

Cover Sheet and Supporting Documents submitted

by Margaret Carter to Judiciary Proceedings

Committee on SB 443

In every jurisdiction where assisted suicide is legalized, safeguards are imposed to prevent abuse and protect the vulnerable. However, in the name of “access,” those safeguards are inevitably relaxed or removed. Dutch ethicist Theo Boer initially championed Physician Assisted Suicide (PAS) legislation in the Netherlands. But since 2014 he has warned legislators both in Europe and North America about the “Slippery Slope” that Physician Assisted Suicide presents. He argues that safeguards are inevitably removed through judicial fiat, legislation or through a change in the attitudes of medical practitioners and the general population.

In the U.S. Oregon was the one of the first states to implement PAS. And it is often touted as a model for other states. Proponents note that the law is mostly unchanged since it was implemented 25 years ago. However, there have indeed been significant changes in the law itself and in the way it is implemented.

- The “waiting period” for the monumental decision to choose PAS has been reduced from 15 days to 48 hours.
- While initially 31.3% of individuals seeking PAS were required to undergo a psychiatric evaluation, now only 1.1 % receive that important evaluation.
- While the law was passed in hopes that it would relieve unbearable suffering for people who were already close to death, many of those who now receive the lethal overdoses do not cite pain as their motivation. Instead, they cite “financial concerns or the “fear of being a burden.”
- The requirement that PAS applicants be Oregon residents has been removed,
- Accurate data on “complications” is now unavailable to researchers.
- Reduction in the length of physician-patient relationship from an average of 18 weeks in 2010 to five weeks in 2022.
- Oregon legislators continue to propose legislation to expand PAS “access” to an increasing number of people.

While Oregon is well behind the Netherlands, where doctors are now euthanizing infants with Spina Bifida and the elderly with dementia, Boer’s prediction of inevitable expansion still holds true. Oregon is not a “model” for Maryland. Instead it should serve as a cautionary tale.

All facts and figures cited above were drawn from the documents which are abstracted in this cover sheet and included in this packet.

Pages 1-2: Op Ed by Theo Boer in the *Calgary Herald*, July 2014. Boer describes the “Slippery Slope” of PAS and warns legislators “Don’t go there....Once the Genie is out of the bottle, it is unlikely to ever go back in again.”

Pages 2-4: In a 2022 Op Ed in the popular French publication *Le Monde* Boer warns the French people of the “dehumanizing choice” that is PAS.

Pages 5-7: David Jones blog, *British Medical Journal Medical Ethics.com* :“Twenty-Five Years of the ‘Oregon model’ of assisted suicide: the data are not reassuring.”

Pages 8-14: Study from *the British Medical Journal of Supportive and Palliative Care* by Claude Regnard, Ana Worthington, Ilora Finley, *Oregon Death with Dignity Act Access: 25 year analysis.*

Pages 15-19: U.S. Conference of Catholic Bishops “Assisted Suicide and Euthanasia: from Voluntary to Involuntary, ” complete with footnotes and citations.

Pages 20-22: March 9, 2023 article from the *Oregon Register-Guard* entitled “Proposed changes to Oregon’s 25-year-old Death with Dignity Act could expand access.”



Opinion

Boer: I was wrong – euthanasia has a slippery slope

In 2001, the Netherlands was the first country in the world to legalize euthanasia and, along with it, assisted suicide. Various safeguards were put in place to show who should qualify, and doctors acting in accordance with these safeguards would not be prosecuted.

calgaryherald

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Theo Boer

In 2001, the Netherlands was the first country in the world to legalize euthanasia and, along with it, assisted suicide. Various safeguards were put in place to show who should qualify, and doctors acting in accordance with these safeguards would not be prosecuted.

Because each case is unique, five regional review committees were installed to assess every case and to decide whether it complied with the law. For five years after the law became effective, such physician-induced deaths remained level — and even fell in some years. In 2007, I

wrote that “there doesn’t need to be a slippery slope when it comes to euthanasia. A good euthanasia law, in combination with the euthanasia review procedure, provides the warrants for a stable and relatively low number of euthanasia.”

Most of my colleagues drew the same conclusion.

