Living and Dying Well

Keeping the law safe for sick and disabled people

What's happening in Oregon?

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In this report, with researcher Madeleine Teahan, he examines the official reports published by the Oregon Public Health Division on the working of that State's physician-assisted suicide law.

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WHAT'S HAPPENING IN OREGON?

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In 1997 the Oregon Death with Dignity Act (ODDA) came into force. The ODDA legalised physician-assisted suicide (PAS) for persons who are terminally ill and mentally competent. Campaigners for 'assisted dying'[i] in Britain generally take the ODDA as their model and often claim that the law in Oregon is operating without problems. How valid is this claim?

The Annual Reports

Every year since 1998 the Oregon Public Health Division (OPHD) has published reports on the working of the ODDA. The format and the amount of detail provided have varied over the period but the twelve reports that have appeared to date, covering 1998 to 2009 inclusive, provide an interesting picture of what has been happening. They tell us, for example, how many prescriptions for lethal drugs were written in each year and how many physicians wrote them; how many deaths from PAS occurred as a result; how many applicants were referred for counselling[ii]; and how many deaths occurred in different age groups. A summary, in tabular form, of what the OPHD reports have said on these questions appears on Page 7[iii].

Numbers

In 1998 24 prescriptions for lethal drugs were written by physicians in Oregon under the terms of the ODDA; in 2009 the number was 95. In 1998 16 deaths occurred as a result of PAS; in 2009 the number was 59. Throughout the twelve-year period the trend has been steadily upwards, with the exception of small dips in 2001 and 2004. The numbers, both of prescriptions written and of deaths occurring as a result, have risen almost fourfold over the period.

Oregon's population is relatively small (3.8 million). The OPHD report for 2009 states that the 59 PAS deaths recorded in that year represent 19.3 per 10,000 total deaths in the State. If this experience were to be replicated in England and Wales, we might expect to see a total of 948 deaths annually as a result of PAS[iv]. If Scotland is included, where MSP Margo MacDonald currently has a bill before the Scottish Parliament that would legalise both physician-assisted suicide and physician-administered euthanasia, that would add a further 104 deaths to the total from PAS alone[v], giving a total of 1,052 deaths from this source annually in Great Britain.

The OPHD reports for 1999-2003 include a caveat on the question of PAS numbers – namely, that "our numbers are based on a reporting system for terminally ill patients who legally receive prescriptions for lethal medications and do not include patients and physicians who may act outside the law".

Prescriptions

In every year since the ODDA entered into force there have been more prescriptions for lethal drugs written than doctors writing them. From 1998 to 2005 the OPHD reports included information about the willingness of Oregon physicians to write such prescriptions. In 1998, for example, six of the 16 people who ended their lives via PAS "had to approach more than one physician before finding one that would start the prescription process"[vi]. In 1999, only eight of the 27 people who died by PAS in that year received a prescription from the first physician they approached. "Of the remaining 18 participants, 10 asked one other physician and eight asked two to three physicians"[vii] [viii] In 2004, "of the 40 physicians who wrote prescriptions, 28 wrote one prescription, nine wrote two prescriptions, one wrote three prescriptions, another wrote four prescriptions and one wrote seven prescriptions"[ix]. The OPHD report on 2005, the last one in which such data are recorded, shows a similar pattern, with one Oregon doctor recorded as writing eight prescriptions for lethal drugs.

The OPHD's 1998 report referred to evidence that "a substantial proportion of Oregon physicians are not willing to participate in legalized physician-assisted suicide". So how are the willing physicians being found? When a select committee of the House of Lords visited Oregon in 2004, its members were told by the organisation Compassion in Dying (now known as Compassion and Choices of Oregon) that, since the ODDA came into force, they had acted as "stewards of the law" and had "participated in a consultative way with about three quarters of the patients who had made a request"[x] for PAS. Compassion and Choices of Oregon currently states on its website that **"**we may be able to recommend another doctor if the patient's doctor continues to refuse to assist the patient in using the Act as one of their end-of-life options"[xi].

