

PHYSICIAN-ASSISTED SUICIDE IN OREGON: THE ‘DEATH WITH DIGNITY’ DATA

WENDY E. HISCOX*

St Mary's University College

ABSTRACT

Pressure to permit voluntary euthanasia and/or physician-assisted suicide is mounting in several jurisdictions around the world. The state of Oregon, which legalised physician-assisted suicide in 1997, provides valuable guidance on the feasibility of effective regulation. The Oregon experience provides the focus of this article. The article comprises two parts. Part I critically analyses the Oregon Death with Dignity Act and evaluates the adequacy of the legislative safeguards. Part II examines the implementation of the Death with Dignity Act. It outlines the significant official findings since physician-assisted suicide was legalised, and calls attention to worrisome aspects and identifiable trends. It then provides an overall assessment of the legislation in light of the available empirical data.

INTRODUCTION

There is pressure to permit voluntary euthanasia and/or physician-assisted suicide in several countries around the world.¹ The experiences of those jurisdictions where euthanasia and/or physician-assisted suicide has been legalised are therefore significant points of reference in the contemporary international debate about decriminalisation. Until relatively recently, most of the empirical data has emanated from the Netherlands, where euthanasia has been permitted for over 20 years.² The state of Oregon, which legalised physician-assisted suicide (‘PAS’) in 1997 (and remains the only American jurisdiction to permit the practice), is an important point of comparison and provides valuable guidance on the feasibility of effective regulation. Indeed, the significance of the Oregon experience to the current debate is illustrated by three recent publications, all of which explore and evaluate aspects of the Oregon system.³ Moreover, empirical data from the first nine years since legalisation now exists, making a reasonable assessment of the Oregon experience possible. This article, which considers the available evidence and evaluates the adequacy of Oregon’s legislative safeguards, questions the claim that the data is ‘reassuring’.⁴

I. THE OREGON DEATH WITH DIGNITY ACT⁵

The DWDA was passed in 1994 but it did not come into effect until 1997.⁶ The Act permits physicians to provide a prescription of lethal drugs to terminally ill Oregon residents, although it does not permit voluntary euthanasia. The Act provides:

An adult who is capable, is a resident of Oregon,⁷ and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with [the legislation].⁸

Eligibility for PAS is therefore restricted to ‘capable’⁹ adult patients who have a terminal illness and, in the opinion of at least two physicians, have a life expectancy of six months or less.¹⁰ The patient is not required to be experiencing any form of suffering. The patient is required to make two oral requests (at least 15 days apart) and one written request for a lethal prescription.¹¹ The written request must be signed in the presence of two witnesses.¹² The attending physician must determine that the patient is capable of making the request, and that the request is voluntary.¹³ A consulting physician is required to confirm these findings, as well as the patient’s terminal diagnosis and prognosis.¹⁴ The DWDA requires that the patient be referred for counselling if either physician feels that depression is impairing the patient’s judgment, or if a psychiatric or psychological disorder causing impaired judgment is suspected.¹⁵ It is the obligation of the attending physician to inform the patient of alternatives to PAS, such as hospice or comfort care, and pain-control possibilities.¹⁶ Physicians must maintain records¹⁷ and they are required to report all lethal prescriptions written by them to the State’s Health Division, the Oregon Department of Human Services (‘ODHS’).¹⁸ The legislation does not, however, permit public access to this information,¹⁹ with the exception of an annual statistical report.²⁰ Finally, physicians who comply in ‘good faith’²¹ with the DWDA are immune from civil and criminal liability and also from professional disciplinary sanctions.²²

A. Safeguards: protective or illusory?

There are thus a number of fundamental safeguards contained in the DWDA including, in particular, the substantive requirements of terminal illness, competency, and an informed decision, as well as the procedural requirements of consultation, witnesses and reporting.

At first blush, it might appear that these provisions largely obviate the potential for abuse.²³ Further inquiry, however, suggests that the safeguards are largely ineffective.

1. *Substantive Requirements*

(a) Terminal Illness

The requirement of a terminal illness is often claimed to be an important limiting provision of the DWDA. This is, however, a problematic and controversial requirement both practically and in principle. Moreover, its usefulness as a safeguard is open to question. In order to be classified as terminally ill under the DWDA a patient's life expectancy must be six months or less according to 'reasonable medical judgment'. However, erroneous medical opinions are a real possibility, particularly because of the difficulty of accurate prediction.²⁴ In one study conducted in Oregon shortly after the DWDA was first passed, 50 per cent of the participating physicians stated that they were 'not confident' that they could predict accurately that a patient's life expectancy was six months or less.²⁵ Further research indicates that physicians are frequently incorrect in their predictions regarding the life expectancy of their terminally ill cancer patients.²⁶

It is unlikely, too, that the terminal illness requirement will prove to be sustainable over time as a matter of principle. The requirement arbitrarily excludes the class of chronically ill patients who may endure suffering similar to – or indeed worse than – that experienced by the terminally ill. Why should they find themselves without recourse to PAS under the DWDA simply because their conditions are not 'terminal'? Is this not unfair and discriminatory? Some proponents of PAS in fact agree that the terminal condition criterion is too limiting.²⁷ One can anticipate that patients suffering from chronic debilitating illnesses – such as amyotrophic lateral sclerosis (ALS), multiple sclerosis, acquired immune deficiency syndrome (AIDS) and others – will argue for inclusion within the legislation. There is indeed evidence to indicate support for PAS among these patient populations.²⁸

(b) Competence

The DWDA requires that a patient be competent in order to be eligible for PAS and thus purports to exclude the incompetent from its scope. The concept of competence to make decisions regarding one's medical treatment variously has been interpreted to denote a capability to understand and appreciate the risks and benefits of a

particular treatment, to evaluate the plausible alternatives, and to arrive at an informed judgment.²⁹ Significantly, the patient's competence is assessed under the DWDA only at the time when the prescription is written. The DWDA does not require the patient's competence or the voluntariness of the patient's actions to be assessed when the patient takes the lethal dose.³⁰

Moreover, unless the DWDA can ensure the proper mental evaluation of a patient's competence to request PAS – including the detection of depression – the safeguard loses much of its force. This is particularly so in light of various studies demonstrating a link between depression and the desire for hastened death among terminally ill patients.³¹ Whilst, admittedly, it might not be reasonable to expect terminally ill patients to be wholly free from depressive thoughts, it seems eminently reasonable to expect that no patient suffering from clinical depression should have access to PAS. The means of detection of depression contemplated by the legislation, however, appear inadequate. First, the statute requires a mental evaluation ('counselling') *only* where a physician feels that the patient is suffering from a psychiatric or psychological disorder, including depression, which causes impaired judgment.³² Depression which does not 'impair judgment' is not, therefore, a bar to eligibility for PAS. Additional problems arise from the fact that an attending or consulting physician need not have any training in performing an evaluation of this nature (the form of which is not specified in the legislation). It can be expected that the more subtle depressive disorders which may underlie requests for PAS will go undetected by physicians lacking psychiatric expertise.³³

Difficulties also arise with the so-called counselling phase under the DWDA. Most notably the Act merely mandates a single psychiatric or psychological consultation.³⁴ The shortcomings of this safeguard, however, are obvious and well-documented. In a 1999 study in which a majority of Oregon psychologists surveyed indicated their support for legalised PAS, half of the respondents stated that they were 'not at all confident' that they could satisfactorily determine in a single consultation whether a mental disorder is impairing a patient's judgment, with only 6 per cent responding that they would be 'very confident' under such conditions.³⁵ Responses changed dramatically, however, when respondents were asked about performing such an evaluation within the context of a long-term clinical relationship, when 64 per cent said that they would be 'very confident'.³⁶ Similarly, in an earlier study involving Oregon psychiatrists, 94 per cent revealed that they did not feel very confident that they could detect a psychiatric disorder impairing judgment in a single consultation.³⁷ The authors of the 1999 study conclude the DWDA requires psychologists to perform extraordinarily important work in conditions that are far from ideal,

thereby diminishing not only the quality of the evaluations, but also their reliability and adequacy as a safeguard.³⁸

(c) Informed Decision

Under the legislation, the physician must inform the patient of the diagnosis and prognosis, potential risks, probable outcome, and possible alternatives to PAS, including pain control, comfort care and hospice.³⁹ In theory, to require a physician to explore the range of alternatives with the patient before proceeding might help to ensure that PAS is an option of ‘last resort’. In practice, however, while a patient may be made aware of the various options, the reality is that services such as palliative care are not always readily available – or affordable.⁴⁰

In addition, physician influence on patient choice bears heavily upon whether there has been an ‘informed decision’. With respect to the provision of life-sustaining therapies, studies have revealed that physicians’ personal biases and stereotypes influence their treatment decisions for their patients.⁴¹ Similar biases may – however subtly – unduly influence a physician’s portrayal of the option of PAS. Moreover, there is nothing in the legislation to prevent a physician from raising the possibility of PAS to the patient or even strongly recommending it.

