Oregon: Twenty-Three Years of Assisted Suicide

by Richard Egan

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Oregon (1997-)

Oregon's *Dying With Dignity Act* allows for medical practitioners to prescribe drugs for self-administration by a person to allow the person to end his or her life. The Act came into force on 27 October 1997.

Oregon publishes annual reports on the operation of the *Dying With Dignity Act*. A careful analysis of this data reveals significant issues with the practice of physician assisted suicide in Oregon.

Increase in number of deaths

The number of deaths from ingesting lethal substances prescribed under Oregon's *Death With Dignity Act* reached 245 in 2020 (up 28.3% from 2019) continuing a steady rise at an average growth of 15% per annum, since 1998, the first year of the Act's operation when 16 people died under its provisions.[1]

These deaths in 2020 accounted for 0.61% of all deaths in Oregon that year (up 19.53% from 2019).

Physical suffering not a major issue – "being a burden" is

The Oregon annual reports indicate that physical suffering is not a major issue for those requesting physician assisted suicide.

Of the 1905 people who had died from ingesting a lethal dose of poison between 1998 and 2020 just over one in four (27.4%) mentioned "*inadequate pain control or concern about it*" as a consideration.[2]

Earlier annual reports noted that "*Patients discussing concern about inadequate pain control with their physicians were not necessarily experiencing pain.*"[3]

However, in 2019 nearly 6 out of 10 (59.2%) of those who died after taking prescribed lethal

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[1] Oregon Public Health Division, *Oregon Death With Dignity Act: 2020 Data Summary, Table 2,* p.14 https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf

[2] Oregon Public Health Division, *Oregon Death With Dignity Act: 2020 Data Summary, Table 1,* p.11, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf

[3] Oregon Health Authority, *Sixth Annual report on Oregon's Death With Dignity Act,* 2004, p. 24 http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year6.pdf

medication cited concerns about being a "*Burden on family, friends/caregivers*" as a reason for the request.[4]

Physician assisted suicide has much more to do with relieving other people of a "*burden*" than relieving unbearable pain.

To facilitate and fund assisted suicide of persons simply because they feel they are a burden on family, friends or caregivers sends a cruel message to the elderly, disabled or chronically ill who may need the care and support of others to function in daily life. It implies that only the strong and fully independent have the right to live.

Mental health: No adequate screening

Research by Linda Ganzini has established that one in six people who died under Oregon's law had clinical depression.[5]

Depression is supposed to be screened for under the Act. However, in 2019 only one person out of 188 people (0.53%) who died under the Oregon law was referred by the prescribing doctor for a psychiatric evaluation before writing a script for a lethal substance.[6] This means it is likely that about 30 people with clinical depression were prescribed and took a lethal poison without being referred for a psychiatric evaluation.

Over the 23 years of legalised assistance to suicide it is likely that around 250 people with clinical depression were prescribed and took a lethal poison without being referred for a psychiatric evaluation.

In 2011 Dr. Charles J. Bentz of the Division of General Medicine and Geriatrics at Oregon Health & Sciences University explained that Oregon's physician-assisted suicide law is not working well. He cited the example of a 76-year-old patient he referred to a cancer specialist for evaluation and therapy. The patient was a keen hiker and as he underwent therapy, he became depressed partly because he was less able to engage in hiking.

He expressed a wish for assisted suicide to the cancer specialist, who rather than making any effort to deal with the patient's depression, proceeded to act on this request by asking

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[4] Oregon Public Health Division, *Oregon Death With Dignity Act: 2019 Data Summary, Table 1,* p.12, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf

[5] Linda Ganzini et al., "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey", *BMJ* 2008;337:a1682, http://www.bmj.com/content/bmj/337/bmj.a1682.full.pdf

[6] Oregon Public Health Division, *Oregon Death With Dignity Act: 2019 Data Summary, Table 1,* p.11, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf

Dr Bentz to be the second concurring physician to the patient's request.

When Dr Bentz declined and proposed that instead the patient's depression should be addressed the cancer specialist simply found a more compliant doctor for a second opinion.

Two weeks later the patient was dead from a lethal overdose prescribed under the Act.