While there is nothing unlawful in such 'doctor shopping', it can lead in some cases to applicants for physician-assisted suicide being assessed by doctors who have no long experience of them as patients. The OPHD report for 2009 records the median duration of the doctor-patient relationship, for the 460 people who had died by PAS between 1998 and 2009, as 10 weeks within a range of 0 to1440 weeks. The reports do not tell us how many cases were towards the top and bottom of this range, but the fact that the median is as low as 10 weeks would seem to indicate that many of those who received lethal prescriptions between 1998 and 2009 had been known by the prescribing physicians for only a short period of time.

Referrals for Counselling

Five (31%) of the 16 PAS deaths in 1998 had been the subject of referrals for psychiatric counselling; in 1999 10 of the 27 PAS deaths in that year (37%) had been so referred. Thereafter a downward trend seems to have set in: by 2009, none of the 59 people who took their own lives under the terms of the ODDA had been so referred.

How can this trend be explained? Are we looking at a changing cohort of people coming forward for PAS? Are Oregon doctors becoming more expert at spotting psychological problems in applicants, so that they are able to reject unsuitable applications without referral? Possibly. Or could this be a consequence of 'doctor shopping' - namely, that a physician who is prepared to process an application for PAS might perhaps be less inclined than others to regard such a request as a pointer to possible psychological disorder or depression? If that is so, it would not be surprising that, as the number of PAS cases has increased, referrals for psychiatric counselling have fallen.

Whatever the explanation, independent research[xii] carried out in 2008 suggests that some applicants with clinical depression are being given lethal drugs to end their lives without prior psychiatric assessment. The researchers examined 58 persons who had sought PAS and classified them on recognised scales for depression and anxiety. 42 of the participants had died by the end of the study. 18 of these had received prescriptions for lethal drugs from physicians and nine of these had died by ingesting them.

The researchers found that "among patients who requested a physician's aid in dying, one in four had clinical depression". They also found that three of the 18 persons who had received prescriptions for lethal drugs from a physician had been suffering from depression at the time the prescription was issued but that none of them had been evaluated by a mental health professional. The researchers observed that "the current practice of legalised aid in dying may allow some potentially ineligible patients to receive a prescription for a lethal drug" and that "in some cases depression is missed or overlooked". They concluded that "the current practice of the Death with Dignity Act in Oregon may not adequately protect all mentally ill patients".

The Elderly

The OPHD reports show that the age group most likely to resort to PAS are the over-65s – two thirds of all PAS deaths between 1998 and 2009 occurred in this age group, with the median age being 71 years. This of itself is not surprising: terminal illness generally affects older rather than younger people. It is however

surprising to read, in research published in 2007[xiii], the conclusion that there is "no evidence of heightened risk" to the elderly from PAS in Oregon. The OPHD reports indicate that resort to PAS in Oregon is predominantly by the elderly.

Licensing Assisted Suicide

There is another issue with the working of the ODDA which is not covered in the OPHD's annual reports but which is of some importance. The Act licenses physicians who are willing to do so to provide lethal drugs to persons who meet the qualifying criteria. It does not, however, contain any safeguards to ensure that those drugs, once they have been issued, are used as intended – ie for conscious and willing self-administration by the person concerned[xiv]. The physician is not required to be present when the drugs are taken: according to the OPHD reports, very few of them are – in 2009 the prescribing physician was present in only one in 20 instances when the prescribed lethal drug was ingested. Nor does the Act mandate other arrangements for ensuring that, at the time when the drugs are taken, they are ingested by the applicant willingly (rather than following coercion or encouragement by another person or persons) and knowingly (rather than, for example, being mixed in with food without the applicant's knowledge).

Here we have one of the central problems of licensing assistance with suicide in advance of the act – namely, that there is no way of knowing whether the conditions that apparently existed when the prescription was given (a terminally ill and mentally competent applicant with a settled wish to end his or her life who is not being coerced) continue to exist at the time when the lethal drug is taken, which on the experience of Oregon can be months later[xv]. Once the licence has been issued, there is no effective constraint on malpractice.