2. *Procedural Requirements*

The DWDA incorporates various procedural requirements, all of which are designed to work in conjunction with the substantive provisions to promote a limited practice of PAS and prevent the incidence of abuse. It seems, however, that the procedural aspects of the legislation cannot ensure that the patient’s decision is either voluntary or informed.

(a) Consultation

A consulting physician must confirm the patient’s diagnosis, prognosis and competence, and must verify that the patient’s decision is voluntary and informed. Such a requirement is designed to protect the interests of the patient against coercion and diagnostic error. As has been observed, however, under the legislation *any* physician who is medically qualified to practise in the State is eligible to act as a consultant – no particular expertise is required.⁴² Furthermore, the statute does not require that the consulting physician act independently of the attending doctor. Without such a requirement the effectiveness

of consultation as a safeguard (against unilateral decision-making in particular) may be compromised. Not only could the consultation be satisfied by the treating physician's friend, colleague, or even subordinate, but there is also nothing in the legislation to prevent the treating physician from 'shopping around' until a second physician who is prepared to grant the request is located.⁴³

(b) Witnesses

The DWDA requires that the patient's written request be witnessed by at least two people who can verify that the patient is competent and that the decision is voluntary and informed. One of the witnesses must be impartial.⁴⁴ The mandatory presence of witnesses is intended to provide a degree of supervision and openness to what is alleged currently to be a clandestine practice of PAS.⁴⁵ Where the legislation is deficient, however, is in its failure to require that witnesses be present at other important instances throughout the decision-making process including, in particular, the time when the patient takes the lethal dose. Indeed, the process after the patient receives the lethal prescription is wholly unregulated. It is equally troubling that the legislation does not prohibit a relative or beneficiary from acting as one of the two witnesses to the patient's request, particularly given the risk of coercion and undue influence from family members. Moreover, there is nothing to prevent a 'witness' from simply being invited in off the street.

(c) Reporting

The ODHS has authority under the statute to make rules for data collection relating to PAS requests. Although physicians are required to maintain records and to report cases in which they have written lethal prescriptions to the ODHS⁴⁶ this data is not publicly available, even in an anonymised form.⁴⁷ Indeed, the only information available to Oregonians is an annual statistical report from the ODHS. Moreover, the ODHS is not required by the legislation to review every occurrence of PAS, but only to review 'sample' cases.⁴⁸ Yet in order to meet the concern that impermissible practices and abuse will go undetected it would seem essential that the DWDA provide for a system that facilitates the rigorous monitoring and objective review of the practice of PAS – particularly given that the legislation is based on a system of self-reporting. In other words, any data generated is derived wholly from those physicians who voluntarily file reports. Such physicians are highly unlikely to report their own non-compliance. The degree of public oversight offered by the legislation is, in short, slight.⁴⁹

II. IMPLEMENTATION OF THE DWDA

The DWDA has been in effect for over nine years and the ODHS has released nine annual reports containing data on the Oregon patients who died by lethal medication from 1997–2006.⁵⁰ It is therefore now possible to evaluate the operation and enforcement of the law and, in particular, the extent to which it supports the concerns outlined above. This section will outline the significant official findings under the following headings: the incidence of PAS; patients' reasons for requesting PAS; number of psychiatric consultations; the timing of PAS; and the circumstances surrounding the ingestion of the lethal dose. It will then call attention to worrisome aspects and identifiable trends and provide an overall assessment of the implementation of the DWDA in light of the available empirical data.

A. Key official findings⁵¹

1. *Incidence of PAS*

According to the reports, there have been 456 lethal prescriptions⁵² written under the DWDA and 292 cases of PAS.⁵³ As a general observation, these figures have increased over the nine years.⁵⁴ In the first year, 24 lethal prescriptions were written and 16 PAS cases were reported. In the ninth year, physicians wrote 65 lethal prescriptions and reported 46 PAS deaths.

2. *Patients' Reasons for Requesting PAS*

Most patients gave more than one reason for wanting to die. Concerns about loss of autonomy figured prominently throughout, with 251 out of 292 patients (87 per cent) citing this as a reason for requesting PAS.⁵⁵ A similar number (250 out of 292, or 87 per cent) expressed fears about a decreasing ability to do enjoyable activities.⁵⁶ Fear of a loss of dignity (added by the ODHS to the list of reasons for choosing PAS in 2003) was cited by 131 out of 163 patients (80 per cent)⁵⁷; 165 out of 292 patients (57 per cent) feared losing control of bodily functions;⁵⁸ and 110 out of 292 patients (38 per cent) expressed fears of being a burden.⁵⁹ Other motivating reasons for PAS were concerns about inadequate pain control (cited by 76 out of 292 patients, or 26 per cent) and worries about the financial implications of their illnesses (cited by 7 out of 292 patients, or 2 per cent).

3. *Number of Patients Referred for Psychiatric Evaluation*

Thirty-six out of 292 patients (13 per cent) were referred for psychiatric evaluation prior to receiving PAS under the DWDA. This percentage has declined over the nine years, from 31 per cent (5 out of 16 patients) in 1998 to 4 per cent (2 out of 46 patients) in 2006.⁶⁰

4. *Timing of PAS*

The duration of the patient-physician relationship before the lethal prescription was provided ranged between 0 and 1065 weeks.⁶¹ The median length of the relationship was 12 weeks.⁶² The time between ingestion of the lethal dose and death ranged between one minute and 48 hours.⁶³ This figure was reported as 'unknown' in 20 of the 292 PAS cases. The median time between ingestion and death, where known, was 25 minutes.

5. *Circumstances Surrounding Ingestion of Lethal Dose*

The prescribing physician was present when the patient ingested the lethal medication in 63 out of the 292 PAS cases (29 per cent). Complications after the lethal drugs were ingested were reported in 17 cases (16 patients experienced 'regurgitation' and one patient awakened after taking the lethal medication). No complications were reported in 1998 or 1999. The highest number of complications occurred in 2006 (four cases). Ninety-four per cent of the PAS deaths were reportedly without complication, with seven cases reported as 'unknown'.