But we were wrong — terribly wrong, in fact. In hindsight, the stabilization in the numbers was just a temporary pause. Beginning in 2008, the numbers of these deaths show an increase of 15 per cent annually, year after year. The annual report of the committees for 2012 recorded 4,188 cases (compared with 1,882 in 2002). Last year saw a continuation of this trend, and I expect the 6,000 line to be crossed this year or the next. Euthanasia is on the way to becoming a default mode of dying for cancer patients.

Alongside this escalation, other developments have taken place. Under the name End of Life Clinic, the Dutch Right to Die Society NVVE founded a network of travelling euthanizing doctors. Whereas the law presupposes (but does not require) an established doctor-patient relationship, in which death might be the end of a period of treatment and interaction, doctors of the End of Life Clinic have only two options: administer life-ending drugs or send the patient away.

On average, these physicians see a patient three times before administering drugs to end their life. Hundreds of cases were conducted by the End of Life Clinic. The group shows no signs of being satisfied even with these developments. They will not rest until a lethal pill is made available to anyone over 70 years who wishes to die. Some slopes truly are slippery.

Other developments include a shift in the type of patients who receive these treatments. Whereas in the first years after 2002, hardly any patients with psychiatric illnesses or dementia appear in reports, these numbers are now sharply on the rise. Cases have been reported in which a large part of the suffering of those given euthanasia or assisted suicide consisted of being aged, lonely or bereaved. Some of these patients could have lived for years or decades.

Whereas the law sees assisted suicide and euthanasia as an exception, public opinion is shifting toward considering them rights, with corresponding duties on doctors to act.

A law that is now in the making obliges doctors who refuse to administer euthanasia to refer their patients to a “willing” colleague. Pressure on doctors to conform to patients’ (or in some cases, relatives’) wishes can be intense. Pressure from relatives, in combination with a patient’s concern for the well-being of his beloved, is in some cases an important factor behind a euthanasia request. Not even the review committees, despite hard and conscientious work, have been able to halt these developments.

I used to be a supporter of legislation. But now, with 12 years of experience, I take a different view. At the very least, wait for an honest and intellectually satisfying analysis of the reasons behind the explosive increase in the numbers. Is it because the law should have had better safeguards? Or is it because the mere existence of such a law is an invitation to see assisted suicide and euthanasia as a normality instead of a last resort?

Before those questions are answered, don’t go there.

Once the genie is out of the bottle, it is not likely to ever go back in again.

Theo Boer is professor of ethics at the Protestant Theological University at Groningen, Netherlands. For nine years, he was a member of a regional euthanasia review committee. The views expressed in this article, which was written for Britain’s Daily Mail, represent his views as a professional ethicist, not of any institution.

OPINION • HEALTH

Assisted dying: 'What is seen as an opportunity by some has become an urge to give in to despair for others'

OP-ED

Theo Boer

Theo Boer, the former regulator of assisted dying in the Netherlands, informs the French of the evolution and unintended consequences of the euthanasia law in his country.

Published on December 4, 2022, at 4:58 am (Paris), updated on December 4, 2022, at 4:59 am | 3 min.

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In your country, a citizens' convention that may lead to the legalization of assisted suicide and euthanasia will be held from December 2022 to March 2023. After the 2002 legalization of euthanasia in the Netherlands, I supported the law and worked from 2005 to 2014 for the authorities in charge of monitoring euthanasia cases. I was convinced that the Dutch had found the right balance between compassion, respect for human life and guaranteeing individual freedoms. However, over the years, I have become increasingly concerned about certain trends.

After an initial stable period, we have seen a dramatic increase in the number of euthanasia cases from 2,000 in 2002 to 7,800 in 2021, with a continued increase in 2022. In some parts of the Netherlands, up to 15% of deaths are the result of intentional deaths. The outgoing director of the Euthanasia Expertise Center (EEC) – which provides assisted dying support to more than 1,000 patients per year – expects the number of euthanasias to double in the near future.

We have also seen changes in the way legal criteria are interpreted. In the early years of euthanasia in the Netherlands, it was almost exclusively available to mentally competent and terminally ill adults. After a few decades, the practice was extended to the chronically ill, the disabled, people with psychiatric problems, non-autonomous adults with living wills and young children. We're currently discussing an extension to elderly people without existing medical conditions.