Dr Bentz concludes "*In most jurisdictions, suicidal ideation is interpreted as a cry for help. In Oregon, the only help my patient got was a lethal prescription intended to kill him.*" He urges other jurisdictions "*Don't make Oregon's mistake*."[7]

Financial considerations

Of those who died from ingesting a lethal dose of medication in 2019, more than one in fourteen (7.4%) mentioned the "*financial implications of treatment*" as a consideration. While this percentage is relatively small it is appalling that since 1998 eighty six (86) Oregonians have died from a lethal prescription after expressing concerns about the financial implications of treatment.[8]

In two notorious cases, those of Barbara Wagner and Randy Stroup, the Oregon Health Plan informed a patient by letter that the cancer treatment recommended by their physicians was not covered by the Plan but that the cost of a lethal prescription to end their life would be covered.[9]

The misleading notion of a peaceful death

Euthanasia and assisted suicide proponents hold out the promise of a peaceful death by fast acting lethal substances. The lethal drugs most likely to be preferred by medical practitioners have been secobarbital and pentobarbital. Between 1998 and 2020, secobarbital had been used in 43.2% of cases and pentobarbital in 20.9% of cases in Oregon.

Neither pentobarbital nor secobarbital are now available in the United States so physicians have been experimenting with various lethal cocktails.

In Oregon in 2020 nearly all (99.6%) of all deaths by ingesting a lethal dose involved a

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[7] Charles Bentz, "Oregon's assisted suicide law isn't working", *The Province,* December 5 2011, http://blogs.theprovince.com/2011/12/05/province-letters-icbc-egypt-assisted-suicide-oregon-christmas-pre-marital-sex/

[8] Oregon Public Health Division, *Oregon Death With Dignity Act: 2019 Data Summary, Table 1,* p.12, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf

[9] Susan Donaldson James, "Death drugs cause uproar in Oregon:, ABC News, August 6, 2008, http://abcnews.go.com/Health/story?id=5517492#.Ty9-VsXy8sI ; Dan Springer, "Oregon Offers Terminal Patients Doctor-Assisted Suicide Instead of Medical Care", July 28, 2008, http://www.foxnews.com/story/0,2933,392962,00.html

cocktail in which morphine sulfate was the main lethal substance.[10]

These experimental lethal cocktails do not always result in a swift and peaceful death.

In fact, there are reported complications each year, with an overall failure rate of 0.42% (8 people recovered consciousness out of 1905) and an overall complication rate of 6.3% (52 out of 827 people for whom this data is available).

In 2020 there were five cases of complications out of 72 – 6.94% of those for whom information about the circumstances of their deaths is available. This included one case of seizures and 3 cases of difficulty ingesting or regurgitating the poison.[11] In 2019 nearly one in ten (9.84%). In 2018 nearly one in eight (12.12%) had complications and additionally, one person failed to die and regained consciousness.[12] Two people had seizures in 2017.[13]

The interval from ingestion of lethal drugs to unconsciousness has been as long as four hours (in 2017).[14] In 2019, at least one person took 90 minutes after ingestion to lose

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[10] Oregon Public Health Division, *Oregon Death With Dignity Act: 2020 Data Summary, Table 1,* p.11
https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf

[11] Oregon Public Health Division, *Oregon Death With Dignity Act: 2020 Data Summary, Table 1,*p.12
https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf

[12] Oregon Public Health Division, *Oregon Death With Dignity Act: 2019 Data Summary, Table 1,* p.12 ,
https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf

[13] Oregon Public Health Division, *Oregon Death With Dignity Act: Data Summary 2017, Table 1. Characteristics and end-of-life care of 1,275 DWDA patients who have died from ingesting a lethal dose of medication as of January 19, 2018, by year, Oregon, 1998-2017,* p.10,
http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year20.pdf

[14] Oregon Public Health Division, *Oregon Death With Dignity Act: Data Summary 2017, Table 1. Characteristics and end-of-life care of 1,275 DWDA patients who have died from ingesting a lethal dose of medication as of January 19, 2018, by year, Oregon, 1998-2017,* p.10,
http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year20.pdf

consciousness.[15]

The time from ingestion to death has been as long as 104 hours (4 days and 8 hours) in a person who ingested pentobarbital. One person in 2019 took nearly two days (47 hours) to die after using DDMP2 and another person took 19 hours to die after using DDMA.[16] In 2020 one person took 8 hours to die after using DDMA, and another two people took more than 6 hours to die.

