

## Episode 87 - Dr. Pam Miller: Oregon's Death with Dignity Act: Hospice Social Work and End-of-Life Decision-Making

[00:00:08] Welcome to living proof A podcast series of the University at Buffalo School of Social Work at [www.socialwork.buffalo.edu](http://www.socialwork.buffalo.edu). We're glad you could join us today. The series Living Proof examines social work research and practice that makes a difference in people's lives. I'm your host Adjoa Robinson and I'd like to take a moment to address you our regular listeners. We know you have enjoyed our pod cast as evidenced by the more than 200000 downloads to date thanks to you all. We'd like to know what value you may have found in the podcast. We'd like to hear from all of you practitioners researchers students but especially our listeners who are social work educators. How are you using the podcast in your classrooms. Just go to our website at [www.socialwork.buffalo.edu](http://www.socialwork.buffalo.edu) forward slash podcast and click on the contact us tab. Again thanks for listening and we look forward to hearing from you. What is a good death. Does it occur at home surrounded by friends and family or in a medical facility. After every technological advance has been exhausted in an effort to prolong life or is it simply being able to determine the time and place of your death. When death is imminent. Do we even have the right to make those decisions. These are just some of the questions raised by passage of Oregon's Death with Dignity Act. Dr Pam Miller is a professor of social work at Portland State University School of Social Work in Portland Oregon.

[00:02:04] She is a Fulbright scholar with a range of practice experience in health care settings including hospice hospital and nursing care facilities. Dr. Miller's research focuses on health care and health care policy best social work practices and end of life and palliative care hospice and Oregon's Death with Dignity Act Oregon's Death with Dignity Act was enacted in 1997 and allows terminally ill Oregonians to end their lives through the voluntary self administration of lethal medications expressly prescribed by a physician for that purpose. In today's podcast Dr Miller discusses her research on social worker attitudes values and practices related to the law's enactment and some of the lessons that have been learned since Dr. Deborah Waldrop associate professor at the University at Buffalo School of Social Work spoke with Dr. Miller by telephone. I have the opportunity to be with Professor Pam Miller in social work at Portland State University this afternoon. Thank you for being with us Dr. Miller. We're here to talk today about the Oregon Death with Dignity Act. Professor Miller has lived and worked in Oregon throughout the years that this act has been in existence and has a lot to share with us today in terms of physician aid in dying. So Professor Miller I'm wondering if you could begin by first telling us about the Oregon Death with Dignity Act. Could you tell us about the tenets and the safeguards of the act. Sure. The act was first passed by ballot initiative in 94 was held up in the courts. That then became effective in 97. And there are many tenants there are many safeguards in the law and those have remained pretty much the same over the 13 years the law has been used.

[00:03:56] And the first one is that the patient or the person who is terminally ill must be 18 years of age or older he or she must be a resident of Oregon. And there are some points about how that might be shall. Like a driver's license tax receipt so forth the person has to be defined as capable and able to communicate and make health decisions. And if we want to talk about capacity more later we can. But the law really talks about capacity and the patient's ability to understand the ramifications of the decision that they're making to get the lethal prescription. The patient has to make two oral requests separated by at least 15 days and then provide a written request to his or her physician that's witnessed by two people and those two people can't be family members or primary caregivers. The request can be rescinded at any time a person can say at any time in the process I don't want to go on with the diagnosis of the patient and a six month or less prognosis has to be confirmed by two physicians not only the one that writes the prescription but also a consulting

physician and both of those physicians must concur that the patient is capable of making the decision if either physician thinks that the person's judgment is impaired. They might be referred for a psychological evaluation. And in Oregon the law states that that person would either be a licensed psychologist or psychiatrist and the prescribing physician has to inform the patient of all the alternatives around end of life care. Palliative care hospice care pain management and so forth and the prescribing physician must request that the patient notify their next of kin of the prescription request.

