

## Physician-Assisted Death Does Not Improve End-of-Life Care

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Dear Editor,

In their recent article, “Geographic variation of hospice use patterns at the end of life,”<sup>1</sup> Wang et al. propose that the Oregon Death with Dignity Act (DWDA) has stimulated “more open conversations and careful evaluation of options” in end-of-life care and “increased hospice referrals and reduced potentially concerning patterns of hospice use in the state.”

The authors appear to see causation where only correlation exists. Further, they misrepresent the sources cited to support this claim: One (Ganzini<sup>2</sup>) specifically rejects the notion that the DWDA is directly responsible for improving terminal care in Oregon; another (Tolle<sup>3</sup>) posits a different relationship between DWDA and hospice care; and the third<sup>4</sup> simply cites Tolle and posits a loose “association” between the presence of DWDA and Oregon’s excellence in end-of-life care. All three, it should be noted, were published between 8 and 14 years ago.

Tolle’s study estimated that for every 1 person who used the DWDA, 200 likely considered the option, and about 10 discussed it with their physicians. Based on the number of deaths under the DWDA in the period of the study, this means that only about 1900 persons out of 85,534 (2%) who died had “more open conversations” about end-of-life options. For those who discussed physician-assisted death (PAD) but did not obtain the drugs, many factors intervened—some personal, some systemic. Most, Tolle concludes, simply found better alternatives to PAD.

These alternatives were available because *end-of-life care was already robust in Oregon*. In 2000, less than 2 years after the DWDA went into full effect, Oregon was ranked in the top or second-top group of states in 9 out of 12 end-of-life care metrics (and never lower than the third grouping out of five), such as hospice utilization, hospital ICU utilization, pain pol-

icy, and advance care planning policy.<sup>5</sup> In parallel with, but completely unrelated to, efforts to legalize and implement PAD, hospice and palliative care pioneers launched multipronged efforts to improve end-of-life care. Notable among these was the establishment of the Physicians Orders for Life-Sustaining Treatment paradigm starting in 1991, which by itself is a much more likely source of many more open conversations about care and treatment choices than the DWDA.<sup>6</sup> In the late 1980s, the Oregon Hospice Association launched an innovative and widely utilized hospice accreditation program to increase quality of care. Thus, rather than the availability of PAD improving hospice use or end-of-life care, *it is more likely that the availability of high-quality end-of-life care has kept utilization of PAD in Oregon low*.

This conclusion is supported by hospice utilization data—the very data Wang et al. rely on in their study. If hospice referrals increased due to the DWDA, one would expect a higher-than-average increase in overall hospice utilization following passage of the law. Hospice utilization in Oregon was higher than the national average *before the DWDA ever went into effect*, and while it has increased in the years since passage of the law, *the amount of increase is below the national average*.<sup>7</sup> Mean length of stay in hospice in Oregon has fallen well behind the national average, and while many states have seen exponential increases in the number of hospice providers, thereby increasing access to care, Oregon has added only five agencies since 2000 (see Table 1).

And what of the other states where PAD is legal? In the Wang study, Montana, Washington, and Vermont all exhibit “potentially concerning patterns of hospice use” in much greater proportions than does Oregon. All three states’ overall hospice utilization is below the national average of 46% (in 2014, MT: 40.6%, VT: 34.9%, WA: 43.4%). In 2013,

TABLE 1. COMPARISON OF OREGON HOSPICE WITH NATIONAL AVERAGES<sup>a</sup>

|          | Hospice utilization <sup>b</sup> |       |       | Mean length of stay, days |      |      | Number of hospices |      |      |
|----------|----------------------------------|-------|-------|---------------------------|------|------|--------------------|------|------|
|          | 2000                             | 2014  | Diff  | 2000                      | 2014 | Diff | 2000               | 2014 | Diff |
| National | 20.7%                            | 45.9% | 25.2% | 48                        | 69   | 21   | 2254               | 4091 | 1837 |
| Oregon   | 28.3%                            | 52.8% | 24.5% | 43                        | 58   | 15   | 43                 | 48   | 5    |

<sup>a</sup>Source: Medicare claims data, 2000–2014, analyzed by Hospice Analytics.

<sup>b</sup>Deaths of Medicare beneficiaries in hospice care/all deaths of Medicare beneficiaries.

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Montana's actually dropped by 2%, one of the biggest reductions in hospice use in any state since the launch of the Medicare Hospice Benefit in 1983.<sup>8</sup>

Oregon is to be commended for its better-than-average end-of-life care. However, claiming that PAD somehow improves care for terminally ill and suffering patients is not only factually incorrect but provides spurious support for efforts to legalize the practice in states where hospice care is not as strong and palliative care not nearly as available. Compassion & Choices, the main advocacy organization behind efforts to legalize PAD in 22 states in 2015, is touting the Wang study as proof of the "benefit" of PAD to terminal care. The evidence just isn't there.

### References

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5. Last acts. Means to a better end: A report on dying in America today. Washington, DC, 2002.
6. For details on the POLST program and its proven contributions to the quality of end-of-life care in Oregon during the 1990s, see [www.polst.org](http://www.polst.org).
7. Utilization data trends from Medicare claims data 2000–2014, analysis by Hospice Analytics.
8. Utilization percentages based on Medicare 2013 hospice dataset, analysis by Hospice Analytics.

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