8 people regained consciousness after taking the supposedly lethal dose, including one person in 2018.[17]

In 2005, "One patient became unconscious 25 minutes after ingestion, then regained consciousness 65 hours later. This person did not obtain a subsequent prescription, and died 14 days later of the underlying illness (17 days after ingesting the medication).[18]

This patient was lumberjack David Prueitt who, after ingesting the prescribed barbiturates spent three days in a deep coma, then suddenly woke up, asking his wife *"Honey, what the hell happened? Why am I not dead?*"

David survived for another 14 days before dying naturally from his cancer.[19]

Since 2005 seven other people have regained consciousness after ingesting the lethal medication.

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[15] Oregon Public Health Division, *Oregon Death With Dignity Act: 2019 Data Summary, Table 1,* p.13, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf

[16] Oregon Public Health Division, *Oregon Death With Dignity Act: 2019 Data Summary, Table 1,* p.13, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf

[17] Oregon Public Health Division, *Oregon Death With Dignity Act: 2018 Data Summary, Table 1,* p.12 https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf

[18]Department of Human Services, Office of Disease Prevention and Epidemiology, *Eighth Annual Report on Oregon's Death with Dignity Act*, p. 13, https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year8.pdf

[19] "Oregon man wakes up after assisted-suicide attempt", *Seattle Times,* 4 March 2005, http://seattletimes.nwsource.com/html/health/2002197134_webwake04.html

"*In 2010, two patients regained consciousness after ingesting medications. One patient regained consciousness 88 hours after ingesting the medication, subsequently dying from underlying illness three months later. The other patient regained consciousness within 24 hours, subsequently dying from underlying illness five days following ingestion.*

In 2011, two patients regained consciousness after ingesting the medication. One of the patients very briefly regained consciousness after ingesting the prescribed medication and died from underlying illness about 30 hours later. The other patient regained consciousness approximately 14 hours after ingesting the medication and died from underlying illness about 38 hours later."[20]

In 2012 "*one patient ingested the medication but regained consciousness before dying of underlying illness ... The patient regained consciousness two days following ingestion, but remained minimally responsive and died six days following ingestion*".[21]

In 2017 "*one patient ingested the medication but regained consciousness before dying from the underlying illness*".[22]

In 2018 one person regained consciousness after ingesting the prescribed substance and later died of the underlying illness.[23]

Two of the cases of regaining consciousness occurred after using DDMP2 – one of the experimental lethal cocktails being used by pro-assisted suicide doctors.[24]

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[20] Oregon Health Authority, *Death With Dignity Act, Year 14 - Table 1, Characteristics and end-of-life care of 596 DWDA patients who died after ingesting a lethal dose of medication as of February 29, 2012, by year, Oregon, 1998-2011*, p. 6, footnote 12 https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year14.pdf

[21] Oregon's *Death With Dignity Act -2012 Table 1, Characteristics and end-of-life care of 673 DWDA patients who died after ingesting a lethal dose of medication as of January 14, 2013, by year, Oregon, 1998-2012*, p. 2, http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf

[22] Oregon Public Health Division, *Oregon Death With Dignity Act: Data Summary 2017* p.5, http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year20.pdf

[23] Oregon Public Health Division, *Oregon Death With Dignity Act: 2018 Data Summary, Table 1,* p.12 https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf

[24] Oregon Public Health Division, *Oregon Death With Dignity Act: 2018 Data Summary, Table 4,* p.15

Faulty prognosis

The *Death With Dignity Act* provides that before prescribing a lethal substance a doctor must first determine whether a person has a "terminal disease". This is defined by section 127.800 (12) of the Oregon Revised Statute to mean "*an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months*".

However, 4% of those who have died from ingesting the lethal substance outlived the six month prognosis – some by several years.