[00:05:47] It's not a requirement but it is the physician will ask and all the data about the law then is compiled by the Oregon Health Division here in Portland. And there are forms for all these different things and some required data that has to be kept every year. So those are sort of the tenant of the law and as I said they've three main pretty much the same. Over the years it sounds really thorough and comprehensive. A lot of thought went into this act. I'm wondering if you could tell us a little bit about the early days. I mean this was a really very controversial law to go in effect and I'm wondering what it was like when it first came into being. Well they all kind of started when it went on the ballot in 94 and one thing to keep in mind about Oregon is we put a lot of things on the ballot here. We vote as a voter initiatives on a lot of things. Some states don't even have voter initiatives but Oregon we sometimes could have 15 or 20 different things to vote on. And so that process of bringing things forward to the voters rather than a decision being made in a state capitol is quite common. And so when it went on the ballot of course it was a lot of ads on TV and newspaper and things like that and a lot of controversy about it. And I remember being at a conference and right before the election an Oregon State chapter of NSW conference speaking about the law.

[00:07:14] The thing about the bill that was going to be on the ballot and somebody said well do you think it'll pass. And I said No I really don't think it will and that'll be the last time I ever predict an outcome because it did pass but it passed by a very narrow margin 51 percent to 49 and because it was so close. And it is so controversial. The legislature actually put it back on the ballot again in 1997 asking your and getting voters. Are you sure that you want to pass this the next time it was passed by a 60 percent to 40 percent margin. So something happened during that time and there are some ideas about that it was very controversial where things at least from a practice perspective were hard. We're on the frontlines of hospice because there was quite a difference in opinion among hospice workers who had you know really worked shoulder to shoulder. I worked in hospice for years and there's a really team effort and we're all in this together and it's really hard work but we're doing wonderful things and giving people autonomy and self-determination and end of life and all of a sudden this option becomes now available and people really went into separate camps. There was a lot of fighting and hard feelings and hospices about what are we going to do with this house is going to work. And some people saying I'm fine with it it's OK with me to the opposite of people saying I don't work with somebody who chooses this option it's morally offensive to me and I'm opposed to it religiously and so forth.

[00:08:44] So there was quite a bit of controversy but it did then the voters said yes we were serious we will allow it here in Oregon and then of course it went forward in 97. The other thing to that happened at the beginning in 94 when it originally passed was that I would say most health professionals were caught off guard. I really don't know that anybody thought it would pass. They'd been on our ballot before several years before in here in Oregon and in Washington and people I don't think thought it would pass this time but that we could have time to prepare for it because it looked inevitable in some ways. But I know that when it did pass the first time Susan toll at the Oregon Health and Sciences University which is our medical school we only have one medical school in Oregon really decided she needed to pull together professionals of all stripes social work nursing medicine hospice professionals hospital systems everybody to come together and say what are we going to do. Now this has passed and we need to come up with policies and practices and guidelines and we need our best minds to do that. That group was threatened. Sometimes they had

to keep their meeting places a secret. So in those early years there was a kind of a big backlash or a lot of people who were really upset about it and made threats and attempt to harm people and to intervene in that way. That has settled down but I'm glad you asked that question because at the very beginning it was pretty crazy and it was kind of scary and a lot of different ways and a lot of unknowns a lot of uncertainties and hard feelings.

[00:10:21] But I think most if not all but most of those things have worked out. That's really interesting to hear the history of it. It sounds very polarizing. As you say you know that the two camps and people fearing for their lives. It's really very dramatic. I'm wondering if there have been efforts along the way to repeal the law or any subsequent legislation that's been proposed to change it in any significant way. Yes there have been and most of them are at the federal level not at the state level because the state had really come to the conclusion that the voters said voted on it twice and more satisfied with that even if they disagreed with it. But at the federal level is really where a lot of action took place over the years starting in 97 when the law went into effect. There were attempts by the Drug Enforcement Agency to say that the law violated the Controlled Substances Act that a physician could write that kind of a prescription. The Federal Government did pass in 1970 assisted suicide funding restriction act no federal money can be used for a dying. So if a person's Medicare recipient and in the hospice benefit they can get hospice care but their Medicare Part D wouldn't pay for the prescription. That kind of an example. If a person's a Medicaid patient in Oregon it's called the Oregon Health Plan that's a shared federal state program. That paperwork has to be capped such that only state dollars are used for Medicaid patients and no federal dollars. And that's not so unlike abortion. You know we can't use the money for abortion either.