A dehumanizing choice

Given this data, one can expect that advocates of assisted dying in France will argue for a more restricted law than the one in the Netherlands. But here is my prediction: Any legislation allowing assisted dying will be perceived by some as an injustice and will be challenged in court.

Take Canada, for instance, where euthanasia became legal in 2016. Less than two years later, the Superior Court of Quebec ruled that the concept of terminal illness in Canadian law is discriminatory and unconstitutional.

Why allow euthanasia only for terminally ill patients, who already have access to an ever-widening range of palliative care, when the chronically ill tend to suffer more intensely and for much longer? In 2020, we decided to include psychiatric patients as well. This created a slippery slope with legal issues, making the next steps easily predictable. Why only allow assisted dying for people suffering from a disease, and not for those who suffer from lack of meaning, marginalization, loneliness, and life itself?

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

Posted on October 27, 2023

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-

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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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Oregon Death with Dignity Act access: 25 year analysis

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ABSTRACT

Objectives Assisted dying has been legally available in Oregon in the USA for 25 years, since when official reports have been published each year detailing the number of people who have used this option as well as sociodemographic and information about the process. The aim of this study was to examine changes over time in these data.

Methods We collated and reviewed data on 2454 assisted deaths included in annual reports on assisted deaths published by the Oregon Health Authority from 1998 to 2022. Descriptive statistics were used to describe time trends.

Results The number of assisted deaths in Oregon increased from 16 in 1998 to 278 in 2022. Over this time, patients' health funding status changed from predominantly private (65%) to predominantly government support (79.5%), and there was an increase in patients feeling a burden and describing financial concerns as reasons for choosing an assisted death. There has been a reduction in the length of the physician-patient relationship from 18 weeks in 2010 to 5 weeks in 2022, and the proportion referred for psychiatric assessment remains low (1%). Data are frequently missing, particularly around complications.

Conclusions The number and characteristics of people accessing assisted deaths, and the process, have changed since data collection started in 1998. Prospective studies are needed to examine the relationship between socioeconomic factors and the desire for an assisted death in Oregon.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Oregon has had assisted dying legislation for 25 years.

WHAT THIS STUDY ADDS

⇒ Many aspects have changed with rising numbers, expanding criteria and sociodemographic changes.
⇒ Much of the data on complications are missing and many variables are not collected, especially around decision-making, drug efficacy and the nature of palliative care support.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Oregon's changing trends in assisted dying require detailed prospective studies examining how socioeconomic factors influence the wish for an assisted death.

Assisted dying is a term which in Oregon's legislation covers only self-administered lethal drugs (physician-assisted suicide (PAS)). In other jurisdictions it also covers clinician-injected drugs (euthanasia) or both.^{2,3} In 1997, Oregon enacted the Death with Dignity Act (DWDA). This legislation allows residents ≥ 18 years of age, capable of making and communicating healthcare decisions, and diagnosed with a terminal illness that will reasonably lead to death within 6 months, to end their lives through the voluntary self-administration of lethal drugs prescribed by a physician for that purpose. Annually, the OHA publishes an annual report containing data on the implementation of the legislation. The annual data report for 2022 provides the 25th year's data.

The official notification requirements vary between jurisdictions. Official reports contain limited characteristics such as total numbers, patient age or broad summaries, without standardised international reporting.⁴⁻⁶ Oregon reports are the most detailed, and as some jurisdictions consider 'assisted dying' legislation

INTRODUCTION

Since 1998, the Oregon Health Authority (OHA) has published an annual data report.¹ This includes aggregate information on the demographics of those accessing an assisted death, their diagnoses, health funding status, lethal drugs used, patient concerns, the nature and extent of care provided, complications, and the timings of an assisted death.

 Check for updates

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based on Oregon, it is important to examine trends in a quarter of a century's data from their experience. The aim of this study was to examine detailed changes over time in the data from Oregon.