B. ODHS researchers' conclusions

Based on their findings over the nine years the researchers observe that, after an initial upward trend both in the number of lethal prescriptions and the number of patients choosing PAS, these figures have remained relatively stable since 2002.⁶⁴ They observe that the decision to request and use a lethal prescription has consistently been associated with concerns about loss of autonomy, loss of dignity, and decreased ability to participate in activities that make life enjoyable.⁶⁵ The researchers also emphasise the 'small' number of PAS cases particularly when compared to data from the Netherlands.⁶⁶ The researchers consistently acknowledge in their reports, however, that their data is based on a system of self-reporting and does not include

patients and physicians ‘who may act outside the provisions of the DWDA’.⁶⁷

C. ‘Impeccable implementation’?

In light of the official annual figures, proponents have observed not only that legalisation has failed to result in a ‘groundswell’⁶⁸ of terminally ill patients seeking PAS, but also that the findings confirm ‘impeccable implementation’⁶⁹ of the DWDA. Indeed, fifty-five of the United States’ foremost bioethicists recently joined together as co-signatories on an *amicus curiae* brief filed with the United States Supreme Court in support of the respondents in *Gonzales v Oregon*,⁷⁰ wherein they contend that the evidence from Oregon is ‘uniformly favourable’⁷¹ and that ‘[s]peculative fears about abuse have not materialized’.⁷² However, on closer examination, the official portrayal of PAS practice in Oregon seems unreliable and the claim that PAS in Oregon is responsible and abuse-free is far from substantiated. There are several areas of concern.

1. *Underreporting and Physician Non-compliance*

The statistics may well be inaccurate. Arguably the biggest cause for concern lies in the fact that the system remains one of self-reporting and therefore the total incidence of abuse is not only unknown but unknowable, as is the true extent of PAS. As noted earlier, the ODHS does not have powers of enforcement under the DWDA and the legislation does not incorporate any penalties for physicians’ non-compliance with reporting requirements. This minimal system of oversight and control cannot therefore monitor cases taking place outside the legislation. Because doctors could simply have elected not to report a case if it involved the breach of a guideline it is impossible to establish the number of deaths that may have occurred where the legal requirements were disregarded. The ODHS researchers acknowledge that it is ‘difficult, if not impossible, to detect accurately and comment on underreporting’ because ‘the reporting requirements can only ensure that the process for obtaining lethal medications complies with the law’.⁷³

2. *Misleading Conclusions*

The process of procuring information raises questions about the reliability of the data and the resulting conclusions. As the reports

disclose, the reporting system relies exclusively on information provided to the ODHS by the participating physicians. Patients' families and friends, and other care workers with perhaps intimate knowledge of the patients and their circumstances, are not involved in the process,⁷⁴ yet undoubtedly could be valuable sources of information, if only to verify the reports of physicians.⁷⁵ The limited nature of the evidence seems particularly problematic in light of the potential for bias in the physicians' reporting. Indeed, as admitted in the ODHS summary of the First-year Report, 'the entire account could have been a cock and bull story. We assume, however, that physicians were their usual careful and accurate selves.'⁷⁶ This seems an unsubstantiated assumption.

Important additional information is missing from official reports. For example, the ODHS did not interview the physicians who refused to write lethal prescriptions for their patients. Their reasons for refusing to assist their patients' suicides could have been revealing, however, and their omission from the official reports appears to compromise the transparency of the decision-making process. Because such pertinent data is excluded it is difficult to discern with any certainty from the official reports what occurred in each case, let alone to conclude (as ODHS researchers have) that physicians are complying with the legislation.⁷⁷ By comparison, a detailed analysis of the first publicly reported⁷⁸ PAS under the DWDA by Professor Herbert Hendin, Professor Kathleen Foley and Margot White reveals a controversial decision-making process and calls attention to the inherent shortcomings of the legislation and the ineffectiveness of its safeguards to protect patients.⁷⁹ The case involved a woman in her 80s with terminal breast cancer. Prior to receiving a lethal prescription, the patient requested assistance from her treating physician. He refused. A second doctor was consulted, but he also declined to provide assistance, claiming that the patient was depressed. The patient's husband then contacted the pro-euthanasia group 'Compassion in Dying'⁸⁰ and was subsequently referred to a willing physician. After the patient was assessed by a psychiatrist (in a single consultation) and another specialist (to confirm a diagnosis of terminal breast cancer), the willing physician assisted in the patient's death – only 2½ weeks after first having met her⁸¹ and in the face of conflicting opinions regarding her suitability for PAS.

3. *Complications Omitted from Official Reports*

The reliability of the Oregon statistics which document only seventeen complications in nine years⁸² is open to question, particularly in light of one Dutch study which revealed that in 18

per cent of cases in which the physician originally intended to assist a patient's suicide, the physician gave a lethal injection because of complications.⁸³ Indeed, doubts about the Oregon data appear well-founded in light of at least two cases involving complications which, although reported extensively in the news media, are inexplicably overlooked in the official reports. One case involved the assisted death of Patrick Matheny, a 43-year old man suffering from ALS, on March 10 1999. In a newspaper article Matheny's brother-in-law revealed that he helped Matheny to die when complications arose, explaining that

[i]t doesn't go smoothly for everyone. For Pat it was a huge problem. It would not have worked without help.⁸⁴

Although an investigation into Matheny's death was ordered, it was dropped when the authorities determined that the objective of the law was attained.⁸⁵

A second case involving a 'botched' PAS which was omitted from the Second-year Report similarly calls attention to the inaccuracy of the official reports. At a seminar in Portland in December 1999 'right-to-die' advocates discussed a case in which an anonymous patient took the prescribed lethal medication but suffered disturbing physical effects. His wife called an ambulance and he was taken to hospital and revived, although he subsequently died.⁸⁶ The case was not reported to state authorities by the physician who issued the prescription and it was concealed from the ODHS researchers and the public as a result. The number of other such failures remains unknown and unverifiable – not least because physicians are not required to be present at the time the patient swallows the lethal dose and therefore have little or no information about what actually transpired at arguably the most crucial time.⁸⁷

4. *Psychiatric Evaluation*

Of the 292 total reported deaths, only 36 patients (13 per cent) were referred for psychiatric evaluation. Perhaps more significantly the official reports indicate an overall downward trend in the percentage of patients so referred, from a high of 37 per cent in 1999⁸⁸ to only four per cent in 2006.⁸⁹ This is notwithstanding the substantial body of evidence that suggests the majority of terminally ill patients who request PAS suffer from treatable depression.⁹⁰ Furthermore, a patient's capacity to make an informed decision may fluctuate. Thus, although at the time of the initial psychiatric evaluation a patient may be adjudged to have sufficient capacity, because (as was noted

above) the DWDA fails to mandate or even provide an opportunity for psychiatric re-assessment when the patient ingests the lethal dose, there can be no way of verifying that the patient retains the requisite capacity to make a free and informed decision to commit suicide. There are other concerns. The official reports fail to include details about the mental state of patients or about the process of psychiatric consultation. Participating psychiatrists were not interviewed by the ODHS, nor were they required to file an extensive report.⁹¹ Additionally, it appears that psychiatric consultations need not be conducted in person to meet DWDA requirements, and in 2000 one psychologist reportedly evaluated a patient by post.⁹² At least two cases encapsulate these shortcomings.

The PAS of 85-year old Kate Cheney on October 17 1999, which was omitted from official reports although details of her death emerged through various newspaper articles,⁹³ calls particular attention to the ineffectiveness of the psychiatric evaluation process as a safeguard. Cheney was initially refused a lethal prescription by her attending physician because she exhibited signs of dementia. She was referred to a psychiatrist who decided that she lacked capacity to weigh the alternatives and was ineligible for PAS. According to the psychiatrist, Cheney's daughter, not Cheney, was pressing for PAS. A psychologist also evaluated Cheney and concluded that although she was competent, she was possibly under the 'somewhat coercive'⁹⁴ influence of her daughter. Notwithstanding these cautionary signs, including the question of undue influence, the managed-care ethicist who was supervising Cheney's case ultimately determined that she was mentally competent to request and receive PAS.

