A POLICY ANALYSIS OF OREGON’S DEATH WITH DIGNITY ACT OF 1997
AND COMPARISON TO CALIFORNIA’S END OF LIFE OPTIONS ACT OF 2015

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Oregon's Death with Dignity Act, 1997 (DWDA).

This act allows qualified Oregon residents to request prescriptions for medications to cause death.

This action is called Physician Assisted Suicide, PAS.

PAS is not the same as euthanasia, murder, or suicide.

California is currently trying to enact a similar policy known as the End of Life Options Act, 2015 (ELOA). (California Legislative Information “Leginfo”, 2015).
Relevance to Social Work

“Social workers respect the inherent dignity and worth of the person” (Code of Ethics of the National Association of Social Workers “(Code of Ethics)”, 2008 pp. 7 - 8).

Terminally-ill individuals must be treated with dignity, even up to their time of death.

“Social workers seek to enhance clients’ capacity and opportunity to change and to address their own needs” (Code of Ethics, 2008 p 1).

Social workers are obliged to respect self-determination of individuals

Engage clients in informed decision making at every possible opportunity

These values are consistent with the NASW code of ethics; however the NASW takes no official opinion on the morality of PAS (NASW Standards for Social Work Practice “NASW”, 2004 p. 13)
Countries that explicitly allow PAS or voluntary active euthanasia (VAE) include: Albania, Belgium, Germany Luxemburg, The Netherlands, Sweden (Anonymous, 2014, Humphry, 2010; ProCon.org).

On average less than 3% of deaths were a direct result of VAE (Onwuteaka-Philipsen, et al., 2012).

Beginning in 1992, Oregon became the first state to allow PAS, implementing the DWDA in 1997.

Currently PAS is allowed in Oregon, Montana, New Mexico Vermont, and Washington (Anonymous, 2014, Humphry, 2010; ProCon.org).

California has attempted to enact PAS legislation 6 times, and is currently on their 7th attempt, with the ELOA (Compassion and Choices “CC”, 2014; Economou, 2008 Robinson, 2007).
Methodology

Secondary data from: academic journals, publications, government documents, and media pulled from the internet, were examined.

For comparison similar bills were examined to the DWDA, and ELOA.

Documents were chosen based on availability, containing at least one of the following search terms:

“Death with Dignity” “Oregon Suicide Law” “Physician’s Assisted Death”

“Physician’s Assisted Suicide” “Voluntary Active Euthanasia” “Voluntary Passive Euthanasia”

A content analysis of the articles, and documents was used to scrutinize the effects of the Oregon’s DWDA, and California’s ELOA.
Oregon’s Death with Dignity Act of 1997 was analyzed utilizing the framework developed by Gil, (1992), and supplemented by Jimenez, Pasztor, Chambers, and Fujii, (2015).

The analysis contains five parts, with subsections focusing the discussion.

The five main components are as follows:

I. The Social Problem Addressed by the Policy
II. The Policy Objectives, Value Premises, Expectations and Target Populations
III. Effect of the Policy
IV. Implications of the Policy
V. Alternative Policies and Relationship to the NASW Code of Ethics
I. The Social Problem Addressed by the Policy

The DWDA set out to allow terminally-ill individuals the right to choose when and how they die (Altmann & Collins, 2007; Chin, Hedberg, Higginson, Fleming, 1999; Humphry, 2010).

In California, Bill Monning (D-District 17), said “The core of this, is respecting the dignity and the self-determination, and I believe a civil right and a human right, of a patient with a terminal diagnosis, who faces a death sentence not of their own choosing” (Bartalone, 2015. par. 8).

II. The Policy Objectives, Value Premises, Expectations and Target Populations

The objective, and inherent value of the policy is to provide qualified, terminally-ill, individuals the opportunity of a dignified death.

DWDA was expected to provide a small number of qualified individuals a dignified death founded by self-determination (Boyle, 2004; O’Brien, Madek, & Ferrera, 2000; Miller, 2000; Robinson, 2007).

Qualified persons are mentally competent terminally-ill individuals, with a less than 6 months prognosis. Who are physically capable of taking their own medication, and have requested, a prescription twice verbally 15 days apart and submitted one written request (Chin, Hedberg, Higginson, Fleming, 1999).
III. Effect of the Policy

As of January 2015, 155 prescriptions were written for 2014; a 22% increase from 2013. 105 known deaths have resulted. Accounting for 0.3% of Oregon’s total deaths (Oregon Data, 2015).

To date in Oregon, 1,327 prescriptions have been written; with 859 deaths (Oregon Data, 2015).

Statistical information is collected, however is very general because of privacy laws.

In California, 0.3% of total deaths is 745 deaths (Centers for Disease Control and Prevention, 2014).

IV. Implications of the Policy

There are no changes in financial, or material resources. There are protections for both patients, and doctors for participating in this or choosing not to (ORS 127.800, 2013).

If enacted, California could follow the same trends as Oregon.

V. Alternative Policies and Relationship to the NASW Code of Ethics

Currently there are no alternative policies for Oregonians, or Californians to allow for medical access to a death with dignity.

Even though the NASW does not have an official stance on PAS, it does affirms the right for individuals to choose for themselves what medical practices they want (NASW, 2004).
Strengths and Limitations

- Where PAS is legal, there is an increase in hospice care, counseling, and mental health services (2013 DWDA Report, 2014).
- With ELOA the secretive, practice of assisting people to take their own life can be regulated, as it has been in Oregon.
- One limitation is that the DWDA also does not have specific language for Nurses, or protections of nurses or counselors who see the PAS patients.
- As a protective measure individuals with disabilities are explicitly excluded.
- Licensed social workers are excluded from being listed as qualified mental health care professionals that can assess patients.
References