In 2019 one person ingested lethal medication 1503 days (4 years 4½ months) after the initial request for the lethal prescription was made, setting a new record for the longest duration between initial request and ingestion which was previously 1009 days (that is 2 years and 9 months).[25] In 2020 one person ingested the prescribed poison 1080 days (2 years 11 ½ months) after requesting it.[26] Evidently in these, and other similar cases the prognosis was wildly inaccurate.

Dr Kenneth Stevens has written about his experience of how the prognosis of six months to live works in practice under Oregon's law:

> *Oregon's assisted-suicide law applies to patients predicted to have less than six months to live. In 2000, I had a cancer patient named Jeanette Hall. Another doctor had given her a terminal diagnosis of six months to a year to live. This was based on her not being treated for cancer.*
>
> *At our first meeting, Jeanette told me that she did not want to be treated, and that she wanted to opt for what our law allowed – to kill herself with a lethal dose of barbiturates.*
>
> *I did not and do not believe in assisted suicide. I informed her that her cancer was treatable and that her prospects were good. But she wanted "the pills." She had made up her mind, but she continued to see me.*
>
> *On the third or fourth visit, I asked her about her family and learned that she had a*

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https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf

[25] Oregon Public Health Division, *Oregon Death With Dignity Act: 2019 Data Summary, Table 1,* p.13, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf

[26] Oregon Public Health Division, *Oregon Death With Dignity Act: 2020 Data Summary, Table 1,*p.12 https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf

son. I asked her how he would feel if she went through with her plan. Shortly after that, she agreed to be treated, and her cancer was cured.

Five years later she saw me in a restaurant and said, "Dr. Stevens, you saved my life!"

For her, the mere presence of legal assisted suicide had steered her to suicide.[27]

Not a terminal illness

Oregon's Death With Dignity Act requires that a person be certified by two physicians as suffering from a terminal illness before a lethal dose of medication can be lawfully prescribed.

The 2016 Annual Report listed conditions that have been accepted as meeting this definition including besides malignant neoplasms (i.e. cancers) and amyotrophic lateral sclerosis, heart disease, chronic lower respiratory disease, HIV/AIDS, benign and uncertain neoplasms, other respiratory diseases, diseases of the nervous system (including multiple sclerosis, Parkinson's disease and Huntington's disease), musculoskeletal and connective tissue diseases, viral hepatitis, diabetes mellitus, cerebrovascular disease, and alcoholic liver disease.[28]

Earlier annual reports[29] specifically mention some diseases that would not normally be classified as a terminal illness:

- myelodyoplastic syndrome (not terminal unless it develops into acute myeloid leukemia which itself is not necessarily terminal) (2003 Annual Report, p. 19);
- Hepatitis C (2004 Annual Report, p. 21)
- digestive organ neoplasm of unknown behavior! (2004 Annual Report, p. 21)
- cardiomyopathy (may cause death but not necessarily terminal) (2006 Annual

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[27] Kenneth Stevens "Doctor helped patient with cancer choose life over assisted suicide", *Missoulian,* 27 November 2012, http://missoulian.com/news/opinion/mailbag/doctor-helped-patient-with-cancer-choose-life-over-assisted-suicide/article_63e092dc-37e5-11e2-ae61-001a4bcf887a.html

[28] Oregon Public Health Division, *Oregon Death With Dignity Act: Data Summary 2016, Table 1. Characteristics and end-of-life care of 1,127 DWDA patients who have died from ingesting a lethal dose of medication as of January 23, 2016 [sic = 2017], by year, Oregon, 1998-2016,* p.9 and footnote 2 on p.11, http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year19.pdf

[29] Oregon's Death with Dignity Act Annual Reports Annual are available at: https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx

Report, p. 5)

- endocarditis (not usually considered a terminal illness, only 20% mortality rate during initial infection) (2006, Annual Report, p. 5).

The 2020 annual report reveals that there have been 18 people for whom the "underlying illness" was listed as "Endocrine/metabolic disease [e.g., diabetes]". There were 5 people in this category in 2020 – representing 2% of all cases.