In 2001 Michael Freeland⁹⁵ received a lethal prescription from Dr Peter Reagan, an assisted suicide advocate affiliated with 'Compassion in Dying'. Notwithstanding Freeland's lengthy history of severe depression and previous suicide attempts, Dr Reagan was of the opinion that a psychiatric consultation was not necessary.⁹⁶ Freeland ultimately decided not to ingest the lethal dose, after intermittent spells in hospital. However, it is only because Freeland, 'out of a wish to help others,'⁹⁷ granted numerous interviews and chose to make his medical records available, that his case came to light. Otherwise, as the authors of his case report observe:

Had Mr Freeland taken his overdose, he would have only been listed in the state report as another patient who did not need to be referred for psychiatric evaluation. The fact that he had a pre-existing psychiatric disorder and previous suicide attempts would not have been revealed, because the Oregon Health Division ... does not ask such questions. ODHS would have only gathered information from Dr Reagan, the assisted-suicide doctor, who did not consider psychiatric consultation

necessary. As it was, he was only listed in the [official 2002] statistics ... as a patient who obtained an overdose but did not take it.⁹⁸

5. *Elasticity of Terminal Illness Requirement*

The official reports expose the elasticity of the terminal illness requirement. Although the DWDA stipulates that only patients with a life expectancy of six months or less are eligible for PAS, the data indicate that at least three patients were inaccurately diagnosed as ‘terminally ill’ and died more than six months after receiving a lethal prescription – in clear breach of the qualifying criteria.⁹⁹ Curiously, such cases – which patently fall outside the legal framework – failed to attract even minimal comment in official reports.

6. *Patients’ Reasons for Requesting PAS*

The case for PAS rests in large part on the importance of relieving patients from serious and prolonged suffering.¹⁰⁰ However, the official research reveals that the fear of intractable pain is by no means the main reason patients give for seeking PAS. Rather, it is the fear of losing control and autonomy which are patients’ primary motivations for committing suicide.¹⁰¹ This would appear to suggest that in many cases PAS is not an option of ‘last resort’. No less significant is the finding that 38 per cent of patients cited the ‘fear of being a burden’ as a reason for requesting PAS. Indeed in the third year alone 63 per cent of patients requested PAS because they feared being a burden on others.¹⁰² Questions also surround the reliability of the finding that financial pressures factored into only seven patients’ requests for PAS,¹⁰³ particularly given that Oregon’s Medicaid (the state program for the poor) covers PAS but does not pay for a number of other medical treatments that patients may require.¹⁰⁴ Moreover, the DWDA does not mandate that physicians make inquiries regarding their patients’ economic status (and a patient may simply choose not to discuss his or her economic concerns with the treating physician), nor does the ODHS require such information to be included in the physicians’ reports.¹⁰⁵

7. *‘Doctor Shopping’ and Counselling by Suicide Advocacy Groups*

Official reports confirm concerns about ‘doctor shopping’. In the first three years (after which time the category was omitted

from official reports), 43 patients (59 per cent) requested a lethal prescription from more than one physician before finding a willing participant.¹⁰⁶ As noted earlier, however, the ODHS did not interview non-prescribing physicians and their reasons for refusing to assist their patients' suicides remain unknown.

Another cause for concern is the extent to which suicide advocacy groups counselled and referred patients to willing doctors. According to the medical director of 'Compassion in Dying', Dr Peter Goodwin, approximately 75 per cent of patients who died under the DWDA between 1998 and 2002 did so with its involvement.¹⁰⁷ In 2003, 'Compassion in Dying' (which maintains a list of physicians willing to participate in PAS) orchestrated 33 of the 42 reported assisted deaths (79 per cent).¹⁰⁸

8. *From PAS to Voluntary Euthanasia?*

The case of Patrick Matheny mentioned above highlights the blurring in practice of the boundary between PAS and voluntary euthanasia and the difficulty of drawing a bright line between them. There are, moreover, official warning signs that the line on PAS may not hold. Implicitly confirming the link between PAS and voluntary euthanasia, the Oregon Attorney General's office has suggested that the DWDA may have to be expanded to include active euthanasia in order to protect the 'rights' of physically disabled individuals.¹⁰⁹ In a letter to the chair of the Senate Judiciary Committee the Oregon Deputy Attorney General opined that, although the purpose of the DWDA is sound, its effect is likely discriminatory against patients who are unable to self-administer medication:

The Act would be treated by courts as though it explicitly denied the 'benefit' of a 'death with dignity' to disabled people. This fact, in turn, makes the [DWDA] vulnerable to challenge under [the Oregon Constitution] ... and the Americans With Disabilities Act.¹¹⁰

CONCLUSION

When the DWDA was passed opponents drew attention to fundamental deficiencies in the legislation which they feared would render the Act incapable of preventing abuse. Many of the criticisms were expressed in abstract terms. Now, however, empirical evidence is available. Far from indicating that the DWDA is being implemented transparently and conscientiously, the data appears instead to confirm the legislation's shortcomings.¹¹¹

In the first nine years there has been an apparent lack of control over PAS practice. The so-called safeguards have proven ineffective in practice to contain PAS within the legislative framework. The evidence discloses that PAS has been carried out in cases where patients were depressed or under potentially coercive influences, and in circumstances where patients were not 'terminally ill'. Moreover, practice in Oregon has proved opaque. Although the annual figures of reported deaths remain relatively low, the statistics may well be inaccurate. The DWDA fails to ensure the investigation of each case to ensure that the guidelines have not been breached. The minimal degree of public oversight renders it virtually impossible, as explicitly admitted in the official annual reports, to establish whether the data provided by participating doctors is truthful or complete or to determine the number of deaths that may have occurred in disregard of the law. The total incidence of abuse is therefore not only unknown but unknowable, as is the true extent of PAS in Oregon.

NOTES

- * BA, LLB, LLM, PhD. The author would like to thank Professor John Keown, Professor David Jones, and the anonymous reviewer for their invaluable comments and suggestions.
- 1 In 2007 assisted suicide measures have been proposed in the American states of Arizona ('Aid-in-Dying' initiative HB 2572), California (Bill AB 374, the 'California Compassionate Choices Act'), Hawaii (five assisted suicide bills were introduced in Hawaii in January 2007), and Vermont (Bill H 44, the 'Patient Choice and Control at End of Life Act,' was introduced in January 2007 and defeated in the House of Representatives on 21 March 2007). Also in 2007 a private members bill that would legalise euthanasia was introduced in Australia ('Rights of the Terminally Ill Bill 2007'). In the United Kingdom, Lord Joffe's *Assisted Suicide for the Terminally Ill Bill*, which sought to legalise physician-assisted suicide, was defeated on 12 May 2006 at its second reading in the House of Lords by a margin of 148 votes to 100. It was Lord Joffe's third such attempt to introduce assisted dying legislation in the UK. For a critique of the Bill, see John Keown, 'Physician-Assisted Suicide: Lord Joffe's Slippery Bill', (2007) 15 *Medical Law Review* 126.
- 2 On 10 April 2001, the Netherlands became the first country in the world to legalise euthanasia by statute with the passage of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001 (available online in English at <http://www.nvve.nl/nvve2/pagina.asp?pagkey=72087>) (accessed 10 December 2006). The law took effect on 1 April 2002.
- 3 Neil Gorsuch, *The Future of Assisted Suicide and Euthanasia* (New Jersey: Princeton University Press, 2006); House of Lords Report of the Select Committee on the Assisted Dying for the Terminally Ill Bill, HL Paper 86-1 (2005); and Bonnie Steinbock, 'The case for physician-assisted suicide: not (yet) proven', (2005) 31 *Journal of Medical Ethics* 235.
- 4 Timothy Quill and Margaret Battin, 'Excellent Palliative Care as the Standard, Physician-Assisted Dying as a Last Resort', in *Physician-Assisted Dying: The Case for Palliative Care & Patient Choice* (Timothy Quill and Margaret Battin