[00:11:59] The Congress tried to pass an act called the Pain Relief Protection Act that was also in the late 90s to stop the law. John Ashcroft the attorney general took it to the Supreme Court through the Ninth Circuit and then on up to supreme court to try to stop the law. So there were many attempts to stop it almost all of them were federal. That's really interesting really helpful to set context for us to understand how something like this comes to life and then what happens after that. What are the most significant points along the way that stand out to you when you think about the history of this and how things have settled down. What do you think is most remarkable about that. Well a lot of the terrible predictions really haven't played out there were predictions that people without insurance who were becoming too costly end of life would be forced to use the law. That hasn't happened. Almost everybody that's used it has insurance. There was worry that people of color would be forced to use the law. There was worry that people who were mentally incompetent or severely depressed to not able to make good decisions would be able to use it. The people who were disabled but not terminally ill might be forced into a diagnosis where they would use it. We thought that more people would use it than actually have. It sounds like those issues really raised the sort of the notion of unintended consequences.

[00:13:29] Yes the marginalized groups that you're mentioning that people were worried about them people would their reason for doing it would be the main reason for doing it would be that their financial burden on their family so that they would end their lives this way quickly to ease that financial burden. And that hasn't borne out either. So I think many of the myths are the worries that were put forward as two reasons why the law shouldn't be allowed to go ahead have not come to bear. There's so much to learn from the Oregon experience certainly. Now Washington has a similar law. I'm wondering what you can tell us about what's happening in other states with this movement. Yes Washington put it on its ballot in 0 8 and it passed and so they've started their law in 2009 in March so they've had a couple of years of data and their data looks very similar to Oregon. Montana has allowed it through a legal process a legal decision it wasn't made a decision in their legislature and it was not a decision made by the voters. I don't know though what's going on in Montana I have to say I'm not up to date with it but I do know that there has been a period of time where it was allowed. But I don't know if it was implemented. I understand. Well let me say first Vermont has

been considering it for years. They have a very active grass roots group there in Vermont who is working on it in Vermont they don't have ballot initiatives that would have to come to their legislature and that makes it a little more difficult because then individual legislators can be tied to that decision yes or no. But in a referendum or a ballot measure it spreads it out among the voters. I understand that Massachusetts will very soon be starting a ballot initiative.

[00:15:20] But the first of course have to get signatures from across the state of Massachusetts in order to put it on their ballot in the fall of 2012. And I'm understanding that that process of getting started on the gathering signatures is just about to get underway. Maine has had it on its ballot. Michigan has had it on its ballot and Hawaii came very close to passing it in their legislature. Maybe about eight or so years ago. So there has been activity in other states besides the ones I mentioned previously. It's absolutely rippling. The movement is rippling through the country for sure. It's really interesting thank you for that. It's just so remarkable to me how history and policy have such an impact on the lives of individuals who are facing the end of their life. I'm wondering if you can tell us a little bit about the people who use the law and those people who do not. I'm wondering particularly if there are distinctions in the use of the law by people of different racial ethnic backgrounds or by way of religious backgrounds. A few things. 98 percent of the people who have used the law is over 13 years of data with 525 people using it over 13 years. Ninety eight percent of them have been white there has been one African-American. Not one percent one person to the point two percent. One person who identified as an American Indian who's used it to Hispanics and seven people who identified as Asian. So of the racial groups after a white Asian is at one point three percent. Cancer is the leading diagnosis.