The 2020 annual report also cites arthritis, arteritis, stenosis and sclerosis (none of which is usually a terminal illness) as the underlying illness in at least one case each, as well as "complications from a fall" and "medical care complications".[30]

This suggests that even the central requirement that an illness be terminal is not strictly applied.

It has been confirmed by the Oregon Health Authority that if a person with a chronic illness, such as diabetes, foregoes treatment such as insulin injections, for any reason (including financial reasons or suicidal ideation) and thereby is likely to die within six months, the person becomes eligible for assisted suicide.[31]

Dr Charles Blanke wrote a lethal prescription for a young woman with a more than 90% chance of surviving Hodgkin's lymphoma because "She did not believe in chemotherapy and feared its toxicity".[32]

The Oregon Health Authority has also clarified that all information about a person's underlying illness is simply based on reports by the physician who prescribes the lethal medication and a second consulting physician. There is no independent checking of the veracity of those reports.[33]

A burden on the family: a recipe for elder abuse

The data from Oregon shows that in 2019 nearly six out of ten (59%) people who died after taking prescribed lethal medication cited concerns about being a "*Burden on family,*

[30] Oregon Public Health Division, *Oregon Death With Dignity Act: 2020 Data Summary, Table 1,* p.11 and footnote 3 on p. 13, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf

[31] Fabian Stahle, *Oregon Health Authority Reveals Hidden Problems with the Oregon Assisted Suicide Model*, Jan 2018, https://drive.google.com/file/d/1xOZfLFrvuQcazZfFudEncpzp2b18NrUo/view

[32] Tara Bannow "Rural Oregonians still face Death With Dignity barriers", The Bulletin, 14 Aug 2017, https://www.bendbulletin.com/health/5512373-151/oregonians-can-choose-how-their-roads-end

[33] Fabian Stahle, Notarised Questions to Oregon health Authority, https://drive.google.com/file/d/1XopTDjBA2SAVBGBxpDazNN899eTHixSe/view

friends/caregivers" as a reason for the request.[34]

Does the concern about being a burden originate from the person or is it generated by subtle or not so subtle messages from family, friends and caregivers - including physicians - who find the person to be a burden or a nuisance or just taking too long to die?

Elder law expert Margaret Dore comments:

> *In both Washington and Oregon, the official reporting forms include a check-the-box question with seven possible "concerns" that contributed to the lethal dose request. These concerns include the patient's feeling that he was a "burden."*
>
> *The prescribing doctor is instructed: "Please check 'yes,' 'no,' or 'don't know' depending on whether or not you believe that a concern contributed to the request."*
>
> *In other states, a person being described as a "burden" is a warning sign of abuse. For example, Sarah Scott of Idaho Adult Protection Services describes the following "warning sign": "*Suspect behavior by the caregiver . . . [d]escribes the vulnerable adult as a burden or nuisance.*"*
>
> *The recommendation is that when such "warning signs" exist, a report should be made to law enforcement and/or to the local adult protective services provider.*
>
> *Washington and Oregon, by contrast, instruct its doctors to check a "burden" box. Washington and Oregon promote the idea that its citizens are burdens, which justifies the prescription of lethal drugs to kill them. Washington's and Oregon's Acts do not promote patient "control," but officially sanctioned abuse of vulnerable adults.*[35]

Short relationship with attending physicians

The Oregon statute specifies that lethal prescriptions only be written by a person's "*attending physician*" who is defined as "*the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease*."[36]

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[34] Oregon Public Health Division, *Oregon Death With Dignity Act: 2019 Data Summary, Table 1,* p.12, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf

[35] Dore, Margaret K. (2010) ""Death With Dignity": A Recipe for Elder Abuse and Homicide (Albeit Not by Name)," *Marquette Elder's Advisor:* Vol. 11: Iss. 2, Article 8. http://scholarship.law.marquette.edu/elders/vol11/iss2/8

[36] Oregon Revised Statute, Section 127.800 (2), http://www.oregon.gov/oha/ph/Pd.roviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ors.aspx

The data indicates that in some cases doctors have had a relationship with the patient of less than one week's duration and that in 2020 in 50% of cases the doctor-patient relationship was of 8 weeks duration or less.[37]

In 2020 a total of 142 physicians wrote 370 prescriptions (1-31 prescriptions per physician) for lethal doses. Of these 30 physicians wrote 3 or more prescriptions, with one writing a prescription for a poison to be used for suicide every 12 days on average.[38]

Taken together this data suggests that there are some doctors in Oregon very willing to write prescriptions for lethal substances for multiple patients they barely know.