METHODS

Starting in 2022, we examined the data contained in every PAS report published by the OHA from 1998 to 2021, adding data from the latest 2022 report in March 2023.¹ We manually extracted information on the number of patients who were prescribed PAS drugs under the DWDA, sociodemographic data such as insurance status, information on the motivations for hastening death, the underlying illness which qualified them for PAS, and the number and types of lethal drugs prescribed under the legislation. Data were extracted into Microsoft Excel, which was used to describe data and trends from 1998 to 2022. Percentages and proportions were calculated, and trends examined graphically. Linear trend lines were generated with Excel's graph function.

RESULTS

Change in numbers of participants

Over 25 years, 2,454 individuals have died from an assisted death. In 1998, 24 prescriptions were written for PAS drugs and 16 patients died from ingesting these drugs. On average, the number of PAS drugs prescribed under the legislation increased by 13% each year and the number of patients who died by ingesting these drugs by 16% annually (figure 1, left panel). In 2022, 431 prescriptions were written, and 278 patients died by PAS. The proportion of deaths following ingestion of prescribed drugs compared with the prescriptions written increased slightly, from an average of 58% in the first decade (1998–2007) to 66% in the second decade (2008–2017), following which it has been stable at an average of 67% over the last 5 years.

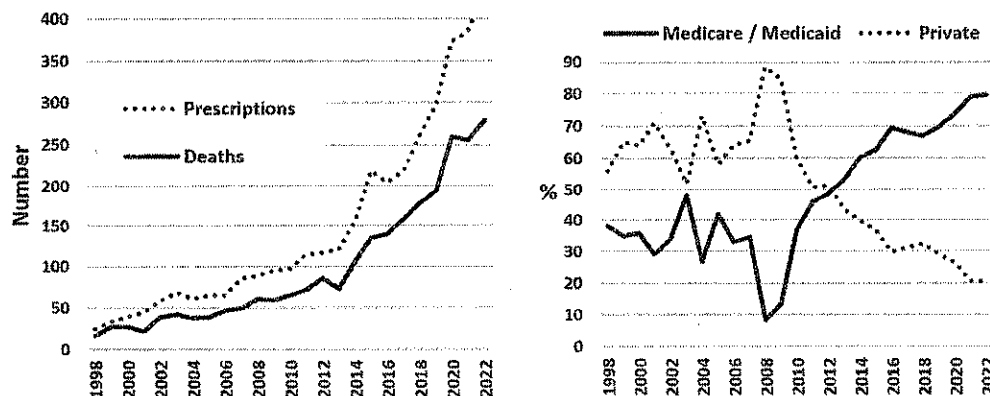


Figure 1 (Left) Numbers of PAS deaths; (Right) percentage of PAS patients with government funding.

Changes in the sociodemographic characteristics and end-of-life care concerns of participants

There has been little change in the mean age of PAS patients of 72.5 years. The proportion of PAS patients aged 75 or more has remained stable, being 48% in 2006 and 51% in 2022.

In the first decade of legislation of PAS in Oregon, an average of 65% of participants were privately insured (figure 1, right panel). Since 2008, this proportion has reversed; in 2022, 20.5% of those who died by PAS held private health insurance, while the majority (79.5%) had government insurance through Medicare or Medicaid.

The percentage of PAS patients who cited being a burden on family and friends increased during the time period (figure 2, left panel). The number of patients reporting financial concerns about treatment as an end-of-life concern is low, though there is evidence of an increase over the time period (up to 8.4% in 2021) (figure 2, right panel). In the first 5 years of PAS, an average of 30% of participants were concerned about being a burden. Since 2017, this concern has been cited by around half of those who die by PAS (46% in 2022).

Changes in patient eligibility

Eligibility under the DWDA requires that patients have been diagnosed with an illness that will reasonably lead to death within 6 months. Cancer remains the main diagnosis of PAS patients, though the proportion has reduced over the time period from an average of 80% in the first 5 years to 64% in 2022. In 2022, 109 patients (25% of prescription recipients) were granted an exemption from the usual 15-day reflection period on the basis that they were terminal. Since 2010, patients with a range of non-cancer diagnoses have received PAS including non-terminal illnesses such as arthritis, arteritis, complications from a fall, hernia, sclerosis, 'stenosis' and anorexia nervosa.

