washington (2008), Vermont (2013), and now California (2015) approved physician-assisted death. Data from Oregon show that the number of physician-assisted deaths, from 0.6 in 1000 deaths in 1998 to 3.1 in 1000 deaths in 2014. (2) Concerns that legalization of physician-assisted death would increase the number of deaths, especially among vulnerable populations and target vulnerable groups, such as the elderly population, the uninsured, and the poor, have not been realized. In fact, in Oregon and Washington the availability of hospice and palliative care has expanded substantially, though the increased availability cannot necessarily be attributed to legalization of physician-

**Not screening
lots of impaired
judgment**

EOLO as enacted

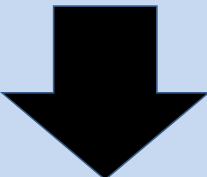


too **FAST** for some

37

But ...

MHA always required

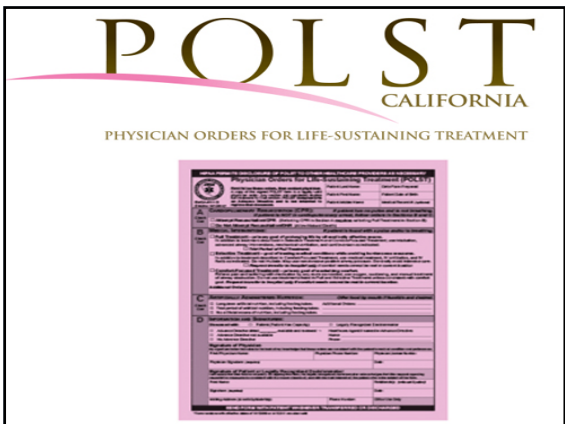


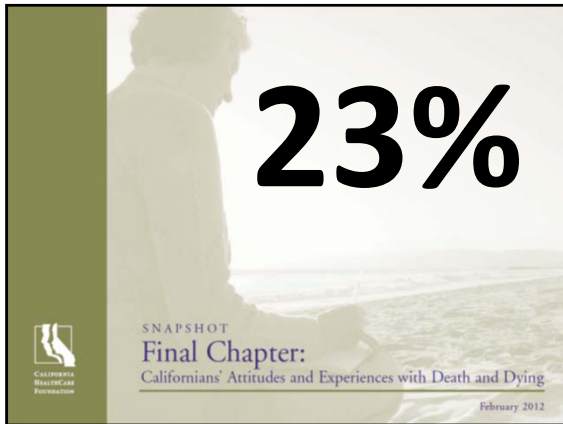
too **SLOW** for others

39

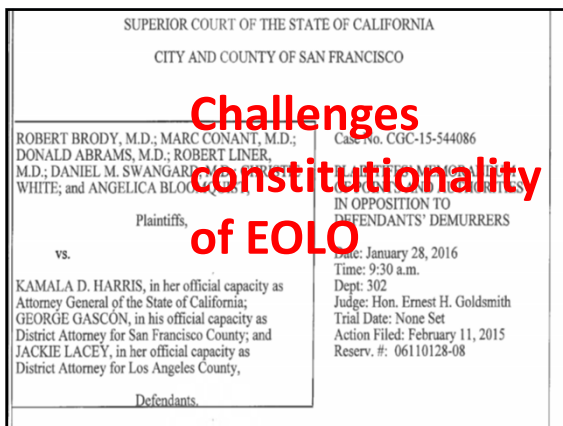
Too Slow

One example







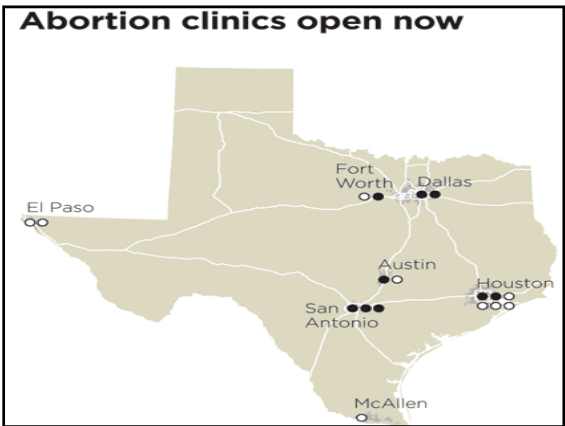


MAID =
constitutional
right

EOL
requirements
are **obstacles**

15 day
waiting
period

Undue
burden



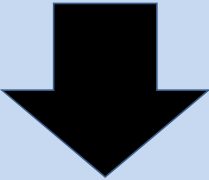
EOLO as enacted



too **SLOW** for some

51

But ...

Remove safeguards

too **FAST** for others

Thaddeus Mason Pope, JD, PhD
Director, Health Law Institute
Mitchell Hamline School of Law
875 Summit Avenue
Saint Paul, Minnesota 55105
T 651-695-7661
F 901-202-7549
E Thaddeus.Pope@mitchellhamline.edu
W www.thaddeuspope.com
B medicalfutility.blogspot.com