- eds.), (Baltimore: The Johns Hopkins University Press, 2004), pp. 323–333, at 329. See also, Charles Baron, ‘Not DEA’d Yet: *Gonzales v Oregon*’, 2006 (March–April) *Hastings Center Report* 8 (referring to the ‘complete lack of abuse’ in Oregon).
- 5 *Oregon Death with Dignity Act*, Oregon Revised Statute 127.800–127.897 [hereinafter, ‘DWDA’]. After the DWDA came into effect, assisted suicide Bills were introduced in twenty-six other states between 1997 and 1998. All were defeated soundly, most falling at the committee stage. See Richard Doerflinger, ‘An Uncertain Future for Assisted Suicide’, (1999) 29 *Hastings Center Report* 52.
 - 6 The DWDA, a citizens’ initiative, passed narrowly (51% to 49%) in a referendum. A court challenge to its constitutionality held up its implementation until November 1997, when 60% of the electorate voted against its repeal. In 2001, U.S. Attorney General John Ashcroft issued a new interpretation of the federal Controlled Substances Act (‘CSA’) which sought to prohibit Oregon physicians from prescribing controlled substances with the knowledge and intent that the patient would use them to commit suicide. However, in *Gonzales v Oregon*, 126 S.Ct. 904 (2006) the United States Supreme Court held, by a margin of 6 votes to 3, that the CSA does not allow the Attorney General to prohibit doctors from prescribing regulated drugs for use in PAS under state law permitting the procedure.
 - 7 Factors demonstrating residency under the DWDA include (but are not limited to): possession of an Oregon driver’s licence; an Oregon voter registration; evidence of property ownership or a lease agreement for property in Oregon; or a recent Oregon tax return: ORS 127.860 ss.3.10(1)–(4). There is no minimum residency requirement, and nothing in the legislation prevents a non-resident from moving to Oregon in order to qualify for PAS under the DWDA.
 - 8 ORS 127.805 s. 2.01(1).
 - 9 Defined initially under the DWDA as ‘not incapable,’ the definition of ‘capable’ was amended by Senate bill 491 in the 1999 Oregon Congress to mean the ability of a patient to make and communicate his or her health care decisions: ORS 127.800 s.1.01(3).
 - 10 ORS 127.805 s.2.01(1); ORS 127.800 ss.1.01(1), (12).
 - 11 ORS 127.805 ss. 3.06, 3.08.
 - 12 ORS 127.810 s. 2.02(1).
 - 13 ORS 127.805 s. 3.01(1)(a).
 - 14 ORS 127.805 s. 3.02.
 - 15 ORS 127.825 s. 3.03.
 - 16 ORS 127.805 s. 3.01(1)(c)(E).
 - 17 ORS 127.805 ss. 3.01(1)(j), 3.09.
 - 18 ORS 127.865 s. 3.11(1)(b).
 - 19 ORS 127.865 s. 3.11(2).
 - 20 ORS 127.865 s. 3.11(3).
 - 21 ORS 127.885 s. 4.01(1). The good faith standard under the DWDA is lower than the negligence standard which customarily applies to physicians administering medical treatments. As a consequence, physicians cannot be held liable under the DWDA for the wrongful deaths of patients if their actions have been carried out in good faith – even, it has been observed, if they have killed patients on the basis of gross negligence (i.e. either by misdiagnosing the patient as terminally ill or by erroneously assessing the patient as capable). See Gorsuch, *supra*, n.3, at 119. For further criticism of the good faith standard in this context see Kathleen Foley and Herbert Hendin, ‘The Oregon Experiment’ in *The Case Against Assisted Suicide: For the Right*

- to End-of-Life Care* (Kathleen Foley and Herbert Hendin eds.) (Baltimore: Johns Hopkins University Press, 2002), pp. 144–174, at 159.
- 22 ORS 127.885 s.4.01(2) states: ‘No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith compliance with ORS 127.800 to 127.897’. The doctors’ regulatory body, the Oregon Board of Medical Examiners (‘OBME’), has minimal jurisdiction over the DWDA. The OBME does not have an investigatory role, and cannot take action against a physician for participating under the DWDA unless it receives evidence that a physician has violated the legislation. The amended OBME rules clarify that those licensees who comply in good faith with the provisions of the DWDA will not be disciplined for unprofessional conduct. See ‘BME Administrative Rules on PAS’; located at: http://www.oregon.gov/BMD/topics.shtml#RULES_ON_PHYSICIAN_ASSISTED_SUICIDE (accessed 7 June 2007). It also has been observed that the DWDA prohibits all other medical organisations (including the American Medical Association, which strongly opposes PAS in its Code of Medical Ethics) from even criticising Oregon physicians ‘who break the medical standards endorsed by virtually every medical organization in the country’. N. Gregory Hamilton, ‘Oregon’s Culture of Silence’ in Foley and Hendin (eds.), *ibid.*, pp. 175–191, at 190. For further discussion of physician immunity and liability under the DWDA, see The Task Force to Improve the Care of Terminally Ill Oregonians, *The Oregon Death with Dignity Act: A Guidebook for Health Care Professionals* (Portland: 2005), chapter 15, located at: <http://www.ohsu.edu/ethics/guidebook.pdf> (accessed 7 June 2007).
 - 23 Margaret Otłowski, *Voluntary Euthanasia And The Common Law* (Oxford: Clarendon Press, 1997), refers at 369 to the ‘narrow scope of the legislation’ and ‘the quite rigorous safeguards it contains’.
 - 24 There is evidence that the six month time frame is an arbitrary limit, and that physicians do not have the requisite skills to predict accurately the life expectancies of their patients. See Robert Pearlman, ‘Inaccurate Predictions of Life Expectancy’, (1988) 148 *Archives of Internal Medicine* 2537. The American Medical Association, too, suggests that ‘[p]rognostication of survival for the very seriously ill is imprecise’. Council on Scientific Affairs, ‘Council Report: Good Care of the Dying Patient’, (1996) 275 *Journal of the American Medical Association* 474, at 476.
 - 25 Melinda Lee et al., ‘Legalizing Assisted Suicide – Views of Physicians in Oregon’ (1996) 334 *New England Journal of Medicine* 310, at 312.
 - 26 A. Vigano et al., ‘The Relative Accuracy of the Clinical Estimation of the Duration of Life for Patients with End of Life Cancer’, (1999) 86 *Cancer* 170. Based on their analyses of physicians’ predictions regarding 233 patients with terminal cancer, the authors reveal that doctors were inclined to overestimate life expectancy. However, among those patients who lived longer than the six-month period, 40 per cent exceeded the life expectancy predicted by their doctors.
 - 27 See Charles Baron et al., ‘A Model State Act to Authorize and Regulate Physician-Assisted Suicide’, (1996) 33 *Harvard Journal of Legislation* 1, at 10; and Franklin G. Miller et al., ‘Regulating Physician-Assisted Death’, (1994) 331 *New England Journal of Medicine* 119.
 - 28 In a study conducted in Oregon and Washington between 1995 and 1997, a majority (56 per cent) of persons with ALS surveyed indicated that they would consider PAS, and 44 per cent stated that they would request a prescription for a lethal dose of drugs from a physician if it were legal. See Linda Ganzini