[00:17:05] About 81 percent of people who have chosen to use and have used the law to its end point 81 percent have had cancer. And that would be more cancer than those diagnoses of other people who've died in Oregon. Another interesting point is that over the 13 years 89 percent of the people who use the law have been enrolled in hospice and that actually comes back to a question you asked me earlier about what were people worried about had that conversation we had one was that they would not come into hospice that they would sort of be rogue people not tethered to any kind of a system or an agency. And what we found is that actually 89 percent have been enrolled in hospice and last year for just 2010. For the one year 93 percent were enrolled in hospice. And I think that might be the highest percentage ever. And as I said earlier only eight of the 525 eight people or one point six percent have not had any insurance of any kind. The three reasons that people have chosen to use the law have remained those top three reasons. Across the 13 years and those are losing autonomy less able to engage in activities making life enjoyable and loss of dignity. Those three have remained the top three. As I said 13 years I think the one thing there's many things that stand out and what I just said. But the one thing that's really remarkable that is statistically significant level is the education level of the people who use the law. Forty four percent have a bachelor's degree or a higher degree in education.

[00:18:56] This is far and above more highly educated group than other people who die in Oregon let's say in any one year. That's probably the difference that stands out the most. This is a group of people that are at 44 percent having a bachelor's degree or higher which is quite educated much more so than the general population that dies here. I think those are probably the main points. One other quick one is that the emergency medical system has never been called to intervene after the medication was ingested. There was worry that people would take the pills and then say oh my god I don't want to do this. Call paramedics dial 911 or their family members would do that. That has not happened at all. There have been some calls for other reasons but not because people have panicked or changed their minds which was something else that was of concern. The statistics really paint a picture. I'm certain the people in Oregon have worked on interpreting that and figuring out who this group is that's more likely to use it. That's really very interesting statistical image of the people that use the law. I think it also speaks to some of the professional activities that social

workers typically Hospice social workers become involved in. It sounds like hospice is intimately and very closely identified with the law and becomes very involved and I'm wondering if you could talk about some of the activities and some of the ways that Hospice social work has been affected by.

[00:20:27] I would like to and just as a kind of a historical context a little bit it was a little tricky at the beginning when the law first passed because National Hospice organization was very opposed to the law. They didn't feel it fit in the hospice philosophy. They were opposed to it. So here sat an organization in Oregon the Oregon Hospice Association who remain neutral. There's always people take sides on ballot measures but a lot of groups remain neutral in the original 94 vote because people weren't really clear would this be something hospice would support. Could people come into hospice and so forth. And really I have to put a lot of credit toward Dan Jackson who's now retired but really weathered those storms in the early years. From a hospice perspective that people can do both hospice and use Oregon's law they are not mutually exclusive but that was not an easy path to walk. So when Hospice social workers are mandated as part of the team under the Medicare Hospice Benefit and now mostly under other insurance providers as well. So social workers are mandated part of the interdisciplinary team that takes care of patients and families who come into hospice. And so yes and I've surveyed Hospice social workers a couple of times about what are their activities what are they doing what are they seeing what are they practicing. And probably the two biggest pieces are the teamwork that comes as part of hospice that's part of its tenet is that we don't operate alone we have a team that services patients and families in order to make sure all needs are met. So those team meetings have really become very important and an integral part of where social works involved for all patients.

[00:22:08] And then when the patient is either considering using the law or gotten to the point where they are going to use the law it often is discussed in the team meeting is everybody understand what's going on. Where is the person in the process. Because it is kind of a long process to get the prescription. Do we know is somebody going to be there if that's allowed. We've been asked to be there what's the mental health status of this person. Should we be concerned about that. What's going on in the family and that leads into the next piece that social workers often do in hospice which is family meetings and Family meetings are usually to talk about a whole host of things but in topic we have today. Social workers are working with families and meeting with families where this option is either being weighed examined discussed and then maybe ultimately decided upon. But it's not unusual for Hospice social workers to be involved maybe with the patient and the family as they think about this as an option amongst many options. Now we're talking about this today but remember only 525 people have used this over 13 years. So social workers are certainly havingness within their professional responsibilities. But this is a small group of people that ultimately go forward and use it. So sometimes the discussions are really much more well-made. I'd like to know something about it or can you referred me to somebody who can talk to me more about it and that's sort of the end of it.