Referrals for psychiatric evaluation have declined as a percentage of assisted deaths (figure 3, left panel). In the first 3 years after enactment (1998–2000), a psychiatric assessment was sought in an average of

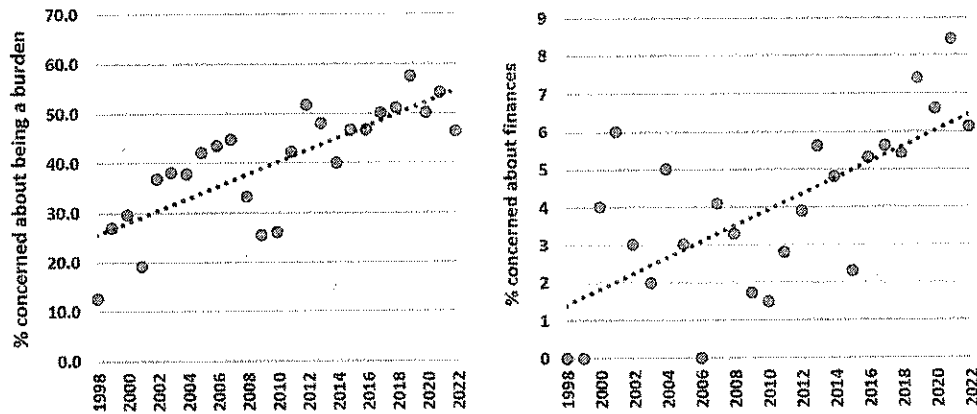


Figure 2 (Left) Percentage of PAS patients with concerns about financial implications of treatment; (Right) Percentage of those concerned about being a burden.

28% of cases. By 2003 this had dropped to 5%, and in 2022, 1% of patients who died from PAS underwent psychiatric evaluation. Since 2010 there has been a reduction in both the median duration of the physician–patient relationship and the time from the first request to death (figure 3, right panel). In 2010 the median physician–patient duration was 18 weeks, dropping to 5 weeks in 2022. The time from the first request to death had reduced from 9.1 weeks in 2010 to 4.3 weeks in 2022.

PAS drugs

From 1998 to 2015, the most common drugs used for PAS were barbiturates, with phenobarbital, secobarbital or pentobarbital used alone. It is now standard for drug combinations to be used, with different combinations being used in the last 8 years, although the dose of each constituent drug is not reported: 2015–2022: DDMAP (diazepam, digoxin, morphine sulfate and propranolol); 2018–2022: DDMA (diazepam, digoxin, morphine sulfate and amitriptyline); 2019–2022: DDMA-Ph (DDMA plus phenobarbital). The 2022 report states that the combinations have resulted in longer times from ingestion to death (3 mins to 68 hours; median 52 min), compared with

an aggregate range of 1–104 hours, with a median of 30 min over the 25 years. The number of prescriptions per doctor has increased from an average of 1.6/doctor in the first 5 years to 1998, to an average of 2.7/doctor between 2018 to 2022 (figure 4, left panel).

Stated complications following the ingestion of PAS drugs have included difficulty in ingesting drugs, regurgitation, seizures, regaining consciousness and ‘other’ complications that are not described. Complications associated with PAS drugs were reported in an average of 11% between 2010 and 2022, with a peak of 14.8% in 2015 (figure 4, right panel). In 2022 complications were identified in 6% of patients, though data on complications was missing in 206 patients (74%). Over the last 25 years, nine patients have regained consciousness.

In Oregon in 2022, 46% of patients did not take their prescriptions. Of these, 84 died of other causes. In 101 patients the ingestion status was not known, only that 43 died. In 58 patients the status of death and ingestion was unknown at the time of the report.

