Twenty five years of the 'Oregon model' of assisted suicide: the data are not reassuring

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By David Jones.

On 27 October 1997, 'physician-assisted suicide became a legal medical option for terminally ill Oregonians'. There are now 25 years of reports on the implementation of the Death With Dignity (DWD) Act. These give some insight into how the practice has changed since it was first introduced. The reports are all available online and an article has just been published analysing all 25 years. What do these reports show?

First and most obviously there has been a dramatic increase in numbers from 16 in 1998 to 278 in 2022. At the same time, the proportion referred for psychiatric evaluation prior to assisted suicide has dropped from 31.3% to 1.1%.

The 25-year review also highlights changes in the drugs used and in the rate of complications. Between 2010 and 2022 complications were reported on average in 11% of cases. In 2022, reported complications fell to 6%. Unfortunately this is not so reassuring as it seems, as an increasing percentage of data on complications is missing. In 2022 there was no data on complications for 74% of cases.

The reports also show shifts in the reasons given for seeking assisted death, with more citing the fear of being a burden and more citing financial concerns. The figures vary from year to year but in both cases the trend is clear. The increasing number of people seeking death because they feel they are a burden to others does not speak well of changes in social attitudes in Oregon since the DWD Act came into force.

Another shift evident in these reports relates to language. The first sentence of the first report refers to 'physician assisted suicide'. This phrase is used in the first line of every report until the ninth report for 2006. This change in language was not associated with any change in practice in Oregon but it may have reflected political efforts in other States to pass similar laws. After 9 years Oregon was still the only State in the United States to have legalised physician assisted suicide. This political motivation is acknowledged by the philosopher Gerald Dworkin, an advocate of such laws: 'the use of the term "Physician-

assisted suicide" is now politically incorrect, for tactical reasons. I understand that the popular prejudice against suicide makes it more difficult to rally support for the bills I favor.'

The term 'assisted suicide' nevertheless remains the ordinary term in Europe and was used by Margo MacDonald MSP for the Assisted Suicide (Scotland) Bill she introduced in November 2013. That bill, which was rejected by the Scottish Parliament, was largely based on Oregon's DWD Act. In 2017, the American Association of Suicidology adopted a statement opposing the characterising of assisted deaths as 'suicide'. However, in March this year that statement was quietly 'retired', a move welcomed by some disability groups. The language of physician assisted suicide remains in use by the American Medical Association. It also has the advantage of distinguishing self-administration of lethal drugs (assisted suicide) from administration by doctors (euthanasia).

If political debates outside Oregon influenced its shift in use of language, they may also account for the recent expansion of the DWD Act. Before 2016 there were only three States with such legislation (Oregon, Washington, Vermont) and one where assisted suicide was legal through case law (Montana). However, by 2021 there were ten jurisdictions with statute laws plus Montana where assisted suicide remained legal by case law. It is remarkable that, before 2019 neither Oregon nor any other jurisdiction in the United States had amended their law on physician assisted suicide. However, in the four years since 2020, there have been seven amendments to such laws across five states: in Oregon in 2020 and 2023; in Vermont 2022, and 2023; in California in 2022; in Washington in 2023; and in Hawaii in 2023 and an amendment has been introduced in New Jersey. This amounts to six out of the ten jurisdictions with such legislation. All these changes expand access, for example, waive waiting times, allow nurses to prescribe the lethal medication, or drop residency requirements. Until 2019 it had been possible to argue that there was 'no evidence of a "slippery slope"' because 'The Oregon law has remained unchanged since 1997'. This is no longer true. In recent years there has been a wave of expansion of such laws and further expansion is surely to be expected.

This increase in the number of States with assisted suicide and increase in number of deaths has also allowed more data on the secondary impact of legislation. In 2015 there were some indications of an association between legalisation of physician assisted suicide in the United States and increases in unassisted suicide. However, the association was not statistically significant once linear trends were included. In contrast, US data analysed in 2022 by two

different methods showed a statistically significant increase in unassisted suicide after physician assisted suicide was introduced. Association does not, of course, demonstrate causation, but neither is such an association grounds for reassurance.

We now have twenty five years of data from Oregon and data from an increasing number of other States with similar laws. However, the more we know, the less reassuring the 'Oregon model' of assisted suicide seems to be.

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