[00:23:33] And I don't know how often that happens because I rarely ask more specifically about people who went on to ultimately use the law but it seems now that the conversation about this option is pretty comfortable for social workers. It's not driven by them it's often waited to be brought up by the patient's family. But it's becoming more in the mix of sort of what are the options that someone might want to discuss think about fight about cry about consider as they're really facing their death. It really sounds like a very specialized type of practice. And it sounds like you have to be aware of it so that it may not be the actual carrying it all the way forward to the endpoint but just even having a comfort level of discussing it with families so that they can learn more about et cetera. Right. And the really tricky part remains but was this was another thing that keep coming back to sort of the worries at the beginning is that social workers and is all mental health professionals or other health professionals. Somebody said they want to kill themselves or they

want to die by their own hand. That was a red flag and we really had to intervene. We had to talk about that we had to stop the person and now all of a sudden we've moved into an area where it's a legal option. We're not necessarily concerned now about a mental health problem. Might be but generally as you can see from the data that's not the case. And so that was a real and that's kind of where when I did workshops and kind of talk to people about it early on we really had to come back to that education and training that we've had about mental health and about suicide and about end of life and how did you figure that all out.

[00:25:11] Because it's moved into a different way of weighing those worries and thinking about end of life versus someone who isn't sick isn't physically ill and who is contemplating suicide. So that was a difficult path for a while and we're still not maybe totally 100 percent clear on all that just yet. At least on a case by case basis it sounds like it's an emerging picture for sure. And it really does beg the question about social work attitudes values and specifically about ethics the ethics of our profession what are the attitudes values and ethics to come into focus around physician aid in dying. Well I have a article that I published a few years ago that was called take some time to look inside their hearts. Hospice social workers contemplate physician assisted suicide. And I was really interested in social workers thinking about sort of our cardinal values and our ethics and so forth. Two big themes that came up were self-determination and that's not an ethical principle it's more of a value that we have as a profession. It's really one of our cardinal values. And so in terms of self-determination if this is a legal option and we're working in hospice which is also patient centered and patient focus then that value of self-determination really comes forward that we work with people to allow them to decide the directions and the paths that they want to take and not interfere with that because of our own feelings or religious beliefs or whatever. And interestingly of all and this has been over several studies including my own.

[00:26:49] Of all professional groups that work in end of life care social workers by and large have always been the profession that's been the most comfortable with discussing the option and accepting the option as a possibility because I think it comes back to this self-determination piece that we really have in social work. We also advocate and empower people. That's also part of our professional values and that gets tricky in this too because do we want to advocate for somebody who wants to choose this option. What would that look like how does that feel and also do we want to empower somebody and you know meaning do we give them information to go forward or find out about how to go forward. And one of the subjects in my study talked about how a patient was really wanting to use it and think about it. But in the social workers mind he or she could tell that the patient was becoming quickly debilitated and probably wouldn't be able to use the law unless they moved the process along fairly quickly. And so the social worker said he or she didn't say anything like that because it felt like a very awkward thing to say even from an empowerment perspective you know you really hear that you want to use this and have it as an option for you. But you're going to be maybe not able to swallow or maybe even physically be able to go forward with this. Because the law really requires the patient to do all the paperwork all the asking all the contacts sperm has to be very intact physically and mentally to get through the process.

[00:28:23] And so the social worker could see that that might not not might not be possible and so he or she decided not to say anything. Some other things that come up for practice implications are social workers were worried about unfinished business that many of us who have worked in hospice have seen this happen some times not often but sometimes at the end of life. People come back to family business or come back to family dynamics that they have lot to apologize for or talk about. Revisit and have some closure on things that does happen sometimes and some of the social workers in my study were worried that unfinished business might get cut short. Some social workers also bring in their own religious or spirituality and worry that people might use this because they are forced into it. That it would go against what they might choose and so social workers in my study anyway had some worries about religion and spirituality and a lot of different

ways and social workers were at least early on. I don't think so much now but we're really worried about havingness now is a legal option and it always has been happening it's happened in end of life care everywhere. One thing works in hospice no matter whether it's legal or not has certainly interface with people who have voiced their desire to kind of do an end run on death and get death before it gets them. But as a rule social workers at least early on we're sound we're worried about it. Some we're worried about how to kind of figure out what would be considered a suicide and what would be considered physician aid in dying and how to keep those two separate but. And how to evaluate and assess those in terms of ethics.