DISCUSSION

Number of deaths

The 25 years of OHA’s official data reports show that the number of assisted deaths rose slowly for the first

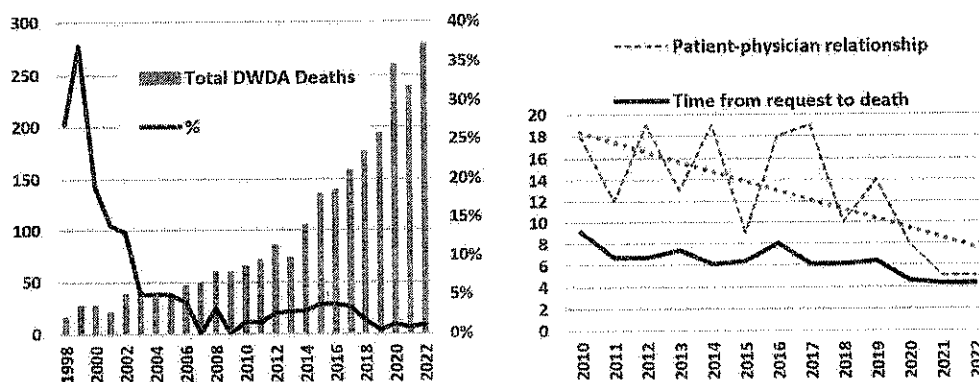


Figure 3 (Left) Percentage of PAS patients referred for psychiatric evaluation; (Right) Duration of physician–patient relationship (includes trend line) and time from first request to death in weeks.

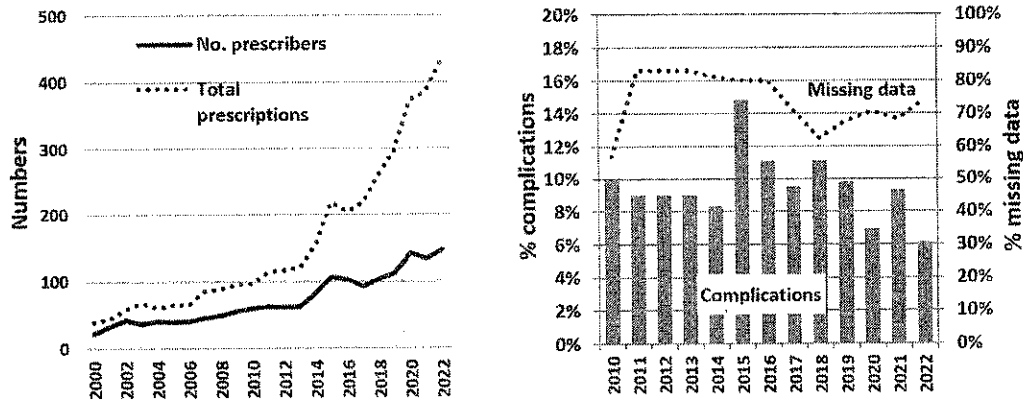


Figure 4 (Left) Total number of PAS prescribers compared with prescriptions; (Right) Percentage of PAS complications (bars) and percentage of missing data on complications (dotted line).

15 years following legislation, then accelerated. When this is considered as the prevalence of PAS deaths overall, the trend is confirmed, with an increase in 2014 from 0.06% (1998) to 0.24% (2012), a slight drop in 2013 to 0.22%, then a steeper rise of 0.66% in 2020 when reporting this statistic ceased. During the pandemic (2021) PAS deaths fell slightly, but numbers rose again in 2022. This trend is similar to that seen elsewhere.⁷ However, it is notable that Oregon PAS deaths remain at a lower prevalence than when euthanasia is also legalised: in 2021 officially notified medically-assisted deaths constituted 4.5% of all deaths in the Netherlands and 3.3% in Canada.

Change in demographics of those accessing PAS

Among Oregonians accessing legal PAS, the proportion of people with government health funding (Medicare and Medicaid) has increased relative to those with private health funding. Since 1999, the Oregon OHA reports have not differentiated between Medicare and Medicaid, but only the latter covers the costs of PAS. Medicare is federal insurance for adults ages 65 and older, whereas Medicaid is an insurance option for adults deemed below the poverty line and its availability expanded through the Oregon Health Plan in 2008/9 and 2014. The relative increase in PAS among those receiving state funded medical aid changed from 2008 onwards (see figure 1, right panel), but the influence of state funding on uptake can only be analysed with a breakdown of the numbers funded by each system. Unfortunately the destruction of OHA records after 1 year makes retrospective analysis impossible.