Same day death on request

Prior to 1 Jan 2020, the Oregon law required a period of 15 days between a first request for a lethal prescription and the supply of the lethal dose.

Now an exemption from this requirement can be claimed if the attending physician (who may have just met the person and who is not required to have any expertise in the person's condition) states that the person is reasonably expected to live fewer than 15 days from the first request.

Doctors claimed this exemption for 75 people in 2020 – representing 30.6% of all deaths from assistance to suicide.[39] The length of time from first request to death by ingestion of the lethal poison is reported to range from 0 days to 1080 days in 2020[40] – so some people asked for assistance to suicide and suicided with the lethal poison on the very same day.

This gives no time to explore other responses to a request for assisted suicide before a person is dead by prescribed lethal poison.

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[37] Oregon Public Health Division, *Oregon Death With Dignity Act: 2020 Data Summary, Table 1,* p.12
https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf

[38] Oregon Public Health Division, *Oregon Death With Dignity Act: 2019 Data Summary,* p.7,
https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf

[39] Oregon Public Health Division, *Oregon Death With Dignity Act: 2020 Data Summary, p. 7*
https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf

[40] Oregon Public Health Division, *Oregon Death With Dignity Act: 2020 Data Summary, Table 1,* p.13
https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf

Who administers the lethal medication?

In 2020 a physician or other healthcare provider was known to be present at the time the person died from ingesting the lethal substance in just over one third of cases (34.29%). This means that in 67% of cases there was no physician or other healthcare provider known to be present at the time of death, and there is no data available on complications for these cases.[41]

In 2020 in 42 cases (out of 245) there was a "volunteer" present at the time of ingestion and at the time of death. These are apparently "Client Volunteers" provided by a non-government organisation End of Life Choices Oregon. According to their job description *they "may be present at a planned death [and] prepare medication for self-administration by the client [which] includes opening drug capsules and/or mixing medication with fluid."*[42]

This still leaves 115 out of 245 cases (47%) cases where there is therefore no evidence that the person took the lethal substance voluntarily. It may well have been administered to them by a family member or other person under duress, surreptitiously or violently. We can never know.

Increase in suicide rate

Proponents have claimed that legalising physician assisted suicide would actually prevent, or at least delay, suicides by giving those faced with a terminal illness an assurance that the means for obtaining peaceful death was legally available. However, a study of comparative rates of suicide in US states found that for the states, like Oregon and Washington, which had legalised physician assisted suicide there is an increase in the overall suicide rate of 6.3% compared to all other states and of the suicide rate of those aged 65 and over of 14.5%. There is no reduction in either the rate of non-assisted suicides or in the mean age of suicide.[43]

Conclusion

Oregon's 32-year experiment with an assisted suicide law, far from providing a model that

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[41] Oregon Public Health Division, *Oregon Death With Dignity Act: 2018 Data Summary, Table 1,* p.12 https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf

[42] Oregon Public Health Division, *Oregon Death With Dignity Act: 2020 Data Summary, Table 1,* p.12 https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf

[43] David Albert Jones and David Paton, How does legalization of physician-assisted suicide affect rates of suicide?, *SMJ: Southern Medical Journal*, Vol. 108, Issue 10, p. 599-604, http://sma.org/southern-medical-journal/article/how-does-legalization-of-physician-assisted-suicide-affect-rates-of-suicide/

other jurisdictions should follow, serves as a warning that such a law cannot guarantee that all deaths from assisted suicide are either voluntary or peaceful, or limited to those who actually meet the eligibility criteria.

Appendix: Concerns leading to requests for lethal medication under Oregon's assisted suicide law

What do attending physicians who prescribe lethal medication under Oregon's Death With Dignity Act know or believe are the concerns contributing to the decision of those who have subsequently died following ingestion of the lethal medication?