- et al., 'Attitudes of Patients with Amyotrophic Lateral Sclerosis and Their Care Givers toward Assisted Suicide', (1998) 339 *New England Journal of Medicine* 967. In two other studies, 63 per cent and 90 per cent of patients with AIDS surveyed stated that they wanted the option of PAS. See William Breitbart et al., 'Interest in physician-assisted suicide among ambulatory HIV-infected patients', (1996) 153 *American Journal of Psychiatry* 238; and B. Tindall et al., 'Attitudes to euthanasia and assisted suicide in a group of homosexual men with advanced HIV disease', (1993) 6 *Journal of Acquired Immune Deficiency Syndrome* 1069.
- 29 New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* (New York: NYSTF, 1994), at 126. For a helpful discussion of the concept of competence in the medical context see the President's Commission for the Study of Ethical Problems in Medicine and Biomedical Behavioural Research, *Making Health Care Decisions: the Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship* (Washington: Government Printing Office, 1982), pp. 55–68. See also *Lane v Candura*, 376 N.E. 2d 1232 (Mass. App. Ct. 1978) for a widely accepted definition of competence to decide on life-sustaining treatment. In the UK, the decision of the Court of Appeal in *Re MB (Medical Treatment)* [1997] 2 FLR 426 remains the leading authority on the legal assessment of capacity to make medical treatment decisions.
 - 30 Dr. Peter Admiraal, a Dutch proponent of voluntary euthanasia, suggests that physicians should witness the patient's death in order to prevent misuse of the lethal medication. He described to an *American Medical News* reporter the details of a case where a Dutch physician prescribed a lethal dose for a patient who subsequently gave the medication to a neighbour who used it to commit suicide. D. Gianelli, 'Dutch euthanasia expert critical of Oregon approach', (September 15, 1997) *American Medical News* 13. The DWDA does not appear to guard against such form of abuse, notwithstanding Section 3 of SB 491 which amends ORS 127.805 to require the attending physician to counsel the patient regarding 'the importance of having another person present when the patient takes the medication'.
 - 31 Recent evidence confirms that persons who are terminally ill do not truly want to commit suicide unless they also suffer from depression or another mental disorder. See Ezekiel Emanuel, 'Depression, Euthanasia, and Improving End-of-Life Care', (2005) 23 *Journal of Clinical Oncology* (No 27) 6456 (psychological distress, including depression and hopelessness, is significantly associated with patients' interest in hastening their own death through euthanasia and/or PAS); William Breitbart et al., 'Depression, Hopelessness, and Desire for Hastened Death in Terminally Ill Patients with Cancer', (2000) 284 *Journal of the American Medical Association* 2907 (depression and hopelessness are the strongest predictors of desire for hastened death among the terminally ill); Ezekiel Emanuel et al., 'Attitudes and Desires Related to Euthanasia and Physician-Assisted Suicide Among Terminally Ill Patients and Their Caregivers', (2000) 284 *Journal of the American Medical Association* 2460 (depressive symptoms appear to be important determinants both of patients' personal interest in euthanasia and the instability of this interest); and Linda Ganzini, 'Commentary: Assessment of Clinical Depression in Patients Who Request Physician-Assisted Death', (2000) *Journal of Pain & Symptom Management* 474 (studies of dying cancer patients reveal that between 59 and 100 per cent of patients wanting hastened death have major depressive disorder). See also Royal College of Psychiatrists, 'Assisted Dying for the Terminally Ill Bill – Statement from the Royal College of Psychiatrists

on Physician Assisted Suicide' (2006); located at <http://www.rcpsych.ac.uk/pressparliament/collegeresponses/physicianassistedsuicide.aspx> (accessed 18 April 2007) (depression is strongly associated with the desire for a hastened death, including the wish for PAS or euthanasia, and requests for assisted suicide should therefore 'trigger effective treatment of depression and its causes – not actual PAS').

32 ORS 127.825 s.3.03.

33 The poor ability of physicians without psychiatric expertise to detect depression is documented by Linda Ganzini and Melinda Lee, 'Psychiatry and Assisted Suicide in the United States', (1997) 336 *New England Journal of Medicine* 1824; and by the Royal College of Psychiatrists, *supra*, n.31. There are also concerns about physician objectivity when performing a mental health evaluation, particularly in this context. See Linda Ganzini et al., 'Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide', (1996) *American Journal of Psychiatry* 1469.

34 ORS 127.800 s.1.01(5).

35 Darien Fenn and Linda Ganzini, 'Attitudes of Oregon Psychologists Toward Physician-Assisted Suicide and the Oregon Death With Dignity Act', (1999) 30 *Professional Psychology: Research and Practice* 235.

36 Only 3 per cent suggested that they would be 'not at all confident'. *Ibid*.

37 Ganzini et al., *supra*, n.33.

38 Fenn and Ganzini, *supra*, n.35, at 247.

39 ORS 127.800 s.1.01(7).

40 Carl Coleman and Alan Fleischman, 'Guidelines for Physician-Assisted Suicide: Can the Challenge Be Met?' (1996) 24 *Journal of Law, Medicine & Ethics* 217, at 221.

41 N.J. Farber et al., 'Cardiopulmonary Resuscitation (CPR): Patient Factors and Decision Making', (1984) 144 *Archives of Internal Medicine* 2229; and R.M. Wachter et al., 'Decisions About Resuscitation: Inequities Among Patients with Different Diseases but Similar Prognoses', (1989) 111 *Annals of Internal Medicine* 525.

42 Alexander Capron, 'Legalizing Physician-Aided Death', (1996) 5 *Cambridge Quarterly of Healthcare Ethics* 10.

43 Franklin Miller et al., 'Can Physician Assisted Suicide be Regulated Effectively?' (1996) 24 *Journal of Law, Medicine & Ethics* 225, at 226.

44 The legislation mandates that at least one witness must not be a relative, a beneficiary of the patient's estate, or an owner or employee of the treating healthcare facility: ORS 127.805 s. 2.02(2). The attending physician is prohibited from acting as a witness: ORS 127.805 s.2.02(3).

45 In a 1994 survey of 1,355 Washington State physicians, 90 per cent suggested that the most important safeguard against abuse is the requirement that a non-beneficiary witnesses the patient's request for PAS. See Jonathan Cohen, 'Attitudes Toward Assisted Suicide and Euthanasia Among Physicians in Washington State', (1994) 331 *New England Journal of Medicine* 89, at 93.

46 Under the Reporting Requirements of the Oregon Death with Dignity Act, 333-009-0010(1)(a) the physician is merely required to submit to the ODHS a copy of the patient's written request and a signed and dated report within seven days of writing the lethal prescription.

47 ORS 127.865 s. 3.11(2).

48 ORS 127.865 s. 3.11(1)(a).

49 The DWDA does not provide any penalties for a physician's failure to comply with the documentation requirements, and merely 'good faith compliance' is required under s.4.01(1). Moreover, the ODHS has no regulatory authority to ensure physicians comply with reporting requirements.