Patients' end-of-life concerns are reported across eight categories, allowing several concerns to be reported. It is unclear whether these are the patients' direct reports or those reported retrospectively by the clinician. Concerns cited about 'losing autonomy' (91%) and 'less able to enjoy activities making life enjoyable' (90%) remain dominant across each year. Over time, there has been an increase in the proportion of patients including concern about being a burden

on their caregivers and in those expressing financial concerns about their treatment.

The OHA reports reveal a higher uptake of PAS among those with higher educational levels, but income levels are not given. In Belgium, lower education levels are associated with less intense pain and symptom alleviation, but income was not examined.⁸ It is possible to have a high education attainment, but be on a low income. Other vulnerabilities are becoming clearer. For example, patients with mental health issues asking for assisted death in the Netherlands were more likely than the general population to be female, single, of lower educational background and with a history of sexual abuse.⁹ In Switzerland, although PAS was associated with higher socioeconomic status, PAS was also more common in females and situations indicating vulnerability such as living alone or being divorced.¹⁰ In 2018 an Oregon Health Statistics official acknowledged that they will accept PAS requests if the patient has refused treatment for financial reasons.¹¹ Although socioeconomic data already exist for some medical conditions in Oregon,¹² these have not been linked to PAS requests.

Recently the cost benefit to individuals and to society of assisted deaths have been discussed in relation to quality-adjusted life years (QALYs).¹² Economic arguments in support of assisted deaths include the avoidance of possible negative quality of life of the patient, and freeing up healthcare resources for others including organs for transplantation.¹³ Canada's C-14 Bill has been estimated to provide a net cost saving overall of \$C86.9 million in 2021 (gross healthcare cost reduction \$C109.2 million less \$C22.3 million cost of administering MAiD (Medical Assistance in Dying)).¹⁴ A 2019, a US Gallup poll found a quarter of respondents reported they or a family member had been put off treatment for a serious medical condition because of the cost.¹⁵ In 2020, 31.6 million people in the USA (9.7% of the population) had no medical insurance.¹⁶

There is a dearth of studies linking socioeconomic vulnerability and PAS data. The change in health funding in Oregon is unlikely to be due to a lag in data since the change to state funding started 15 years ago. Detailed studies are needed to explain the marked change in medical funding for PAS patients in Oregon.

Factors influencing the wish to die

The very low referral rate for psychiatric evaluation could be the result of an efficient screening process. However, there is evidence that depression and existential issues such as hopelessness can influence a wish to die and are commonly missed by doctors.^{17 18} Loneliness is known to be associated with depression which, in turn, increases the likelihood of a wish to die.¹⁹ Elder abuse, which can be difficult to identify, has become a major public health issue in both the USA and the UK,^{20 21} and in Oregon, elevated rates of non-assisted suicide have been observed in older women.^{6 22} The OHA data show that the duration of the patient–physician relationship is now almost the same as the time from first request to the assisted death. This steady reduction in the physician–patient relationship in Oregon may have made it more difficult to identify treatable factors influencing the wish to die, but there is a lack of recent data on how many Oregon PAS patients have a treatable depression.

PAS drugs

Until 2014, most prescriptions in Oregon were for secobarbital (54.2%) or phenobarbital (42.8%). US barbiturate availability fell in 2014 as barbiturates were used in state executions and prices rose over seven-fold from 2010 to 2016 (US\$387.52 to \$2878.09).²³ Attempts to improve their efficiency in inducing unconsciousness and in time to death have resulted in different drug combinations since 2015. Despite some collation of data by the American Clinicians Academy on Medical Aid in Dying, no research institution has orchestrated studies to evaluate the mode of action and efficacy normally required of clinical processes, with ethical and clinical safeguards for patients.^{24 25}

In 2022, 146 Oregon physicians wrote prescriptions, one of whom wrote 51 prescriptions. These doctors represent <0.9% of the 16 621 active medical licensees.²⁶ There is a lack of data on whether this results in difficulty seeking a prescriber, whether those writing few prescriptions have limited experience of assessing eligibility, and what happens to the nearly half of prescribed PAS drugs that are unused.

