

I, **DAVID RAYMOND GRUBE, MD** of Corvallis, Oregon, United States affirm:

1. I refer to my first affidavit and reaffirm that I continue to comply with the Code of Conduct for Expert Witnesses. I have been asked to comment on the following matters, based on my own experience of:
 - (a) the impact that the Oregon Death with Dignity Act ("ODDA") had on doctor-patient relationships;
 - (b) the impact of ODDA on palliative services;
 - (c) the effect on doctors of providing aid in dying services.
2. In no way did legalizing aid in dying change the nature of the doctor-patient relationship for the worse. In fact, it probably strengthened it. The doctor-patient relationship is based upon cooperation and understanding. The good doctor is sympathetic, concerned, attentive, and compassionate. A dying patient needs to know that he or she can count on a physician to provide that support. Accepting that the dying patient may need end of life options expands the doctor-patient relationship to include control, by the patient, of terminal dilemmas.
3. From my perspective, the process of aid in dying is no less significant, intimate, or important than assisting a woman in child birth (which I did for many years in my practice). It involves repeated deep conversations and discussions with the patient about the significance of her or his life, choices, and legacy. Perhaps it was the least "routine" thing I ever did as a doctor. Each situation, while unique, was powerfully significant for me as a doctor. I was both honored and awed by it.
4. A majority of doctors in Oregon now support aid in dying.¹ We understand that everyone will die. That is not to say that most doctors participate in aid in dying. No doctor is compelled to do so. Some doctors work at institutions that do not allow them to participate in the legal process of aid in dying. More than one-sixth of all doctors have these kinds of restrictions upon them. A number of others doctors are subspecialists, (such as dermatologists and pathologists), and so their practice would never encompass aid in dying.
5. Doctors who care for patients with terminal diseases try their best to attend to their patient's needs. They work hard to treat the illness and the symptoms of it. They focus on all aspects of their patient's problems. And yet, often the disease becomes the enemy, and the patient becomes secondary. We call people "our patients," which often means to us that the disease is ours, too. And we attend to defeating it at all costs. Quality palliative care reminds us to make the patient, not the disease, the centre of our focus. Aid in dying certainly does not remove the focus from the patient. Indeed, in my experience, it intensifies that focus.
6. I reject any suggestion that legalisation of aid in dying leads doctors to lose sight of treating the distress of their patients, and to focus instead on providing aid in dying. Compassionate doctors, in my opinion, pay attention to their patients' needs, symptoms, disease, and so on. They

¹ <https://www.compassionandchoices.org/userfiles/Polls-Show-Most-Voters-Support-Aid-In-Dying-Death-with-Dignity-3-11-15.pdf>

honor their patients' autonomy, provide informed consent, spend hours explaining the patient's issues, and ultimately do not restrict legal options from their patients. They care.

- 7. In the USA, if you listen to the tone of many of those (including doctors) who are opposed to aid in dying you will find a surprising amount of anger and irritability, scolding, and guilt and shame flavored statements. In my view it is they who have lost sight of treating the distress of their patient, who prevent their patient from a dignified death. As described in my first affidavit, there is a huge amount of work and intimacy between the doctor and the dying patient, in making a decision as to whether or not they wish to obtain a prescription under the DWDA.
- 8. I certainly do not consider aid in dying to be inconsistent with palliative care. For the suffering patient who has no other treatment options, aid in dying is the ultimate comfort. Many patients who choose aid in dying and receive the medication, never take it. That is because they are comforted just knowing that now they have control of their end days. The comfort provided is not transient.
- 9. The data in Oregon has shown that palliative services have actually been expanded after OODA was instituted. More patients than ever (now over 93%) who consider aid in dying are under hospice care. Hospice care for patients with terminal conditions is so important. But it is also important for hospice patients to have choice as they near the end of their days. Oregon's aid in dying law allows that. There has been no erosion of palliative care services.
- 10. At paragraphs 18 and 19 of my first affidavit I describe how obtaining a prescription relieved the anxiety and distress of my patients and improved their family relationships. In all cases, I observed that the relief they felt lasted until the time of their death.
- 11. In other words, the relief felt by my patients is very different from the temporary improvement in the mental state of a person who has definitively decided to make a suicide attempt. This is not surprising because my patients who obtained prescriptions under the DWDA were not suicidal: they were not mentally ill. Had they not been suffering from a terminal illness they would not have wished to die. However they had been sick for a long time and were going to die. They were not acting impulsively or alone; they were acting in community with their family, hospice and physician.

AFFIRMED at Corvallis, Oregon, United States this day of May 2015 before me:

David Raymond Girard
David Raymond Girard

Jill E Perdue 5/27/2015
A person duly authorized to administer oaths in Oregon

Jill E Perdue