- 50 Although the DWDA was implemented in November 1997, no cases of PAS were reported until 1998. The annual reports can be found on the ODHS website, located at <http://www.oregon.gov/DHS/ph/pas/ar-index.shtml> (accessed 18 April 2007). Shorter summaries have also been published occasionally in the *New England Journal of Medicine*. See Arthur Chin et al., 'Legalized Physician-Assisted Suicide in Oregon – The First-Year's Experience', (1999) 340 *New England Journal of Medicine* 577; Amy Sullivan et al., 'Legalized Physician-Assisted Suicide in Oregon – The Second Year', (2000) 342 *New England Journal of Medicine* 598; Amy Sullivan et al., 'Legalized Physician-Assisted Suicide in Oregon, 1998–2000', (Letter) (2001) 344 *New England Journal of Medicine* 605; K. Hedberg et al., 'Legalized Physician-assisted suicide in Oregon, 2001' (Letter) (2002) 346 *New England Journal of Medicine* 450; and K. Hedberg et al., 'Five years of legal physician-assisted suicide in Oregon', (2003) 348 *New England Journal of Medicine* 961.
- 51 All data discussed in this section comes from the official ODHS annual reports.
- 52 Twenty-four prescriptions were written in 1998; 33 in 1999; 39 in 2000; 44 in 2001; 58 in 2002; 68 in 2003; 60 in 2004; 65 in 2005; and 65 in 2006.
- 53 There were 16 cases reported in 1998; 27 in 1999; 27 in 2000; 21 in 2001; 38 in 2002; 42 in 2003; 37 in 2004; 38 in 2005; and 46 in 2006. By way of comparison, 85,755 Oregonians died between 1998–2006 from the same underlying diseases. According to the United States Census Bureau, the population of the state of Oregon in 2006 was 3,700,758. See <http://quickfacts.census.gov/qfd/states/41000.html> (accessed 7 June 2007).
- 54 The increase has not been steady over the nine years. For example, there was a slight drop in 2001, and conversely a minor spike in 2003.
- 55 By year, the number of patients who cited concerns about loss of autonomy as a reason for choosing death was: 12 in 1998; 21 in 1999; 25 in 2000; 16 in 2001; 32 in 2002; 39 in 2003; 32 in 2004; 30 in 2005; and 44 in 2006.
- 56 Eleven patients expressed this concern in 1998; 22 did so in 1999; 21 in 2000; 13 in 2001; 32 in 2002; 39 in 2003; 34 in 2004; 34 in 2005; and 44 in 2006.
- 57 Fear of loss of dignity was cited as a reason for choosing PAS by 31 patients in 2003; 29 patients in 2004; 34 patients in 2005; and 35 in 2006. It did not appear on the list of reasons for requesting PAS prior to 2003 (accordingly, the dataset for this category is 163 rather than 292).
- 58 Nine patients cited a fear of losing control of bodily functions in 1998; 16 did so in 1999; 21 in 2000; 9 in 2001; 18 in 2002; 24 in 2003; 24 in 2004; 17 in 2005; and 27 in 2006.
- 59 Only 2 patients gave the fear of being a burden as a reason for requesting PAS in 1998. However, 7 patients expressed this concern in 1999; 17 in 2000; 4 in 2001; 14 in 2002; 16 in 2003; 14 in 2004; 16 in 2005; and 20 in 2006.
- 60 The number of patients referred for psychiatric evaluation in the intervening seven years was 10 (37 per cent) in 1999; 5 (19 per cent) in 2000; 3 (14 per cent) in 2001; 5 (13 per cent) in 2002; 2 (5 per cent) in 2003; 2 (5 per cent) in 2004; and 2 (5 per cent) in 2005.
- 61 The shortest range was in 2002 (between 0 and 379 weeks).
- 62 The median duration was highest in 1999 (22 weeks) and lowest in both 2000 and 2005 (8 weeks).
- 63 The evidence that death is not always rapid and straightforward after ingestion of the lethal medication parallels Dutch findings. See Johanna Groenewoud et al., 'Clinical problems with the performance of euthanasia and physician-assisted suicide in the Netherlands', (2000) 342 *New England Journal of Medicine* 551.

- 64 Oregon Department of Human Services (Office of Disease Prevention and Epidemiology), *Eighth Annual Report on Oregon's Death with Dignity Act* (9 March 2006) (Portland, Oregon) located at: <http://www.oregon.gov/DHS/ph/pas/docs/year8.pdf> (accessed 7 June 2007). The 46 PAS deaths in 2006, however, represent the highest total in the nine years since the DWDA came into effect.
- 65 They note that interviews with family members during 1999 corroborated physician reports. Ibid. In the second year, researchers decided to interview family members of 19 patients among the 24 who died between September 15 1998 and October 15 1999 because of criticism directed at the ODHHS after the publication of the First Annual Report. When asked the reasons behind the patients' PAS requests, loss of control of bodily functions and loss of autonomy were most often cited (68 and 63 per cent respectively), although 47 per cent of family members cited patients' concerns about being a burden on others. See Sullivan et al., *supra*, n.50, at 601. According to family members, one patient expressed concern about the financial impact of the illness. Ibid.
- 66 ODHHS Eighth Annual Report, *supra*, n.64, at 15.
- 67 Ibid.
- 68 Howard Wineberg, 'Oregon's Death With Dignity Act: Fourteen Months and Counting', (2000) 160 *Archives of Internal Medicine* 21, at 22.
- 69 Associated Press, 'In first year, 15 people use Oregon's assisted suicide law', (February 18, 1999) *Florida Today*, at 3A (quoting Barbara Coombs Lee, chief sponsor of Measure 16). An Editorial in the *New York Times* also expressed 'relief' that the First Annual Report found 'no run on death, no confusion and no abuse'. Editorial, 'Oregon's First Year', (February 27, 1999) *New York Times*.
- 70 *Supra*, n.6. The full Amicus Brief #9/14 [hereinafter, 'Bioethicists' Brief'] is found at <http://www.compassionandchoices.org/documents/bioethicists.pdf> (accessed 18 April 2007).
- 71 Bioethicists' Brief, *ibid.*, at 16.
- 72 Ibid., at 17.
- 73 Oregon Department of Human Resources (Center for Disease Prevention and Epidemiology), *Oregon's Death with Dignity Act: The First Year's Experience* (18 February 1999) (Portland, Oregon), at 583, located at: <http://www.oregon.gov/DHS/ph/pas/docs/year1.pdf> (accessed 7 June 2007). The authors of the Second Annual Report similarly admitted the difficulty in assessing underreporting and non-compliance 'because of possible repercussions for non-compliant physicians'. See Oregon Department of Human Resources (Center for Disease Prevention and Epidemiology), *Oregon's Death with Dignity Act: The Second Year's Experience* (23 February 2000) (Portland, Oregon), at 12, located at <http://www.oregon.gov/DHS/ph/pas/docs/year2.pdf> (accessed 7 June 2007). Research on euthanasia in the Netherlands confirms widespread underreporting on the part of Dutch doctors. See John Keown, *Euthanasia, Ethics and Public Policy* (Cambridge: Cambridge University Press, 2002), chs. 8–13; and Gorsuch, *supra*, n.3, ch.7.
- 74 A number of family members were interviewed in the second year only. As Kathleen Foley and Herbert Hendin note in 'The Oregon Report: Don't Ask, Don't Tell', (1999) 29 *Hastings Center Report* 37 at 41, it would have been useful to compare interviews with physicians of the patients who obtained lethal prescriptions but did not commit assisted suicide, in order to gain 'further insights into the complicated aspects of patient requests'. See also, Wineberg, *supra*, n.68, at 23 (research is needed 'to find out why some people who receive the medication do not use it').

- 75 The authors did not conduct such interviews because of apparent restrictions in the DWDA and because they were concerned about patient confidentiality. Katrina Hedberg et al., 'The Oregon Report: Neutrality at OHD?' (Letter) (2000) 30 *Hastings Center Report* 4, at 5.
- 76 ODHS, 'A Year of Dignified Death', (March 16, 1999) 48 *CD Summary Issue* 1, located at <http://egov.oregon.gov/DHS/ph/cdsummary/1999/ohd4806.pdf> (accessed 18 April 2007).
- 77 ODHS Second Annual Report, *supra*, n. 73, at 603.
- 78 There was reportedly an earlier case of PAS that had been arranged by the Hemlock Society of Oregon after the passage of the DWDA, although the date and details of the death are not known. See E. Hoover and Gail Hill, 'Two Die Using Suicide Law', (March 26, 1998) *The Oregonian*, at A1.
- 79 Herbert Hendin et al., 'Physician-Assisted Suicide: Reflections on Oregon's First Case' (1998) 14(3) *Issues in Law and Medicine* 243.
- 80 Consultation with suicide advocacy groups is not uncommon. Indeed, according to Dr. Katrina Hedberg, one of the authors of the First-year Report, suicide advocacy groups had counselled patients or otherwise played a role in '10 or 11' of the 15 PAS cases reported in the first year. 'Key Points: Oregon's First Year...', (1999) 9 *Life at Risk* 3. This information was not included in the official reports. In this particular case, the medical director of Compassion in Dying considered – merely on the basis of several telephone conversations with her – the patient to be 'rational, determined and steadfast' and questioned the earlier depression diagnosis. He described her as 'frustrated' and 'stressed' because 'she was feeling powerless'. The patient was not confined to bed, nor was she in severe pain. Hendin et al., *ibid.*, at 245.
- 81 Indeed, according to the ODHS First Annual Report, *supra*, n.73 at 583, six of the 15 patients who died requested a lethal prescription from more than one doctor, and at least one patient had known the physician who provided assistance for only 15 days.
- 82 As noted above, the official reports suggest that 94 per cent of the PAS cases reported in Oregon occurred without complication. See also, Linda Ganzini et al., 'Physicians' experiences with the Oregon Death with Dignity Act', (2000) 342 *New England Journal of Medicine* 557 (no complications or problems documented).
- 83 See Groenewoud et al., *supra*, n.63, at 554–555. The complications reported included vomiting, difficulties swallowing the medication, and patients' becoming unconscious before ingesting the entire lethal dose. See also, Sherwin Nuland, 'Physician-Assisted Suicide and Euthanasia in Practice', (2000) 342 *New England Journal of Medicine* 583. Nuland questions the Oregon statistics and notes at 584 that the Dutch study will surprise those 'who have never considered that the procedures involved in PAS and euthanasia might sometimes add to the suffering they are meant to alleviate and might also preclude the tranquil death being sought'. See also, Ezekiel Emanuel, 'The Future of Euthanasia and Physician-Assisted Suicide: Beyond Rights Talk to Informed Public Policy', (1998) 82 *Minnesota Law Review* 983, at 1002, whose survey of oncologists who have admitted performing voluntary euthanasia and PAS indicates that as many as 20 per cent of physician-assisted suicides fail. The Oregon statistics therefore lie in stark contrast to this research documenting complications in PAS and euthanasia practice, raising the possibility that in Oregon not all failed or complicated PAS cases are being reported.
- 84 'Editorial,' *The Oregonian*, March 11, 1999.
- 85 The case also raises questions about the degree of assistance which a person – in this case, the patient's brother-in-law – can provide to a dying patient,