[00:30:11] I don't think there's anything in our ethical code that would prevent social workers from working in this with this option or with patients and families who choose it. In fact the NSW policy statements that come out every so often after the big group meets I can't remember the name of what that is. But they get together and make policies and those policies as long as it's legal in a state. Those policies are very clear that social workers are free to work with patients and families who want to choose or just discuss this option. So I think ethically there's no problems. I think where we might get into more discussion is around sort of the values of our profession and how those fit or how maybe they get a little grey or blurry as we talk about physician aid in dying. As you're listening to talk about this makes me realize that it just underscores again for me how important it is for us to know ourselves our own values to look inside our hearts before we work with people who are reaching the end of life for the were careful about those boundaries and we don't bring our own issues into this kind of work. So it's really really helpful to hear you talk about that. I would guess that the loved ones of someone who receive assistance in dying might be facing particular challenges in bereavement. I'm wondering if you found that to be the case and if you know of any best practices or particularly specialized ways to work with people who are a family member of someone who's had assistance in dying. Well I have a couple comments about that in my survey of Hospice social workers.

[00:31:44] I asked about bereavement in a more general sense and wanting to know if the program actually had specific policies for people who the deaf came by using the law. Was there a way to say well this person's death was by this and this person's death wasn't really there is and everybody's kind of put into the bereavement program because their family member died and it really isn't a demarcation or a flagging of somebody who might be from a family or a patient that use the law. And so I asked the social workers if family members participated in the Breneman groups because that's usually how bereavement is there's telephone contact and then there's the offer often of bereavement groups and the social workers said to me that there were no challenges. Some said that family members chose not to participate. Some were referred for individual counselling and another social worker quotes where I think the initial discussion or disclosure is a challenge. I did ask if family members talked about the cause of death openly. Nine responded that they had. And so I look for some quotes about that. One social worker said that the person in the group viewed the choice for physician assisted death as a private one did not want to have this choice scrutinised by others. Another quote is in one instance the patient's spouse chose not to talk about it.

[00:33:09] He wanted confidentiality and then I asked the social workers if they had talked to family members either individually or in a family session away from a group about a deceased patient who used the law and almost a third of them said that they had and what came up during those discussions were that there was a judgment and this is a quote there was a judgmental stance of some family members regarding deceased who use the law another person's quotas that they were afraid of being judged. Another person said and I love this quote. The family was concerned about the state of the patient's soul and how to discuss this with others and so kind of the long and the short of it is is that these are just some qualitative comments from social workers doing both bereavement groups which they often do and are as hospices set up or sometimes if they would meet with patients and families individually. But there was a quantitative study done by Linda

Ganzi which was in a journal of pain symptom management about two or three years ago called mental health outcomes of family members of Oregonians who requests physician aid in dying. And just as a summary she said that family members of Oregonians who did receive a lethal prescription claimed or were more likely to believe that their loved one's choices were honored and they were less likely to have regrets about how the loved one died. And she goes on to say that family members who requested aid in dying felt more prepared and accepting of the deaths than comparison. Family members and those would be family members who did not use the law. So in summary her article was pretty clear that pursuit of aid and dying does not have negative effects on surviving family members and may actually be associated with greater preparation and acceptance of death.

[00:35:11] So it actually is another thing people were really worried about at the beginning was that the survivors would have particular needs particular challenges maybe complicated grief. That's a term we hear sometimes and actually at the beginning there were some groups set up in Portland for people to come to if they wanted to if they were family members of people who would use the law. But I guess they weren't very well attended and it didn't really work out very well. But over the years now I think what Dr. Ganzi and her colleagues have shown us at least through this study is that it does not seem to have negative effects on survivors. And that actually because the death is so planned and so controlled and usually so worked out down to the hour of death that people are better prepared and more accepting now that's not saying that they don't grieve and that they're not sad but it doesn't look like from a mental health standpoint that they require or are seeking any more help than people who die of other causes. State is really powerful in particular the qualitative codes just speak volumes about the quantitative data also really illustrate. I think it does a lot of myth busting. I mean things that we might have expected are assumed going into this. This data has really shown us that people's experience is different than that. So thank you very much for sharing that.