Conclusions

These findings should be kept in proportion. They do not tell us that legalised PAS in Oregon is out of control. They do, however, indicate that the situation in Oregon is not as problem-free as campaigners for 'assisted dying' in Britain sometimes suggest and that there are lessons to be learned from Oregon's experience. Among those lessons are that:

- the number of PAS deaths annually in Oregon has been rising – it is nearly four times the level of 12 years ago. If we extrapolate Oregon's 2009 experience to Britain, on current levels we could be looking at more than 1,000 deaths a year from physician-assisted suicide.

- the reluctance of many physicians in Oregon to participate in PAS is likely, given the opposition of the majority of British doctors to legalisation of the practice here, to be replicated in Britain if an 'assisted dying' law were to be

enacted. In that event we could expect to see the emergence of Oregon-style 'doctor shopping', with the risks this poses to the assessment of applicants for PAS.

- the absence of any objective check on how prescribed lethal drugs are used puts qualifying applicants at heightened risk of abuse or manipulation once the approval process has been completed and the drugs have been issued.

These lessons need to be borne in mind when considering demands for similar legal change here.

PHYSICIAN-ASSISTED SUICIDE IN OREGON – DATA FROM OPHD REPORTS

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Number of PAS Prescriptions Written	24	33	39	44	58	68	60	64	65	85	88	95
Number of Deaths from PAS	16	27	27	21	38	42	37	38	46	49	60	59
Number of Physicians Prescribing	14	22	22	33	33	42	40	39	40	45	59	55
Number of Applicants referred by Physicians for Counselling	5	10	5	3	5	2	2	2	2	0	2	0
Median age of those dying by PAS	69	71	70	68	69	73	64	70	74	65	72	76
Most Common Age Group for PAS Deaths	65-74	65-74	65-74	65-74	65-74	75-84	65-74	65-74	75-84	55-64	65-74	75-84

[i] The term 'assisted dying' has no recognised meaning in English law but is commonly used by campaigners for a change in the law to denote assisted suicide or voluntary euthanasia for those who are terminally ill.

[ii] Where it is believed that an applicant for PAS may be "suffering from a psychiatric or psychological disorder or depression causing impaired judgment", the ODDA requires that he or she be referred by the assessing physician for "counselling".

[iii] Copies of the reports themselves can be found at www.oregon.gov/DHS/ph/pas/index.shtml

[iv] Based on 19.3 per 10,000 of 491,134 deaths registered in England and Wales in 2009

[v] Based on 19.3 per 10,000 of 53, 856 deaths registered in Scotland in 2009

[vi] "Oregon's Death with Dignity Act: The First Year's Experience", Oregon Public Health Division, 18 February 1999

[vii] The apparent discrepancy in numbers is explained by the fact that one of the 27 persons who died by PAS in 1999 received the prescription for lethal drugs in the previous year

[viii] Oregon's Death with Dignity Act: The Second Year's Experience, Oregon Public Health Division, 23 February 2000

[ix] Seventh Annual Report on Oregon's Death with Dignity Act, Oregon Public Health Division, 2005

[x] House of Lords Report 86-II, Page 310

[xi] http://www.compassionoforegon.org/news/frequently-asked-questions-2/

[xii] "The prevalence of depression and anxiety in terminally ill patients pursuing aid in dying from physicians", British Medical Journal 2008; 337: a1682

[xiii] "Legal physician-assisted suicide in Oregon and The Netherlands: evidence concerning the impact on patients in 'vulnerable' groups", Journal of Medical Ethics 2007;33;591-597

[xiv] In fact, the ODDA does not require a physician to establish that an applicant for PAS is capable of administering to him/herself the lethal drugs that are being sought. This surprising omission would appear to leave open the possibility that prescribed drugs could be administered by a third party.

[xv] According to the OPHD's 2009 report, over the period 1998-2008 the mean interval between requesting PAS and ingestion of lethal drugs was 43 days, with a range of 15 to 1009 days.