Data on this question is published annually by the Oregon Health Authority. The 2018 report initially reported this data differently than in previous reports by excluding "Don't know" answers in calculating the percentages.

The data is derived from Question 15 in Part B of the "Oregon Death with Dignity Act Attending Physician Follow-up Form"

On 5 March 2019 I queried by email to the Oregon Health Authority the percentages given in Table 1 of the 2018 Data Summary under End of Life Concerns as they did not seem to be correct.

For example for 2018, if N=168 then the correct percentage for "Losing autonomy (%) "if N=168 and the number was 154 should have been 91.7% rather than 95.1% as given.

In an email reply dated 8 March 2019 Craig New, Research Analyst, Oregon Health Authority explained:

"*The discrepancy is because we exclude unknown values from the denominator when calculating percentages. So, for example, 154 patients had "losing autonomy" as a reason for seeking DWDA in 2018, but six patients were reported as "unknown" on this reason. 154 / (168-6) = 95.1%*"

I applied this information to the data on "End of Life Concerns" for 2018 and for the total data 1998-2018) and produced the table below.

The 2018 report was reissued on 25 April 2019 with this data recalculated using the approach previously employed of including "don't know" responses with "No" responses.

What is immediately striking is the lack of knowledge attending physicians admit to having about some of the concerns that may have contributed to a person requesting a prescription for lethal medication.

A lack of knowledge by the attending physician of whether or not a particular concern contributed to a request for a prescription for lethal medication necessarily implies either that the attending physician NEVER explored that possible concern with the person or, if the attending physician did attempt to explore that possible concern he or she did not succeed in eliciting a sufficient response from the person to form a view as to whether or not the person had that possible concern.

Steady loss of autonomy and decreasing ability to participate in activities that made life enjoyable

These concerns clearly dominate the discussion between attending physicians and persons

requesting a prescription for lethal medication. Only in around 1 in 20 cases does the attending physician admit to not knowing if these were concerns contributing to the request.

Loss of dignity

In about one out of six cases the attending physician reports not knowing if loss of dignity was a concern for the person.

Burden on family, friends or caregivers

In 2018 in 14.9% of cases (nearly one in seven cases) the attending physician reported not knowing if the person who requested lethal medication and subsequently died after ingesting had a concern about physical or emotional burden on family, friends or caregivers.

ORS 127.815 sets out as the very first responsibility of an attending physician under the Death With Dignity Act a duty to "*Make the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily*"

How can a physician come to a firm conclusion that a person is voluntarily requesting lethal medication in order to end their lives without exploring whether or not the person is motivated by a concern about the physical or emotional burden on family, friends or caregivers?

Surely such a discussion is necessary to exclude any possibility that the person is making the request under duress, subject to coercion or undue influence from a family member or caregiver.

Additionally, in the absence of such a discussion there may be a missed opportunity to relieve the person's concern about being a burden by arranging respite for family caregivers or additional care or support.

If the 14.9% of cases where the attending physician does not even bother exploring this issue with a person before writing a prescription for lethal medication are added to the 54.2% of cases in 2018 where the attending physician reports knowing that the person had a concern about the physical or emotional burden on family, friends or caregivers then in nearly seven out of ten cases (69.1%) concern about being a burden was or may have been a factor in a request for lethal medication.

Given what we know about elder abuse this is cause for alarm.

Inadequate pain control at the end of life

In 2018 in 17.9% of cases (nearly one in six) the attending physician reports that he or she does not know whether the person who has died after ingesting lethal medication which the physician prescribed had any concern about inadequate pain control at the end of life.

ORS 127.815 sets out as another of the responsibilities of an attending physician under the Death With Dignity Act a duty "*To ensure that the patient is making an informed decision,*

inform the patient of the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control".

Before lethal medication is prescribed a person must sign a request form affirming, among other things, "*I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care and pain control*."

But if the attending physician has not asked the person about any concerns about inadequate pain control at the end of life how can the attending physician possibly have properly informed the person about feasible alternatives to ingesting lethal medication such as "comfort care, hospice care and pain control"?

Loss of control of bodily functions, such as incontinence and vomiting

In over one in five cases (20.2%) in 2018 the attending physician reports not knowing whether the person had any concern about the loss of control of bodily functions, such as incontinence and vomiting.