[00:36:36] And so finally I think looking back there must be many lessons that you've learned from your experiences with this law and I think that these lessons apply for social workers in a variety of health care settings as well as other professionals in health care settings specifically for those who work with people who are dying and I'm wondering if you could just identify any lessons that you think are really important takeaway points. Sure. I think one of the things that really helped us here in this state was the gathering of the task force to improve care for terminally ill Oregonians which actually has on the OHSU website. It would be W W W dot OHSU dot edu slash ethics the guidebook for the law is on that website. So if people want to look at that. But the story behind that guidebook was that so many professionals came together to talk about the law to figure out how to we might make policies to make this fair and workable and equitable and efficient. But what really helped me was to be able to sit around a table with physicians nurses people representing all different kinds of professional organizations and health systems. And we worked as a group and had to decide on everything of the language that's in that book so you can imagine how tedious that was. But it was seemed so important because this was such a big deal. And so the one lesson that I learned is whether this is the topic or it's another topic. You've really got to get a lot of different professional affiliations and a lot of different heads to gather and talk about it converse about it think about it. Design Studies whatever you're going to do but to work together in that professional team to see what you need to do.

[00:38:27] And I think the other takeaway is that if you live in a state where it's legal which right now is really only three you know I think people are having conversations about how to set up policies and how this is going to work in all the different particular agencies and religiously affiliated organizations really struggle with this. It's been a real struggle in Washington because so many more of their health systems in the state of Washington are religiously affiliated more than here. And so that even takes a more particular length of time to kind of figure out because you know some of the religious organizations said well we're not going to allow this. Well they couldn't really



say that because it's legal and they can't. Once a person signs into to say for example a religiously affiliated hospice program or two or three weeks in and then make the announcement you know I'm going to pursue this they can't abandon that patient they can't kick them out. So some of the patients that are of these 525 many of them have been in religiously affiliated organizations and the social workers that worked in those organizations had to really help with kind of thinking about what those conversations would look like and that they should be allowed to have them that they're important and they're part of end of life so social workers have to be prepared for that. But in states where it's not legal social workers are still going to have these conversations and other people who work in hospice will as well. And so I think rather than hide those conversations and keep them secret I really think organizations and agencies particularly hospices would really want to be thoughtful about how they want to handle those.

[00:40:03] Document them support people at end of life through whatever it is that they need to talk about and consider but really be thoughtful about that and be planful about it rather than just pushing it off to the side because my stand on this is from working for many many years and hospices that there are people who are dying who are going to want to consider some other way some other way out. And sometimes that's only a conversation. Sometimes it's just something to be talked about. Sometimes people really want to actively pursue it whether it's legal or not. So I think it's better for hospices and social workers and the professionals who work within them to be prepared for that. Wherever you work. Because it is sort of part of what's going on. Now there's so many more discussions and things being written about end of life planning the psychotherapy networker for example has four articles in it in a summer issue. This most recent one about end of life care and technology and choices and what should people do and what's out there that they can consider that I think it's really time that we have those hard conversations as professionals because we're going to have to have them with their patients and families. This has been so enlightening thank you so much for sharing your experiences and for educating us about this really important conversation. Thank you so much Pam. It was my pleasure. You've been listening to Dr Pam Miller discuss her research on social worker attitudes values and practices in the wake of Oregon's Death with Dignity Act. Thanks for listening. And join us again next time for more lectures and conversations on social work practice and research.

[00:41:57] Hi I'm Nancy Smyth Professor and dean at the University at Buffalo School of Social Work. Thanks for listening to our podcast. For more information about who we are our history our programs and what we do we invite you to visit our website at [www.socialwork.buffalo.edu](http://www.socialwork.buffalo.edu). At UB we're living proof that social work makes a difference in people's lives.