Oregon does not provide data on what proportion of PAS deaths take a particularly long time to die. Washington reported that in 2021 31% of patients died within 30 min and 16% took more than 2 hours to die. Although the time was unknown in 17.9%, the Washington reports provide no information on the drugs used and whether they were changed to achieve shorter dying times.²⁷

The Oregon OHA reports show that complications affect one in nine patients on average, although Oregon does not include prolonged deaths or patients who regained consciousness in their complication percentages. A peak in the complication rate (14.8%) in 2015 coincides with a switch to drug combinations. However, the true incidence of complications is unknown since in 2022 data on complications were missing in 206/278 (74%) of assisted deaths.¹

Changes in criteria

Oregon is often given as an example of stable assisted dying legislation.^{28 29} In January 2020 Oregon waived the statutory 15-day waiting period for patients estimated to have a shorter prognosis, resulting in a quarter being granted this exemption in 2022.¹ In 2022, 16 patients (6%) outlived their 6-month prognosis following prescription of PAS drugs, but there is no detail on how many had treatable conditions or had been misdiagnosed. In 2017 the OHA confirmed that incurable terminal illness is when there is an affirmative response to the question ‘should the disease be allowed to take its course, absent further treatment, is the patient likely to die within 6 months?’¹¹ Any patient has the right to refuse treatment, but it is concerning that there is a lack of data on why they refused treatment and how they were advised and counselled.

For example, in 2021 anorexia nervosa was one of the diagnoses listed, but without any details of comorbidities, if this was an isolated case, or whether the clinician misjudged the prognosis or misapplied the law. Anorexia nervosa in any young adult with capacity is terminal if it persists, but it can be challenging to determine the point at which treatment cannot succeed.

In 2022a federal lawsuit brought by an Oregon doctor forced Oregon to allow non-residents to access PAS.

Palliative care

In 2022, 92% of people requesting PAS were enrolled in hospice care and the mean for 1998–2020 was 90.8%. However, there are no data on what services were provided and the term ‘palliative care’ is not mentioned in any reports, nor the duration of enrolment. Unlike in the UK, enrolment in hospice care was described to Lord Mackay’s Select committee as ‘pretty much a one way street’ for ‘comfort only’, as other interventions would no longer be paid for.³⁰

In 2012, a study looked at the policies of 56 Oregon hospice programmes regarding the state’s PAS legislation; 36 hospices (64%) were not directly involved in, or actively opposed to, PAS.³¹ Although many of the hospices were willing to have PAS discussions and refer to PAS doctors, nine (16%) hospices were clear that any involvement violated their policies. In addition, 31 (55%) of hospices had policies specifically preventing their staff from being present during the ingestion of

PAS drugs. A more recent study interviewed 10 experienced professionals in Oregon, and some stated that hospice organisations continued to be unsupportive of Oregon's PAS legislation.³² The lack of information on whether Oregon PAS patients are receiving care from specialist, interdisciplinary palliative care, or a single, non-specialist practitioner makes it difficult to evaluate whether adequate palliative care was received before PAS in Oregon.

Limitations of analysis

We limited our analysis to descriptive trends. Retrospective analyses for PAS in Oregon are limited to the content of published reports since Oregon destroys all source records 1 year after each annual report, making verification of data impossible.³³ In addition, missing data for some variables (eg, complications) is high and Oregon does not collect data on how or why PAS decisions were made, pre-evaluation or post-mortem review of cases and the details of rejected requests.

We have found no evidence of the completeness or otherwise of the notification process. As there is no prescription monitoring service in Oregon, it is not possible to triangulate data on prescribed lethal drugs, their ingestion and disposal of unused drugs. As physicians are not required to be present when lethal drugs are taken, data provided for the reports depends on information from whoever was present and from provider questionnaires.

CONCLUSIONS

Oregon is often cited as a stable example of assisted dying legislation. Despite Oregon producing detailed and regular post-death reports of value, there are considerable gaps in the data across US states.³⁴ Most importantly, there is no monitoring in any form of the quality of the consultation in which the decision was made to prescribe lethal drugs.³⁵ Although population mortality follow-back studies have been used to study end-of-life care, these have limitations.³⁶ Detailed, prospective studies that include socioeconomic and clinical information are essential to understand fully the changes seen in Oregon PAS data.

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