In many cases these concerns can be alleviated. There are many methods for treating or managing incontinence or vomiting. Simply discussing the concern with a listening, compassionate physician may be sufficient to relieve it, at least to the point where it is not a reason to request lethal medication.

The financial cost of treating or prolonging his or her terminal condition

In more than one out of four cases (26.8%) in 2018 the attending physician simply did not bother to find out whether a concern about the cost of treatment or care was underlying the request for lethal medication.

How can an attending physician form a valid view that a request for lethal medication is being made "voluntarily" if a possible concern about the financial costs of treatment or care is never explored with the person?

In some cases treatments may be available that are effective and could either cure the person from the terminal condition or significantly extend their life with good quality. If the person is forgoing such treatments because of a concern about the cost which is not even discussed with the attending physician isn't that a tragedy and a failure of the care due from a physician to a patient?

The attending physician is obliged by ORS 127.815 "*To ensure that the patient is making an informed decision, inform the patient of the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control*".

If the person has a concern about the cost of "comfort care, hospice care and pain control" that is not disclosed to the attending physician because he or she never bothers to ask then how can a decision by the person to request lethal medication instead of "comfort care, hospice care and pain control" possibly be fully informed and voluntary?

Conclusion

Thanks to the explanation from Mr New of the Oregon Health Authority we are now better placed to interpret the data from Oregon on the concerns people requesting lethal medication discuss with attending physicians and the concerns that may motivate such requests but are simply not explored by attending physicians or at least not explored sufficiently for the attending physician to form a view as to whether such a concern was contributing to the person's request for lethal medication.

In more than **one in four cases** there is no discussion of concerns about the **financial cost of** treating or prolonging his or her terminal condition.

In more than **one in five cases** there is no discussion of concerns about the loss of control of bodily functions, such as **incontinence and vomiting**.

In nearly **one in six cases** there is no discussion of concerns about **inadequate pain control** at the end of life.

In nearly **one in seven cases** there is no discussion of concerns about being a physical or emotional burden on family, friends or caregivers.

This suggest that in many cases discussions between attending physicians and persons requesting lethal medication are almost solely around autonomy and related matters and that there is no serious discussion about underlying issues such as family dynamics, feelings of being a burden, financial considerations, pain control or loss of bodily functions at the end of life.

In the absence of such discussions, it seems that an attending physician could not have properly fulfilled the obligation under the Death With Dignity Act to have fully informed the person of feasible alternatives.

Nor could the physician come to a genuine conclusion that the person was making a fully informed and truly voluntary decision to request lethal medication.

Table 1: Concerns contributing to request for lethal medication in Oregon for 2018 and for 1998-2018

Question 15 in Part B of the "Oregon Death with Dignity Act Attending Physician Follow-up Form" reads:

Several possible concerns contributing to the patient's decision to request a prescription for lethal medication are shown below. Please check yes, no, or unknown to indicate whether you believe each concern contributed to the patient's request.

The results in the table below are derived from data as originally published in the 2018 annual report but subsequently revised.

A CONCERN ABOUT …	2018 YES	2018 NO	2018 UNKNOWN	TOTAL YES	TOTAL NO	TOTAL UNKNOWN
the financial cost of treating or prolonging his or her terminal condition?	5.4%	67.9%	26.8%	3.9%	79.2%	16.9%
the physical or emotional burden on family, friends, or caregivers?	54.2%	31.0%	14.9%	44.8%	41.5%	13.6%
his or her terminal condition representing a steady loss of autonomy?	91.7%	4.8%	3.6%	90.6%	4.2%	5.1%
the decreasing ability to participate in activities that made life enjoyable?	90.5%	4.2%	5.4%	89.1%	5.1%	5.8%
the loss of control of bodily functions, such as incontinence and vomiting?	36.9%	42.9%	20.2%	44.3%	34.1%	21.5%
inadequate pain control at the end of life?	25.6%	56.5%	17.9%	25.7%	60.5%	13.8%
a loss of dignity?	66.7%	17.3%	16.1%	74.5%	10.7%	14.8%