and illustrates some of the ambiguities of the DWDA. For example, the legislation (which as mentioned earlier does not require any information on what transpires after the lethal prescription is written) is vague about how patients should take the lethal dose of drugs, and also does not say whether a person who is at the patient's bedside can help, such as by raising a cup to the patient's lips.

- 86 See David Reinhard, 'The pills don't kill', (March 23, 2000) *Oregon Live*, located at <http://www.oregonlive.com/opinion/index.ssf> (accessed 1 April 2001).
- 87 Overall, according to the official reports, in only 29 per cent (63 out of 292) of the reported assisted suicides was the prescribing physician present when the lethal medication was taken.
- 88 ODHS Second Annual Report, *supra*, n.73, at 24, Table 4.
- 89 Oregon Department of Human Services (Office of Disease Prevention and Epidemiology) Year 9 – 2006 Summary, Table 1, located at: <http://egov.oregon.gov/DHS/ph/pas/docs/yr9-tbl-1.pdf> (accessed 7 June 2007).
- 90 See *supra*, n.31.
- 91 The ODHS requires only that psychiatrists submit a form confirming that the patient's judgment is not impaired. It is therefore impossible to assess the nature and quality of these evaluations. Moreover, a psychiatrist is not required to complete a form if he or she concludes that the patient's judgment is impaired. Thus the number of patients who undergo psychiatric evaluation and are deemed too impaired to choose PAS is unknown.
- 92 The psychologist apparently mailed a form to the patient, who reportedly completed it with the assistance of her children. (June 26, 2000) *The Medford Mail Tribune*.
- 93 Wesley Smith, 'Caring – Not Killing – Is the Answer to Serious Illness', (March 16, 2000) *San Francisco Chronicle* (Editorial); and Erin H. Barnett, 'Is Mom capable of choosing to die?' (October 16, 1999) *The Oregonian* at 1.
- 94 Smith, *ibid*.
- 95 For an analysis of Michael Freeland's case see N. Gregory Hamilton and Catherine Hamilton, 'Competing Paradigms of Response to Assisted Suicide Requests in Oregon' (2005) 162 *American Journal of Psychiatry* 1060.
- 96 *Ibid*, at 1063.
- 97 N. Gregory Hamilton and Catherine Hamilton, 'Competing Paradigms of Responding to Assisted-Suicide Requests in Oregon: Case Report', presented at the American Psychiatric Association Annual Meeting Symposium on Ethics and End-of-Life Care: New Insights and Challenges, New York, 6 May 2004 (located at <http://www.pccef.org/articles/art28.htm>) (accessed 18 April 2007).
- 98 *Ibid*.
- 99 In 1999, one patient received a lethal prescription more than 8 months before using it to commit suicide. See ODHS Second Annual Report, *supra*, n.73, at 599. Similarly, one patient, having received a lethal prescription in 1999, was still alive on December 31, 2000. See Oregon Department of Human Services (Center for Disease Prevention and Epidemiology), *Oregon's Death with Dignity Act: Three Years of Legalized Physician-Assisted Suicide* (22 February 2001) (Portland, Oregon) at 3, located at: <http://www.oregon.gov/DHS/ph/pas/docs/year3.pdf> (accessed 7 June 2007). A third patient died in 2003 having obtained a lethal prescription in 2001. See Oregon Department of Human Services (Office of Disease Prevention and Epidemiology) *Sixth Annual Report on Oregon's Death with Dignity Act* (10 March 2004) (Portland, Oregon), at 4, located at: <http://www.oregon.gov/DHS/ph/pas/docs/year6.pdf> (accessed 7 June 2007).

- 100 See for example, Margaret Battin, 'Voluntary Euthanasia and the Risks of Abuse', in *The Least Worst Death* (Margaret Battin ed.), (New York: Oxford University Press, 1994), pp. 163–181.
- 101 Over the nine years, the most commonly expressed reasons for requesting assisted suicide were 'fear of losing autonomy' (cited by 251 patients or 87 per cent), 'fear of decreasing ability to do enjoyable activities' (250 patients or 87 per cent), and 'fear of losing control of bodily functions' (165 patients or 57 per cent).
- 102 ODHS Third Annual Report, *supra*, n.99, at 18, Table 3.
- 103 Financial concerns were cited by one patient in 2000, 2001, 2002, 2003, and 2005 and by 2 patients in 2004.
- 104 Erin H. Barnett, (April 26, 1999) 'Suicide coverage passes review', *The Oregonian*.
- 105 Foley and Hendin, *supra*, n.74, at 39. Further information is required to make a proper assessment.
- 106 This figure comprises 8 patients in the first year, 19 in the second and 16 in the third.
- 107 Transcript of tape of Peter Goodwin, 'Oregon', January 11, 2003, presented at 13th National Hemlock Biennial Conference, 'Charting a New Course, Building on a Solid Foundation, Imagining a Brighter Future for America's Terminally Ill', January 9–12, 2003, San Diego, California (cited at <http://www.internationaltaskforce.org/orrpt7.htm>, at 5) (accessed 18 April 2007).
- 108 'Compassion in Dying of Oregon Summary of Hastened Deaths' (Data attached to Compassion in Dying of Oregon's IRS Form 990 for 2003).
- 109 See Update, 'Oregon's First Year...', (1999) 9 *Life at Risk* 1, at 1.
- 110 Reprinted in (1999) 9 *Life at Risk* 4. The letter was written after details of Matheny's assisted death were published in March 1999. See also, Erin H. Barnett, 'Laws separate euthanasia and assisted suicide', (April 14, 1999) *The Oregonian* at 1.
- 111 Notwithstanding the deficiencies in the Oregon system, there are those in the UK who remain optimistic about the viability of a legislative framework for PAS in this country based largely upon the DWDA. The data from Oregon offers helpful guidance, and should raise doubts about the feasibility of effective PAS regulation in *any* jurisdiction. However, it does not necessarily follow that if the Oregon model were exported to the UK our experience would mirror Oregon's. It has been suggested that Oregon is unique, a 'very curious, isolated bubble' and that PAS in the UK would likely be much closer to the Dutch experience. See John Keown, *Considering Physician-Assisted Suicide* (London: Carenotkilling Alliance, 2006), at 17, located at http://www.carenotkilling.org.uk/pdf/Keown_report.pdf (accessed 7 June 2007).